Jigawa State, Nigeria

Ministry of Health

Monitoring and Evaluation
Plan/Framework for the
Adolescents and Young People's Health and
Development Policy Implementation Plan
2022 – 2027

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INTRODUCTION

The World Health Organization (WHO) defines 'Adolescents' as individuals who are going through the phase of life between childhood and adulthood, from ages 10-19 years and 'Youth' as persons between the ages of 15-24 years. Adolescents and Youth comprise of what is referred to as 'Young People' group, which covers the age range 10-24 years[1].

There are over 1.8 billion young people in the world today representing about 16% of the World population. 90 per cent of these young people live in developing countries, where they tend to make up a large proportion of the population. India, China, and Indonesia occupy the top 3 positions of countries with highest Youth Population in the World. In Nigeria, the 'Young People' make up about 31% of the country's population.

The proportion of the world's young people between the ages of 12-24 years living in Africa is expected to rise from 18 per cent in 2012 to 28 per cent by 2040, while paradoxically declining in other regions of the world largely due to decreasing fertility. On the overall, the proportion of young people is a set to decline from 17.6 per cent in 2010 to 13.5 per cent in 2050.

Even though Young people are generally considered the healthiest, the international differences of mortality amongst youth are striking. In developed regions, only 1 percent or less of 15-year olds die before their 25th birthday. The situation is twice as high in South Asia and four times higher in sub-Saharan Africa[2].

Despite regional variations in mortality amongst the youth, causes of adolescent deaths worldwide seem to be the same. They include communicable diseases (HIV/AIDS, tuberculosis, and lower respiratory-tract infection) and non-communicable diseases related to behaviours (motor vehicle fatalities, violence, self-harm, alcohol, tobacco, and other drugs, and risky sex leading to early or unintended pregnancy)[3].

The adolescence phase is a unique stage of human development and an important time for laying the foundations of good health[4]. People at this stage of development (Adolescents) experience rapid physical, cognitive and psychosocial growth which affects how they feel, think, make decisions, and interact with the world around them.

For these reasons, the international development community has identified the health, social development and well-being of adolescents as a priority. There is also an increasing awareness and efforts in recent times by organizations to engage and enable young people to participate in decision making and policy dialogues in global health. This is particularly important as achieving global development agendas like the Sustainable Development Goals (SDGs) will not be possible without the meaningful engagement of young people.

[1] https://www.who.int/southeastasia/health-topics/adolescent-health#:~:text=WHO%20defines%20'Adolescents'%20as%20individuals,age%20range%2010%2D24%20years. Retrieved 2nd October, 2022

[2] Report of the Expert Group Meeting on Adolescents, Youth and Development UN-DESA (ESA/P/WP/225)

[3] Patton et al. "Global patterns of mortality in young people" The Lancet 2009; 374: 881-892

[4] https://www.who.int/health-topics/adolescent-health#tab=tab_1 - Retrieved 2nd October, 2022

Many interventions and programmes were also introduced to advance the development of Adolescent and Young People's health. Notable among the programmes include Global Strategy for Women's, Children's and Adolescent's Health, the Global Accelerated Action for the Health of Adolescents, and the Lancet Commission on Adolescent Health and Well-Being.

To track progress towards improving adolescent health, measurement of health behaviours and determinants, outcomes, and policy and programme implementation is essential. In recognition of this need, organizations collecting data across a wide range of domains to monitor adolescent health in countries have increased over time.

Comparability, sharing and use of adolescent health data across countries and populations is limited due largely to non-standardization and inconsistency in the use of adolescent health indicators and data collection efforts.

"To address these issues and improve alignment and capacity for adolescent health measurement, WHO, in collaboration with the UN H6+ partnership agencies (UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, the World Bank Group, and the World Food Programme (WFP), has established the Global Action for Measurement of Adolescent health (GAMA) Advisory Group. This Group of experts advises WHO and UNH6+ partners in their process of harmonizing and prioritizing adolescent health indicators, to converge data collection and reporting efforts".[5]

The goals of Global Action for Measurement of Adolescent Health (GAMA) are "To provide technical guidance to WHO, UN H6+ agencies and other relevant measurement groups to define a core set of adolescent health indicators, for the purpose of harmonizing efforts around adolescent health measurement and reporting" and "To promote harmonized guidance for adolescent health measurement, supporting countries and technical organizations in collecting useful data to track progress in the improvement of adolescent health".

The objectives of GAMA are

- To increase alignment and harmonization of adolescent health measurement among WHO, UN partners and other key measurement stakeholders, considering country needs
- To develop GAMA guidance for the measurement of priority indicators and materials for technical support to strengthen adolescent health measurement in countries
- To disseminate GAMA measurement guidance and related materials and information for effective use by stakeholders and countries

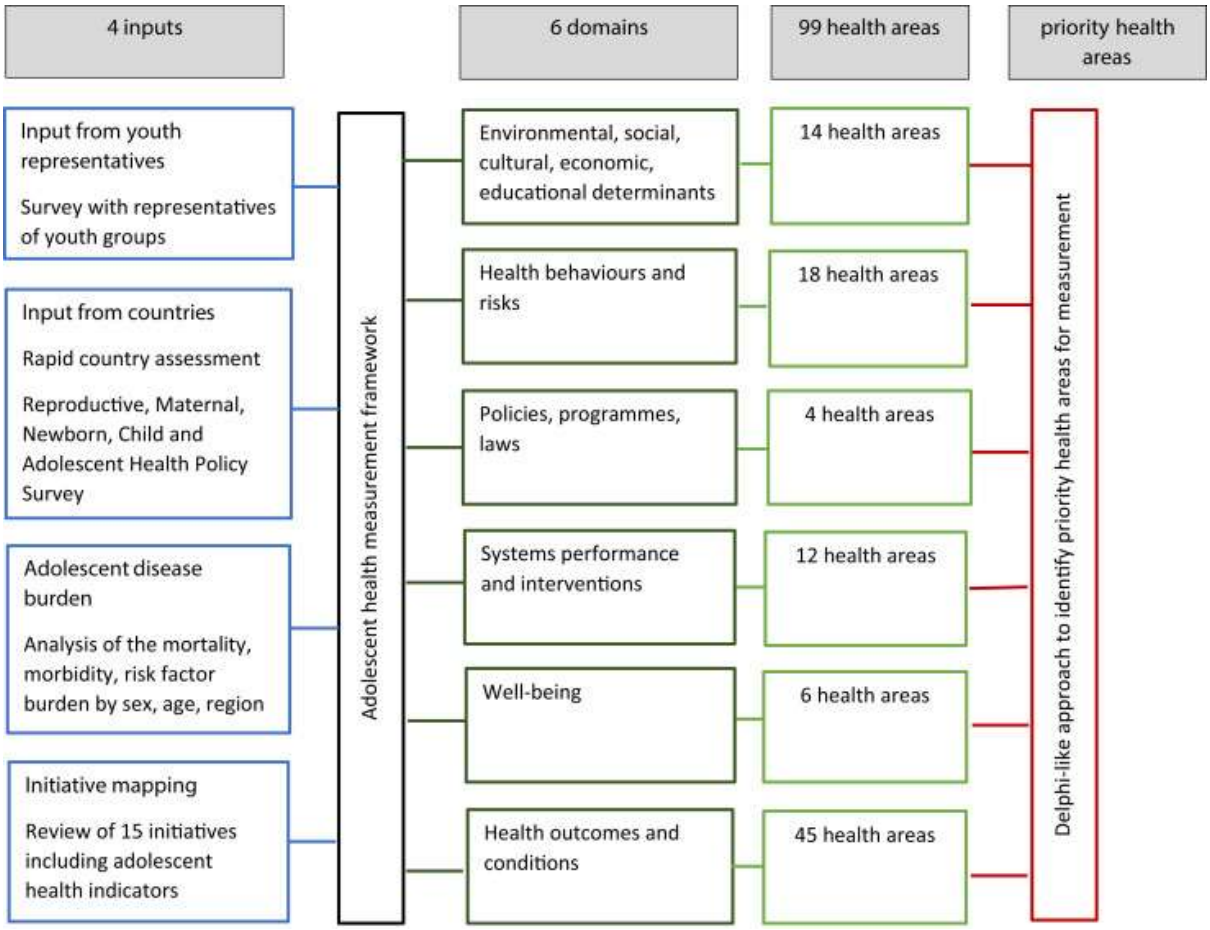
GAMA established priority areas for measurement of adolescent health and also identified current gaps, aiming to focus resources on the most relevant data to improve adolescent health. Four critical inputs were collected to set the priority areas which are perspectives of youth representatives, country priorities, disease burden, and existing measurement efforts.

Ninety-nine measurement areas relevant to adolescent health across the four inputs were identified and grouped under six domains: policies, programs, laws; systems performance and interventions; health determinants; health behaviours and risks; subjective well-being; and health outcomes and conditions.

[5] https://www.who.int/groups/the-global-action-for-measurement-of-adolescent-health - Retrieved on 4th October, 2022

Experts selected 33 core, 19 expanded, and 6 context-specific adolescent health measurement areas based on the four inputs and six domains as shown in figure 1 (approach to priority setting) below.

Figure 1. Approach to priority setting.[6]



Like in many countries of the world, programmes aimed at advancing the health of the Adolescents and Young People (AYP) are being planned and implemented in Nigeria. The country developed its first National Adolescent Health and Development Policy in 1995 and was reviewed twice in 2007 and 2019 (2021 – 2025). An assessment of the National response to young people's sexual and reproductive health was conducted in 2008 which revealed lack of M&E system and tools to manage adolescent health data and reporting.

In 2013, draft M&E tools were developed and were only finalized and improved upon along with the present National policy (2021 – 2025) taking into consideration emerging Adolescent Health and Development (AHD) issues.

National Guidelines for Adolescent and Youth-Friendly Health Services (AYFHS) integration into PHCs in Nigeria and the National Standards and Minimum package for Adolescent and Youth Friendly Services developed in 2013 and 2018 respectively are also indicative of Nigerian Federal government's increased interest in Adolescents and Young People (AYP).

[6] https://www.sciencedirect.com/science/article/pii/S1054139X20308466 - Retrieved on 5th October, 2022

National Indicators for monitoring AHD performance in Nigeria based on the defined programmatic areas were developed and proposed to the National Technical Working Group on Adolescent Health and Development (NTWGAHD) by the Gender, Adolescent / School Health and Care of the Elderly (GASHE) division of the department of Family Health of the Federal Ministry of Health. This informed the development of the first M&E Plan for monitoring and Evaluation of AHD in Nigeria in 2019.

Jigawa state has domesticated the National Policy on Health and Development of Adolescent and Young People in Nigeria (2021 – 2025) and named ' Policy on the Health and Development of Adolescents and Young People in Jigawa State: 2022-2027'.

This document developed along with the Costed Implementation Plan are aimed at measuring investment and driving accountability in Adolescent Health and Development in Jigawa state.

1.1 Purpose of the Monitoring & Evaluation (M&E) Plan

Monitoring and Evaluation (M&E) is an integrated part of the Adolescent and Young People Health and Development (AYPHD) programme design. The Public Health team in Jigawa state will conduct routine programme monitoring and data verification based on the regular collection, analysis, and dissemination of information to assess and manage progress in programme implementation. This routine monitoring will be supplemented with periodic evaluation of the programme and its interventions through operations research (OR), International and National surveys and other special studies. The evidence generated will support accountability and facilitate effective programme management and learning.

This M&E plan is designed to be used by the Public Health team of the state Ministry of Health, most especially the Adolescent and Reproductive Health staff in Jigawa state to guide the consistent collection, collation and analysis of data and also for reporting, providing feedback and utilisation of the data and evidence generated by the AYPHD programme. It is a living document that will be reviewed and updated on a regular basis.

The Department of Public Health of the state Ministry of Health will provide leadership and effective coordination in the implementation of the M&E plan while actual implementation activities of the plan will be anchored and managed by the Adolescent and Reproductive Health units of the Department of Primary Health Care (PHC) at the Jigawa State Primary Health Care Development Agency (JSPHCDA). Specifically, this plan is governed by the Jigawa state Ministry of Health (Department of Public Health) through the JSPHCDA Adolescent and Reproductive Health units of the PHC department to ensure that the AYPHD data and evidence collected is used for decision-making by relevant stakeholders for continuous programme and intervention improvement.

1.2 Structure of M&E Plan

The plan contains the following core sections outlining the fundamental activities, tools and users involved in M&E:

- ***Section 1*** provides a brief introduction to the programme, and the purpose and structure of this M&E plan.

- ***Section 2*** outlines the programme's M&E framework, which is governed by the Conceptual Framework/Theory of Change and the logical framework.
- ***Section 3*** describes how programme performance will be monitored and evaluated, focusing on tracking outcomes and outputs (monitoring), the role of operations research and other special studies (evaluation).
- ***Section 4*** outlines how AYPH's M&E system will be coordinated and implemented. This will guide the user to identify their specific roles and responsibilities and flow of M&E information as per the various programme levels and functions.
- ***Section 5*** describes the processes for engaging various stakeholders, both internal and external, in utilising information generated from the M&E system to inform performance management and decision making.

1.3. Priority programmatic areas and targets

The state adapted the 11 priority programmatic areas suggested by the Federal Ministry of Health with some modifications, targets and timeframe. Below are priority areas and their targets.

- **Mental Health, Substance Use, and Addictions**

Targets:

- By 2027 at least two-thirds of adolescents and young people, parents, and teachers have good knowledge of adolescent mental health issues
- By 2027 reduce the incidence of substance abusers among adolescents and young People by 50% compared to 2018
- By 2027 provide screening for potential mental health conditions in at least 50% of school attending adolescents and young people (10-14 years; 15-19 years; and 20-24 years) and adequate support for those diagnosed with mental health conditions through the screening process
- At least two-thirds of adolescents and young people with mental disorders have access to skilled mental health services from the formal health system by 2027
- At least 50% of adolescents and young people with substance use disorders, harmful use of digital technology-and addictions receives appropriate treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare services) by 2027
- By 2027 ensure that at least 75% of health and social care facilities managing people with mental health disorders are assessed using the WHO Quality Rights tool kit and develop as well as implement quality improvement plans based on the results of the assessment.

- **Violence and Injury: unintentional injuries**

Targets:

- At least 90% of drivers age 18-24 years are knowledgeable of the highway code and duly licensed and approved by the relevant government agencies engaging in driving by 2027
- By 2027 at least 90% of motor parks are free of the sales of alcohol and illicit substances
- By 2027 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
- By 2027 reduce the mortality rate due to road traffic injuries among adolescents and youths by one-third compared to 2018
- By 2027 reduce the incidence of physical violence among male and female adolescents and youths by two-thirds of the rate for 2018.

- By 2027 reduce the incidence of violence and conflict-related deaths among male and female adolescents and youths by two-thirds compared to 2018.

- **Sexual and Reproductive Health and Rights**

Targets:

Pubertal development and health literacy

- At least 75% of students in upper primary and secondary school students (private and the public sector) are provided with school-based family life and HIV/AIDS education by 2027
- Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2027
- At least 80% of early adolescent girls (10-14 years) and 60% of early adolescent boys (age 10-14 years) have adequate knowledge regarding menstruation and menstrual hygiene management by 2027
- At least 75% of female adolescents have all they need to adequately manage their menstruation by 2027
- At least 70% 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 by 2027.

Sexual activity, contraception, and sexually transmitted infection

- By 2027 increase the proportion of married adolescents (15-19 years) who need contraception by 20%.
- By 2027 at least 90% of adolescents and young people (15-24 years) with symptoms suggestive of STIs seek treatment from formal health services

Early marriage, childbearing, and maternal mortality

- Reduce adolescent childbearing rate from 19% in 2018 to 12% by2027
- At least 75% of adolescents who experience abortion complications receive appropriate post-abortion care by 2027
- By 2027 reduce the maternal mortality ratio among adolescent girls by at least 40% compared to 2018.

Maternal care for pregnant adolescents

- At least 80 percent of pregnant young people (age 10-24 years) attend at least 8 ANC visits throughout the course of every pregnancy by 2027.
- At least 75% of pregnant adolescents and young people have skilled attendants at birth by 2027.
- At least 80 percent of adolescents and young mothers receive postnatal care services within 48hours of delivery by 2027.
- By 2027, 90% of pregnant adolescents and young women are tested for HIV, 90% of HIV – exposed infants are placed on cotrimoxazole prophylaxis at 2 months and 90% of HIV exposed infants receive PCR test for their HIV status within 2 months of birth.

Sexual violence and harmful practices

- Eliminate female genital mutilation by 2027
- By 2027 reduce the proportion of male and female adolescent (age 15-19 years) and youths (age 20-24 years) who experience sexual violence or any other form of gender-based violence by at least 60% compared to 2018

- **Nutrition and Physical Activity**

Targets:

- By 2027 reduce the prevalence of acute undernutrition among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018
- Reduce the proportion of non-pregnant adolescent girls (age 15-19 years) with anaemia from 61% in 2018 to 30% in 2027
- By 2027 reduce the prevalence of over nutrition (overweight and obesity) among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018
- By 2027 achieve a 5% relative reduction in the prevalence of insufficient physical activity among adolescents compared to 2018

- **Non-Communicable Diseases**

Targets:

- By 2027 at least 80% of young people have knowledge about behavioural risk factors for non-communicable diseases
- By 2027 reduce the percentage of adolescents (age 10-14 years, and age 15-19 years) who had used intoxicants before age 15 and before age 18 by half compared to 2018.
- By 2027 reduce the percentage of adolescents and young people (age 10-14 years, 15-19 years, and 20-24) who use tobacco by half compared to 2018.
- By 2027 at least 90% of schools have no advertising and/or sales of cigarettes or any tobacco within 300 metres of its premises
- By 2027 reduce the percentage of physically inactive adolescents and young people (age 10-14 years, 15-19 years, and 20-24) of both sexes by half compared to 2018.
- By 2027 Increase the proportion of early adolescents (age 10-14 years) who are immunized against HPV from 0% to 10%
- By 2027 eliminate stigma against epilepsy among young people, and increase treatment coverage for young people with epilepsy by 50% compared to 2018
- By 2027 at least 50% of adolescents and young people (age 15-24 years) are knowledgeable about sickle cell disorder and how to prevent it by 2027, at least 50% of adolescents and young people with sickle cell disorder have received counselling about their condition and are on appropriate management

- **Disabilities**

Targets:

- By 2027 at least 75% of adolescents and young people with disability have access to relevant health services
- By 2027 at least 50% of adolescents and young people have appropriate assistive technologies to enhance their mobility and self-care
- By 2027 ensure that the state rehabilitation board has given 40% Persons with Disabilities acquired skills/training for livelihood

- **Communicable Diseases**

Targets:

- End the incidence of HIV among adolescents and young people by 2030

- By 2027 reduce the incidence of tuberculosis among adolescents and young people by two thirds compared to 2018
- Increase the percentage of adolescents (15-19 years) who sleep inside an insecticide-treated net or in a room sprayed with internal residual spray within a 12-month period from 77.6% in 2021 to 97% in 2027.
- By 2027, reduce malaria incidence by 40% compared to 2015 and malaria mortality rates by 60% compared to 2015 among adolescents and young people (15-24 years)
- By 2027 ensure at least 30% hepatitis B vaccination rate among adolescents and young people

- **Oral Health**

Targets:

- By 2027, at least 70% of adolescents and young people have good knowledge of oral health and its importance to health and wellbeing
- By 2027, at least 50% of PHC facilities provide the basic package of oral health care
- By 2027, at least 50% of adolescents and young people have access to oral health care

- **Health system and services**

Targets:

- Ensure that all adolescents age 14 years and above have the rights to receive ambulatory and non-surgical reproductive health services appropriate for their age and health situation – including contraceptive information, counselling and services, prevention and treatment of sexually transmitted infections, management of sexual abuse and post-abortion care with the consent of their parents, guardians or husbands.
- At least 50% of all public sector primary health care facilities have at least one service provider trained in the provision of adolescent and youth friendly health services by 2027
- At least 50% of adolescent and young people have access to public sector PHC facilities that offer the full complement of the nationally-specified minimum package of adolescent- and youth friendly health services by 2027
- By 2027, all LGAs RH coordinators to manage Adolescent Health in their respective domains
- By 2027 to have a functional State Adolescent Health and Development Technical Working Group
- An annual progress report on the policy implementation is produced and publicly available electronically every year between 2022 and 2027

- **School health system and services**

Targets:

- By 2027, at least two-thirds of all public and private sector primary and secondary schools have a school health service or are linked to such a service
- By 2027, at least two-thirds of all public and private sector primary and secondary schools have adequate water and sanitation facilities for males and females, including separate female friendly toilets with appropriate provisions for menstrual hygiene management, safe drinking water facilities; clean and separate female and male students and are disability-inclusive
- By 2027, ensure that at least 90% of all private and public schools incorporate and implement physical activities as part of their school curriculum and have adequate facilities for physical activities for the school population

- By 2027, at least half of all public and private sector primary and secondary schools attain the status of health-promoting schools

- **Family and community systems**

Targets:

Parental care and family environment

- By 2027, at least 50% of adolescents report that their parents or guardians understand their problems or worries most of the time
- By 2027, at least 50% of adolescents report that their parents or guardians really know what they are doing in their free time

Community system

- By 2027, at least half of community and religious leaders are supportive of adolescent health services and programmes
- By 2027, at least 75% of Community Health Influencers, Promoters and Services (CHIPS) personnel and the 'jakadan lafiya' are knowledgeable and supportive of the provision of adolescent health services and programmes in their communities
- Ensure that not more than 50% of adolescents and young people (females and males) report a serious problem in accessing health care for themselves when they have a need for such.

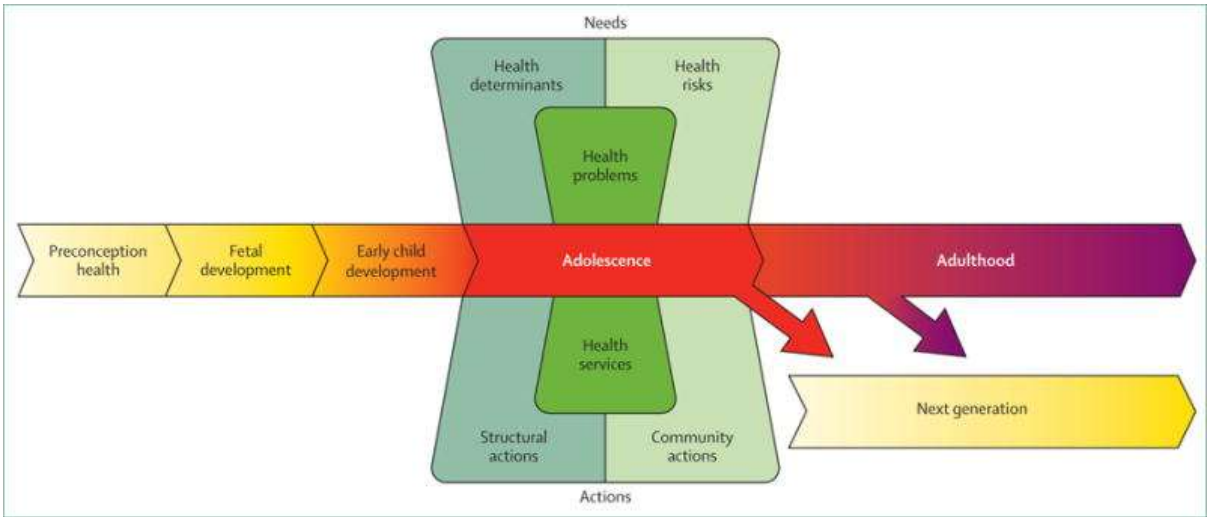
M&E FRAMEWORK

Conceptual Framework

The period of transition between childhood and adulthood is the Adolescence phase. The adolescence phase is a unique stage of human development and an important time for laying the foundations for good health and that of the next generation.

The adolescents experience significant and rapid physical and mental changes which affect their reasoning, feeling, thinking, decision making and their social interaction. Considering their peculiar health and social needs, deliberate efforts would have to be made to prioritize them. Therefore, it is critical to invest and monitor the investment and progress during this phase.

Figure 2. Conceptual framework for defining health needs and actions in adolescents and young adults[7]



[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5832967/figure/F6/

Table 1. Logframe for Health and Development of Adolescents and Young people in Jigawa state: 2022-2027

Impact Indicators		Baseline (2022)	Milestone 1 (YR1 - Jan 2022-Dec 2022)	Milestone 2 (YR2 - Jan 2023-Dec 2023)	Milestone 3 (YR3 - Jan 2024-Dec 2024)	Milestone 4 (YR4 - Jan 2025-Dec 2025)	Milestone 5 (YR5 - Jan 2026-Dec 2026)	Target (Dec2027)
Marriage before 18 years	**Planned**	43.4% (Females) 3.2% (Males)	38.4% (Females) 3.0% (Males)	33.4% (Females) 2.5% (Males)	28.4% (Females) 2.0% (Males)	23.4% (Females) 1.8% (Males)	18.4% (Females) 1.3% (Males)	12% (Females) 1% (Males)
	Achieved							
	Source	NDHS, 2018 and 2023						
Adolescent mortality rate	**Planned**							*
	Achieved							
	Source							
Adolescent maternal mortality ratio	**Planned**							Reduce by 40%*
	Achieved							
	Source	NDHS, 2018 and 2023						
DALYs due to communicable, maternal, and nutritional diseases in individuals aged 10–24 years	**Planned**	*						
	Achieved							
	Source	*						
DALYs due to injury and violence in individuals aged 10–24 years	**Planned**	*						No current country remains in the injury excess category by 2030*
	Achieved							
	Source	*						
DALYs due to non-communicable diseases in	**Planned**	*						Under 1500 DALYS from non-communicable diseases per 100000 10-24year olds per year*

individuals aged 10–24 years	**Achieved**							
	Source	*						
Outcome Indicators		**Baseline (2022)**	**Milestone 1 (YR1 - Jan 2022-Dec 2022)**	**Milestone 2 (YR2 - Jan 2023-Dec 2023)**	**Milestone 3 (YR3 - Jan 2024-Dec 2024)**	**Milestone 4 (YR4 - Jan 2025-Dec 2025)**	**Milestone 5 (YR5 - Jan 2026-Dec 2026)**	**Target (Dec2027)**
Completion of 12 or more years of Education in 20-24years	**Planned**	34.2% (Females) 41.5% (Males)	42% (Females) 47% (Males)	50% (Females) 52% (Males)	57% (Females) 58% (Males)	64% (Females) 64% (Males)	72% (Females) 72% (Males)	80% completion rate*
	Achieved							
	Source	NDHS, 2018 and 2023						
Adolescent fertility rate	**Planned**	10-14 = 2 births/1,000 15-19 = 106 births/1,000 20-24 = 239 births/1,000 women	10-14 = 2 births/1,000 15-19 = 98 births/1,000 20-24 = 220 births/1,000 women	10-14 = 2 births/1,000 15-19 = 88 births/1,000 20-24 = 200 births/1,000 women	10-14 = 1 birth/1,000 15-19 = 79 births/1,000 20-24 = 180 births/1,000 women	10-14 = 1 birth/1,000 15-19 = 70 births/1,000 20-24 = 160 births/1,000 women	10-14 = 1 birth/1,000 15-19 = 60 births/1,000 20-24 = 140 births/1,000 women	10-14 = 0 birth/1,000 15-19 = 53 births/1,000 20-24 = 120 births/1,000 women
	Achieved							
	Source	NDHS, 2018 and 2023						
Proportion of adolescents aged 10 – 24 years with unmet need for contraceptives	**Planned**	15 - 19 = 5.7% 20 -24 = 14.3%	15 - 19 = 5.5% 20 -24 = 13.3%	15 - 19 = 5.1% 20 -24 = 12.3%	15 - 19 = 4.7% 20 -24 = 11.3%	15 - 19 = 4.3% 20 -24 = 10.3%	15 - 19 = 3.9% 20 -24 = 9.3%	15 - 19 = 3.2% 20 -24 = 7.3%
	Achieved							
	Source	NDHS, 2018 and 2023						

Parent-child communication and rela tionship	**Planned**	*						1. By 2027, at least 75% of adolescents report that their parents or guardians understand their problems or worries most of the time. 2. By 2027, at least 75% of adolescents report that their parents or guardians really know what they are doing in their free time
	Achieved							
	Source	*						
Prevalence of current use of tobacco products among adolescents (10–19 years) (%), and by age, sex and type of tobacco used	**Planned**	0.1% (Females) 0.8% (Males) (Any type of tobacco)	0.1% (Females) 0.8% (Males) (Any type of tobacco)	0.05% (Females) 0.4% (Males) (Any type of tobacco)	0.05% (Females) 0.4% (Males) (Any type of tobacco)	0.05% (Females) 0.4% (Males) (Any type of tobacco)	0.05% (Females) 0.4% (Males) (Any type of tobacco)	0.05% (Females) 0.4% (Males) (Any type of tobacco)
	Achieved							
	Source	NDHS, 2018 and 2023						
Current alcohol use among adolescents	**Planned**	15 - 19 = 3.4% 20 - 24 = 5.9%	15 - 19 = 3.12% 20 - 24 = 5.5%	15 - 19 = 2.84% 20 - 24 = 5.0%	15 - 19 = 2.56% 20 - 24 = 4.5%	15 - 19 = 2.28% 20 - 24 = 4.0%	15 - 19 = 2.0% 20 - 24 = 3.5%	15 - 19 = 1.7% 20 - 24 = 3.0%
	Achieved							
	Source	MICS, 2017						

Prevalence of overweight and obesity among adolescents	**Planned**	8.0% & 9.0% among males and females						By 2025, reduce the prevalence of overnutrition (overweight and obesity) among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018
	Achieved							
	Source	UNICEF country dashboard, 2016 to 2027						
Prevalence rate of underweight among adolescents (10–19 years), by age category and sex (%)	**Planned**	24.0% & 11.0% thinness among males and females						By 2025, reduce the prevalence of acute undernutrition among adolescents and young people (age 10-14 years, 15-19 years, and 20- 24 years) of both sexes by half compared to 2018
	Achieved							
	Source	UNICEF country dashboard, 2016						
Prevalence of iron deficiency anaemia in 10–24-year-olds	**Planned**	60.5%	55.50%	50.50%	45.50%	40.50%	35.00%	30%
	Achieved							
	Source	NDHS, 2018 and 2023						
Percent of Sexually active adolescent who used a condom at last sex	**Planned**	15 - 19 = 31.5% 20 - 24 = 37.6%	15 - 19 = 33% 20 - 24 = 39%	15 - 19 = 36% 20 - 24 = 40.5%	15 - 19 = 37.5% 20 - 24 = 42%	15 - 19 = 39% 20 - 24 = 43.5%	15 - 19 = 41.5% 20 - 24 = 45%	15 - 19 = 43% 20 - 24 = 46%
	Achieved							
	Source	NDHS, 2018 and 2023						

Output Indicators		**Baseline**	**Milestone 1 (YR1 - Apr 2014-Mar 2015)**	**Milestone 2 (YR2 - Jan 2023-Dec 2023)**	**Milestone 3 (YR3 - Jan 2024-Dec 2024)**	**Milestone 4 (YR4 - Jan 2025-Dec 2025)**	**Milestone 5 (YR5 - Jan 2026-Dec 2026)**	**Target (Dec 2027)**
Services available for adolescents in PHCs	**Planned**	TBD						At least 50% of public sector primary health care facilities offer the full complement of the nationally specified minimum package of adolescent- and youth-friendly health services by 2025
	Achieved							
	Source	DHIS2						
In-school young people (10-24 years) reached with Family Life and HIV Education Curriculum	**Planned**	*						At least 75% of students in upper primary and secondary school students (private and the public sector) are provided with school-based family life and HIV/AIDS education by 2027
	Achieved							
	Source	*						
Out-of-school young people (10-24 years) reached with Family Life and HIV Education Curriculum	**Planned**	*						Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2027

	Achieved							
	Source	*						
*2030 Global Target								
Note: Impact is measured at national level and so the state contributes to these targets, but is not judged against them. Programme focuses on Jigawa State and aims to reduce the gap observed in Nigeria.								

PROGRAMME M&E ACTIVITIES

This section describes programme's monitoring and evaluation activities. Programme **monitoring** refers to tracking changes in programme performance over time and has the following characteristics[8]:

- Conducted continuously;
- Keeps track and maintains oversight;
- Documents and analyses progress against planned programme activities;
- Typically focuses on programme inputs, activities and outputs;
- Looks at processes of programme implementation;
- Considers programme results at output level;
- Considers continued relevance of programme activities to the health problem;
- Reports on programme activities that have been implemented; and
- Reports on immediate results that have been achieved.

In the context of AYPHD, **evaluation** refers to an approach to attribute changes in specific outcomes to programme activities. It has the following characteristics:

- Conducted at important programme milestones;
- Provides in-depth analysis;
- Compares planned with actual achievements;
- Looks at processes used to achieve results;
- Considers overall relevance of programme activities for resolving health problems;
- References implemented activities;
- Reports on how and why results were achieved;
- Contributes to building theories and models for change; and
- Attributes programme inputs and outputs to observed changes in programme outcomes and/or impact.

While monitoring is primarily done through tracking programme indicators on a routine basis, evaluation includes the AYPHD research activities.

Programme Monitoring

Monitoring matrix

All programme impact, outcome and output indicators will be routinely and periodically monitored as the case may be to ensure the programme is on target. Table 2 presents the monitoring matrix for these indicators, which provides the data sources, how the data will be collected, who is responsible for data collection, how the information will be used, and the expected users of this information.

The AYPHD M&E Officer is the custodian of all data collected and reported under the programme.

[8] Source: https://www.k4health.org/toolkits/measuring-success/me-process#Staircase

Table 2. Monitoring Matrix

Performance Indicator	Data source	Data collection plan	Frequency of data collection and reporting	Responsibility for Data Collection	Use of information	Expected users of the information
Impact indicators						
Marriage before 18 years	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Adolescent maternal mortality rate	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Adolescent maternal mortality ratio	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
DALYs due to communicable, maternal, and nutritional diseases in individuals aged 10–24 years						

DALYs due to injury and violence in individuals aged 10–24 years						
DALYs due to non-communicable diseases in individuals aged 10–24 years						
Outcome indicators						
Completion of 12 or more years of Education in 20-24years	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Adolescent fertility rate	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Proportion of adolescents aged 10 – 24 years with unmet need for contraceptives	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Parent-child communication and relationship						

Prevalence of current use of tobacco products among adolescents (10–19 years) (%), and by age, sex and type of tobacco used	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Current alcohol use among adolescents	MICS 2017 and 2025	Data will be obtained from the relevant MICS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Prevalence of overweight and obesity among adolescents	UNICEF country dashboard, 2016 to 2027					
Prevalence rate of underweight among adolescents (10–19 years), by age category and sex (%)	UNICEF country dashboard, 2016 to 2027					
Prevalence of iron deficiency anaemia in 10–24-year-olds	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries, Partners and Stakeholders
Percent of Sexually active adolescent who used a condom at last sex	NDHS 2018 and 2023	Data will be obtained from the relevant NDHS survey report covering the period under review	Collected and reported Annually	AYPHD M&E Officer	Track progress toward Impact targets	AYPHD staff; State MOH staff; JSPHCDA, Line Ministries,

						Partners and Stakeholders
Output indicators						
Services available for adolescents in PHCs	DHIS2	Statistics from DHIS2 will be downloaded each month (15 days after the end of the reporting month) by the AYPHD M&E Officer to assess progress againstlogframe targets.	Collected monthly and reported monthly, quarterly and Annually	AYPHD M&E Officer	Track progress toward output targets	AYPHD staff; State MOH staff; JSPHCDA,
In-school young people (10-24 years) reached with Family Life and HIV Education Curriculum						
Out-of-school young people (10-24 years) reached with Family Life and HIV Education Curriculum						

Overall programme management will be monitored through monthly activity reports assessed against the annual workplan. This is in addition to monitoring progress against the programme logframe.

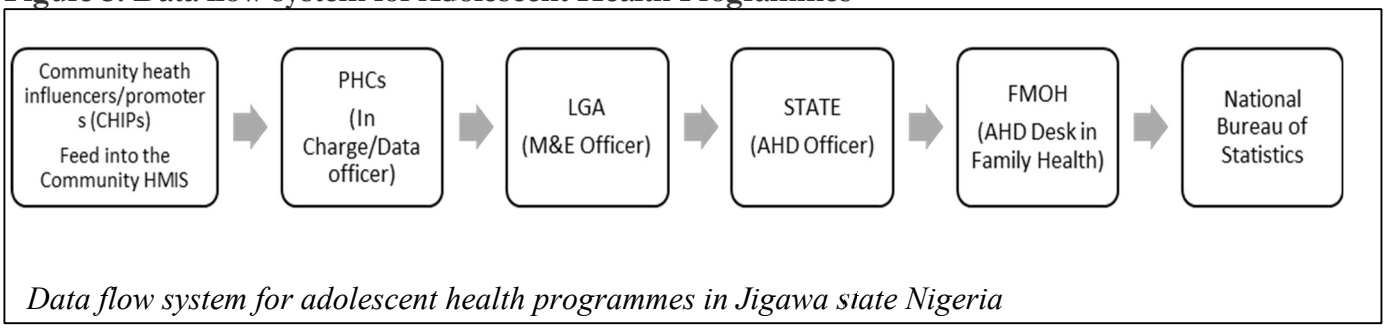
Data collection procedures

As described briefly in the monitoring matrix and the Performance Indicator Reference Sheets (PIRS), data will be collected and aggregated monthly/quarterly and reported annually or as may be required for all logframe indicators.
The AYPHD programme team has adopted or adapted a number of tools to facilitate data collection, described in Table 3.

Data Flow

Adolescent health data are mostly generated from communities through community interventions and at the health facilities through the PHC services. The Community Health Influencers Promoters and Services (CHIPS) personnel collect community level adolescent data and transmit same to the supervising PHCs in the CHIPS area of jurisdiction where they are collated and transmitted to the LGA M&E Officer. LGA M&E Officers transmit all AYPHD data to the state AHD Officer who sends it to his/her counterpart at the FMOH who finally sends all AYPHD data to the national repository at the National Bureau of Statistics (NBS). Analysis and use of data will take place at every stage of data management from the community to NBS. Partners working in the AYPHD area at the state are expected to key-in to the data flow pattern as enshrined in the national Health Information System (HIS) Policy.

Figure 3. Data flow system for Adolescent Health Programmes



Data flow system for adolescent health programmes in Jigawa state Nigeria

Data Collection tools

Supervisory Planning Schedule

This planning schedule helps the monitoring team to plan the facilities to visit. This schedule should be shared with the states and LGA teams to prepare them for the supportive supervisory visit.

Supervisory Checklist

The supportive supervisory checklist is a tool designed to provide supervisory and on-the-job mentorship to service providers. In the context of AYPHD, the tool will monitor the services available to adolescents and young people at the facility level and how it feeds into the National Health Management Information System (NHMIS). In addition, inclusion of adolescents and young people's health in routine data management including staffing and also services available to adolescents and young people will be monitored. This will be integrated into the Jigawa state Integrated Supportive Supervisory checklist and plan.

Score Card

To determine impact of state investment to the health and development of adolescents and young people, a score card was adapted to be used as an evaluation tool in the state. The scorecard will be updated annually and results shared and disseminated alongside other results to the relevant stakeholders.

Indicator Framework

Jigawa state adapted the national Indicator Framework for adolescent health developed for monitoring and evaluation of AYPHD investments in the state.

The framework is an outcome of different global and national measurement initiatives and relates only to the measurement and evaluation of adolescent and young peoples' health and development within Jigawa state as in the country. The indicators are classified as **core**, **additional** and **thematic** as described by the M&E Plan of the National Policy on the Health and Development of Adolescents and Young People in Nigeria: 2021 – 2025.

The core indicators are indicators that are key to the measurement of adolescent health following the state of adolescent health in Nigeria, what can be measured, and international standards. There were 19 core indicators included in this framework. **Jigawa state listed only the core indicators on its logframe.**

The additional indicators are a list of indicators that are also important to the health of adolescents, but may not have equal importance across the country. There were 15 additional indicators included in this framework.

Thematic indicators were developed following the programmatic areas as described in the Policy document. Each thematic area consists of important indicators to adequately measure the area within the context of the targets described in the Policy document. There were 156 thematic indicators included in this framework.

Note: that there are some indicators that are described as core or additional and are still included in the thematic list of indicators.

Data quality assessment tool

This is a national tool used to assess the quality of NHMIS data at health facilities. In this context, it will be used to assess the quality of AYPHD data in relevant health facilities in the state. This will be done quarterly or as may be prescribed. AYPHD DQA will not be conducted in silo as AYPHD services form part of the integrated PHC system.

Table 3. AYPHD data collection tools

Name of Tool	Purpose	Where is it filled?	Who fills in the form?	Where is the completed form sent?
Supervisory Planning Schedule	Used to plan Integrated Supportive Supervision	Prepared at the LGA and State levels	Prepared by the ISS teams at the LGA and State	Shared with ISS teams at LGA and State
Supervisory Checklist / Integrated supportive supervision tool	It is used to identify gaps in Human resources for health, funding and health facility infrastructure. It is also used to provide on-the-job training to service providers.	At the HF, community, LGA and SMOH levels	ISS Teams at LGA and SMOH	LGA and SMOH
Data quality assessment tool	Used to assess the quality of AYPHD and other NHMIS data at health facilities	At the health facility level	State DQA team	LGA and State
Score Card	Used to self- evaluate the Health Facility and LGA health department and state health parastatals	At the health facility, LGA and State	Peers at health facility, LGA and state agencies	Facility, LGA and State
Health facility assessment tool	Used to assess infrastructure, human resources, equipment and medical supplies at the Health Facility	At the health facility level	Assessment team formed from LGA and state agencies	Analyzed at the state and shared with key stakeholders
Indicator Framework	Used as a guide to measure performance and impact of AYPHD Interventions in the state	Communities, Health facilities, National and global survey resources	AYPHD M&E officer	Used and kept in the LGA and JSPHCDA, SMOH, disseminated to stakeholders and transmitted to the FMOH

Data analysis

Analysis of all routinely collected data on either monthly or quarterly basis will be conducted at the end of each month or quarter by the AYPHD M&E Officer. This will examine trends, assess progress, and identify outliers and any possible issues that are relevant to programming. This data will be shared at quarterly review, HDCC and TWG meetings with all personnel and partners involved in the programme implementation. Where necessary, routine monitoring data will be triangulated with findings from national data sources, operations research and special studies.

Data management

The AYPHD M&E Officer is responsible for the coordination and maintenance of all of the programme's collated data and maintaining the programme's internal database to track progress against indicators.
The programme will develop a database to serve as a repository for data from all of its components including secondary data generated from the DHIS2 system. The AYPHD M&E Officer will be responsible for the management, maintenance and quality assurance of the database.

Quality assurance

Data quality assurance will include checking data for completeness, accuracy, timeliness, and reliability. Before data is submitted to the subsequent level, data validation checks will be conducted to ensure the information provided is accurate and relevant.

At each stage, spot checks will be undertaken monthly or quarterly depending on reports produced. Any errors observed in the data will be corrected and documented. After the AYPHD M&E Officer has checked the data, the Deputy Director Planning and Monitoring & Evaluation (HMIS) will also verify all the data and do additional spot checks before sending the data to Director Planning and Monitoring & Evaluation (DPM&E). At each stage of verification, the process will be documented.

Programme Evaluation

Operations Research

Targeted research studies with specific focus on research questions designed to inform implementation and testing the effectiveness of different interventions of the AYPHD programme will be conducted as the need arises. These research works which will build on the growing body of works will be carried with the approval and under the guidance of the state research ethics committee.

Special studies

Other special studies to inform the design and refinement and contribute to the AYPHD evidence base will be conducted in addition to the Operations Research agenda. These may include household surveys to measure programme performance and track outcome indicators, and facility assessments to assess the current state of AYPHD-supported health facilities to identify gaps and areas of services that can benefit from programmatic intervention.

Household Survey

Focused household survey may be conducted to measure the AYPHD programme performance. The objectives may be to estimate population-level outcomes across the programme and project what state-level outcomes would be if interventions were scaled up. Dissemination meetings will be conducted with various stakeholders, including programme staff, state AYPHD line ministries and local governments. It is expected that findings from the surveys will be used to inform annual planning and budgeting to improve performance at all levels.

Health Facility Assessments

Health facility assessments will be conducted to assess the current state of services in all facilities that the programme supports. The objective of these assessments is to obtain a complete picture of the way AYPHD services are offered across the state. Only relevant AYPHD services will be assessed, including facilities, equipment, commodities, providers, and more.

Independent evaluation

An independent evaluation of the AYPHD may also be conducted as may be determined by the Honorable Commissioner of Health.

ADOLESCENT AND YOUNG PEOPLE'S HEALTH AND DEVELOPMENT (AYPHD) M&E SYSTEM

M&E Team

The AYPHD programme's M&E function sits under the M&E Unit of the Jigawa state Primary Health Care Development Agency (JSPHCDA), which is led by the Director Planning and Monitoring & Evaluation (DPM&E). Other key M&E staff and their responsibilities are described in Table 4 below.

Table 4. M&E Team Roles and Responsibilities

Role	Responsibilities
Director Planning and Monitoring & Evaluation (DPM&E) - JSPHCA	• Coordinate the activities of the Agency's M&E and manage the M&E team; • Facilitate development of the overall Agency's M&E strategy, plan / framework; • Ensure programme performance monitoring, evaluation, dissemination and utilization of information; • Ensure skills transfer, technical assistance and capacity development in M&E within the programme and among principal stakeholders; • Lead assessments for demonstrating programmes efficiency and sustainability within the Agency; • Coordinate the collation and dissemination of all programmes progress reports and lessons learnt and ensure their incorporation into the overall strategy in the Agency. • Facilitate conduct of Data Quality Assessments (DQAs) and other relevant assessments in the programme;
Deputy Director Planning and Monitoring & Evaluation (HMIS) - JSPHCA	• Support the Director Planning and Monitoring & Evaluation in all duties listed above; • Lead programme M&E and HMIS methodology, evidenced-based decision making, management, analysis, and translating results; • Verify and authenticate all AYPHD data reported by the AYPHD M&E Officer • Establish, maintain the programme M&E and HMIS (DHIS2) database / dashboard and other software for data management in the state; • Monitor data collection, collation, storage, analysis, and reporting in the state; • Ensure collected data is utilised in programme implementation; • Assess project progress, identify problems, and bring issues to the attention of relevant parties. • Support monthly / quarterly M&E and HMIS meetings with stakeholders and partners.

Designated AYPHD M&E Officer - JSPHCDA	• Support the Deputy Director Planning and Monitoring & Evaluation (HMIS) in all duties listed above; • Lead AYPHD programme M&E methodology, evidenced-based decision making, management, analysis, and translating results; • Establish, maintain the AYPHD programme M&E database / dashboard and other software for data management in the state; • Monitor data collection, collation, storage, analysis, and reporting on AYPHD in the state; • Ensure collected data is utilised in AYPHD programme implementation; • Assess AYPHD progress, identify problems, and bring issues to the attention of relevant parties. • Lead monthly AYPHD M&E meetings and the M&E session at the quarterly stakeholder and partner meetings. • Ensure timely collection, management, analysis, and reporting of valid and reliable AYPHD data that meet government and donor reporting requirements at the state level • Ensure maintenance and update of the programme M&E database / dashboard and other software for data management in the state.
Executive Secretary (ES) JSPHCDA	• Provide management and technical assistance to and oversight of all Jigawa state AYPHCDA implementation and M&E activities. • Assist in mobilising specialised technical assistance from Partners and other stakeholders, as and when necessary. • Recommends management decisions on AYPHD to the Honourable Commissioner of Health through the Permanent Secretary Ministry of Health.
Director Primary Heath Care (DPHC) - JSPHCDA	• Support the Executive Secretary (ES) JSPHCDA in all duties listed above; • Lead implementation and data generation on AYPHD activities
Director Public Health (DPH) - SMOH	• Lead production / review of AYPHD and related policy documents including those of M&E and HMIS and thus facilitate linkages between results reporting and the activities on the ground. • Assist M&E Unit with reviewing and quality assuring data related to technical activities which come in from the state.
Director Planning, Research and Statistics - SMOH	• Provide oversight and technical assistance on AYPHD Research. • Lead on dissemination of AYPHD Research studies to ensure findings are incorporated into AYPHD programming and government decision-making; • Conduct research in areas where AYPHD M&E data indicate sub-optimal performance to identify root causes; • Provide support to DPM&E - JSPHCDA on AYPHD programme research data analysis and interpretation;
Permanent Secretary / Honourable Commissioner of Health	• Lead and provide overall oversight on Policy, design, implementation and M&E of AYPHD in the state. • Approve and communicate AYPHD reports and research findings to the Federal Ministry of Health (FMOH) and stakeholders

Schedule of Key AYPHD M&E Activities

Table 5 provides an overview of the key AYPHD M&E activities and their timing.

Table 5. M&E Schedule

Activity	Timing
Monthly activity reports for the preceding month	15th of every month
Quarterly reports	January, April, July and October
Annual reports including reporting against logframe targets	February
Data collection and analysis for programme monitoring	January, February, March, April, May, June, July, August, September, October, November and December.
Quarterly Data review meetings with partners and other stakeholders and Health Data Consultative Committee (HDCC) meetings	March, June, September and December
Annual review of M&E plan	February or as may be required
Research	As the need arises
Health facility assessments and Household survey	Year 2, Year 3, Year 4 and Year 5

DISSEMINATION AND USE OF AYPHD DATA

AYPHD data and evidences generated from research findings will be disseminated and reviewed by various personnel in the programme and the state Health Sector management and used internally to improve the AYPHD programme's success. Externally, data and evidence will be shared with various stakeholders to facilitate ownership of interventions, decision-making and uptake of lessons learned about AYPHD in Jigawa state.

Internal data dissemination and use

Monthly reviews

The Designated AYPHD M&E Officer at the JSPHCDA will conduct continuous monitoring of programme indicators to allow rapid identification and response to emerging issues. This will be shared with key programme staff on a monthly basis to provide an informal forum for knowledge sharing and programme improvement.

Quarterly reviews

On a quarterly basis, the AYPHD M&E Officer, Deputy Director Planning and Monitoring & Evaluation (HMIS), and Director Planning and Monitoring & Evaluation (DPM&E) at the JSPHCA will conduct a detailed data analysis and focused programme improvement planning to assess progress toward achieving performance targets, identify performance gaps and, if necessary, implement remedial action. This will be shared with all stakeholders including partners during the quarterly HDCC and TWG meetings to obtain feedback and recommendations for implementation. During these meetings, stakeholders and partners will receive updates on all research activities and be engaged in discussions about the implications of findings and potential avenues of further dissemination.

External data dissemination and use

There are a number of target audiences of the information and evidences generated by the AYPHD Programme, each of the target audiences have their unique and specific information and knowledge needs. Their background knowledge of the AYPHD also vary. The nature, or purpose, of the information produced varies in the way it contributes to accountability, learning and decision-making. Table 6 below captures the different information needs for each stakeholder and target audience.

Table 6. External Dissemination - Audience Analysis

Audience	Audience Background	Information required	Purpose	Frequency

Partners, CSOs and other stakeholders	Well informed	• Programme level indicators • Institutional strengthening reporting • Success stories	To demonstrate performance and impact	Quarterly Annually
Federal Ministry of Health	Relatively well informed about AYPHD in Jigawa state	• Programme level indicators • Institutional strengthening reporting • Success stories and challenges	• To demonstrate performance and impact • government programme planning	Biannually Annually
State Ministry of Health (including HDCC and relevant TWGs)	Well informed	• Programme level indicators • Institutional strengthening reporting • Success stories and challenges	Decision-making and government programme planning	Quarterly Biannually Annually
Ministries of Women Affairs & Social Development; Information, Youth, Sport and Culture; Education, Science and Technology, Justice; Agriculture and Natural Resources; Local Government and Community Development; Finance and Economic Planning; and Environment	Relatively informed about AYPHD in Jigawa state	• Programme level indicators • Institutional strengthening reporting • Success stories and challenges	To demonstrate performance and impact	Quarterly Annually
Jigawa state Health Sector Management	Well informed	• Programme level indicators • Institutional strengthening reporting	Decision-making and government programme planning	Quarterly Annually

		• Success stories		
Jigawa state AYPHD staff	Well informed	• Programme level indicators • Sub-programme level data • Success stories	• Decision-making and AYPHD programme planning • To demonstrate progress, challenges and value for money	Quarterly Annually
Other AYPHD implementers (Nigeria)	Relatively well informed about AYPHD related work in Jigawa state	• Success stories and challenges • Research studies (including publications & briefs)	Learning & programme planning	As available
Other AYPHD implementers (global)	Uninformed about AYPHD related work in Jigawa state	• Success stories and challenges • Research studies (including publications & briefs)	Learning & programme planning	As available