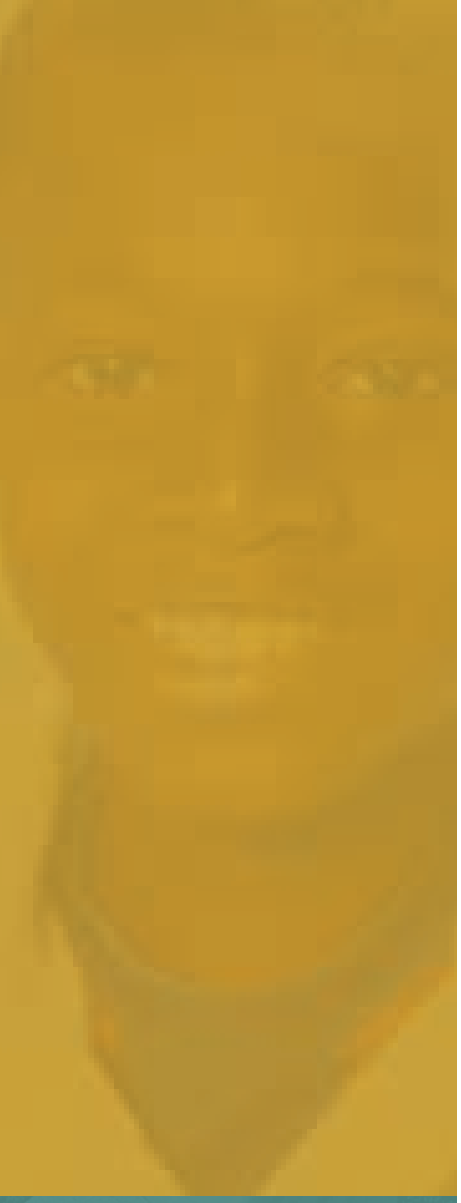


A Guide for the Implementation of Community-Based HIV Programmes Focused on Adolescents and Young People in Nigeria

PART ONE

Understanding the HIV epidemic and response towards planning an effective HIV programme for adolescents and young people (AYP).

Dec. 2020

Bawo Ni!
Kedu!
Sannu!
What's up!

About this Guide

This Guide lays out principles, processes and steps relating to HIV programming for adolescents and young people (AYP). The Guide is designed to support community-based implementers as they develop or expand their HIV projects/programmes to reach adolescents and young people. It introduces an approach to programming that is informed by evidence and focused on achieving results. The Guide aspires to contribute to reducing new HIV infections and improving sexual and reproductive health and rights among adolescents and young people.

This Guide is the first in a four-part series designed to equip implementers with the necessary skills to design, deliver, monitor and sustain the impact of an effective HIV response for AYP.

Who is this Guide for?

The guide is intended for use by individuals, entities and organisations involved in planning and implementing HIV interventions focused on adolescents and young people. It is primarily aimed at the community level but can also be used at state and national levels. The audience includes community-based organisations, non-governmental organizations, faith-based organisations, youth-led organisations and networks, community advocates, implementing partners, private sector, public sector. The Guide will also be useful to donor and development partners who provide financial and technical assistance to Nigeria's HIV and AIDS response.

How to use this Guide?

The Guide is not a comprehensive planning guide; it should be complemented by other tools and guidance documents developed by NACA, FMOH, UNAIDS and other technical partners. This guide may be referred to from time-to-time at the beginning of the planning cycle to refresh the mind about the processes and steps. This guide may be used to check that planned processes are adequate. The guide can also be referred to for links to additional resource materials around specific topics.

Layout of the Guide

The guide is divided into six chapters organized as follows:

Chapter 1: Background
Chapter 2: HIV epidemic among AYP in Nigeria
Chapter 3: Principles of HIV programming for adolescents and young people
Chapter 4: Ensuring adolescent and youth participation
Chapter 5: Establishing the local situation and context
Chapter 6: Mapping and size estimation of the most vulnerable AYP in the community

Throughout the Guide, there are boxes placed to highlight key concepts that are important for implementers to know, understand and carry through in their work.

Foreword

Nigeria has one of the largest populations of adolescents and young people (AYP) in the world aged 10-24 years. Adolescents and young people make up a segment of the population that is particularly vulnerable to HIV. They have low levels of comprehensive knowledge of HIV, HIV risk perception, and limited access to appropriate sexual and reproductive health (SRH) services. Rapid scale-up of HIV interventions is required to achieve country targets and reduce new HIV infections among adolescents and young people. HIV programmes at all levels must be responsive to the needs of AYP. This is an investment in AYP's health and wellbeing for the present, for their future adult lives, and for the next generation who will be their children.

We have a more supportive policy environment and stronger strategic information to guide the HIV response for AYP. NACA is working to mobilise resources to boost the HIV programme for AYP. It is necessary to strengthen programme implementation to ensure effectiveness and efficiency of the programme. NACA has developed this simple programming guide to strengthen the capacity of community-based implementers to conduct targeted community-based HIV and SRH interventions for adolescents and young people.

This guide is designed to support community-based implementers as they develop or expand their HIV projects/programmes to reach adolescents and young people. It introduces an approach to programming that is informed by evidence and focused on achieving results.

We hope that all stakeholders involved in planning and implementing HIV interventions focused on adolescents and young people, especially at the community level, will use this guide. This will ensure that all efforts and resources put to control the HIV epidemic are optimized for effectiveness and efficiency.

Dr. Gambo Aliyu

Director General NACA

Acknowledgement

This programming guide was developed by the Community Prevention and Care Services Department of NACA in consultation with young people, implementing partners, development partners and the Federal Ministry of Health. The contributions of the following organisations are greatly appreciated: African Network of Adolescents and Young Persons Development (ANAYD), AIDS Healthcare Foundation (AHF), Education as a Vaccine (EVA), FCT Agency for the Control of AIDS, FMOH, Youth Network on HIV/AIDS in Nigeria (NYNETHA), Society for Family Health (SFH), UNAIDS, UNFPA, UNICEF, West African Centre for Public Health & Development (WACPHD) and WHO.

The NACA Community Prevention Division staff who organised the development workshops and led the drafting and review of this programming guide are also appreciated for their efforts.

We appreciate the FGN for providing the funds for this document.

Alex Ogundipe

Director, Community Prevention and Care Services

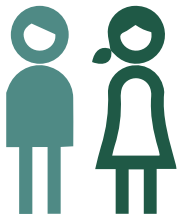
Table of Contents

01. Background

Nigeria has one of the largest populations of adolescents and young people aged 10-24 years in the world, one in every three persons. In 2019, the estimated population of adolescents and young people (AYP) was over 66 million. AYP make up a segment of the population that is particularly vulnerable to HIV. They have unique needs and characteristics relating to HIV and AIDS. These need to be considered and addressed appropriately as we invest in adolescent health and wellbeing for the present, for the future adult lives of AYP, and for the next generation who will be children of current AYP.

Human immunodeficiency virus (HIV) remains a leading global health challenge and the control of HIV and the resulting disease, Acquired Immune Deficiency Syndrome (AIDS), is a national priority in Nigeria's health and development agenda.

In 2019, over
66 Million
AYPs in Nigeria



"One in every three persons is between ***10-24 years of age***

Within the broader HIV response, AYP are a priority population. For Nigeria to achieve epidemic control, HIV needs to be controlled in AYP. Experience shows that without adequate targeting and a conscious effort to reach AYP, they often fall through the cracks. Young people do not have adequate access to HIV services. Strong programme implementation will enhance efforts to achieve HIV prevention, treatment, care and support targets for adolescents and young people in Nigeria.

There has recently been renewed focus on AYP with a need for adequate guidance that will enable evidence-based, implementable programmes that are focused on priority issues and delivered at scale in priority locations. To succeed, it is important that at all levels, HIV programmes are appropriately designed to reach AYP with an orientation for results and sustained impact. It will contribute to the optimization of community-based programmes to reach AYP most in need of HIV interventions. The Guide outlines for the community-level implementer the basic principles and steps of the "know your epidemic, know your response" paradigm.

TERM	DEFINITION	SOURCE
Adolescents	Persons between the ages of 10 and 19	UNICEF, WHO, UNFPA, NACA
Young people	Persons between the ages of 10 and 24	UNICEF, WHO, UNFPA
Young people	Persons between the ages of 20 and 24 This was introduced in the Nigerian context to make a clearer distinction between adolescents and older young people. Both terms "adolescents and young people" (AYP) are used when referring to persons between the ages of 10 and 24	National HIV Strategy for Adolescents and Young People (2016-2020)
Youth*	Persons between the ages of 15 and 24	United Nations General Assembly Resolution A/ RES/50/81
Early Adolescents	Persons between the ages of 10 and 13	National Policy on the Health and Development of Adolescents and Young People in Nigeria
Middle Adolescents	Persons between the ages of 14 and 16	National Policy on the Health and Development of Adolescents and Young People in Nigeria
Late adolescents	Persons between the ages of 17 and 19	National Policy on the Health and Development of Adolescents and Young People in Nigeria
**Nigeria's National Youth Policy (2019-2023) defines youth as persons between the ages of 15 and 29. This classification is not commonly used in the HIV response.*		

Sub-populations of adolescents and young people

The National HIV Strategy for Adolescents and Young People highlights the following sub populations:

1. Young key populations (female sex workers, men who have sex with men, people who inject drugs, transgender people)
2. In-school: AYP presently enrolled in informal / formal educational institutions
3. Out of school – AYP presently not in any formal/informal educational institution
4. Adolescent girls and young women should also be prioritised due to their relatively high vulnerability

In each community, it is important to consider which subpopulations experience exposure and vulnerability to HIV risk, lower access to SRH/HIV services, worse outcomes and greater social consequences as a result of HIV infection. Sometimes these inequalities can be seen among groups that differ by socioeconomic status, education, sex, gender, sexual orientation, marital status, and rural or urban residence.

02. HIV epidemic among AYP in Nigeria

Epidemiological indicators used here are derived from the Nigeria AIDS Indicator and Impact Survey (NAIIS) conducted in 2018 and up-to-date estimates from the UNAIDS AIDSInfo dashboard on *https://aidsinfo.unaids.org/*

HIV Prevalence Among AYP by Age and Sex

10-14 YRS	15-19 YRS	20-24 YRS	TOTAL 15-24 YRS
0.2% FEMALES	0.3% FEMALES	1.3% FEMALES	0.8% FEMALES
0.2% MALES	0.1% MALES	0.3% MALES	0.2% MALES

Source: NAIIS 2018

Estimated Number of Adolescents and Young People living with HIV

10-19 YRS

49,000

58,000

TOTAL **10-19** YRS
110,000

15-24 YRS

72,000

120,000

TOTAL **15-24** YRS
190,000

Source: AIDSInfo, 2019

Rate of new HIV infections among persons aged 15-24 years

50 NEW HIV INFECTIONS
per 100,000 males

94 NEW HIV INFECTIONS
per 100,000 females

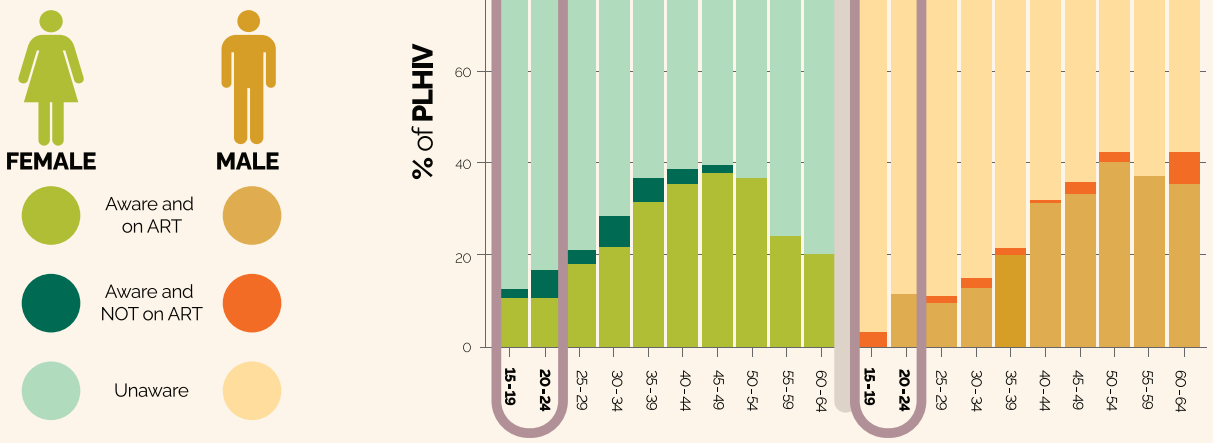
Source: AIDSInfo, 2019

95-95-95 Cascade Analysis of persons aged 15-19 years and 20-24 years in Nigeria

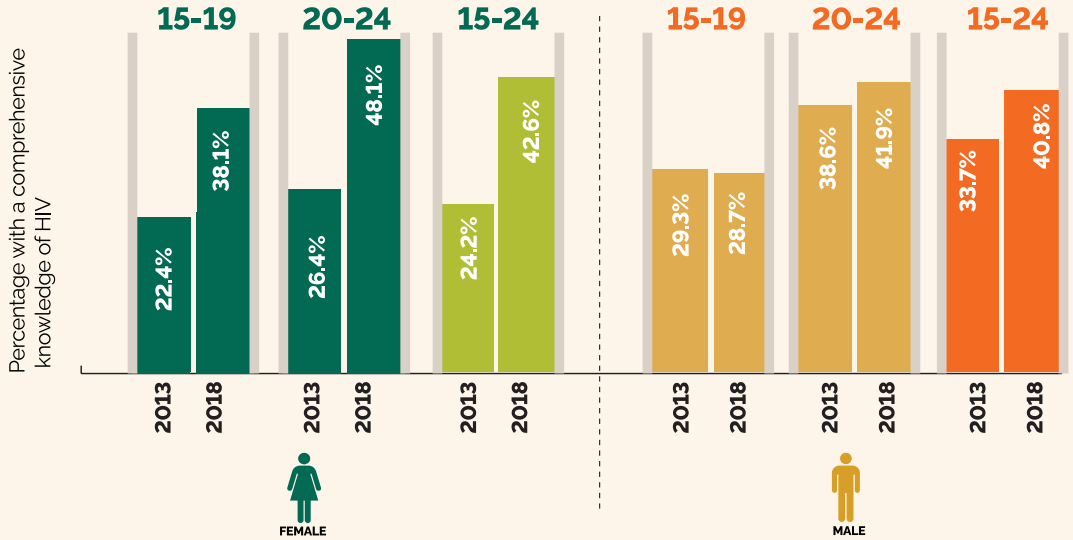
		Percentage of Persons living with HIV who are aware of their HIV status	Percentage of Persons living with HIV who are aware of their HIV status and are on Antiretroviral Treatment	Percentage of Persons living with HIV who are aware of their HIV status, are on Antiretroviral Treatment and have viral suppression
15-19 YRS	46,383 Living with HIV	35.5%	96.7%	75.8%
20-24 YRS	135,741 Living with HIV	29.4%	90.5%	77.7%

Source: NAIIS 2018

Proportion of HIV-positive adults reporting awareness of HIV status and antiretroviral therapy status by age and sex



Comprehensive knowledge of HIV among AYP



Knowledge of HIV prevention measures, HIV transmission including mother-to-child transmission was **poorer among adolescents aged 15-19 years compared to older adults.**

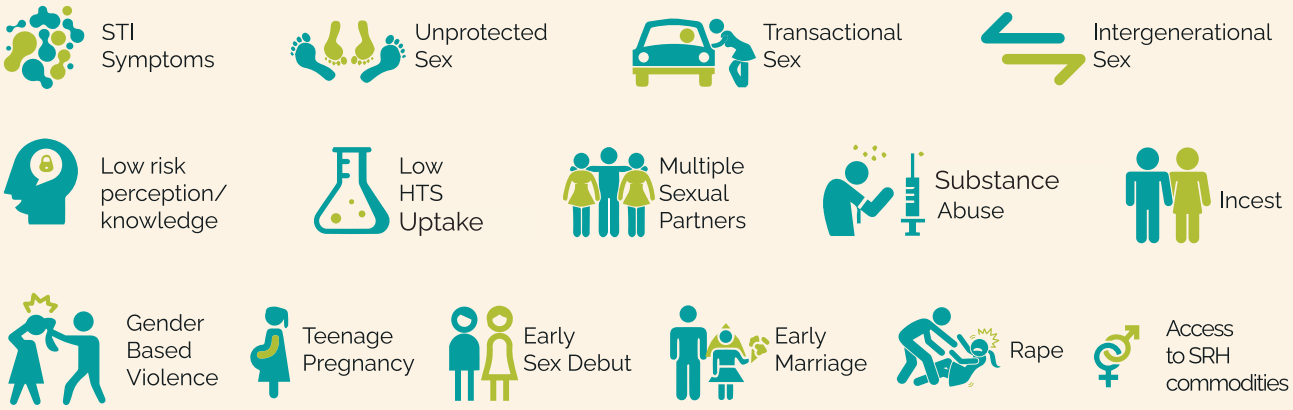
Source: NDHS 2018

HIV risk behaviours among AYP in Nigeria

	15-19 YRS	20-24 YRS	15-19 YRS	20-24 YRS
Percentage who had sexual intercourse before age 15 years	2.4%	2.2%	8.6%	15.0%
Percentage who had two or more partners in the past 12 months	1.3%	8.0%	0.7%	1.9%
Percentage who had intercourse in the past 12 months with a person who neither was their wife/husband nor lived with them	7.9%	27.5%	9.6%	16.3%
Percentage who had intercourse with two or more partners in the past 12 months and used a condom	56.0%	55.1%	35.6%	37.6%
Percentage who had prevalence of Sexually Transmitted Infection in the past 12 months	1.6%	3.8%	6.0%	8.9%

Earlier sexual debut was reported in female AYP than their male counterparts but **males aged 20-24 years exhibit high HIV sexual risk behaviours.**

Vulnerability factors to HIV transmission



Social, cultural and legal issues impacting AYP in Nigeria

CONSERVATIVE NORMS RELATED TO SEX

Secrecy and non discussion. Experimentation. Limited empowerment. Abuse.

DISABILITIES

AYP with disabilities also face significant barriers to accessing HIV-related prevention and treatment services

SOCIOCULTURAL PRACTICES

Sociocultural practices and rites that make AGYW vulnerable to HIV infection *e.g. female genital mutilation, negative widowhood practices, child marriage etc.*

UNEQUAL ACCESS TO EDUCATION

AGYW especially those in rural communities face barriers to school and education progression because of their gender

MASCULINITY STEREOTYPES

Stereotypes associated with masculinity affect the behaviour, knowledge and confidence of male about sex negatively. *Early, risky and sometimes multiple sexual relationships*

Norms, stereotypes and expectations can also discourage males from seeking HIV-related prevention and treatment services

SUBSTANCE ABUSE

Substance use is a risky behaviour that compounds other issues faced by AYP. Criminalization by law enforcement officers can hinder access to harm reduction services.

SOCIOECONOMIC FACTORS

Poverty, lack of employment, value erosion and lack of hope may constitute socio-economic factors that lead this group to behaviours that predispose them to HIV

03. Principles for implementing HIV services for AYP

Several principles are at the heart of the HIV response for AYP. These are specified in the **National HIV Strategy for Adolescents and Young People (2016-2020)** and summarized below and expanded on throughout this guide:

1 Evidence-informed programming

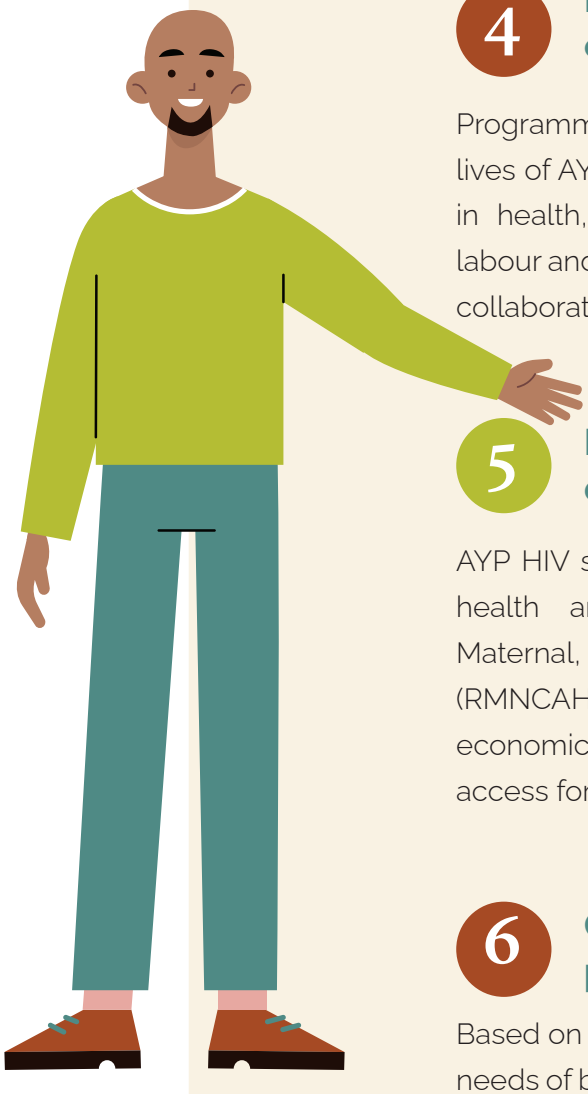
Interventions should be based on relevant information and current data on the population size estimates, location, and characteristics (e.g. sex, age, education level, socio-economic background, marital status, sexual practices, risk behaviours like substance use) of AYP.

2 Meaningful involvement of AYP

AYP should be involved in the design, implementation, monitoring and evaluation of polices and interventions targeting or affecting them. This will help to build trust and make the policies and interventions holistic and more responsive to the needs of AYP.

3 Youth responsive programming

Programmes should be designed taking into consideration the sociocultural environment around AYP and the full range of the needs of AYP.



4 Multi-sectoral collaboration

Programmers should take into account the fact that the lives of AYP are affected by operational and policy decisions in health, social welfare, education, youth development, labour and employment sectors. Programmes should ensure collaboration across relevant sectors.

5 Integrated service delivery

AYP HIV services should be integrated and linked to other health and development services like Reproductive, Maternal, Newborn, Child and Adolescent Health + Nutrition (RMNCAH+N), OVC, SGBV, TB, education, technology and economic empowerment. This is important to increase access for AYP and make the services more effective.

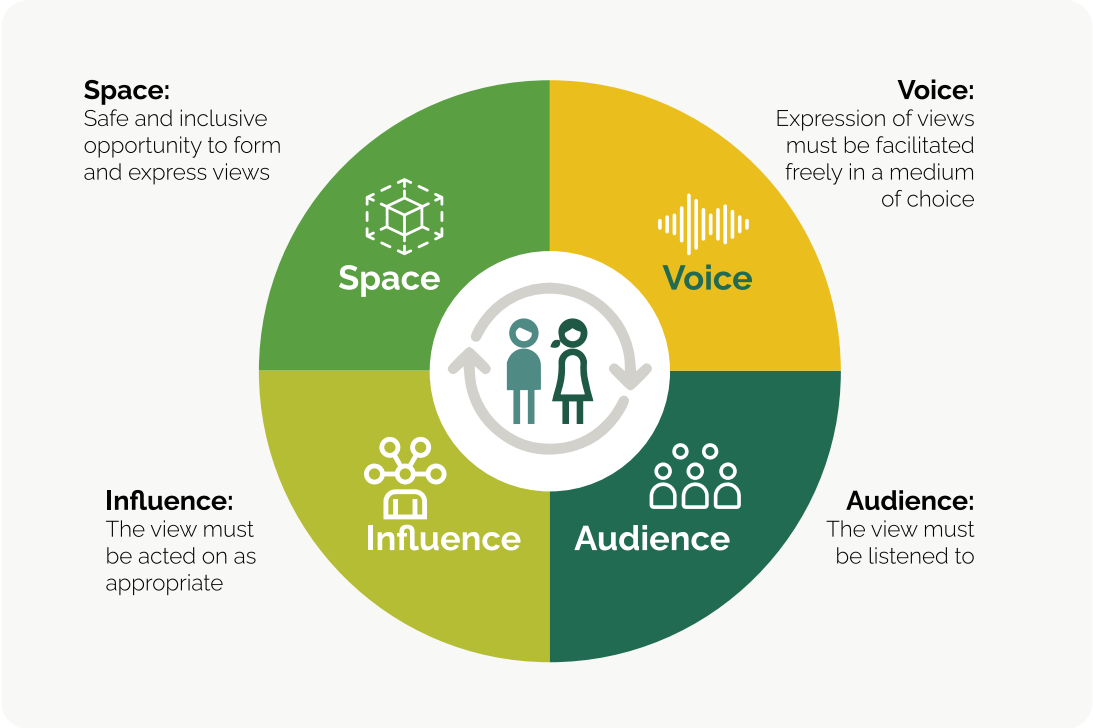
6 Gender-responsive programmes

Based on gender analysis, programmers should address the needs of both males and females and take action to promote gender equality and equity. This should be considered throughout the design, implementation, monitoring and evaluation of programmes.

04. Ensuring adolescent and young people's participation"

The participation of AYP is necessary for building trust and making the programme holistic and responsive to their needs. Features and requirements for participation presented in this chapter will focus on the period of childhood from 10 years to the 18th birthday. These features and requirements however remain applicable to AYP aged 18 years and above.

UNICEF defines adolescent participation as: Adolescent girls and boys (individually and/or collectively) form and express their views and influence matters that concern them directly and indirectly.[1]



1 Conceptual Framework for Measuring Outcomes of Adolescent Participation', UNICEF, 2019, https://www.unicef.org/media/59006/file)

How well does your programme meet these requirements for adolescent and young peoples participation?[2]

TRANSPARENT AND INFORMATIVE
Adolescents must receive full, accessible, diversity-sensitive and age-appropriate information about their right to express their views and the purpose and scope of participation opportunities.

VOLUNTARY
Adolescents should never be coerced into expressing views against their wishes, and they should be informed that they can stop involvement at any stage.

RESPECTFUL
Adults should acknowledge, respect and support adolescents' ideas, actions and existing contributions to their families, schools, cultures and work environments.

RELEVANT
Adolescents should have opportunities to draw on their knowledge, skills and abilities and to express their views on issues that have real relevance to their lives.

ADOLESCENT-FRIENDLY
Environments and working methods should consider and reflect adolescents' evolving capacities and interests.

INCLUSIVE
Participation opportunities should include marginalized adolescents of different ages, genders, (dis)abilities and backgrounds.

SUPPORTED BY TRAINING
Adults and adolescents should be trained and mentored in facilitating adolescent participation so they can serve as trainers and facilitators.

SAFE AND SENSITIVE TO RISK
Expression of views may involve risks. Adolescents should participate in risk assessment and mitigation. They should know where to go for help if needed.

ACCOUNTABLE
Adolescents should receive clear feedback on how their participation has influenced outcomes and should be supported to share that feedback with their peers.

Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement, UNICEF 2020. Available at: https://www.unicef.org/media/73296/file/ADAP-Guidelines-for-Participation.pdf

Adolescence

This is the period of transition from childhood to adulthood. It is one of the most rapidly changing formative phases of human development. During this period of social, economic, physical and psychological development, characterised by stress, innovation, and experimentation, adolescents face a lot of challenges. Adolescence is also a period when many risky or protective behaviours start or are consolidated. Examples include diet, physical activity, substance use and sexual risk behaviours that may lead to HIV infection. HIV is recognized as a health priority for adolescents in Nigeria.

What is special about adolescents ?

1

Rapid physical, cognitive, social, emotional and sexual development

- Hormonal changes and puberty
- New and complex sensations and emotions
- Sexual awareness and gender identity
- Burst of electrical and physiological brain development
- Enhanced and evolving cognitive ability
- Context-influenced emotional and impulse control

2

Widening gap between biological maturity and social transition to adulthood

- More years in education and training due to the expansion of primary, secondary and further education
- Later onset of employment and family formation
- More independent involvement in health services, which may be ill prepared to serve adolescents' special needs

3

Balance between protection and autonomy

- Emerging autonomy but limited access to resources (e.g. finances, transportation)
- Appropriate representation in decision-making bodies
- Rights to consent to services, commensurate with evolving capacity
- Increased vulnerability to some aspects of globalization (e.g. increased vulnerability to gaming, pornography, online bullying)

Source: Source: Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. Summary. WHO, 2017

05. Establishing the local situation and context

Planning result-oriented programmes for adolescents and young people requires that implementers set the right priorities, allocate adequate resources and take the necessary steps that would significantly reduce HIV transmission and improve the quality of life of AYPLHIV. It is important that programme design is based on evidence and reflects the epidemic among AYP population in the locality and its effects on specific population subgroups. It is also necessary to analyze trends, understand the risk factors as well as the root causes of the epidemic among AYP and how they get infected with HIV in the target community.

Often times, programmes are implemented in ways they have been done before or using generic (one-size-fits-all) strategy which does not yield the desired result. Community-level implementers may also have limited understanding of the HIV epidemic among AYP including how HIV is transmitted among them. Other times, implementers take actions that are not adequately linked to the results that ought to be achieved for HIV epidemic control. To avoid the waste of effort and resources, the foundation upon which implementers operate should be based on available evidence.

Understanding the local situation (situation analysis) should directly inform what implementers do. The situation analysis must include a description of the specific risks, vulnerabilities and needs of different subgroups of AYP bearing in mind that they are not homogeneous. The types of information required for situation analysis include, but are not limited to, the following:

- Data on the HIV epidemic in the community: how HIV transmission happens, distribution of PLHIV, risk factors, affected population groups.
- Socio-economic content and determinants (e.g. harmful norms and practices, barriers to access to HIV services for AYP, policy and legal barriers)
- Existing HIV programmes/activities, locations and the actors
- Evidence on good practices and effective programmes
- Information about costs and financing

TYPE OF INFORMATION	DESCRIPTION	USEFUL FOR
Data on the HIV epidemic in the community	How HIV transmission happens, geographic distribution of HIV, risk factors, where new infections are happening, affected population groups, extent of co-infections	Describing the need for and coverage of HIV prevention, treatment and care services in the community
Socio-economic context and determinants (e.g. harmful norms and practices, barriers limiting access to HIV services for AYP)	Political, social, economic and legal environment Factors that impact on HIV and affect access to services such as cultural norms, education, poverty, gender norms, mobility, age of consent policies, displacement, criminalization, stigma, discrimination, violence including gender-based violence, conflict, etc.	Understanding the root causes of HIV acquisition and transmission. Identifying the factors that may facilitate or prevent access to HIV services
Existing HIV programmes/ activities, locations and the actors	Services being provided in the community, who is providing them, who are the services designed for, who are those accessing the services	Assessing how well existing services are meeting the HIV needs of AYP. Identifying gaps in HIV prevention, treatment and care services in the community
Evidence on good practices and effective programmes	Outcomes and impact achieved by past programmes and how applicable they are to AYP. What do we know about what works and what does not work for addressing HIV needs of AYP in this community?	Important tips about how to design programmes that will effectively focus on AYP and achieve results. Helpful information about what works and what does not work
Information about costs and financing	What it costs to deliver programmes and the different cost input. Different ways in which programmes have been/could be financed	Developing a budget and identifying ways to finance programmes

Data gotten from the above situation analysis must be disaggregated by sex, age and other relevant characteristics (e.g. ethnicity, socio-economic status, urban-rural, etc.). This will help implementers identify gaps and inequalities that exist in terms of sex, age, socio-economic status, human rights, etc.

It takes time and resources to conduct situation analysis. As much as possible, implementers should ensure that they gather all relevant information that may already exist about the local situation. This may be available as follows:

- State HIV and AIDS Strategic Plan
- Policy documents on health, HIV/AIDS and socioeconomic development
- Policies and Laws related to health and HIV that may affect access to or delivery of services (e.g. confidentiality law, age of consent policies)
- Reports of epidemiological, behavioural, health services and other relevant surveys including the Demographic Health Survey, AIDS Indicator Survey, Health Sector Survey, Integrated Biological and Behavioural Sentinel Survey
- Synthesis reports, epidemic reviews
- Relevant research studies about socio cultural and economic context of HIV/AIDS
- Programme reviews by government, NGOs, donors and others

What implementers need to do

Implementers should interact with relevant stakeholders to strengthen their work and avoid duplications of efforts. Stakeholders can be defined as individuals that have vested interest in the HIV/AIDS response and/or health and development of young people in general. Stakeholders can potentially be affected by or influence your project efforts.

Stakeholders in the HIV response for AYP include, but are not limited to the following:

- Government: policy makers, technical programmes (SACA, SMOH, SASCP), relevant sectors (youth development, education, women affairs and social development, justice)
- Service providers: public, private, civil society
- Affected populations: adolescents girls and young women and adolescent boys and young men including those with disabilities, AYP living with HIV, key populations, local communities including religious groups
- Interest groups: academia, advocacy groups
- Development partners: Donors, technical partners
- Media

By doing a stakeholder analysis, implementers can identify those involved in the HIV response for AYP and those who could potentially contribute. It also helps to identify groups that can participate in the activities. Potential conflict and risk that can arise during implementation can be identified and mitigated.

STAKEHOLDER ANALYSIS MATRIX

	More Influence	Less Influence
More Affected	*Work with them and keep them onboard*	*Empower them and keep them onboard*
Less Affected	*Win their support*	*Keep them informed*

Implementers should actively mobilise and engage young people in this process; this is the only way to assess and understand the needs of AYP to inform interventions to be prioritized and how to deliver them. It is important to know that some young people, including persons living with disabilities, may be at higher risk or vulnerability to HIV. Implementers should take deliberate steps to ensure that these subgroups of AYP are engaged in the process of undertaking the situation analysis.

Meaningful engagement

Adolescents and young people should be involved at all stages from programme planning through implementation and monitoring.

Engagement should go beyond mere invitation to meetings. This could be achieved by working through youth-led as well as youth-serving organisations. Meaningful engagement involves young people's active learning, participation and contribution. Young people's capacity should be built to ensure that they are empowered to be partners and leaders rather than only beneficiaries. This is critical for promoting ownership and sustainability of development efforts at the community level.

Specifically, implementers should engage adolescents and young people to:

1. Identify the issues to be investigated
2. Collect information from their peers
3. Analyse the information
4. Prepare a report
5. Validate the report
6. Identify priorities from the situation analysis

Important points for implementers

1. Need to understand the different HIV dynamics and needs among subgroups of AYP e.g. out of school, in school, key populations, married adolescent, non-married, persons with disabilities etc. and the different age group e.g. early adolescent, mid adolescent and late adolescent
2. Adolescent girls and young women have greater vulnerability to HIV. However, in every locality, it is important to ascertain if this holds true and to understand the factors that make AGYW more vulnerable
3. Need to understand the existing structure(s) at the community level – Identify government institutions and gatekeepers in the community e.g. traditional, religious, market and opinion leaders.

5.1 Identifying the gaps in the HIV response for AYP

Situation analysis described above will help implementers to understand the gaps in the HIV response for AYP in the community. This is critical for the next steps in the process prioritizing and designing programmes. Implementers should identify the unmet need for HIV prevention, treatment and care services for AYP in the community as well as policy and programmatic gaps. State Strategic Plan/Operational Plans usually establish state-wide need and targets for the different programme areas. Implementers should draw from these as a first step towards identifying and addressing the needs of the community. Within this framework, unmet need within the target community should be identified in order to focus the programme appropriately. A comprehensive understanding of the local situation empowers the community-level implementer to leverage resources and contribute more meaningfully to the country's HIV response. It ensures that the implementer can do more with the limited resources available.

5.2 Information required for prioritisation

Based on the outputs from the situation analysis and available resources, Implementers have to make strategic decisions about what services to provide, who to provide them to and where to implement services. A usual approach is to:

1. Target communities with highest populations of AYP to enable them optimize reach and achieve results even with limited funding. Within these communities, identifying locations and venues where AYP gather or spend a significant part of their time (formal and informal institutions e.g. schools, church, mosque, recreational centers) is also important for programming. This information should be collected and disaggregated by age, sex and other relevant characteristics.

2. Prioritise the most vulnerable AYP or AYP most in need of HIV services to maximise the impact of programmes. Studies have identified and investigated a variety of factors that increase risk and vulnerability among AYP. These are listed on Page 13. The situation analysis will help to identify the factors that are relevant to the target community. There is no one-size definition for vulnerability but as a general rule, existence of multiple factors would make AYP at increased risk/vulnerability. Vulnerability and risk should be assessed at the level of the individual during service delivery. However, for the purpose of programme design, the assessment of the community of AYP sub-groups would be sufficient.

An important pointer is identifying locations where new HIV infections are happening. HIV incidence estimates (the rate of new HIV infections) up to the LGA level are available at UNAIDS AIDSInfo. Implementers should try to identify the populations in which new HIV infections are occurring. This will help to ensure that HIV prevention activities are properly focused.

The next chapter in this guide gives the steps for conducting mapping and size estimation exercise to identify AYP that are most vulnerable/most in need of HIV services.

06. Mapping and size estimation of the most vulnerable AYP in the community

Almost all local government areas in Nigeria have at one time or other had HIV programmes delivered in them. Today, many LGAs have established and functional structures for the HIV response either stand-alone or integrated in the larger health response. Implementers should therefore start with existing information and resources relevant to the target community and build on them (update the information and fill gaps in information). This activity can be conducted to varying degree of complexity. This chapter will mainly provide details of how to go about mapping and size estimation in the most basic form. Implementers should not be discouraged by the number of steps involved. Most of these steps are intuitive and all are necessary to ensure effective and efficient use of resources. Mapping and size estimation should be focused on helping the implementer identify the AYP who are most vulnerable and what HIV services they are most in need of. As introduced in the previous chapter, there could be a number of risk and vulnerability factors. As we understand more about the HIV epidemic and response dynamics among AYP in Nigeria, definitions of vulnerability may become standardized.

VULNERABLE ADOLESCENTS INCLUDE THOSE:

1. Living with HIV
2. In conflict/disaster situation and living in IDP camps and other displaced settings
3. Living with disabilities
4. Stigmatised and marginalized due to sexual orientation, gender identity or other reasons
5. Exploited and abused (e.g. those forced into employment)
6. Who experience stigma and discrimination e.g. those from families where one parent is absent due to separation or divorce
7. Living in the street i.e. homeless with no shelter
8. Exposed to domestic violence or substance abuse in their family
9. Not in education, employment or training
10. With limited access to health services (e.g urban-poor and rural residents)
11. Who migrate for work or education without family or social support (e.g. Almajiri, area boys and street hawkers)

6.1 Estimating the size of the most vulnerable AYP in the community

1 DEVELOP A PLAN

In its most basic form, this plan should detail the objectives, methods and specific activities, timeline and budget for the exercise. The plan should be clear and coherent.

2 ASSEMBLE THE TEAM OF PERSONS TO OVERSEE AND CONDUCT THE EXERCISE

This team should include staff of the implementing organization, persons familiar with the community, experts familiar with the local HIV response (LACA officers), and young persons from the target community who have intimate knowledge of the community. This team will need to take the following actions:

Identify existing information and resources
This will guide the team on what information already exists (e.g. LACA and community maps, population estimates, list of youth-friendly facilities, list of HIV service delivery points) and what information needs to be directly gathered by the implementer.

Develop a list of key stakeholders and gatekeepers within the community
It is important to identify stakeholders and gatekeepers in the community. These people understand the community, have in-depth knowledge and can influence decisions. Their input cannot be overestimated.

Conduct advocacy to key stakeholders and gatekeepers
Advocacy is a never-ending process. It is important to gain the support of the stakeholders. Their appropriate engagement right from the beginning will provide an enabling environment for programmes for AYPs in the community.

Identify existing community AYP structures and bodies (formal and informal)
Document existing organizations, networks, clubs or societies with membership of AYPs in the community.

Identify AYP led and/or focused organisations (CBOs, Networks etc.)
Identifying this category of organizations helps to profile AYP that have been engaged in the past, are presently engaged and those to be engaged in the future. Project reports from these organizations will also help in size estimate and mapping processes as well as identifying key AYP concerns and mobilizing resources.

Develop a list of questions
Generate a list of questions for relevant stakeholders with the aim of establishing (i) locations where AYP at risk/vulnerable to HIV can be found; and (ii) estimated number of AYP who fit into this at risk/vulnerable category.

3 TRAIN DATA COLLECTION TEAM

Persons who will collect the information should receive an orientation on how to communicate effectively, how to conduct interviews including ensuring proper documentation. Data collection team should include young people especially those that closely match or can easily relate with other young people who face higher HIV risk and vulnerability.

4 COLLECT DATA

This can be done by interviews with key informants in the community. Key informants could be "Okada riders", school principals, recreation area managers, sports club managers, religious and community youth groups etc. They usually have vital information about AYPs, their activities and risk factors in the community. Information should be gathered from vulnerable AYP groups in sensitive and ethically appropriate manner.

5 ANALYZE DATA

Data analysis doesn't necessarily mean statistical packages are employed in the analysis. This process involves the review of the different data and information gathered and identifying similarities across different information sources. This also enables the implementer to note information that should be subjected to confirmation during the validation stage or before finalizing the report.

6

GENERATE A LIST OF LOCATIONS/SITES/VENUES AND POPULATION ESTIMATES

The report should highlight key information gathered and include list of locations/sites/venues where AYP at risk/vulnerable to HIV can be found and estimated number of AYP who fit into this at risk/vulnerable category.

Validating size estimates and locations: *This is conducted using data and information generated from steps 1-6 above or using existing mapping and size estimate reports.*

7

STUDY AND REVIEW THE EXISTING OR PRELIMINARY REPORT

To validate estimates and locations, these reports should be studied to extract needed information including address, type of AYP subgroup and population estimates at the location/site/venue.

8

VISIT LOCATION/SITE/VENUES

To validate estimates and locations, these reports should be studied to extract needed information including address, type of AYP subgroup and population estimates at the location/site/venue.

9

ANALYZE DATA

The list should be reviewed to identify locations/sites/venues that have been verified as active for reaching AYP at risk/vulnerable to HIV. Population estimates should also be reviewed based on the additional information gathered.

10

GENERATE FINAL VALIDATED LIST FOR PRIORITISATION/ IMPLEMENTATION

This will be the final list to use by the implementer to make decisions about where to implement HIV services in the community i.e. identify locations/sites/venues that are of high priority for implementation.

A NOTE ABOUT ASSESSING STRUCTURAL BARRIERS

There is need for implementers to understand the role that structural barriers can play in the implementation of adolescent health development programs, some of these structural barriers range from lack of services that are adolescent and youth friendly, attitude of health workers, myths and misconceptions about contraception, services operational hours, age of consent, cost of accessing services and location of health facilities. A good understanding of this structural barriers that exist in the community will help the programmer in his program planning- how to mitigate these barriers and be able to achieve the desired results of the program. Mitigation measures could include, community dialogue, advocacy for supportive policy/legal frameworks, economic empowerment activities, human right education and reorientation of service providers, etc.

6.2 Obtaining information on risk behaviours, risk perception and barriers to inform initial project design

AYP population subgroups of interest, those vulnerable to/at risk of acquiring HIV should be engaged in small group discussions to obtain specific information about risk behaviours and potential barriers to access of HIV services. These discussions will provide essential information about the experiences, beliefs, opinions, practices, needs and preferences of AYP.

Implementers should keep in mind the size of their project and the different groups they intend to focus on in order to ensure that an adequate number of group discussions are held. Ultimately, findings will be used to establish/refine the response to this key question "Who are the AYP at risk and what is their level of risk and vulnerability?".

Implementers are encouraged to conduct focus group discussions (FGD), a qualitative research method for obtaining this information. Several good resources about FGDs are available online. A simple resource with specific steps and tips on designing and conducting FGDs is provided in the resources section of this guide.

6.3 Mapping of resources to aid implementation

This exercise will give a picture of what the community looks like and where services and resources can be located. It also shows the proximity of services to the priority population group.

1. **Draw map of community:** This provides a pictorial view of the community indicating streets, landmark etc.
2. **Map out location/sites/venues where AYP congregate:** This is highlighted on the community map and it pinpoints spots where AYP congregates like, gaming spots, joints, schools, skill acquisition centers etc.
3. **Map out service points/facilities for referral:** This is also highlighted on the community map indicating service delivery points including referral facilities where AYP can receive SRH and psychosocial services. These include hospitals, counseling centers and youth friendly services.

07. Conclusion

This is an exciting time for the HIV response for adolescents and young people. We have more supportive policy environment and stronger strategic information. Many implementers are taking steps to reach more adolescent and young people with HIV prevention, treatment, care and support services. Now is the time to invest and act. This guide supports community-level implementers to develop or expand their HIV programmes to respond to the needs of adolescents and young people.

08. Other guides in the series

Other guides are in place for the community-level implementer to plan effective and efficient programmes focused on adolescents and young people. They are:

PART ONE	**Understanding the HIV epidemic and response** towards planning an effective HIV programme for adolescents and young people
PART TWO	**Designing** an effective HIV programme for adolescents and young people
PART THREE	**Delivering** a HIV programme for adolescents and young people
PART FOUR	**Monitoring and sustaining** the impact of a HIV programme for adolescents and young people

*Visit **www.naca.gov.ng** for these guides.*

Selected terms and explanations

(Source UNAIDS Terminology Guidelines 2015)

AIDS	acquired immunodeficiency syndrome
AIDSinfo	AIDSinfo is a data visualization and dissemination tool intended to facilitate the use of AIDS-related data, both within individual countries and globally. AIDSinfo is populated with multisectoral HIV data from a range of sources, including WHO, UNICEF, UNAIDS and Measure DHS. The data provided by UNAIDS, for instance, includes AIDS spending, epidemiological estimates, information on policies, strategies and laws, and other country-reported data from government and civil society. The tool's visualization capabilities allow for the rapid production of charts, maps and tables for presentations and analysis. For more information, contact aidsinfo@unaids.org or see http://aidsinfoonline.org.
Gender	Gender "refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities"
Human Immunodeficiency Virus (HIV)	HIV is a virus that weakens the immune system, ultimately leading to AIDS.
Key populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere—they are key to the epidemic and key to the response. In Nigeria key populations are- female sex workers, men who have sex with men, people who inject drugs, transgender people and people in closed setting.

Know your epidemic, know your response	UNAIDS uses the expression know your epidemic, know your response to emphasize the approach to programme planning that uses granular data analysis to tailor the HIV response accordingly.
Opportunistic infections	Opportunistic infections are infections caused by various organisms, many of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in people diagnosed with AIDS include Pneumocystis jirovecii pneumonia, cryptosporidiosis, histoplasmosis, bacterial infections and some kinds of cancer, as well as other kinds of parasitic, viral and fungal infections. In many countries, tuberculosis is the leading HIV-associated opportunistic infection.
Population and location	In the context of HIV, population and location or local epidemic is a concept that is used to help prioritize programme activities within the HIV response. It refers to the need to focus on specific areas and specific populations where there is high HIV prevalence or incidence. The result of using a population and location approach will be a more efficient HIV response based on a more distilled knowledge of the HIV epidemic in the country.
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV, and certain behaviours create, increase or perpetuate risk. Avoid using the expressions groups at risk or risk groups— people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.
Vulnerability	Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Resources

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Joint United Nations Programme on HIV/AIDS (UNAIDS): www.unaids.org

United Nations Children's Fund (UNICEF): www.unicef.org

World Health Organisation (WHO): https://www.who.int/health-topics/hiv-aids/#tab=tab_1

World Bank: www.worldbank.org

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Notes

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