



**YOUNG
PEOPLE
TODAY**

**TIME TO
ACT NOW.**

FULFILLING OUR PROMISE TO YOUNG PEOPLE TODAY

2013-2015 Progress Review

The Eastern and Southern African Ministerial Commitment on
comprehensive sexuality education and sexual and reproductive
health services for adolescents and young people

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This report is dedicated to the memory of Taban Robert Aggrey, a journalist from South Sudan who dedicated his life to championing the cause of young people. Taban, who reported for the Young People Today website, often under very difficult and complex situations, was known for his passion, resilience and commitment to the youth of South Sudan.

“

I am a passionate journalist and I love what I do. I am motivated by the important role media plays in our community, especially engaging young people on sexuality education in a country that faces both high HIV prevalence and very low school enrolment. People tell me that I should leave my current work to find another job that is less risky – I understand why they worry. People are arrested, tortured and killed every day in South Sudan for doing what I do. But I always tell them ‘death has no escape.’

”

Taban passed away on 3 May 2016.

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Acronyms

AAI	AIDS Accountability International
ACRWC	African Charter on the Rights and Welfare of the Child
AfriYAN	Africa Youth and Adolescent Network on Population and Development
ALHIV	Adolescents living with HIV
ARVs	Antiretroviral drugs
ASRH	Adolescent sexual and reproductive health
ASRHR	Adolescent sexual and reproductive health and rights
AYAS	Adolescent and Young Adult Stakeholder Group
AYFHS	Adolescent and youth-friendly health service
BMZ	German Ministry for Economic Cooperation and Development
CBO	Community-based organization
COMESA	Common Market for Eastern and Southern Africa
CSE	Comprehensive sexuality education
CSO	Civil society organization
DHS	Demographic and health survey
DRC	Democratic Republic of Congo
EANNASO	East Africa Network of AIDS Service Organizations
EAC	East African Community
ECSA	East, Central and Southern Africa Health Community
EMIS	Education Management Information Systems
ESA	Eastern and Southern Africa
FBO	Faith-based organization
GBV	Gender-based violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GPE	Global Partnership for Education
HLG	High Level Group
HCT	HIV counselling and testing
HEMIS	The Higher Education Management Information System
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
ITGSE	International Technical Guidance on Sexuality Education
LSE	Life Skills Education
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-governmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
REC	Regional economic community
REPSSI	Regional Psychosocial Support Initiative
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SADC	Southern African Development Community
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SBCC	Social and behaviour change communication
SDC	Swiss Agency for Development and Cooperation
SDGs	Sustainable Development Goals
SERAT	Sexuality Education Review and Assessment Tool
SRGBV	School-related gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TCG	Technical Coordinating Group
UNAIDS	United Nations Joint Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YFHS	Youth-friendly health services
YFS	Youth-friendly services
ZINGO	Zambia Interfaith Networking Group on HIV and AIDS

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Acknowledging the generous support of:



Foreword

Every young person has the right to a full and healthy life. As governments, development agencies, civil society, community leaders and parents, we have a duty to prepare and support adolescents and young people with the right information and skills to make safe and healthy decisions about their life and future.

Visualize two scenarios. In one, an adolescent girl has little or no access to comprehensive sexuality education (CSE), or sexual and reproductive health services and rights (SRHR). She is forced to leave school as a result of an unintended pregnancy or to help her family earn a living. She is not free to decide when to marry, how many children to have, or when to have them. She may suffer illness, injury or even death from childbirth. She does not have decent employment opportunities, and cannot adequately provide for her children. Eventually, years down the road, she is confronted with an insecure old age. Not only is she unable to contribute to her country's potential as part of harnessing the demographic dividend, she is unable to achieve her true potential and worth as a citizen and as a human being – a tragedy which is far greater.

In the other scenario, this adolescent girl accesses the sexuality education and sexual and reproductive health (SRH) services she needs in an environment that allows her to make good, informed choices. She graduates from school and she has a choice of whom to marry when she is ready. She chooses how many children to have and remains healthy through childbearing. She is protected from gender-based violence (GBV) and displacement. She has the opportunity for gainful and satisfying employment. She achieves her true potential and worth – as a girl, a woman, a citizen, a human being. That, in turn, ensures that this adolescent girl of today fully achieves a 'double dividend' – demographic and democratic – of tomorrow.

For too many young people in the Eastern and Southern region, the first scenario is their lived reality. This is why on 7 December 2013, in Cape Town, South Africa, the region witnessed history in the making when ministers of education and health from 20 ESA countries came together to endorse and affirm their commitment to better health outcomes for adolescents and young people. The landmark Commitment, which recognizes the importance of SRHR for young people in the region, quickly became a platform to foster collaboration across sectors, harmonize related efforts at local, national and international levels, and champion the political momentum around four key results for adolescents and young people: reducing HIV infection; reducing early and unintended pregnancy; reducing GBV; and eliminating child marriage.

We are truly witnessing bold leadership and joint coordinated action in some countries in the region, but we need this momentum to expand. As the window for a demographic dividend opens ever wider for the region, we hope governments will seize this historic moment to ensure a life of dignity for all, leaving no one behind.


Let us step up and deliver for young people today. The time to act is now.



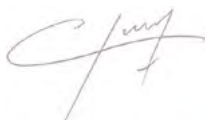
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What the ESA Commitment means to me

Lebogang Brenda Motsumi, 27, young South African advocate, member of the African Youth and Adolescent Network.

"I have dedicated my life to ensuring that no one should live my story again. I want young people to tell a new story. One of a young African who is empowered and educated; one of an adolescent who is supported and not ridiculed; one of a woman standing tall, making informed decisions about her life."

We all have a story to tell – each one marks and shapes us into who we are. It is what we value and believe, what we stand for and how we make decisions that impact our lives.

My story starts when I was a child. Growing up, I struggled with low confidence and self-esteem. My insecurities only grew as I went into my teen years. Like many girls, I would follow what my peers were doing for the sake of 'fitting in'. By the time I was 14, I had begun drinking, partying and skipping school. I had even lost my virginity. After one of my friends told me about her first sexual experience, I went on to do the same, not knowing how decisions as serious as this would impact me.

I went on living a life that sought approval from friends and the men I dated. I never thought about the potential of falling pregnant, but that's what happened when I was 16. Terrified of what my life would look like, I knew I couldn't have the child and tried terminating the pregnancy at seven months at a 'backdoor' clinic. I was unsuccessful. I later gave birth to a premature baby that passed away.

After that, I knew I needed to be more careful so I went to the clinic to get contraception. Instead of supporting me, the nurses interrogated me about why I was having sex. That discouraged me from ever going back to a clinic. I ended up falling pregnant three more times and each time I terminated the pregnancy. I was using termination of pregnancy as a

contraception method. Did I know about condoms? Yes! But I was not only afraid to go back to a clinic, I was also unsure how to negotiate with the man I was with to use a condom before having sex – 'it was his responsibility', or so I thought.

When I was 17, I met the man who changed my life forever. He was a local celebrity – a kwaito star – and it felt so good being next to him at different parties and events. I thought I was living a dream. I ended up having unprotected sex with him, which became the biggest mistake of my life. Two years later, I found out he was HIV positive and had known all along. I refused to get tested because I was in denial – I thought I was superior to the virus and that it was only for those who 'slept around' or came from poor backgrounds.

In 2009, I fell pregnant again and gave birth to a baby girl. I was rushed into surgery shortly after where I lost my womb, which I believe is connected to the numerous unsafe terminations I had.

I believe if I had received education that taught me about my rights and how to express my sexuality safely, it would have given me the skills to negotiate condom use. If I had been able to access youth-friendly health services while growing up, I would be a very different person today. I would maybe be a graduate, have a womb, and even be HIV-free.

I see the ESA Commitment as a solution we have been long waiting for. It symbolizes a new story for young people everywhere.

Executive summary

On 7 December 2013, in Cape Town, South Africa, Ministers of Education and Health from 20¹ countries in Eastern and Southern Africa (ESA) agreed to work collaboratively towards a vision of young Africans who are global citizens of the future, who are educated, healthy, resilient, socially responsible, informed decision-makers, and have the capacity to contribute to their community, country, and region. They affirmed a commitment to the right to the highest possible level of health, education, non-discrimination, and well-being of current and future generations. The Commitment had two sets of targets to be achieved in 2015 and 2020 respectively.

By the end of 2015, significant progress towards the ESA Commitment targets could be observed across a number of ESA countries, thanks to concerted action by governments, civil society, and development partners at national and regional level. This report presents the progress made after two years of implementation (2013-2015), and proves that with targeted interventions, sound strategies, adequate resources, and political will, the ESA Commitment targets are attainable. The data presented was obtained and validated through a multi-sectoral country reporting process as stipulated by the respective coordination mechanisms of the ESA Commitment.

2015 Target highlights

TARGET 1:

15 out of 21 countries

report providing CSE/Life Skills in at least 40% of primary and secondary schools

TARGET 2:

All 21 countries

report having CSE training programmes for teachers

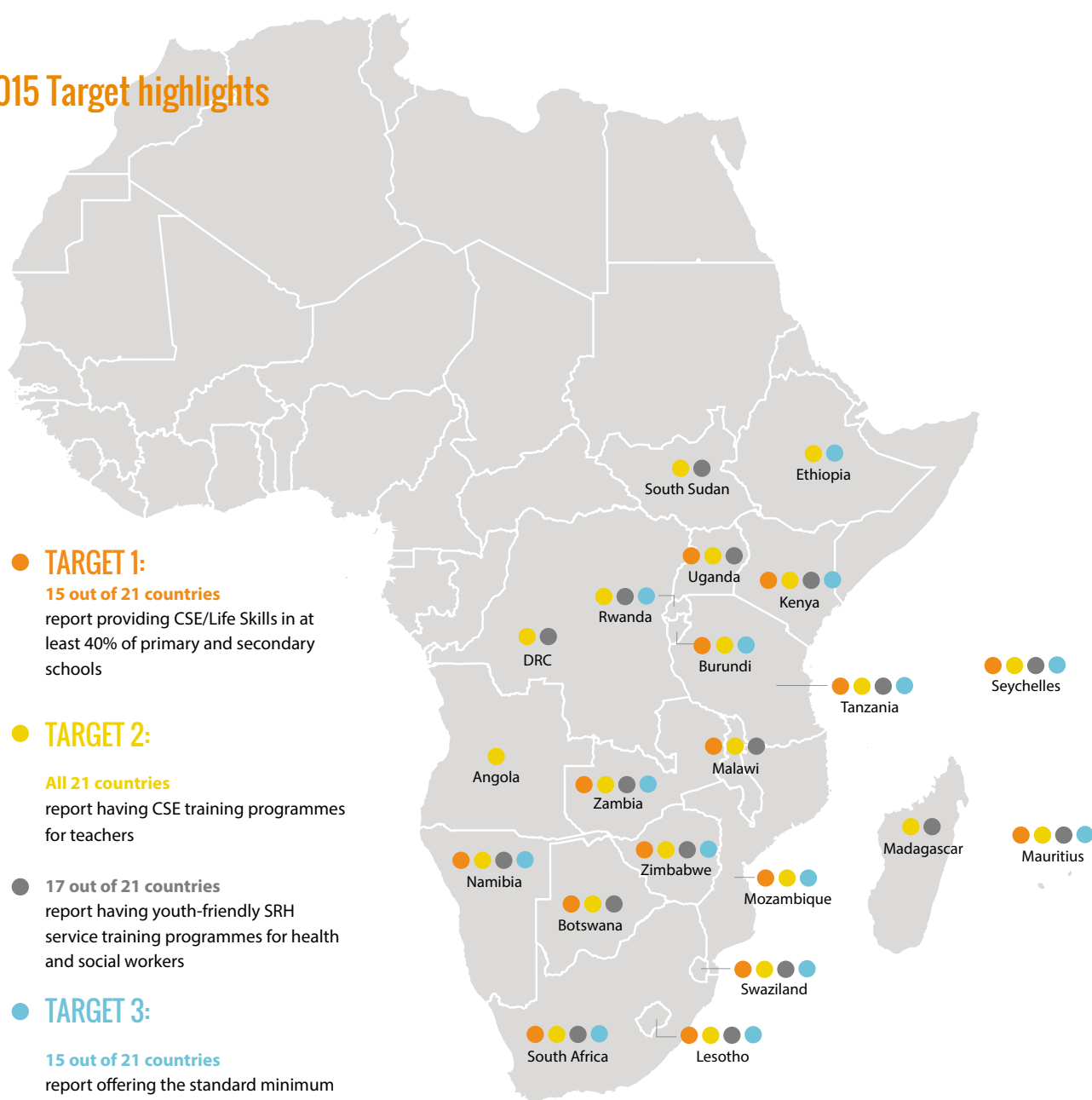
17 out of 21 countries

report having youth-friendly SRH service training programmes for health and social workers

TARGET 3:

15 out of 21 countries

report offering the standard minimum package of adolescent and youth-friendly SRH services



¹ Although Rwanda did not attend the meeting in Cape Town, the country has been, and continues to be, a part of the ESA Commitment process and has produced a country report, bringing the number of countries reporting to 21.

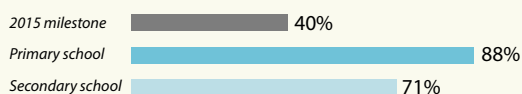
ESA Commitment 2015 targets overview

TARGET 1: A good quality comprehensive sexuality education (CSE) curriculum framework is in place and being implemented in each of the 20² countries by 2015



Milestone met and exceeded

Indicator: % of schools that provided life skills-based HIV and sexuality education in the previous academic year



Indicator: Number of countries that have a national CSE strategy or framework for out-of-school youth



- The ESA Commitment has put a spotlight on sexuality education. Two years since the endorsement of the ESA Commitment, the ESA region has witnessed a growing acceptance of the concept of sexuality education.
- 15 out of 21² countries report providing CSE/Life Skills in at least 40% of primary schools, while 6 countries are in progress.
- 12 out of 21 countries report providing CSE/Life Skills in at least 40% of secondary schools, while 9 countries are in progress.
- 16 out of 21 countries have policies or strategies relating to sexuality education for out-of-school youth.

While most countries now include CSE in the curriculum, a number of countries are yet to fully integrate CSE at scale, as this often happens in the context of a wider curriculum reform. Where CSE has been largely scaled-up, there is still a need to strengthen the quality of delivery to ensure that core essential topics are included and are taught early (before sexual debut). Furthermore, there is a need to strengthen programmes reaching those not enrolled in school.

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20² countries

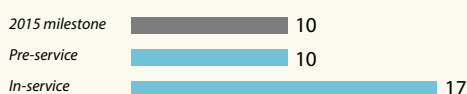


Milestone met and exceeded

Indicator: % of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year



Indicator: Number of countries that provided pre- and in-service training programmes on the delivery of adolescent youth-friendly services



- 10 out of 21 countries have pre-service teacher training programmes on CSE/Life Skills.
- All countries have in-service teacher training programmes on CSE/Life Skills.
- 10 out of 21 countries have pre-service health and social worker training programmes on the delivery of adolescent and youth-friendly SRH services.
- 17 out of 21 countries have in-service health and social worker training programmes on the delivery of adolescent and youth-friendly SRH services.

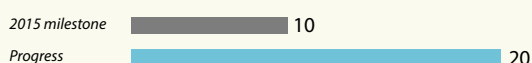
Improving efforts to capacitate teachers to transfer knowledge and skills using effective teaching practices remains a priority. More work is needed to ensure that training material for health workers is fully aligned to WHO standards and are instituted within health ministries.

TARGET 3: By the end of 2015, decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services, including HIV, that are equitable, accessible, acceptable, appropriate and effective



Milestone met and exceeded

Indicator: Number of countries with a costed national strategy/plan to improve young people's access to AYFHS aligned to regional/international standards



Indicator: % of countries that offer a standard minimum package of youth-friendly SRH services



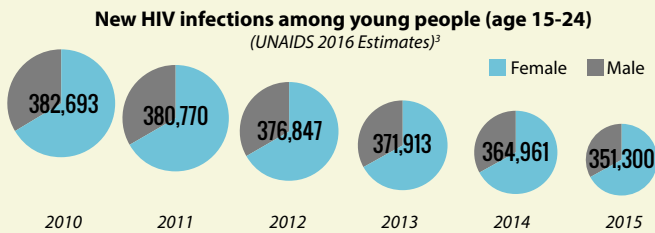
- 15 countries offer the minimum standard package of youth-friendly SRH package.

The levels of alignment and implementation of national standards according to WHO guidelines vary within and among countries, and recent reviews reveal limited progress on improvements of service delivery, especially to the most vulnerable and marginalized populations. As a result, young people continue to face barriers when accessing SRH services. These include conflicting laws, fear and shame, stigma, negative attitudes of health workers, and lack of knowledge on where and what services are available.

² The 20 countries that were present at the ESA Commitment meeting in Cape Town in December 2013 plus Rwanda.

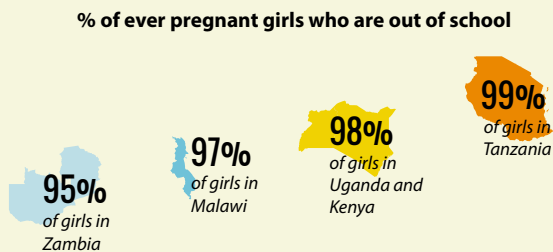
Progress towards 2020 targets

TARGET 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA and push towards eliminating all new HIV infections among adolescents and young people aged 10-24



Although new HIV infections are on the decline across the region, these reductions remain insufficient. Significant numbers of young people, predominantly adolescent girls and young women, are still becoming newly infected. UNAIDS notes that adolescent girls and young women are a key population in danger of being left out in the AIDS response⁴. While trends in the region are showing encouraging declines in risk behaviours the reality is that young women and girls continue to face difficulties in navigating these risks due to power imbalances in relationships.

TARGET 6: Reduce early and unintended pregnancies among young people by 75%

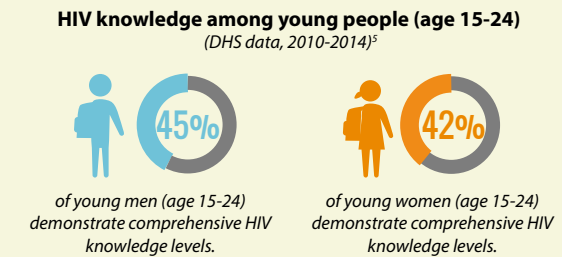


Early and unintended pregnancy rates among adolescent girls aged 15-19 remain high across the region, ranging from 39% in Tanzania to 59% in Kenya⁶. This is largely as a result of a lack of access to contraception due to factors such as cultural and religious opposition, poor quality of available services, gender-based barriers, and spousal disapproval⁷. Pregnancy almost always means an end to education for most girls; with at least 95% of ever pregnant girls being out of school across four study countries.

TARGET 8: Eliminate child marriage

The African Charter on the Rights and Welfare of the Child (ACRWC) prohibits the marriage of any child under the age of 18 years. However, in the majority of countries in the ESA region, traditional or customary law continues to support early marriage and more than one third of women aged 20-24 years (6.5 million) have been married or in a union before the age of 18. Child marriage is associated with higher rates of teenage pregnancy and higher fertility, resulting in girls having to care for many children while they themselves are still young. The African Union has launched a Continental Campaign to End Child Marriage in Africa. Regional efforts to end child marriage include a model law on child marriage developed by SADC for countries to adopt across the Southern African sub-region.

TARGET 5: Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels



While there have been modest improvements in young people's HIV related knowledge globally, improvements in knowledge levels are apparent in Eastern and Southern Africa⁵. By 2014, more young people in the region were knowledgeable about HIV than a decade ago. However, the majority of young people still lack sufficient knowledge about HIV transmission and young women are less likely than young men to have accurate and comprehensive knowledge about HIV transmission.

TARGET 7: Eliminate gender-based violence



Gender-based violence remains high across all countries. Sexual violence puts girls at higher risk of HIV infection and has knock-on effects on educational and health outcomes for women and children. In Southern African countries, where one in every three girls has been forced to have sex by the age of 18 years⁸ a very large proportion of the population have limited agency in making choices regarding their sexual health. Young people experience violence and harassment in, around, and on the way to school.



³ UNAIDS 2016 estimates for ESA countries. Missing data from DRC, Burundi, Ethiopia South Sudan (2013) and Seychelles.

⁴ UNAIDS. 2015. *How AIDS changed everything, MDG6; 15 years, 15 lessons of hope from the AIDS response*. Geneva, Switzerland.

⁵ Most recent DHS data for the period 2010-2014 from 12 ESA countries namely, Burundi (2010 DHS); DRC (2013-14 DHS); Ethiopia (2011 DHS); Kenya (2014 DHS); Malawi (2010 DHS); Mozambique (2011 DHS); Namibia (2013 DHS); Rwanda (2010 DHS); Tanzania (2010 DHS); Uganda (2011 DHS); Zambia (2013-14 DHS) and Zimbabwe (2010-11 DHS)

⁶ Birungi H. et al. 2015. *Education Sector Response to Early and Unintended Pregnancy: A Review of Country Experiences in Sub-Saharan Africa*.

⁷ Ford Foundation and HIVOS. 2016. *Draft Briefing Note for SADC Meeting: Sexual and Reproductive Health and Rights and the Sustainable Development Goals*.

⁸ Anderson N. 2006. *Prevention for those who have freedom of choice – or among the choice-disabled: confronting equity in the AIDS epidemic*.

Recommendations

Despite the significant progress in meeting the short-term targets of the ESA Commitment, much more work needs to be done in order to realize the 2020 targets.

1

Coordination and management of the ESA Commitment:

The ESA Commitment provides a platform for action to address the ESA targets, but leadership and ownership by countries is a critical success factor, including a coordinated response and allocation of domestic resources. It will be important to ensure that strategies for the attainment of the ESA Commitment targets are included in country work plans and costed. Countries must prioritize working across sectors (education, health, gender, justice, and youth) to support joint action, while increasing domestic financing for young people's SRH programmes.

2

Accelerate provision of CSE and youth-friendly SRH services:

Provision and access to good quality CSE for all adolescents and young people in and out of school needs to be strengthened. Likewise, adolescent and youth-friendly services should be provided at all clinics and hospitals, and services such as mobile clinics to accommodate the hours of school-going adolescents and young people offered.

3

Engagement of parents and communities:

Given their influential role in young people's access to sexuality education and SRH services, engagement of parents and communities remains critical. There is a need to develop creative strategies for working 'with' and 'through' young people to reach their parents and engage with traditional and religious leaders on programmes, as well as enable dialogue around key religious principles.

4

Involvement of young people:

It is critical the needs of all young people, including the most marginalized and vulnerable, are factored into the development and implementation of all relevant policies and programming by ensuring that they are consulted and are able to represent their needs.

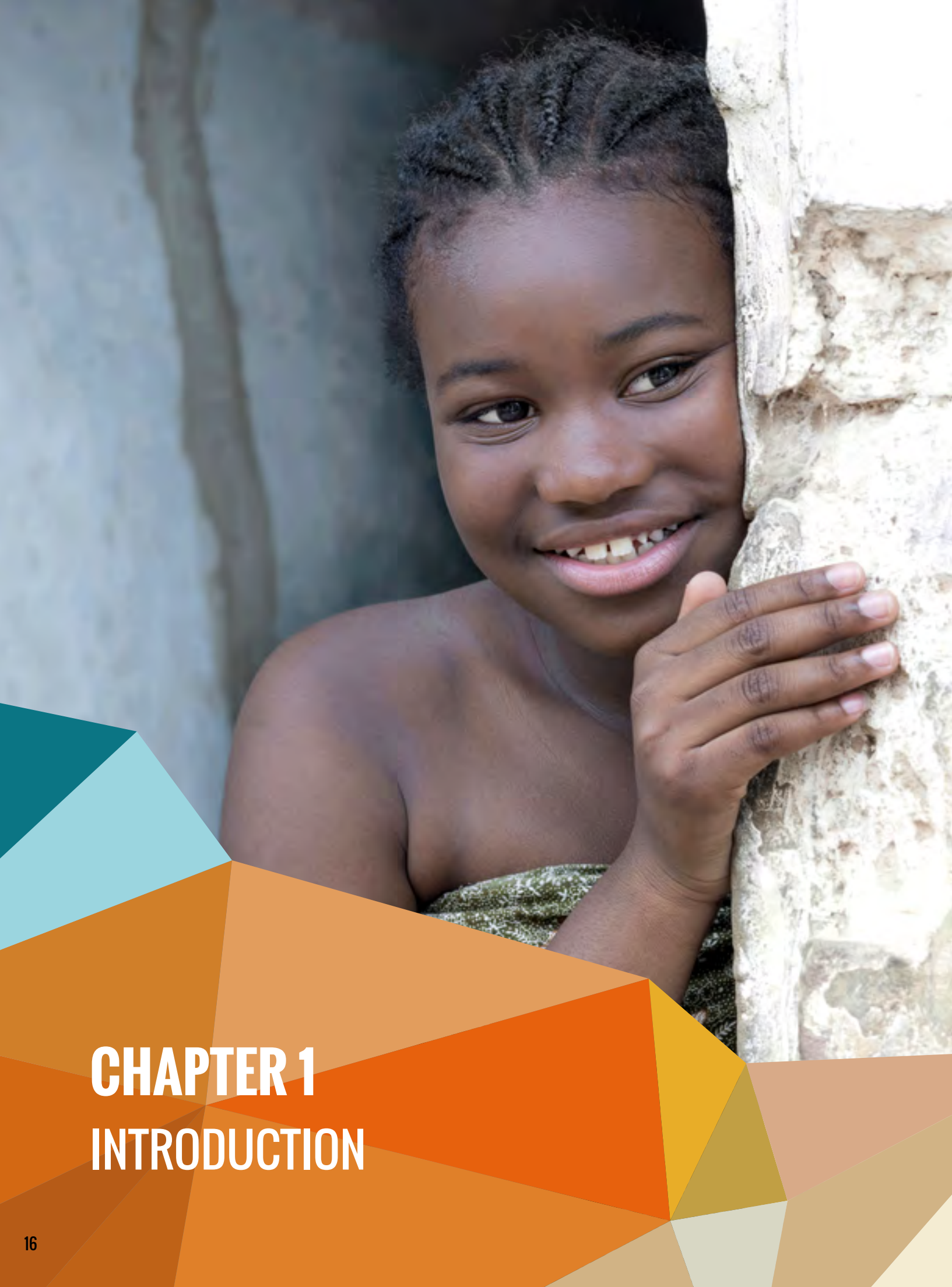
5

Prioritizing adolescent girls and young women:

Governments, development partners, and other stakeholders must invest in programmes that encourage girls to remain in school; ensure that schools are safe and equitable places for learning; support access to SRH services for young people; enforce legislation to eliminate child marriage; and strengthen child protection systems, with an emphasis on legal reform and on strengthening norms and standards that eliminate discrimination based on gender. At the same time, efforts need to be directed towards engaging boys and men as they are critical influencers of the realization of the rights of girls and women.

How can Eastern and Southern Africa turn our 158 million young people into 158 million opportunities?

Countries will need to continue working together towards a common vision of a young African, a global citizen, who is empowered, educated, healthy, resilient, and socially responsible – an autonomous decision-maker who has the capacity to reach their full potential and contribute to the development of their community, country, and the region.



CHAPTER 1

INTRODUCTION

1.1 Status of young people in Eastern and Southern Africa

Eastern and Southern Africa (ESA) has 158 million young people aged 10-24; a number that is expected to rise to 281 million by 2050. Better education and public health measures will be hugely beneficial to the health and development of these young people. For most adolescents and young people, this period of their lives is a time of enormous vibrancy, discovery, innovation, and hope. Yet it is also the time when they face many sexual and reproductive health (SRH) challenges, including early and unintended pregnancy, HIV and sexually transmitted infections (STIs), gender-based violence (GBV) and child marriage – all of which can undermine education opportunities, especially for girls, and affect future health and opportunities. Investing in the education and health of adolescents and young people at the right time ensures that they transition into healthy adults who can contribute productively to the economy⁹.

In 2014, nearly half the estimated 2 million global new infections occurred in Eastern and Southern Africa, where adolescent girls and young women often acquire HIV five to seven years earlier than their male counterparts¹⁰. Furthermore, AIDS is the leading cause of death for adolescent girls in the region. Keeping adolescent girls and young women HIV- and AIDS-free is critical for their well-being and health, the health of their families and communities, and their countries' future.

Knowledge levels on HIV and AIDS in the ESA region have historically been well below the target of 95% set by the United Nations General Assembly Special Session on HIV and AIDS in 2001. With inadequate knowledge, young people are ill-equipped to make healthy and safe decisions in regard to their sexual health¹¹. However, knowledge – while a crucial foundation – is in itself not sufficient to change behaviour and reduce risk to HIV infection. It needs to be combined with the right skills and attitudes, which can be taught and developed through good quality comprehensive sexuality education (CSE)¹².

A lack of comprehensive knowledge on SRH and access to services is highly correlated with early adolescent childbearing. Early and unintended pregnancy is a major public health issue in the sub-Saharan Africa region, where adolescent girls (15-19 years) experience the highest rates of pregnancy in the world¹³, largely because sex, marriage, and pregnancy are often not voluntary or consensual for them, and many lack access to information to make informed decisions.

Violence against adolescents and young people is not uncommon in the ESA region and ranges from physical violence and sexual violence or harassment, to female genital mutilation and child marriage. Although sexual violence affects all children, girls are particularly vulnerable because of gender norms that encourage men to be aggressive and women to have little control over their bodies and safety. Girls who experience sexual violence are at higher risk of HIV infection and, because they are usually unable to exercise their power to make and act on prevention decisions, are also often unable to respond to AIDS prevention programmes¹⁴.

Girls face the additional challenge of child marriage, with more than a third (38%) of women aged 20-49 in ESA having been married before the age of 18¹⁵. Child marriage is associated with higher rates of teenage pregnancy, resulting in girls having to care for many children while they themselves are still young. Early pregnancy poses life-threatening consequences in terms of SRH, and interrupts girls' education. Furthermore, child marriage is linked to commercial sexual exploitation, as well as higher exposure to intimate partner violence.

In line with the Sustainable Development Goals (SDGs), the UNAIDS Strategy (2016-2021) – which focuses on ending AIDS and delivering dignity, equity, and sustainable development and issues a call to Fast Track our efforts to protect future generations by 'turning off the tap' of new HIV infections – underscores the importance of empowering young people, particularly young women, to prevent HIV, end GBV and promote healthy gender norms.

The African continent is facing the opportunity of realizing the demographic dividend; the economic benefit that can arise when a population has a relatively large proportion of working-age people who are effectively invested in for their empowerment, education, and employment. With 40% of Africa's population under the age of 15, adolescents and young people can be a great force for attaining social, economic, and political change, but to do this the region will need strong political leadership that upholds and expands the commitments made to increase the empowerment of girls and women, ensure universal and quality education that is tailored to new economic opportunities, and augment secure employment, as well as health care that enables fertility decline.

The UNAIDS Strategy 2016-2021 calls for a world where young people, regardless of where they live or who they are, have the knowledge, skills, services, rights and power to protect themselves from HIV.



⁹ UNESCO. 2013. Young People Today. Time to act now. Why adolescents and young people need access to comprehensive sexuality education and access to sexual and reproductive health services in Eastern and Southern Africa.

¹⁰ UNAIDS Strategy for 2016-2021.

¹¹ SACMEQ. 2010. How successful are HIV-AIDS prevention education programmes? SACMEQ Policy Issue Series.

¹² UNESCO. 2009. International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators (Vols 1 & 2).

¹³ UNFPA. 2013. Adolescent pregnancy: A review of the evidence.

¹⁴ Anderson N. 2006. Prevention for those who have freedom of choice – or among the choice-disabled: confronting equity in the AIDS epidemic.

¹⁵ UNICEF. 2014. A Statistical Snapshot of Violence against Adolescent Girls.

1.2 The Eastern and Southern Africa Ministerial Commitment

On 7 December 2013, in Cape Town South Africa, Ministers of Education and Health from 20 ESA countries endorsed and affirmed their commitment to positive health outcomes for all young people in the region. Together with Rwanda, who, while not able to attend the meeting in Cape Town, has been, and continues to be, a part of the ESA Commitment process, they agreed to work collaboratively towards a vision of young Africans who are global citizens of the future, who are educated, healthy, resilient, socially responsible, informed decision-makers, and have the capacity to contribute to their community, country, and region. They affirmed a commitment to the right to the highest possible level of health, education, non-discrimination, and well-being of current and future generations.

The historic ESA Commitment has time-bound targets agreed upon by member states and paves the way for actions to scale up delivery of sexuality education and related health services; support joint action around developing programmes and sharing information; reinforce linkages and referrals between schools and health services; and foster an overall approach which facilitates access and equity and strengthens national responses to HIV and adolescent sexual and reproductive health and rights (ASRHR).



The 20 Ministers of Education and Health affirming their commitment to scale up comprehensive sexuality education and sexual and reproductive health services for adolescents and young people (December 2013)

“The ESA Commitment can make a difference for all young people. We call on our governments to honour their commitment and make comprehensive sexuality education and sexual and reproductive health services accessible to all young people in their different settings.”

Lebogang, 27, South Africa

1.2.1 Extract from the endorsed ESA Commitment

The Ministers of Education and Health committed to:

Work together on a common agenda for all adolescents and young people to deliver comprehensive sexuality education and youth-friendly SRH services that will strengthen our national responses to the HIV epidemic and reduce new HIV/STI infections, early and unintended pregnancy and strengthen care and support, particularly for those living with HIV. Establish inter-sectoral coordination mechanisms led through the existing regional economic communities, EAC, SADC and ECSA. Where such mechanisms already exist they must be strengthened and supported.

Urgently review - and where necessary amend - existing laws and policies on age of consent, child protection and teacher codes of conduct to improve independent access to sexual and reproductive health services for adolescents and young people and also protect children. Laws, policies and practices regulating access to services and in child protection must recognise the need for a balance between protection and autonomy and the evolving capacity of adolescents as they begin to make their own choices about their education and health needs.

Make an AIDS-free future a reality by investing in effective, combination prevention strategies to build on current declines in HIV prevalence amongst young people in the region as well as addressing underlying structural factors including poverty and a lack of livelihoods. Concerted effort will be made to build the capacity of teachers, health service providers and young people and to particularly advocate for increasing HIV testing and counselling, treatment access and expansion of agreed essential SRH services especially in marginalised communities and hotspot areas and including in non-formal and out of school settings.

Maximise the protective effect of education through Education for All by keeping children and young people in school which reduces HIV risk, maternal mortality and improves gender equality, whilst ensuring access to educational opportunities for those living with HIV or adolescent and young women who may be pregnant.

Initiate and scale up age-appropriate CSE during primary school education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases. Using agreed international standards, ensure that CSE is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills and values as preparation for adulthood: decisions about sexuality, relationships, gender equality, sexual and reproductive health and citizenship⁸. Wherever possible, make in-school CSE programmes intra-curricular and examinable.

Ensure that the design and delivery of CSE and SRH programmes includes ample participation by communities and families - particularly adolescents, young people, civil society and other community structures including faith-based organisations. At the same time, adolescents and young people should be guaranteed safe spaces, the right to be their own advocates and agents of change in their own communities, and to recommend good practices and innovations which meet their needs.

Integrate and scale up youth-friendly HIV and SRH services that take into account social and cultural contexts to improve age-appropriate access to and uptake of high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HIV counselling and testing (HCT), HIV/STI treatment and care, family planning, safe abortion (where legal), post abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) and other related services for young people in and out of school.

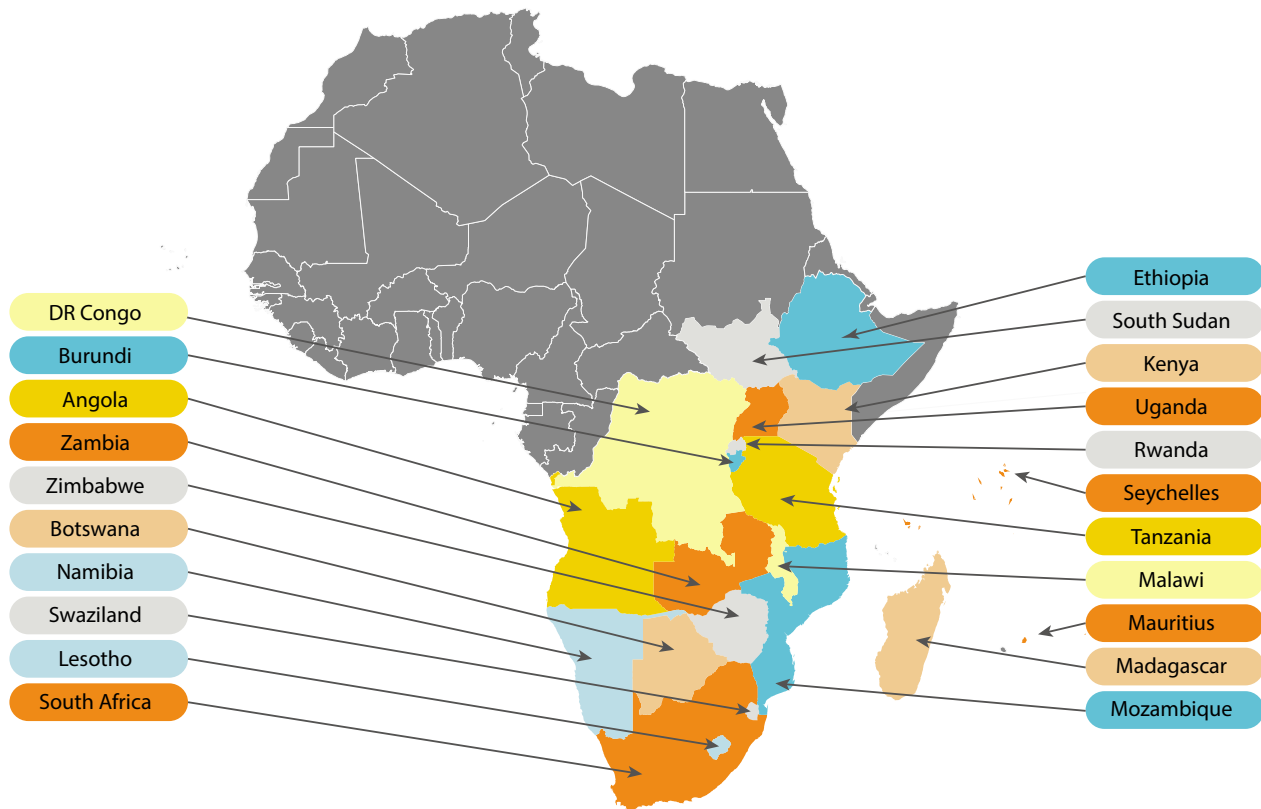
Ensure that health services are youth-friendly, non-judgemental, and confidential and reach adolescents and young people when they need it most, and are delivered with full respect for human dignity, including for young people considered most at risk, young people living with disabilities, or young people experiencing any other forms of discrimination. Reliable, affordable commodities must be made available as part of service delivery through public, private and civil society channels.

Strengthen gender equality and rights within education and health services including measures to address sexual and other forms of violence, abuse and exploitation in and around school and community contexts whilst ensuring full and equal access to legal and other services for boys and girls, young men and women.

Mobilise national and external resources by exploring new, innovative finance mechanisms and seeking technical and financial support from national and international sources to fulfil these commitments.

1.2.2 The ESA Commitment countries

FIGURE 1.0: Map showing countries that are implementing the ESA Commitment



1.2.3 The ESA Commitment targets

To ensure effectiveness, impact, and accountability – working together within a multi-sectoral and whole government approach – education and health ministers committed to meet the following targets:

2015 targets



A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries.



Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries.



By the end of 2015, decrease by 50% the number of adolescents and young people who do not have access to equitable, accessible, acceptable, appropriate and effective youth-friendly SRH services, including HIV.

2020 targets



Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24.



Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels.



Reduce early and unintended pregnancies among young people by 75%.



Eliminate gender-based violence and child marriage.



Increase the number of schools and teacher training institutions that provide CSE to 75%.

1.2.4 Accountability Framework of the ESA Commitment

The Technical Coordinating Group (TCG), under the leadership of UNAIDS and with support from UNESCO and the strong engagement of the SADC and EAC Secretariats, developed an Accountability Framework to monitor country and regional progress towards the agreed Commitment. The intended audience for the framework is primarily governments in the 21 countries, civil society partners, including young people and community-based organizations (CBOs), and other development partners.

The accountability framework monitors 20 indicators with specific year-end targets for 2015, 2017 and 2020 along the following key areas:

1. Development of an enabling environment;
2. Scale-up of CSE;
3. Improvement in access to youth-friendly SRH services;
4. Increase in comprehensive HIV knowledge levels;
5. Reduction of new HIV infections, early and unintended pregnancies, and GBV; and
6. Elimination of child marriage.

At country level, governments agreed to establish an inter-ministerial, multi-sectoral mechanism (aligned with, or utilizing, existing systems) to strengthen planning, coordination and to monitor the implementation of the Commitment. These country mechanisms engage key stakeholders, including government, civil society, young people, the UN, and other development partners.

With support from development partners, SADC and the EAC lead in the regional monitoring of the ESA Commitment. In 2015, the Common Market for Eastern and Southern Africa (COMESA) came on board to join the other regional economic communities (RECs) in supporting the monitoring and implementation of the ESA Commitment across member states. It was agreed that RECs would report on the Commitment annually at their respective summits involving the relevant ministers and through national status reports.

Ministers agreed to institutionalize monitoring and evaluation (M&E) systems in their respective ministries and improve the collection of age- and sex-disaggregated data through existing M&E mechanisms, such as Education Management Information Systems (EMIS) and Health Management Information systems (HMIS). These will be supplemented by periodic adolescent and youth surveys on the education and health status of adolescents and young people.



RECs in a technical coordinating meeting, sharing progress on the ESA Commitment and the accountability mechanism. From left to right: Dr Michael J. Katende, EAC; Ms Ahamada Andjouza, COMESA; and Dr Vitalis Goodwell Chipfakacha, SADC. Photo credit: UNESCO/Corrie Butler

1.3 The ESA Commitment 2015 progress report

1.3.1 Overview

This report provides an overview of the progress made, as well as what barriers and challenges remain, towards achieving the ESA Commitment targets. It draws on specific information about the status of the Commitment in the 21 countries¹⁶, generated through analysis of country reports and triangulated with existing resources and studies. The report takes stock of political support for the ESA Commitment and examines how the Commitment has had an impact at national level on the delivery of quality CSE and increased access to SRH services.

1.3.2 Methodology

In 2015, progress data for the report on ESA Commitment targets for 2015 and 2020 was collected through a country reporting template which is closely aligned to the regional accountability framework. The template was sent to each country ESA Commitment focal point, who then convened technical working groups in a national meeting to complete the template.

Review of progress against targets for 2015 is reported based on milestones set out in the accountability framework, while results on coverage were calculated based on data reported by countries through the country reporting templates.

In some countries, not all members of the technical working groups were present to validate the results. The country results documented may therefore not always reflect a balance between government and civil society input. The reports were sent back to countries for validation. RECs were engaged in communicating with governments and following up on the reports, and they supported the report validation process. The final report is thus a product of the joint efforts of governments, partner agencies, and young people themselves to document progress attained by the region two years after the historic affirmation of the ESA Commitment in 2013.

¹⁶The 20 countries that were present at the ESA Commitment meeting in Cape Town in December 2013 plus Rwanda.



CHAPTER 2

POLICY, COORDINATION AND PARTNERSHIPS

2.1 Policy environment for implementing the ESA Commitment

The ESA Commitment recognizes the responsibility of the state to promote human development, including good quality education and good health, and to implement effective strategies to educate and protect all children, adolescents and young people, including those living with disabilities, from early and unintended pregnancy, unsafe abortion, HIV and other STIs, and risks of substance misuse, as well as to combat all forms of discrimination and rights violations, including child marriage.

Consequently, across the 21 countries, the development of policies and strategies has provided an enabling environment for programming and the majority of countries have developed or strengthened policies governing the provision of good quality CSE for young people in school. There has also been a growing recognition of the need to strengthen policy provisions for young people out of school.

2.1.1 Legal and policy support for SRH services

A broad range of international and regional commitments exist that explicitly recognize adolescents' and young people's rights to health and to access SRH services. The 1994 International Conference on Population and development (ICPD) was a critical milestone to create the link between sexuality education and SRH services for young people. However, although progress has been made in strengthening access to youth-friendly services (YFS), young people still face legal and implementation barriers.

In 2014, a detailed review of the laws and policies in 23 countries from the ESA region was commissioned by UNFPA and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) to determine how legislative and policy provisions directly or indirectly impact on adolescents' and young people's sexual and reproductive health and rights (SRHR) in the different countries. The review focused on laws pertaining to ages of consent to sexual activity, marriage and medical treatment; laws enabling or restricting adolescent sexual and reproductive health and rights (ASRHR); the criminalization of consensual sexual activity, HIV transmission and sexual diversity; legal restrictions on harmful cultural practices; and learner pregnancy policy and CSE in schools.

The report indicates that there is a disjuncture between the relevant policies and laws in the majority of these countries. Furthermore, it demonstrates that many countries' laws do not comply with international and regional commitments. In some other instances, there are clear conflicts between civil/common law and customary law systems, including:

1) Legal age of consent to access medical treatment for young people across the region

The age of consent to medical treatment, including HCT, is not provided for in laws and policies in the majority of the countries. This can lead to great confusion as to when young people can consent to medical treatment themselves and when they need parental consent. Furthermore, as the health services providers are not always clear on what the age of consent is for different services either, this creates a barrier to access to SRH services. Countries like South Africa and Uganda have made legislative provision for the ages of consent to SRH services by setting the minimum age at 12 years.

2) Learner pregnancy and re-entry policies

Only about half the ESA countries have legislation and policies on the prevention and management of learner pregnancy and re-entry after delivery. The majority of those countries tend to approach learner pregnancy from a punitive perspective, which is clear from some of the policies that bar learners from returning to the specific school, exclude them from school for a specific time, or expel them on the grounds of pregnancy.

FIGURE 2.0: Map showing legal age of consent to access medical treatment

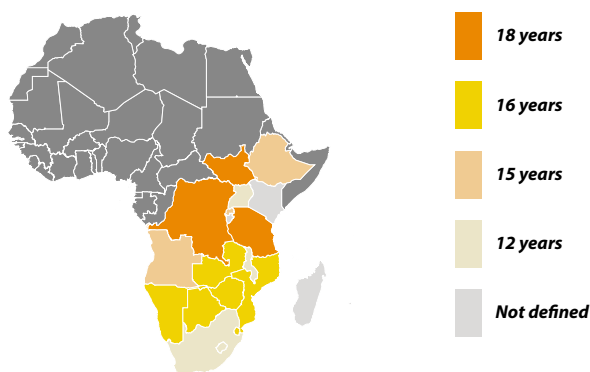


FIGURE 2.1: Map showing legislation and policies on prevention and management of learner pregnancy and re-entry after delivery



3) Legal age of consent to sexual activity

Approximately half the ESA countries do not have clear legislation on the minimum age of consent to sexual activity. This makes it difficult for young people and the community at large to ascertain with certainty what the minimum legal age for sexual activity is. The age of consent to sex varies from 14 years in the Democratic Republic of Congo (DRC), to 18 years in Ethiopia, Rwanda, Seychelles, South Sudan and Uganda.

4) The age of consent to marriage

All 23 countries in the UNFPA study have set ages of consent to marriage, however, there is disharmony between the legislative provisions and the international standards, as well as between statutory and customary laws. This leads to the continued practice of child marriage, which has dire consequences, particularly for young girls. Eight countries in the ESA Commitment region (Botswana, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, South Sudan, and Uganda) set the age of consent to marriage at 18 years without exception. Although the Zimbabwean Constitution indirectly sets the age of marriage at 18 years, the Marriage Act still provides for a lower age of 16 years for girls.

FIGURE 2.2: Age of consent to marriage and sexual activity

COUNTRY	Minimum age of consent to sex		Minimum age of consent to marriage	
	Male	Female	Male	Female
Angola	18	16	16	15
Botswana	16	16	18	18
DRC	18	14	18	15
Ethiopia	18	18	18	18
Kenya	18	18	18	18
Lesotho	16	16	18	16
Madagascar	14	14	18	18
Malawi	16	16	15 ¹⁷ -18	15-18
Mauritius	16	16	16 ¹⁷ -18	16-18
Mozambique	18	18	18	18
Namibia	14	14	18	15
Rwanda	18	18	21	21
Seychelles	18	18	18	15
South Africa	16	16	14 ¹⁸ -18	12 ¹⁸ -18
South Sudan	18	18	18	18
Swaziland	16	16	18	16
Tanzania	18	15	18	15
Uganda	18	18	18	18
Zambia	16	16	16	16
Zimbabwe	16	16	18	16

¹⁷ With parental consent.

¹⁸ Parental and ministerial consent required.

2.2 Coordination and management of the ESA Commitment

2.2.1 Country level coordination

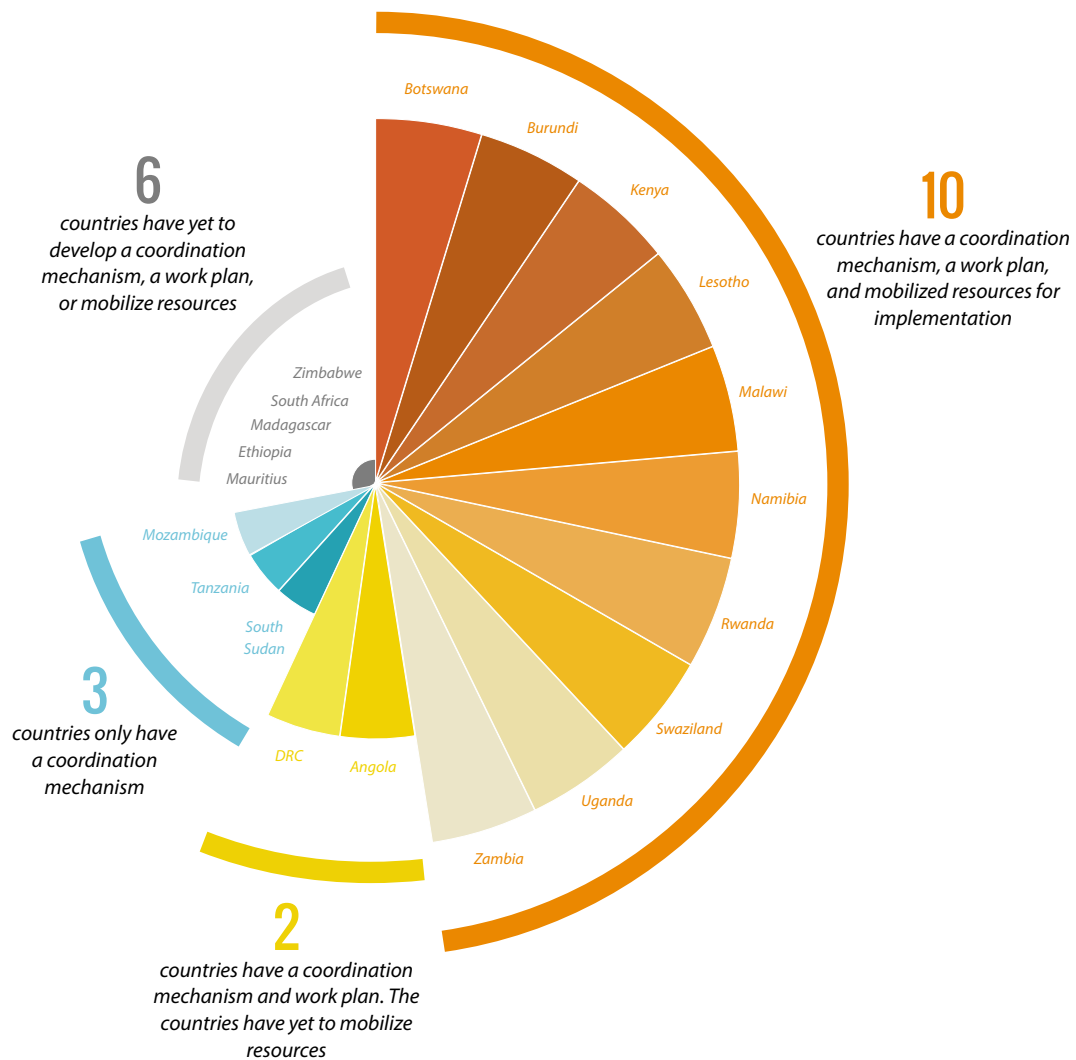
The ESA Commitment is guided by the conviction that the education and health sectors, working jointly, have enormous potential to promote the good health and well-being of all individuals and communities. In addition, working in collaboration with ministries of gender, youth, and others will greatly enhance the effectiveness of our efforts and ensure a coordinated, multi-sectoral approach that will benefit adolescents and young people.

Across the region, all ESA Commitment countries have either established a new or utilized an existing coordinating mechanism with clear terms of reference to guide the implementation of the ESA Commitment, many of them explicitly multi-sectorial. The majority of countries have included the ESA Commitment in sector work plans with costed activities and allocated resources.

The chart below shows that 10 countries have country coordination mechanisms, work plans, and financial resources allocated to the ESA Commitment, while five are yet to develop these structures.

The development of terms of reference for technical working groups has been critical in guiding and providing direction to countries for implementing the ESA Commitment. Currently eight countries have developed terms of reference, with the most common tasks being around coordinating and monitoring CSE- and ASRH-related activities. Countries with technical working groups that are guided by clear terms of reference are better able to ensure a comprehensive and joint national response for addressing the issues of adolescents and young people.

FIGURE 2.3: Countries with coordination mechanisms, work plans and resources that have been mobilized for implementation



SPOTLIGHT: Coordination of ESA Commitment in Tanzania

In early 2014, a country working group for the ESA Commitment was formed and co-chaired by the ministries of education and health with the secretariat provided by UNESCO. The intention was to create momentum and mobilize partners to implement the ESA Commitment in a more coordinated manner.

In January 2015, the national HIV Prevention Technical Working Committee (P-TWC) began developing a youth sub-committee. The main goal of the sub-committee was to coordinate a multi-sectoral national response to reduce adverse SRH outcomes among 10-24-year-old Tanzanians.

To avoid duplication of efforts, the groups merged to form the Adolescent and Young Adult Stakeholders (AYAS) in June 2015. AYAS has a strong focus on CSE, SRH, and improved multi-sectoral support to adolescents, including adolescents living with HIV (ALHIV). AYAS is co-chaired by the ministries of education and health with the Tanzania Commission for AIDS as Secretariat.

In Tanzania, resources for youth CSE and SRH initiatives (including the ESA Commitment) have come from many different sources, including government, development partners (e.g. UN agencies), donors (e.g. the Global Fund), Global Partnership for Education (GPE), non-governmental organizations (NGOs), and civil society organizations (CSOs). The role of mobilizing resources for the implementation of the ESA Commitment falls to the implementers, e.g. the government, NGOs, and CSOs. In 2016, the Global Trust Fund will begin providing substantial support to adolescent sexual and reproductive health (ASRH) delivery points.

2.2.2 Regional level coordination

At regional level, the ESA Commitment process is steered by a High Level Group (HLG) of 10 champions and leaders with a firm interest in SRHR. The HLG is assisted by a Technical Coordinating Group (TCG), whose key task is to provide technical, administrative, and financial support to the ESA Commitment process.

Together, the TCG and HLG play a critical role in advocating for the ESA Commitment in international, regional, and local contexts, in addition to overseeing a unifying regional vision. The ESA Commitment has also resulted in the RECs (SADC, EAC and COMESA) working together to support countries. RECs are the lead in championing accountability and overseeing implementation of the ESA Commitment.

2.3 Strategic partnerships

The ESA Commitment process relies heavily on broad-based partnerships, including development partners, CSOs, parents, community leaders, religious leaders, and young people, to make it a reality. This has enabled the mobilization of additional resources to support country level implementation. The region has seen instances where increased and better focused funding has been mobilized to support adolescents' and young people's SRH issues, such as in Tanzania where, through the ESA Commitment working group, partners were able to mobilize around 3 million USD to support implementation.

The last two years have seen many key influential organizations increasing their support to programmes that will contribute to the attainment of the ESA targets:

- In 2013, the governments of Sweden and Norway invested significant resources to support countries in scaling-up good quality CSE in eight focus countries (Malawi, Mozambique, Lesotho, Zambia, Uganda, Tanzania, Namibia and South Sudan).
- In 2014, the Swiss government availed resources through the Safeguard Young People project to support access to good quality CSE and SRH services for young people in nine countries (Malawi, Mozambique, Zambia, Botswana, Zimbabwe, Lesotho, Swaziland, Namibia and South Africa).
- In 2014, the German Ministry for Economic Cooperation and Development (BMZ) announced the funding of a 3 million euro project to support the targets of the ESA Commitment in four countries (Namibia, Zambia, South Africa and Mozambique).
- The *All In!* initiative¹⁹, launched in early 2015, provides a platform to unite voices and work together to stop AIDS-related deaths, new HIV infections, and violence caused by AIDS among adolescents. *All In!* focuses efforts on the specific needs of adolescents in the HIV response, bringing together partners and supporting countries to carry out assessments and better tailor their national HIV responses.
- The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has also earmarked nearly half a billion USD for the DREAMS initiative to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries (Malawi, Mozambique, Zambia, Tanzania, Zimbabwe, Lesotho, Swaziland, Kenya, Uganda and South Africa).

Forming effective partnerships between relevant initiatives to leverage each other's momentum, expertise, and financial resources is critical to the success of the ESA Commitment. Furthermore, partnerships and sharing of intellectual insights can possibly tackle one of the greatest challenges around the availability of data for monitoring, learning and evaluation purposes.

¹⁹ <http://allintoendadolescentaids.org/>

2.4 Civil society engagement in the ESA Commitment



From left to right: Nyasha Sithole with AfriYAN; Prof Sheila Tlou from UNAIDS; and Daniel Molokele from AIDS Accountability International (AAI)



Remy Shawa from Sonke Gender Justice and member of the ESA Commitment High Level Group (Photo credit: JJArts Photography)



Young people, parents, and religious leaders engaging on the ESA Commitment

2.4.1 A collective civil society strategy

The civil society community has been strongly involved in the ESA Commitment from its inception to present day in various ways at both the country and regional levels. CSOs are actively involved in monitoring the accountability framework, conducting advocacy for the rights of young people to CSE and SRHR, implementing CSE, and providing SRHR services to young people. Given the scope of the issues in which civil society engagement is required in order for the ESA Commitment to be realized, the need to engage CSOs in a systematic fashion was recognized, leading to the development of a robust, forward-looking civil society engagement strategy.

One of the key outputs has been the development of the ESA Commitment CSO Engagement Strategy. Civil society partners agreed that a regional coordination mechanism responsible for implementing the strategy be put in place. At country level, CSOs are key partners in the country coordination mechanism, supporting the development of national action plans for the implementation of the ESA Commitment. Civil society partners include: International Planned Parenthood Federation (IPPF), Ford Foundation, AIDS Accountability International (AAI), Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), Save the Children, International Network of Religious Leaders Living with or Personally affected by HIV and AIDS (INERELA+), the Regional Psychosocial Support Initiative (REPSSI), Africa Youth and Adolescent Network on Population and Development (AfriYAN), Zambia Interfaith Networking Group on HIV and AIDS (ZINGO), loveLife, Childline, IBIS Reproductive Health, East Africa Network of AIDS Service Organizations (EANNASO), Population Council, Population Services International (PSI) and ONE.



Youth-led ESA Commitment session on accountability held at the pre-youth conference at ICASA 2015

2.4.2 CSO Engagement Strategy

The CSO Engagement Strategy is based on the recognition that there is a need to systematically engage CSOs in the realization of the ESA Commitment in the region and ensuring space for the voice of youth at all levels. Furthermore, the strategy is intended to stimulate action for quality scaled-up and integrated service delivery and policy responsiveness in order to reach the targets of the ESA Commitment.

Goal of CSO Engagement Strategy: To ensure that by 2020, governments in the ESA region have made significant progress towards achieving the targets of the ESA Commitment.

Expected outcome of CSO Engagement Strategy: To ensure that CSOs in the region are fully engaged in the implementation of, and advocacy for, the implementation of the ESA Commitment, contributing to improving SRH outcomes and strengthening HIV prevention through increased access to CSE and integrated SRH services for young people.

CSO Engagement Strategy key outputs:

1. Accountability is enhanced by consistent monitoring and reporting of the progress at country and regional levels on the implementation of the ESA Commitment by governments and partners.
2. Effective civil society advocacy with government and partners for increased support for the implementation of strategies on SRHR, HIV and CSE to reach the ESA Commitment targets is undertaken.
3. Civil society and youth organizations are briefed, aware, updated on the ESA Commitment, and effectively engaged in policy, planning, and decision-making platforms and advocacy efforts to consolidate and input civil society perspectives.
4. Partnerships are mobilized to advocate for improved coordination of initiatives for adolescent and young people in the areas of SRHR, CSE, and HIV prevention.
5. Communication and information dissemination on the ESA Commitment is strengthened.

Next steps for CSOs:

- Enhance both the regional and national coordination of all CSOs on the ESA Commitment;
- Effectively use new social media platforms to ensure regular and active communication;
- Implement sustainable resource mobilization to ensure active participation;
- Recruit more CSO members to join the ESA Commitment process;
- Undertake consistent engagement to ensure that the region meets all the targets of the Commitment by 2020.

2.5 Meaningful engagement of young people

Partnerships with young people and youth-led organizations have proven to be a vital part of implementing the ESA Commitment. Countries have worked with youth networks and organizations to provide in-depth reviews of adolescent and young people's experiences. Countries have worked with youth networks and organizations to provide in-depth reviews of adolescent and young people's experiences at the local levels; disseminating resources on CSE and SRH; providing platforms to support dialogue at regional and local levels between youth and government officials; and working with health professionals to build their capacities to deliver strong SRH needs.

AfriYAN has led the process for increased youth leadership and engagement in the implementation of the ESA Commitment in country technical working groups and at international and regional levels, as well as prioritized advocacy at key events since 2013, including the 2nd ASRHR/HIV Symposium in Zambia (December 2014), the first Africa Girl's Summit on Ending Child Marriage in Zambia (November 2015), and ICASA in Zimbabwe (December 2015).

In several countries, young people have used media as a platform to share their views as experts, fostering dialogue on CSE and SRH issues, for example:

- South Sudan is building the capacity of a youth organization to publish a newsletter;
- Lesotho is training adolescents in journalistic reporting for advocacy on SRHR and CSE;
- Zambia has been highlighting young people and their perspectives on various radio programmes as well as other social media platforms, including TuneMe (TuneMe.org) and U-report;
- In Uganda, youth-led organizations are actively participating in the national coordination forum and have successfully convened inter-generational dialogues and community discussion to increase the awareness of the ESA Commitment and CSE/SRH issues among adolescents and young people;
- Organizations such as the YWCA have also provided innovative approaches to advocacy, using safe spaces where young girls can share experiences and stories related to teenage pregnancy, child marriage, and HIV with each other and with governments officials and policy-makers.

At country level, various methods have been used to attract and connect with young people about important topics on CSE. In particular, poetry, flash mob dance routines, radio stations, and sport. For example, Namibia has been engaging young people through sport with the Galz & Goals programme, which educates young girls on a healthy lifestyle, including HIV prevention and care. It has received international recognition for its interventions, was awarded the 'sporting federation of the year', and has reached thousands of adolescent girls with lifestyle messages over the years.

Social media has been an important tool in connecting with youth-led organizations and young people. The use of SMS has also been an important tool in countries such as Malawi, Zambia, and Zimbabwe, where a youth engagement platform provides accurate and relevant SRH information in a youth-friendly manner.



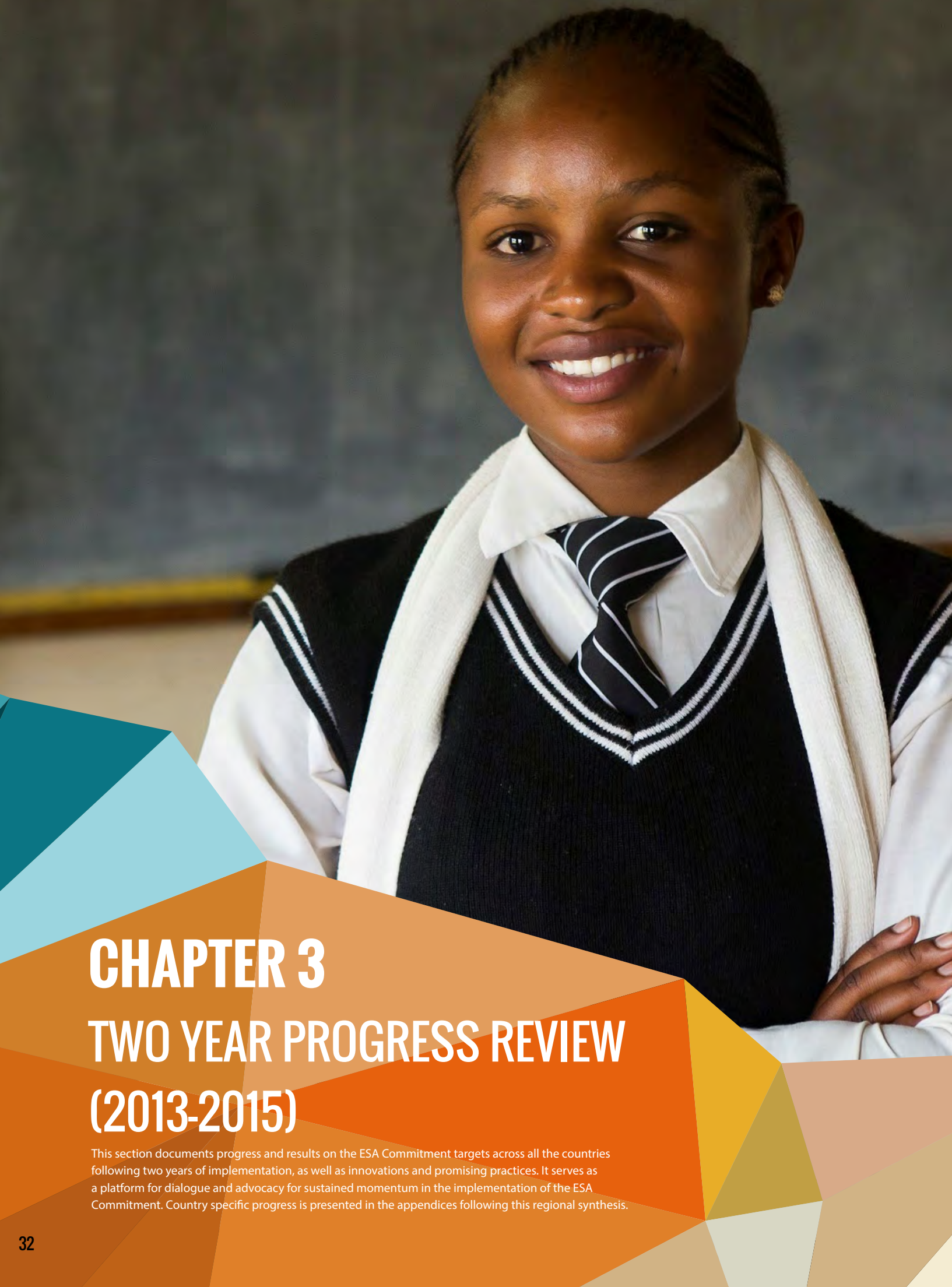
SPOTLIGHT: Engaging youth through innovative approaches in southern Africa

TuneMe is a youth engagement mobisite platform which leverages mobile technology to deliver behaviour change communication, empowering adolescents to improve their SRH outcomes. Developed by the UNFPA's regional youth programme, in collaboration with the Ford Foundation and Praekelt Foundation, and launched in late 2015, TuneMe works on both basic handsets and smartphones, allowing any young person with a data connection to access the platform. Initially launched in Zambia and Malawi, the site already has almost 9,000 young people registered and will be expanded to reach an additional five southern African countries between 2016 and 2017, although it is accessible from any country which chooses to use TuneMe.org. It includes an in-built M&E system and tools for quality purposes. The mobisite will soon include GPS coordinates to make it easier for young people to identify the closest health facility to their location.

The mobisite can be accessed at www.TuneMe.org.

2.6 Lessons learnt on coordination and management of the ESA Commitment

- 1 The ESA Commitment provides a platform for action to address the ESA targets, but leadership and ownership by countries is a critical success factor, including a coordinated response and allocation of domestic resources. It will be important to ensure that strategies for the attainment of ESA Commitment targets are included in country work plans and costed accordingly.
- 2 Engagement of key stakeholders beyond health and education is necessary for the achievement of targets on reducing new infections, teenage pregnancy, school-related gender-based violence (SRGBV), and child marriage. For example, in Tanzania, the creation of AYAS in 2015 is meeting the urgent need for a coordinated, national, multi-sectoral effort to reduce adverse SRH outcomes among young people.
- 3 It is important to systematically engage CSOs in the implementation of the ESA Commitment. Under the leadership of UNAIDS, regional CSOs have developed a strategy for CSO engagement with the ESA Commitment process. This strategy will be critical for ensuring coordinated implementation of CSE- and SRH-related programming, as well as a systematic approach to holding governments accountable to the Commitment.
- 4 Young people play a critical role at all levels, not only in the national coordination mechanisms, but also in advocacy with government, parliament and partners for the implementation of the ESA Commitment. This has been done through engaging with young people's networks such as AfriYAN.
- 5 The ESA Commitment needs communication channels that reach stakeholders from government and also young people from harder to reach communities who do not have access to the internet. This will ensure that the voices and needs of all critical stakeholders and affected communities are represented and taken into account in decision-making and programme design.
- 6 Change of personnel in government, for example, as a result of elections, may affect continuity of programmes. This highlights the importance of strengthening engagement with technical officers in all relevant ministries to ensure institutionalization and continuity of programmes.
- 7 There needs to be advocacy and continued communication with partners to ensure all opportunities are used to harmonize partner efforts around existing commitments and advocate for joint action on these agreements.



CHAPTER 3

TWO YEAR PROGRESS REVIEW (2013-2015)

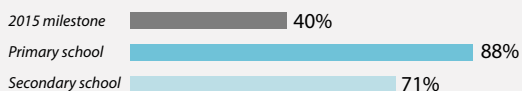
This section documents progress and results on the ESA Commitment targets across all the countries following two years of implementation, as well as innovations and promising practices. It serves as a platform for dialogue and advocacy for sustained momentum in the implementation of the ESA Commitment. Country specific progress is presented in the appendices following this regional synthesis.

3.1 Target 1

Target 1: A good quality comprehensive sexuality education (CSE) curriculum framework is in place and being implemented in 20 countries



Indicator: % of schools that provided life skills-based HIV and sexuality education in the previous academic year



Indicator: Number of countries that have a national CSE strategy or framework for out-of-school youth



3.1.1 Overview

Across the region, there is growing recognition of the importance of high-quality CSE which provides opportunities for young people to explore their values and attitudes and to build decision-making, communication, and risk reduction skills about many aspects of sexuality. In Eastern and Southern Africa, there are many different names for, and approaches to, CSE but all are driven by the same objective: to ensure that young people are receiving comprehensive, life skills-based sexuality education to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality.

What is comprehensive sexuality education?

Comprehensive sexuality education is recognized as an “age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgemental information” (UNESCO 2009). CSE has a demonstrated impact on improving knowledge, self-esteem, changing attitudes, gender and social norms, and building self-efficacy. This is particularly critical during adolescence as young people transition into adulthood. Integrating content on gender and rights, and delivering CSE together with efforts to expand access to a full range of high quality, youth-friendly SRH services and commodities makes sexuality education even more effective.

One of the main challenges in defining sexuality education, and particularly the elements that comprise comprehensive programming, may stem from the different terminologies used across national policies and curricula. Many different names are used, reflecting an emphasis on various aspects of CSE by different countries. These include: prevention education, relationships and sexuality education, family life education, HIV education, life skills education, healthy lifestyles and the basics of life safety. However, core elements of these programmes bear similarities, and incorporate some or many aspects of CSE (UNESCO 2015).

3.1.2 Provision of CSE

Through the ESA Commitment, there has been a notable move towards integration of CSE in the formal curricula, although implementation at scale is yet to be realized. Sexuality education is delivered as a stand-alone subject or integrated across relevant subjects within the school curricula. Although a number of countries have made CSE mandatory and examinable, there are still countries that provide non-compulsory, extra-curricular or only partially compulsory courses.

Across the region there have been small and isolated pockets of opposition to comprehensive sexuality education from various groups. However, because of the momentum created by the ESA Commitment, governments have stood firm in their support and unwavering belief in the value of comprehensive sexuality education.

SPOTLIGHT: UGANDA GOVERNMENT’S RESOLUTION TO PROVIDE THE SEXUALITY EDUCATION IN THE SCHOOL CURRICULUM

Uganda has made significant strides in integrating sexuality education into the newly revised secondary school curriculum to be rolled out in 2017. However, the country has recently experienced opposition from local and international NGOs and media who have shared concerns about the contents of the subject. The government publicly stated its resolution to provide sexuality education as follows:

“The Ministry of Education, Science, Technology and Sports acknowledges that sexuality education is part and parcel of Adolescent Health Programs meant to empower young people with skills of making safe and healthy choices. Our mandate requires us to provide age appropriate, culturally and religiously acceptable information in this area.”

(Ministry of Education, Science, Technology and Sports, Circular No 5, 26 April, 2016)

In addition to the official communication from the Ministry of Education, a series of community dialogues have been held with parents, religious leaders and NGOs to dispel the myths and misconceptions about sexuality education.

3.1.3 Quality of CSE curriculum

In 2015, UNESCO commissioned a study to assess the quality of CSE curricula and delivery across five countries (Uganda, Zambia, Lesotho, Malawi, and Namibia). The review used an in-depth assessment tool, the Sexuality Education Review and Assessment Tool (SERAT), which was completed with key stakeholders. SERAT results across all five countries revealed moderate to strong curriculum content for the 9-18 age ranges, and weak to no content for the 5-8 year age group, with the exception of Malawi. In Lesotho, Uganda and Zambia, CSE is offered from age 10 years onwards and there is no CSE curriculum developed for the younger age group (5-8 years). An analysis of the 12-15-year-age group curricula by content revealed that human development and sexuality and sexual behaviour are often missing some essential content. Under human development, the commonly missed topics include: i) Pregnancy testing (how to find it, when and how to use it, and how to interpret it); ii) Healthy and harmful behaviour to foetal development; iii) Right to privacy, not to be harmed, to be in control over one's sexuality, and to move freely from place to place; iv) Biological aspects of sex and gender; and v) Social aspects of sex and gender.

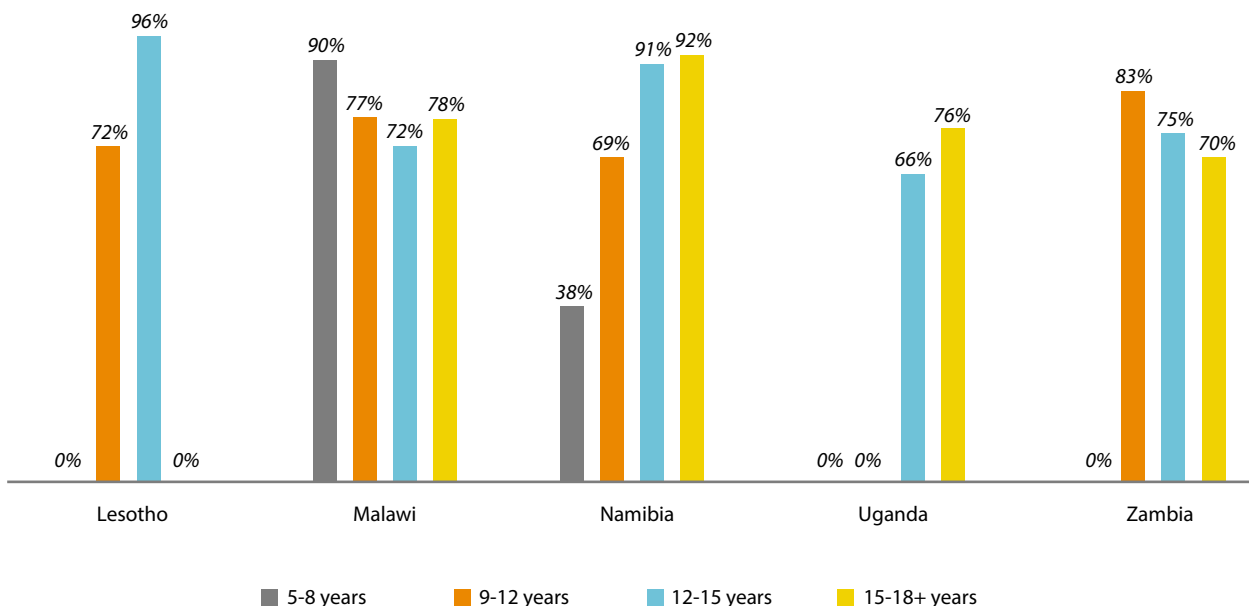
“CSE helps young people become confident in making the right choices since they have the right info and not hearsay. They can confidently walk into a health centre or pharmacy and by a condom or SRH commodities or ask for help in regard to their sexuality without fear.”

Caroline, 22, Uganda

For the theme on sexuality and sexual behaviour, commonly missing topics include: i) Confidence in discussing and using different contraceptive and protection methods; ii) Emergency contraceptive pills; iii) Access to prevention methods (barriers and solutions); and, iv) Going to health services to access personal risk, perceived vulnerability, and attitudes about safer sex practices.

The study also cited common delivery challenges hindering teachers' ability to deliver the lessons as lack of subject matter specialization and poor quality of teacher training CSE. These, coupled with high pupil-teacher ratio and high pupil-textbook ratio, were critical factors affecting quality of classroom delivery.

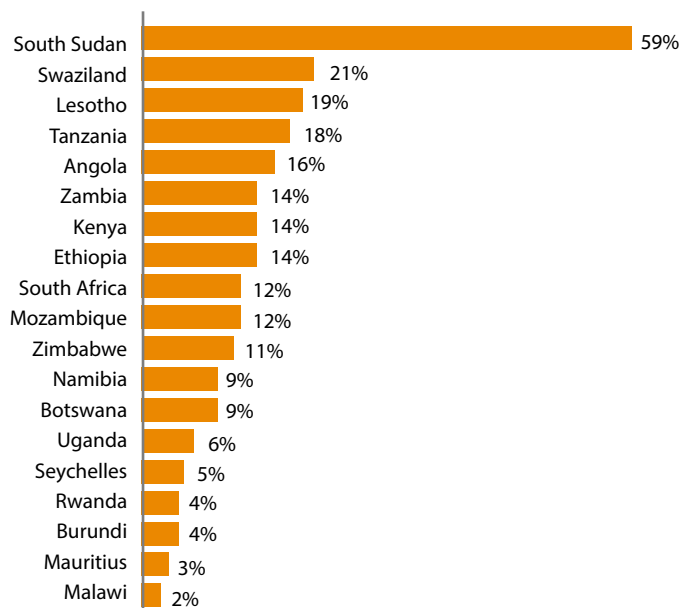
FIGURE 3.0: Average score of content by topics covered in the curriculum across the five SERAT countries



3.1.4 CSE for out-of-school youth

Achieving universal access to good quality CSE requires specific strategies for reaching marginalized young people who are out of school. The percentage of young people who are out of school varies considerably across the ESA region. In Botswana, South Africa, the Seychelles and Kenya, less than 5% of all adolescents are out of school, compared to 20-25% in Malawi, Lesotho and Uganda. As many as 33-39% of adolescents aged 10-19 years are out of school in Swaziland, Mozambique and Ethiopia, with more than half of all 10-19-year-olds in Burundi reportedly out of the formal schooling system. Rates of secondary and higher education enrolment remain low in many countries, and girls are more likely to be out of school compared to boys (PRB and UNFPA, 2012). The percentage of primary school aged children out of school across ESA ranges from 5% or less in Seychelles, Rwanda, Burundi, Mauritius, and Malawi, to more than 50% in South Sudan, as illustrated in Figure 3.1.

FIGURE 3.1: Percentage of primary school children who are out of school across 19 countries in Eastern and Southern Africa. No data for Madagascar or DRC²⁰



Out-of-school young people cannot benefit from in-school CSE and school health initiatives that are provided in the region, and are excluded from

other school-based social and health interventions that are systematically delivered within the formal education system. Because they are out of school, and therefore do not regularly gather together, they are harder to reach, requiring extra effort. This is especially true among young married girls who are largely consumed by their duties as homemakers and mothers and are socially isolated.

Where the policy environment is not inclusive of specific policy provisions for out-of-school youth, creative and innovative approaches have been developed – often in partnership with young people themselves – to reach marginalized young people out of school, utilizing new media and community channels.

FIGURE 3.2: Number of countries that developed national policies and/or strategies related to sexuality education for out-of-school youth



²⁰ UNESCO Institute for Statistics 2016. UNESCO eAtlas of Out-of-School Children, 2005-2014.

3.1.4 Strengthening community support for sexuality education

The ESA Commitment acknowledges that families, carers, guardians, and community members play a primary role in the education and guidance available to adolescents and young people as they transition to becoming young adults. Faith and faith-based teachings on life, family, community, sexuality, and reproductive issues play a major part in the beliefs, practices, and norms of many communities in the region.

It follows that to ensure full support for CSE, there is a need to engage with key gatekeepers at the state and community level, from policy-makers to the religious community, in order to garner their support in the creation of an enabling environment for the provision of CSE. Engaging parents and communities in the scale-up of CSE is critical, both to ensure there is support for the subject within the school community and to enhance overall understanding of the issues facing adolescents and young people.

Parents can play an important role in communicating with their children about sexuality, relationships and well-being, particularly among younger age groups. Studies have repeatedly shown that favourable parental attitudes influence children's attitudes, whether this is related to acceptance of sexuality education or uptake of HIV testing or contraceptives. Parents and families play a key role in shaping attitudes, norms and values related to gender roles, sexuality and the status of adolescents and young people in the community (Svanemyr et al, 2015).



7,354

schools have engaged community on CSE since the ESA Commitment was affirmed (based on available data from 12 countries in the region).



300,000

young people reached with live performances by seven young Southern African artists with the Safeguard Young People Programme. The artists produced a music album titled 'We Will' comprising of 10 thematic songs on correct and consistent condom use, child marriage, teenage pregnancy, multiple concurrent partners, and healthy relationships among others.



SPOTLIGHT: Zambia TV and radio programme to reach communities and young people in and out of school with CSE

To complement the newly revised CSE curricula in both primary and secondary schools, the Zambian government piloted a TV and radio programme designed to engage communities around CSE and access to SRH services for young people. The programme offered young people in and out of school, teachers, health care workers, parents, and the broader community an opportunity to come on air and discuss issues concerning the health of young people in Zambia. Topics discussed related to understanding love, sex, and healthy relationships; self-esteem and understanding yourself and your rights as an adolescent; peer pressure; and making healthier decision and choices for the future. An episode has also been dedicated to bettering communication between parents, guardians, and young people. The initial programme reached over 1.8 million adults, including parents, and over three million adolescents and young people in and out of school aged between 10-24. According to a radio feedback survey based on a sample of 300 radio listeners, knowledge on HIV and safer sex practices have increased significantly and plans are now underway to roll out the programme in six ESA countries.

Photo credit: UNESCO/SAFAIDS



“Religious leaders’ voices in Africa are very important. They still have a lot of influence in terms of developing people’s moral compass. I think that it is important for religious leaders to help young people to understand that sexuality is part of your identity and it’s something that you are born with. We have a responsibility as religious leaders to give young people information. Research has shown us that when girls have access to information and are able to talk about sexuality to their parents the chances of them falling pregnant in their teens are reduced.

It is important for us to start talking to our children about sexuality, their responsibilities, and their rights as early as possible using accurate and appropriate language that they can understand. We know that as parents we made lots of mistakes because we did not have information. Therefore, we need to protect our children if we don’t want them to go through the very same process. We have a responsibility as parents and as religious leaders to make sure that children have access to information, especially girls and those who are vulnerable. In order for us to develop mature adults who will be leaders tomorrow we need to start talking about the issues that affect them now. We mustn’t wait until they are much older.”

Reverend Phumzile Mabizela, Executive Director, INERELA

3.2 Target 2

Pre- and in-service SRH and CSE training for teachers, health and social workers are in place and being implemented in all 20 countries



Milestone met and exceeded

Indicator: % of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year



Indicator: Number of countries that provided pre- and in-service training programmes on the delivery of adolescent youth-friendly services



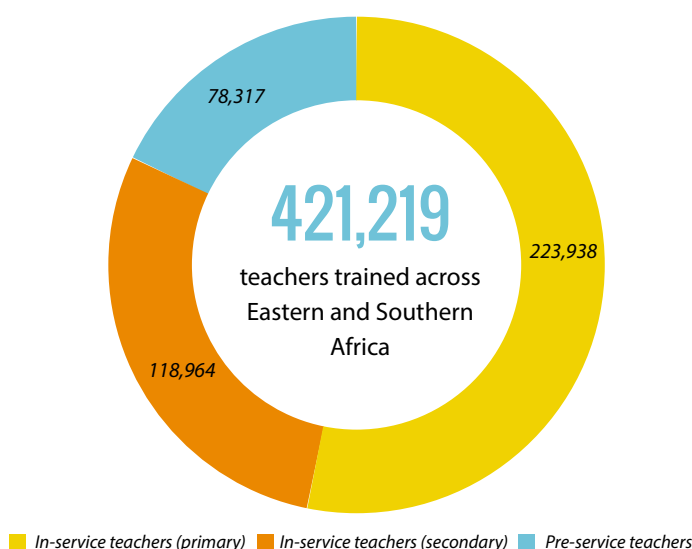
3.2.1 Teacher training

The ESA Commitment acknowledges that quality education and health outcomes which can be achieved through CSE require us to invest in teachers to ensure that they are well trained, resourced, and supported to deliver programmes in and out of school. Effective teacher training includes values clarification which aims at deconstructing personal prejudices, personal judgement, and values in discussing sexuality issues. This changes teachers' values, attitudes and knowledge on CSE and makes them self-reflect on sexuality from a personal perspective.

Findings from a 2015²¹ report on the status of CSE in teacher training on pre- and in-service teacher training indicate that 95% of the ESA countries report some form of in-service training on life skills-based HIV education for in-service teachers. However, only 38% of the countries have CSE as a compulsory module in teacher training. This implies that teachers in some countries may not be adequately prepared to deal with every aspect of CSE in the classroom and suggests the need for further clarifying research to confirm whether pre-service teacher training is in fact preparing teachers for the suggested CSE course content and those areas outlined in the International Technical Guidance on Sexuality Education (ITGSE).

The report recommends more and better training for teachers and building their skills in the use of participatory methods and ongoing mentoring and support. Training should focus on the key health outcomes in the prevention and management of HIV, STIs, and early and unintended pregnancy, and supporting young people to make informed choices regarding their SRH needs. In response to the huge demand for teacher training in CSE, hundreds of thousands of teachers have been trained over the past two years.

FIGURE 3.3: Total number of teachers trained on CSE from 2013-2015



SPOTLIGHT: Launch of the first-ever online teacher training tool for Eastern and Southern Africa

In 2015, a regional online in-service training course on CSE was launched by the ESA Commitment partners. The online course aims to increase the number of teachers in the ESA region who are qualified to teach sexuality education, thus improving the quality of school-based sexuality education programmes.

The course first launched in September 2015 with nine countries registered (Zambia, Malawi, Swaziland, South Africa, Lesotho, Namibia, Uganda, South Sudan, and Botswana). Teachers were selected through the teacher education departments in the Ministries of Education and course coordinators were nominated to supervise and support the delivery of the course at country level. A total of 847 teachers were trained with an average knowledge increase of 10% (typical courses have around a 5% knowledge increase). In total, 99% of educators that completed the course rated the content and experience on a quality scale of more than 80%. The course has been translated into Swahili, Portuguese and French.

The demand for the course is increasing and has attracted other educators who may not be classroom teachers but also play a critical role in curriculum supervision and implementation at country level. Among these include school inspectors, education standards officers, curriculum developers and assessment officers. The course will be scaled up to all countries in the ESA region.

“My teacher sometimes calls our life orientation lesson a free period and encourages us to study for other subjects. He says we should focus on subjects where we know we have exams at the end of the year. Sometimes we have discussions about puberty and things like that but not often.”

Young boy, 14, South Africa

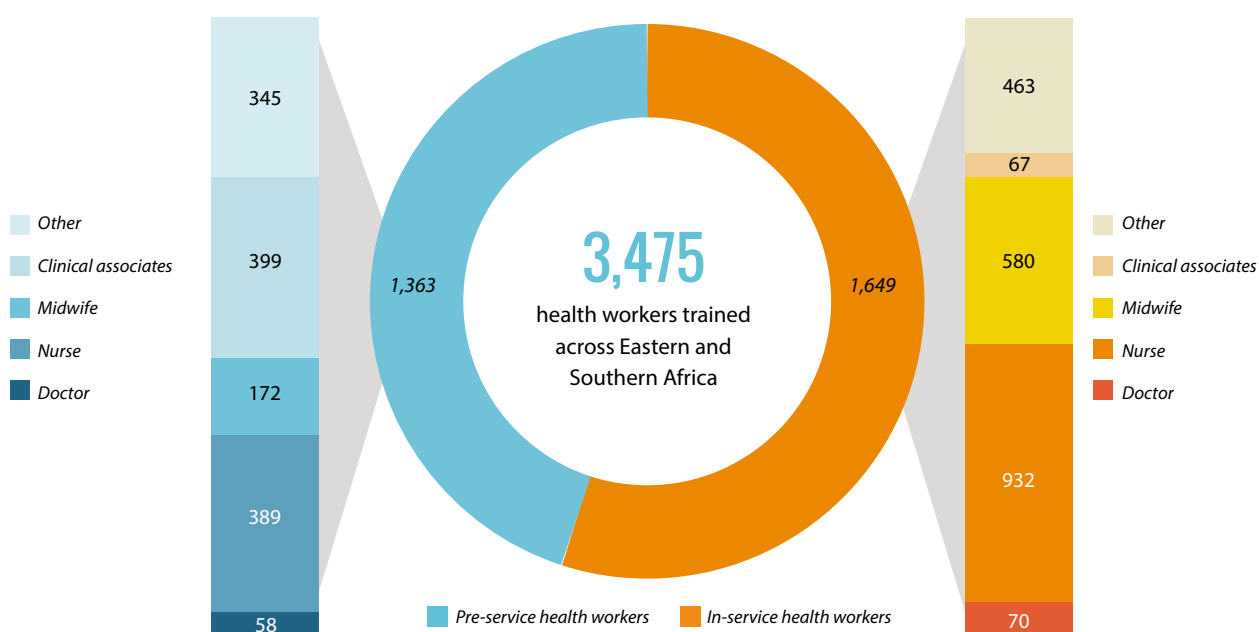
²¹ UNESCO. 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa*.

3.2.2 Health and social worker training

The Commitment emphasizes the critical importance of training and supervision of health care providers for quality provision of SRH services. Continuous learning through pre- and in-service education is essential to strengthen their capacity to address the developmental and contextual aspects of adolescents' and young people's health within a society, familiarize them with national policies, guidelines, and standards that are relevant to those needs, and enhance skills for consultation, interpersonal communication, and interdisciplinary care. Training and supervision also helps to clarify personal and professional attitudes among health providers towards youth sexuality and to minimize provider bias.

In 2015, a review to assess the level of institutionalization of adolescent and youth-friendly health service (AYFHS) delivery in pre and in-service training institutions for health care providers in ESA was conducted. The findings from the study show that most countries have training curricula in place and are implementing AYFHS for pre- and in-service health care providers, however, more work is needed to ensure that the training curricula and materials are fully aligned with and implemented according to the latest WHO guidelines, as well as institutionalized within ministries of health and education and national training institutions. The study also found that policies, guidelines, strategies, action plans, capacity-building programmes, and curricula/training materials are not fully aligned to the latest national and international guidance and will need to be reviewed and updated. Furthermore capacity-building of pre- and in-service health care educators and trainers is not sufficient to enable them to deliver and train their students on quality AYFHS delivery, indicating that both pre- and in-service trainers were in need of training on AYFHS delivery.

FIGURE 3.4: Total number of health and social workers trained on youth-friendly health service delivery between 2013-2015



The findings from the study will be used to inform the development of a regional guideline for institutionalization of AYFHS as well as state of the art pre- and in-service AYFHS training courses and materials for health care providers, which can then be adopted by the RECs, training institutions, and ministries of health and education in the region.

“It has been difficult to witness girls as young as 13, 14, 15 becoming pregnant. Girls that don’t understand what is happening to their bodies. Often times, they have no one to talk to or turn to. So sometimes I ask them personally, ‘what are you thinking, what are you feeling?’ because no one is there to really listen to these girls. They need opportunities to speak out and share what they are thinking and how they are feeling in their families, communities and health facilities.”

Daphne, 31, doctor in Central Hospital in Malawi

3.3 Target 3

Decrease by 50% the number of young people without access to youth-friendly SRH services



Indicator: Number of countries with a costed national strategy/plan to improve young people's access to AYFHS aligned to regional/international standards



Indicator: % of countries that offer a standard minimum package of youth-friendly SRH services



The ESA Commitment has specifically committed to integrate and scale-up youth-friendly HIV and SRH-services that take into account social and cultural contexts to improve age-appropriate access to, and uptake of, high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HCT, HIV/STI treatment and care, family planning, safe abortion (where legal), post-abortion care, safe delivery, PMTCT, and other related services for young people in and out of school.

What are considered 'youth-friendly SRH services'?

According to the WHO quality of care framework (2015), to be considered adolescent and youth-friendly, health services for young people should be:

- i) Acceptable:** adolescents are willing to obtain the health services that are available;
- ii) Equitable:** all adolescents, not just selected groups, are able to obtain the health services that are available;
- iii) Appropriate:** the right health services are provided to them;
- iv) Effective:** the right health services are provided in the right way, and make a positive contribution to their health; and,
- v) Accessible:** adolescents are able to obtain the health services that are available.

Across the ESA region, only four countries provided cumulative data on the number of adolescents and young people accessing youth friendly health services during the reporting period. Even for those reporting the numbers did not necessarily reflect the collective national figures. This points to the need to strengthen data collection and reporting of the provision of ASRH services.

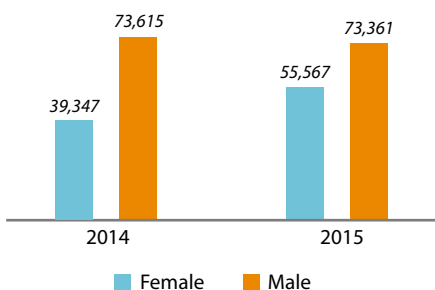
Poor access to quality health care is one of the greatest barriers to the realization of SRHR for young people in the region. Of particular importance is the access to SRH care which includes support related to sexual development, reproductive health, relationships, intimacy, and gender-related issues. All young people, regardless of gender, sexual orientation, marital status, age, disability, or religious or political beliefs should have the right to access these services. However, access to SRH services is prevented by stigma, judgemental health providers, lack of confidentiality, lack of knowledge, and, in many cases, legal and policy constraints related to age of consent, gender roles, and marital status.

In ESA, the unmet need for family planning is estimated to be 26%²², which puts the region at the top spot in the world, joint with Latin America and the Caribbean. One of the most concerning public health crises in the region is unsafe abortion, which accounts for up to 13% of maternal deaths in many sub-Saharan African countries²³. Adolescents and young people need more than services for family planning purposes, and under the momentum of the ESA Commitment there is increasing awareness and understanding of access to youth-friendly health services (YFHS). Adolescents and young people face significant discrimination and barriers to access of SRHR information, goods and services. Some of the barriers stem from age restrictions on access services, while others are generated by social norms that hamper, in particular, young women's ability to seek information about their sexuality and their SRHR.

"When I was growing up my parents were very open to me about sexuality and relationships. It gave me the self-assurance to wait until I was out of school and mentally and emotionally ready to get into my first sexual relationship. Even when all my friends and peers were engaging in sexual activities I was confident in my decision to delay having sex."

Young man, 26, Kenya

FIGURE 3.5: Number of young people accessing youth-friendly health services in 7 of the 21 countries that provided data²⁴



250,824

adolescents and young people accessing youth friendly health services in 7 of the 21 countries that provided data.

²² Loaiza E. and Liang M. 2013. *Adolescent Pregnancy: A Review of the Evidence*.

²³ Sawyer S. et al. 2012. *Patton Adolescence: a foundation for future health*.

²⁴ Country reporting template. 2016. Note: The 7 countries that provided data on YFS are: Angola, Burundi, Kenya, South Sudan, Swaziland and Uganda.

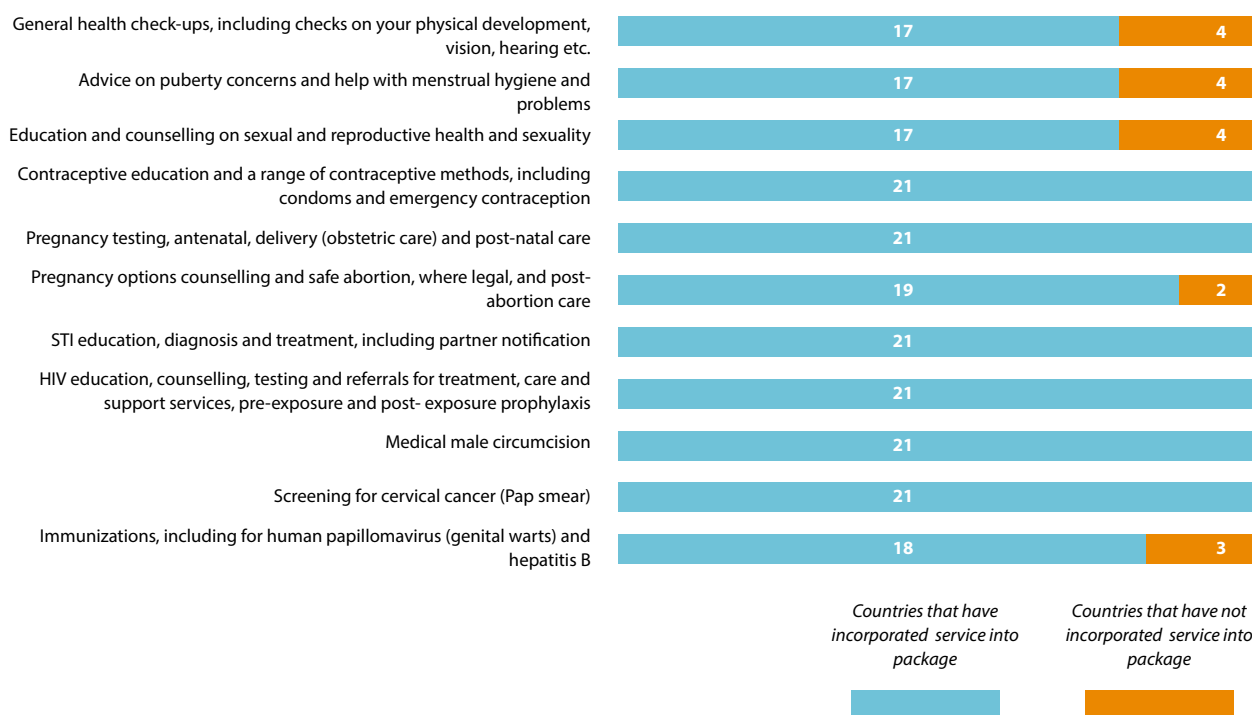
3.3.1 Status and quality of AYFHS

While progress has been observed in the ESA region, preliminary findings from a regional assessment of AYFHS delivery²⁵ indicate that the level of alignment and implementation of national standards according to international WHO guidelines vary within and among countries.

The assessment included literature and desk reviews of assessments, evaluations, policies, guidelines, and standards from 23 countries²⁶. Findings from the assessment reveal that:

1. Guidelines and/or standards for AYFHS delivery are available in 16 countries, i.e. Botswana, Burundi, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, and Zambia. Eritrea and Seychelles have draft guidelines, however, it is not clear whether these have been adopted yet.
2. The standard on the appropriate package of services is addressed by all 16 countries and they each define a package of services that should be provided to adolescents and young people.
3. While most national guidelines seeks to align to the WHO Global Standards, some areas need further improvement:
 - 12 of the 16 countries have clear standards on adolescent health literacy; Botswana, Madagascar, Namibia, and Zambia do not have a specific standard.
 - The standard on community support is addressed by 13 of the 16 countries; Burundi, Malawi and South Africa do not have a specific standard addressing this.
 - The standard on facility characteristics is addressed by 13 of the 16 countries; Malawi, Rwanda and Tanzania do not have a specific standard on this.
 - The standard on equity and non-discrimination is addressed by only 10 of the 16 countries.
 - The standard on data and quality improvement is addressed by 13 of the 16 countries; Botswana, Ethiopia and Kenya do not have a specific standard for this.
 - The standard on adolescents' participation is addressed by 13 of the 16 countries; Burundi, Malawi and South Africa do not have a specific standard on this.

FIGURE 3.5: Youth-friendly SRH service package offered across the region



²⁵ IPPF Africa Regional Office and UNFPA ESARO. *Assessment of Adolescents and Youth Friendly Health Service Delivery in the East and Southern Africa Region*. (Ongoing) (Findings are subject to validation by countries).

²⁶ Includes all 21 ESA Commitment countries, as well as Comoros and Eritrea.



SPOTLIGHT: Malawi strengthens access to SRH services for young people

In 2014, the Ministry of Health in Malawi carried out a comprehensive evaluation of the YFHS programme to assess coverage, quality, and achievements. The evaluation highlighted strengths and weaknesses in the current YFHS programme as follows:

Coverage of services: The majority of young people who reported visiting YFHS did so for the first time in the 12 months prior to the evaluation, conveying that the YFHS programme has gained more prominence over the last year or two. While overall knowledge of the availability and location of general health services available to youth is high (69.7%), awareness and ever use of the YFHS programmes is low in Malawi; less than one third of community youth survey respondents reported to have heard about YFHS and only 13% reported to have ever used a YFHS. Those living in communities where health facilities offer YFHS reported that they knew more about YFHS than those living in communities where facilities do not; about 35% versus 25%, respectively. Similarly uptake of services was also higher in communities where YFHS was available. Knowledge and use of YFHS varied by districts and zones as well as by age, sexual experience, and school attendance status of the young people being interviewed. Sexually experienced youth, those who were out of school, and those who were older more often accessed YFHS than their counterparts. Most of those who had accessed YFHS expressed satisfaction with the services they received.

Training and supervision of service providers: 68% of health centre providers and 73% of those in hospitals said they had been trained to offer YFHS.

The evaluation results are expected to guide future YFHS, including HIV programming in Malawi. This should help strengthen capacity of health care providers and increase adherence to the key principles of the YFHS National Standards, further delay sexual initiation among early adolescents, and promote healthier sexual behaviours among older youth.

3.3.3 Status of AYFHS delivery

Preliminary findings from a facility assessment which was undertaken in 14 countries²⁷ confirms findings from earlier assessments regarding the barriers to accessing AYFHS in the ESA region, which include fear and shame, stigma, negative attitude of health workers, lack of knowledge on where the services are available, as well as what services are available. It also highlights what young people want in AYFHS, including privacy and confidentiality, low costs, and friendly staff.

Moreover, the findings indicated limited progress on improvement of service delivery, especially to the most vulnerable and marginalized populations of adolescents and young people; poor use of data for quality assurance and improvement of services; and limited availability of continuous learning opportunities on AYFHS delivery for health care providers.

Findings from the literature review in the study show that 9 of the 23 countries have scaled up AYFHS to varying degrees of success. These countries are Botswana, Burundi, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, South Africa, and Tanzania. However, in most countries, AYFHS are implemented as boutique, small-scale pilot projects.

The type of service provided to youth is important. Condom programming designed to reach young people can increase accessibility and confidence among those who are sexually active. In addition, removing barriers such as parental and spousal consent, which further institutionalizes sexual and reproductive rights violations, is critical for scaling services and ensuring access. Integrating HIV and AIDS services within broader health service provision will ensure better health outcomes for all young people. For young women living with HIV, access to youth-friendly SRH services, including screening for and treating reproductive cancers, preventing and addressing violence, and HIV prevention, treatment, care and support, has proven to be life-saving. Studies from southern Africa found that access to such services and peer support groups helped young people adhere to antiretroviral treatment²⁸. Ensuring that young women and adolescents have access to good-quality contraceptive services and antenatal care is essential to reducing the number of unintended pregnancies and new infections among children.

Available evidence has shown that increasing uptake of ASRH requires implementing four critical and complementary components together: (1) training and sustained support to health care workers; (2) improving the adolescent-friendliness of health facilities; (3) communication to and outreach activities for adolescents to encourage their use of SRH services; and (4) community support of the importance of these services for adolescents.

²⁷ IPPF Africa Regional Office and UNFPA ESARO. *Assessment of Adolescents and Youth Friendly Health Service Delivery in the East and Southern Africa Region*. (Ongoing)(Findings are subject to validation by countries).

²⁸ UNAIDS and the African Union. 2015. *Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa*.

3.4 Lessons learnt from two years of action

- 1 Government ownership is vital to implementing the ESA Commitment successfully; this calls for a key role for government in the coordination, allocation of resources, and implementation of programmes that work towards attaining ESA targets, while ensuring sustainability of interventions.
- 2 At country level, the ESA Commitment has promoted the inclusion of CSE and SRH services in policy and strategic documents, a great milestone which makes the Commitment targets easier to apply at domestic level. At the same time, it has allowed for identification of major gaps in some policy provision, for example, on the need to involve parents around the provision of CSE and ASRH services for young people and the need to urgently review or develop policies around teenage pregnancy.
- 3 Partnerships between government sectors in the country technical working groups have been impactful and allowed for better harmonization of plans and resources. For example, in Namibia, youth health development has succeeded through a comprehensive approach which concentrates on three main areas: cooperation between ministries and other CSOs to improve delivery; empowerment of young people to actively involve target groups; and linkages through leisure activities for young people with SRH service provision.
- 4 Given the high primary school enrolment rates in the ESA region, integration of CSE in the new curricula has reached large numbers of adolescents and young people. However, as dropout rates increase from late primary into secondary school grades, CSE programmes targeting out-of-school youth become important and these have not been well developed across the region.
- 5 More efforts are needed in the ESA region to move toward institutionalization and implementation of AYFHS at scale to ensure impact on adolescents and young people's health and well-being.
- 6 There is a need to harmonize partner efforts to ensure that all initiatives focusing on young people are coordinated from the same working group and are well aligned. For example, most countries noted leveraging the All In! initiative to coordinate data collection and analysis and programme planning as a major opportunity for the ESA Commitment.
- 7 The lack of resources to implement the ESA Commitment work plan has been highlighted as a challenge which compromised achievements of the targets. There is a need for dialogue at country level to lobby for domestic resources to support streamlined ESA Commitment activities. This domestic budget would be complemented by support from development partners.
- 8 Harnessing community and youth leadership is important for attaining ESA Commitment targets. Engagement with CBOs and youth-led initiatives is critical in order for the ESA Commitment to reach the majority of adolescents and young people in communities. Buy-in from community leaders, including religious leaders remains a critical ingredient for success as they have the potential to influence large numbers of congregants.



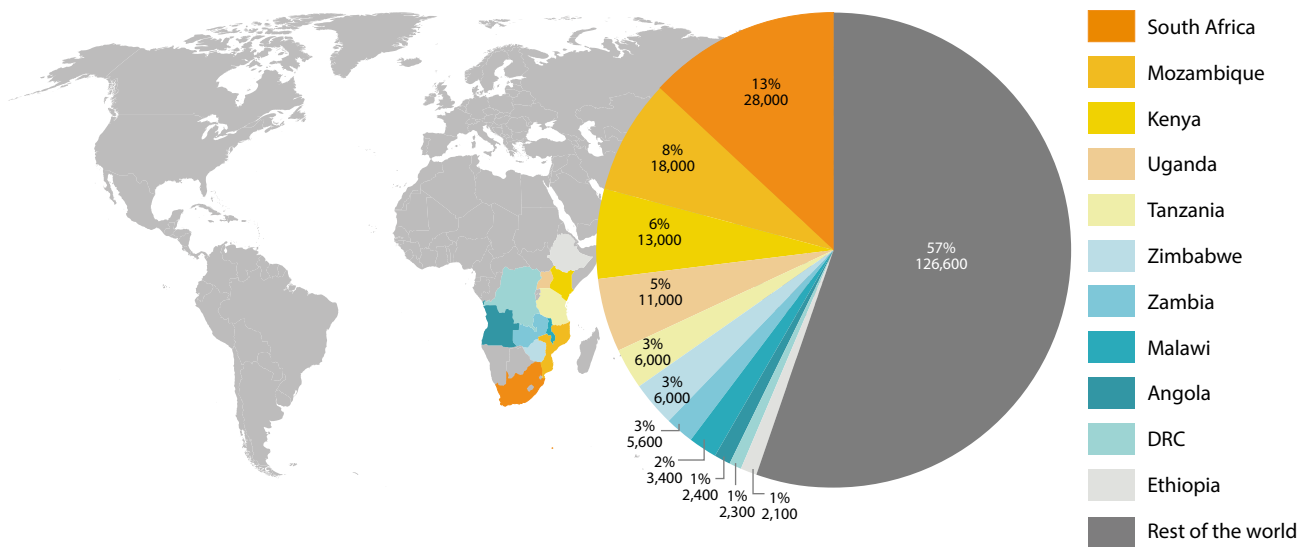
CHAPTER 4
JOURNEY TOWARDS IMPACT:
PROGRESS OF 2020 TARGETS

4.1 New HIV infections among adolescents and young people

Target 4: To consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA and push towards eliminating all new HIV infections among adolescents and young people aged 10-24

In 2013 when the ESA Commitment was endorsed, the region reported 430,000 new infections among young people aged 15-24²⁹. Since then, the region has witnessed a decline of approximately 6%³⁰. However, these reductions remain insufficient and significant numbers of young people, predominantly young women and young key populations, are still becoming newly infected. Young key populations³¹ are especially vulnerable to HIV and less frequently access SRH services due to widespread discrimination, stigma, and violence, factors that also contribute to risky behaviours, such as unprotected sex and sharing of needles and syringes. Eastern and Southern Africa remains the epicentre of the global HIV epidemic, contributing 11 of the top 20 high burden countries for new HIV infections among 15-19-year-olds globally³².

FIGURE 4.0: New HIV infections among adolescents (age 10-19) in high burden countries³²



Adolescent girls and young women remain significantly more vulnerable to HIV than their male counterparts. According to UNAIDS 2016 estimates³³, girls constitute approximately 70% of new HIV infections among young people aged 15-24. AIDS is the leading cause of death for adolescent girls in the region, and as many as 4,541 girls and young women are newly infected with HIV on a weekly basis³³. Despite these high numbers of new infections, only 10% of young men and 15% of young women are aware of their HIV status³⁴.



In 2015³³,

GIRLS CONSTITUTED APPROX. 70%

of new infections among adolescents and young people aged 15-24 and contributed

4,541 NEW INFECTIONS/WEEK

But there is cause for optimism. The ESA region is witnessing positive trends in behaviour change by young people with notable declines in the percentage of young people who are sexually active before the age of 15 and increases in condom use for the age group 15-24 years³⁵. While these trends show encouraging declines in risky behaviour, young women and girls continue to face challenges navigating these risks due to power imbalances in relationships.

²⁹ UNAIDS 2013 estimates.

³⁰ Percentage calculation based on 2014 UNAIDS estimates.

³¹ Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. UNAIDS. 2011. *Getting to Zero: UNAIDS Strategy 2011-2015*.

³² Draft *All In!* Report companion document with figures, 2015. Based on UNAIDS 2014 estimates.

³³ UNAIDS 2016 estimates.

³⁴ UNAIDS Strategy 2016-2021.

³⁵ UNAIDS. 2015. *How AIDS changed everything, MDG6; 15 years, 15 lessons of hope from the AIDS response*. Geneva, Switzerland.

In 2015, PEPFAR launched the DREAMS initiative, a multimillion dollar programme aimed at preventing HIV in adolescent girls and young women across 10 high prevalence countries. DREAMS aims to ensure that girls are “Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe” and, in so doing, safeguard the health of families, communities, and the region as a whole. Many of the drivers of HIV among girls and women increase the risk of negative outcomes such as poverty, early pregnancy, and child marriage. These factors include lack of education, transactional sex, and GBV. By addressing the structural determinants of HIV infection, adolescent girls and young women will be protected from other harmful outcomes.

There is now compelling evidence from the region that better education leads to improved health outcomes for young women and girls, particularly when it comes to HIV³⁶. A 2015 study in Botswana showed that for every additional year of schooling, there was an 8% reduction in the risk of HIV infection, particularly for young women³⁷. Better health outcomes include delayed sexual debut and reduced unintended and early pregnancy, exposure to HIV and STIs, and GBV.

Girls and young women therefore have to be placed at the centre of the response in meaningful ways through targeted combination prevention interventions. These should include programming around key HIV, health, and social driver interventions such as ensuring girl-friendly services, including modern contraception to prevent early and unintended pregnancies, preventing child marriage, keeping girls in safe schools, and ensuring CSE and reducing GBV, while involving men and boys.

4.2 Knowledge on HIV and AIDS among young people

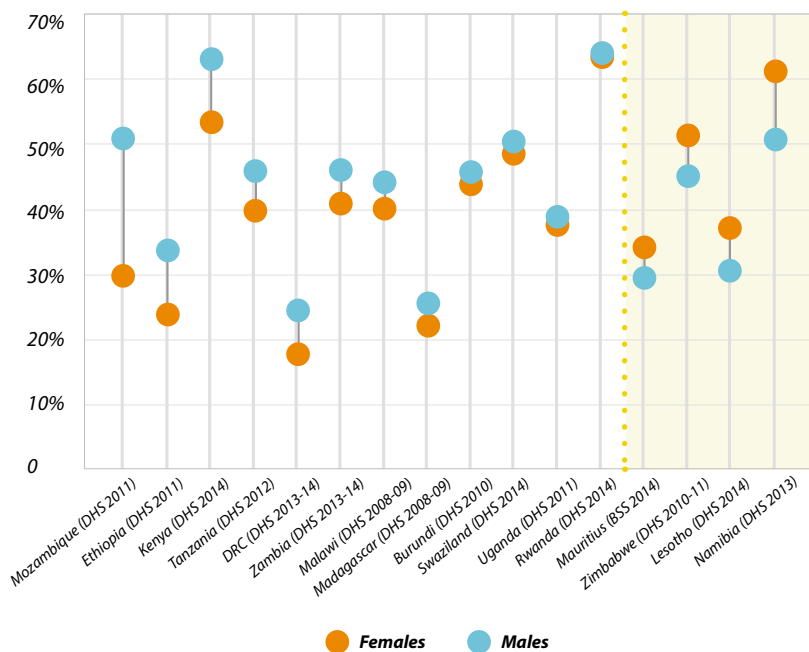
Target 5: Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels

Average knowledge levels among young people in the region currently stand at 45% for men and 42% for women³⁸. Demographic and health survey (DHS) data from the ESA region indicates that in the majority of countries (12 out of 15 countries with data available), knowledge is higher among boys, with Mozambique showing the largest knowledge gap between boys and girls. In nearly all countries with available data, researchers attribute gender, education, household wealth, and place of residence as factors that contribute to disparities in knowledge about HIV prevention among adolescent girls and boys³⁹. Overall, young women and men living in rural areas are less likely to have high levels of HIV knowledge than young men living in urban areas⁴⁰.

Lower HIV knowledge levels are consistent with higher rates of HIV infection, particularly among young girls and therefore, good quality CSE, which includes a focus on HIV, is critical for increasing HIV and SRHR knowledge levels among young people. CSE should start at an early age favouring the gradual acquisition of information and knowledge necessary to develop the skills and attitudes needed for a full and healthy life as well as to reduce SRH risks.

The vast efforts to scale up CSE and ASRH services in the ESA region are laying the groundwork for increased knowledge and behaviour change for adolescents and young people. Realizing increased knowledge and behaviour change amongst young people requires continued efforts and commitment from all stakeholders.

FIGURE 4.1: Comprehensive knowledge on HIV and AIDS among both females and males (DHS, AIS and BSS Data 2011-2014)



³⁶ Santelli J. et al. 2015. Trends in HIV acquisition, risk factors and prevention policies among youth in Uganda, 1999-2011.

³⁷ De Neve J. et al. 2015. Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment.

³⁸ Data from 12 countries with recent DHS (2010 – 2014).

³⁹ Idelele P. et al. 2014. Epidemiology of HIV and AIDS Among Adolescents: Current Status, Inequities, and Data Gaps.

⁴⁰ Ibid.

4.3 Teenage pregnancy

Target 6: Reduce early and unintended pregnancies among young people by 75%

In 2015, there were an estimated 3.3 million live births among adolescent girls aged 15-19 years in East and Southern Africa, a figure which is projected to rise 5.4 million by 2035⁴¹. A lack of comprehensive knowledge on SRH and poor access to reproductive health services is highly correlated with adolescent childbearing. Girls without this knowledge are more likely to have their first live birth before age 18. A high proportion of pregnancies among adolescent girls aged 15-19 years are unintended, ranging from 39% in Tanzania to 59% in Kenya⁴². A critical factor in the number of unintended pregnancies is the lack of access to contraception. UNFPA estimates that there were 2.4 million sexually active 15-19 year olds in ESA who had an unmet need for family planning, and projections point to this figure rising to 6.4 million by 2020⁴³ in the absence of accelerated interventions for improved access to family planning for young people.

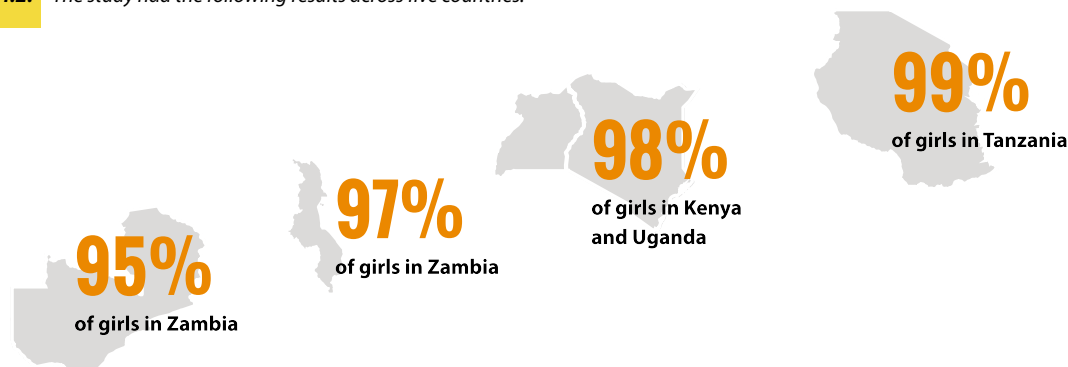
In the ESA region, one of the greatest health challenges associated with unintended adolescent pregnancy is unsafe abortion with the consequences of severe complications⁴⁴. It is, for instance, estimated that 25% of unsafe abortion cases in sub-Saharan Africa occur among adolescent girls⁴⁵. In addition, hospital-based studies in various countries in the region show that a high proportion of women seeking post-abortion care services in health facilities are below 20 years: 17% in Kenya, 21% in Malawi, between 49% and 58% in Tanzania, 60% in Zambia, and 68% in Uganda⁴⁶.

The protective effect of education is highly evident when analysing the adolescent birth rates for disparities and inequalities. Adolescents with no education in poor rural areas have birth-rates almost three times those observed in urban areas with a secondary or higher education. A 2014 study conducted in Kenya, Uganda, Tanzania, Malawi, and Botswana that focused on examining how the education sector is responding to teenage pregnancy⁴⁷ found that when girls drop out of school as a result of pregnancy, fewer than 5% are able to return to the schooling system. This implies that early pregnancy among adolescent girls and young women marks the end of their education.

“The problem is that even though we know that we should use condoms it’s very difficult for us to get them. So you end up taking a risk of making your girlfriend pregnant and hoping you get lucky. If I knew where I can get condoms without any problems then I would use them.”

Young man, 17, Zimbabwe

FIGURE 4.2: The study had the following results across five countries:



A detailed review of the various laws and policies in 23 ESA countries in 2015⁴⁸ reveals that only about half of the ESA countries have legislation and policies on the management of learner pregnancy and re-entry after delivery. The majority of those countries that have re-entry policies tend to approach learner pregnancy from a punitive perspective, for example, by barring learners from returning to their original school, excluding them for a specific pre-determined time-frame, or expelling them on the grounds of pregnancy.

Pregnancies among girls less than 18 years of age have irreparable consequences. Teenage pregnancy has life-threatening consequences in terms of SRH, and by interrupting the educational trajectory of girls it poses high development costs for communities, particularly in perpetuating the cycle of poverty. Trend projections estimate that by barring new interventions and assuming a status quo in programming, the ESA region will have about 6 million teenage pregnancies by 2020 and 7.4 million by 2030⁴⁹.

⁴¹ UNFPA. 2016. *Universal Access to Reproductive Health: Progress and Challenges*.

⁴² Birungi H. et al. 2015. *Education Sector Response to Early and Unintended Pregnancy: A Review of Country Experiences in Sub-Saharan Africa*.

⁴³ UNFPA. 2016. *Universal Access to Reproductive Health: Progress and Challenges*.

⁴⁴ WHO. 2011. *Early marriages, adolescent and young pregnancies: report by the Secretariat*.

⁴⁵ Shah I. and Ahman E. 2004. *Age patterns of unsafe abortion in developing country regions*. *Reproductive Health Matters* 12 (suppl. 24): 9-17.

⁴⁶ Birungi H. et al. 2015. *Education Sector Response to Early and Unintended Pregnancy: A Review of Country Experiences in Sub-Saharan Africa*.

⁴⁷ Ibid.

⁴⁸ UNFPA (2016). *Harmonization of the legal environment of adolescent sexual and reproductive health in the East and Southern Africa region*. Includes all 21 ESA Commitment countries, as well as Comoros and Eritrea.

⁴⁹ Loaiza E. and Liang M. 2013. *Adolescent Pregnancy: A Review of the Evidence*.

4.4 Gender-based violence

Target 7: Eliminate gender-based violence

GBV has serious consequences for the health and well-being of young people; it negatively impacts on their educational outcomes, can cause psychological distress, and lead to serious health outcomes. GBV happens in the home, in communities, and also in public institutions, including schools. Young people learn best in schools that provide a safe and supportive environment; however young people experience violence and harassment in, around, and on the way to school.

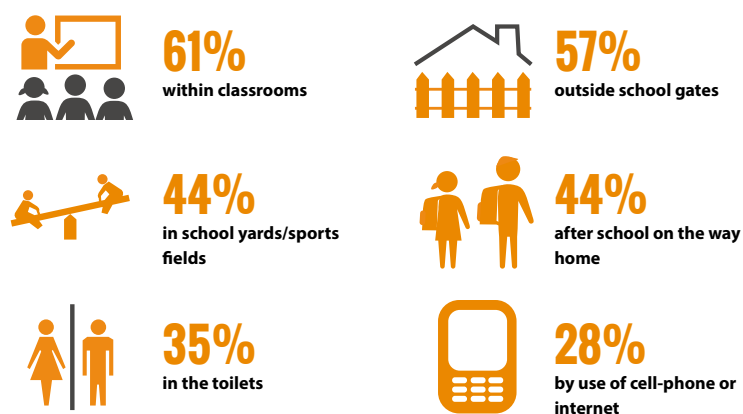
School-related gender-based violence is defined as acts or threats of sexual, physical, or psychological violence occurring in and around schools, perpetrated as a result of gender norms and stereotypes, and enforced by unequal power dynamics⁵⁰. SRGBV is complex and multi-faced, including different manifestations of physical, sexual, and psychological violence, such as verbal abuse, bullying sexual abuse and harassment, coercion, and assault and rape.

A five-country study undertaken in 2014, which addressed gender, diversity, and violence in schools to sensitize ministries and others in the education sector on these issues and ensure that schools are a safe environment for all youth, including youth who do not conform to existing gender norms and stereotypes or are perceived as such, identifies areas where violence commonly occurs in schools as below:

What is gender-based violence?

Gender-based violence (GBV) means all acts perpetuated against women, men, boys and girls on the basis of their sex which causes or could cause them physical, sexual, psychological, emotional, or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict. GBV covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse.

FIGURE 4.3: Where SRGBV occurs



“I was forced into marriage in form 3 when I came home late from school one day with a boy who had asked me for a relationship. My father told me to ‘go back to the boy I was with’. I was not pregnant then but after staying with him for four months I fell pregnant. After giving birth to my baby, I wanted to go back to school but the boy I was with refused to let me go. He began doing drugs and drinking – he couldn’t afford food and clothes for me and the baby. I would go see my mother so I could get food but I could only do this if he was not around because if he was, he would beat me.”

Young woman, 20, Zimbabwe

In southern African countries, where one in every three girls has been forced to have sex by the age of 18 years, a significant proportion of the population have limited agency in making choices regarding their sexual health⁵¹. Girls who experience sexual violence are at higher risk of HIV infection and are often unable to respond to AIDS prevention programmes⁵¹. Although sexual violence affects all children, girls are particularly vulnerable because of gender norms that encourage men to be aggressive and women to have little control over their bodies and safety.

Education has been used effectively in many contexts to engage young people in critical reflections on gender and social norms, on stereotypes around masculinity and femininity, and on how these norms and stereotypes can affect young people’s lives and relationships. Education can equip young people with the life skills and attitudes to engage in healthy peer relationships and violence prevention. Efforts to strengthen gender-responsive curricula and pedagogy and provide CSE are crucial in this respect. This is important not just for reducing SRGBV, but also for equipping young people with the skills to avoid and reduce violence in the wider community and in their own lives in future.

⁵⁰ UNESCO. 2015. *School-related gender based violence is preventing the achievement of quality education for all*. Policy paper 17.

⁵¹ Anderson N. 2006. *Prevention for those who have freedom of choice – or among the choice-disabled: confronting equity in the AIDS epidemic*.

4.5 Child marriage

Target 8: Eliminate child marriage

The African Charter on the Rights and Welfare of the Child (ACRWC) prohibits the marriage of any child under the age of 18 years. However, in the majority of countries in the ESA region, traditional or customary law continues to support child marriage. The rate of child marriage among women aged 20-24 is high in many ESA countries. In 12 of the 21 countries with available data, more than one in three young women aged 20-24 reported being married before their the age of 18⁵². Poverty is a key driver of child marriage, with twice as many girls from the poor households marrying before the age of 18 compared to girls from richer households. Child marriage is also associated with higher rates of teenage pregnancy and higher fertility resulting in girls having to care for many children while they themselves are still young.

Africa is making concerted efforts towards the elimination of child marriage. The African Union has launched a Continental Campaign to End Child Marriage in Africa and regional efforts to end child marriage include a model law on child marriage developed by SADC for countries to adopt across the southern African sub-region. In addition, the constitutional court of Zimbabwe recently made an historic ruling against under-aged marriage⁵³, Zambia has developed a five-year national strategy on ending child marriage which is expected to be adopted in 2016, and Malawi has passed a declaration to end child marriage, with traditional leaders in the country annulling 300 marriages in 2015.

Education works as a powerful tool against child marriage. Girls with higher levels of schooling are less likely to marry as children. In Mozambique, around 60% of girls with no education are married by 18, compared to 10% of girls with secondary schooling and less than 1% of girls with higher education. Similarly, in Malawi, as many as two out of every three women without formal education were married as children, in comparison to one in twenty women with secondary or higher education⁵⁴.

The Harmonization of the Legal Environment of Adolescent Sexual and Reproductive Health in the East and Southern Africa Region report found that only six countries set the age of consent to marriage at 18 years without exception. Despite the presence of such laws, rates of child marriage remain high due to conflicting laws or lack of enforcement. For example, in Malawi, the constitution allows marriage of 15-18-year-olds with parental consent, however, recent domestic law sets the age of consent to 18 for all forms of marriage. Harmonization between constitutions and laws, and between civil and customary laws, will have to be achieved if child marriage is to be eradicated.

In November 2015, the Heads of State and governments at the First African Girls' Summit on Ending Child Marriage in Africa committed to redouble efforts to eliminating child marriage and all harmful traditional practices (HTPs), including female genital mutilation (FGM). They also committed to facilitating a social movement in all countries at local, regional, and national levels, with the participation of the youth, traditional and religious leaders, community leaders, government and CSO partners, parents, and elders on ending child marriage. Lastly they committed to employ focussed interventions and measures to keep girl children in school beyond the age of 18.



2 out of 3

women who have no education are married by 18



Girls with

high levels of schooling

are less likely

to marry as children

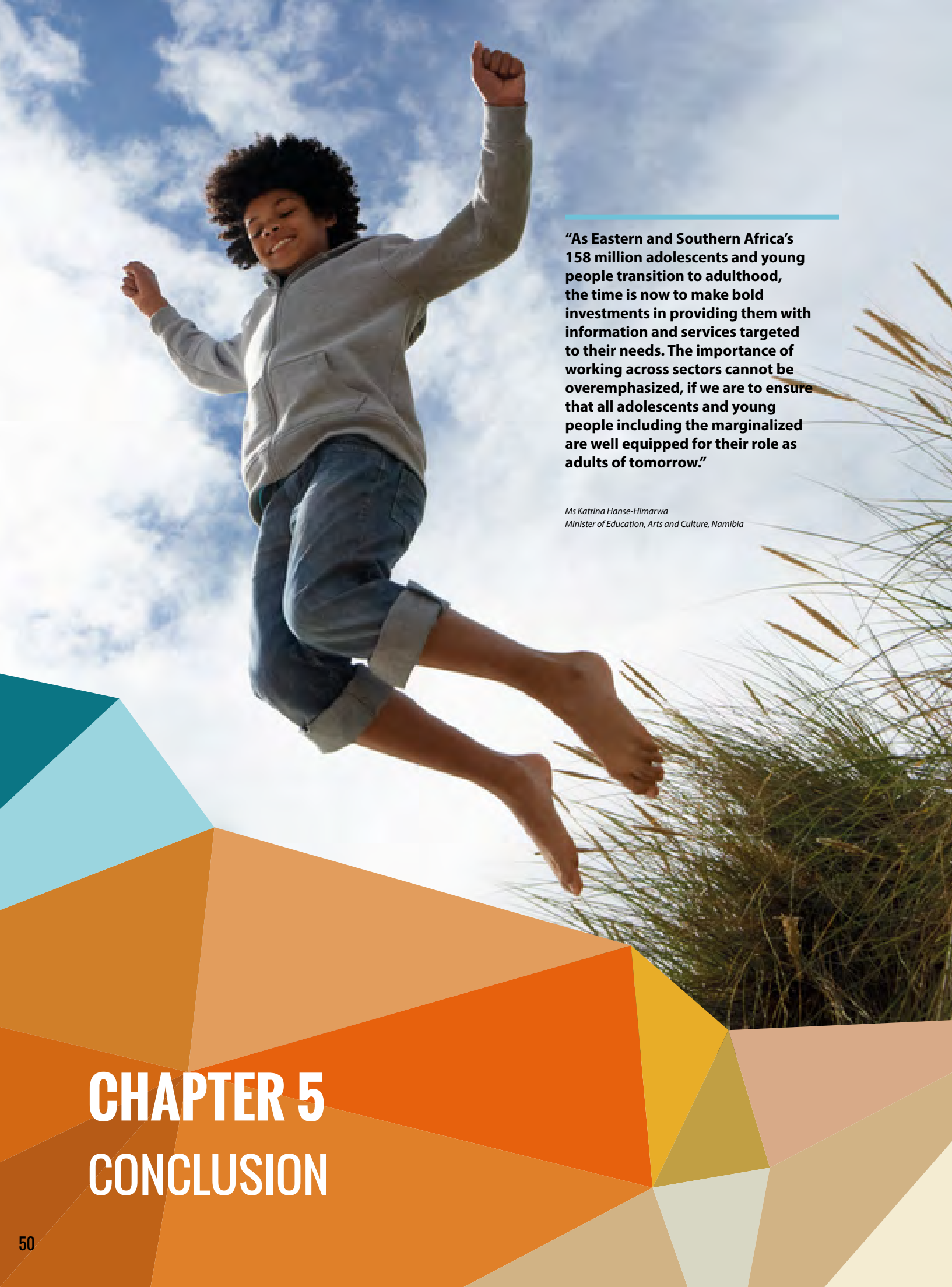
"I was forced into marriage at 14 years old when my parents divorced and my family told me they could not afford taking care of me anymore. They found me an older man to marry who was very abusive. When I married him, he would lock me in the house while he went out for days without returning. Even when I went back to my village to get away from him, no one received me with welcome. They said I ran away from a marriage, that I was not a strong women, and that I would suffer for it. I did not know who to turn to – I felt so alone. I wanted to kill myself."

Young woman, 19, Malawi

⁵² UNICEF. 2015. *State of the World's Children*.

⁵³ Constitutional Court Of Zimbabwe. 2016. Judgment No. CCZ 12/2015 Const. Application No. 79/14.

⁵⁴ UNICEF. 2014. *A Statistical Snapshot of Violence against Adolescent Girls*.



“As Eastern and Southern Africa’s 158 million adolescents and young people transition to adulthood, the time is now to make bold investments in providing them with information and services targeted to their needs. The importance of working across sectors cannot be overemphasized, if we are to ensure that all adolescents and young people including the marginalized are well equipped for their role as adults of tomorrow.”

*Ms Katrina Hanse-Himarwa
Minister of Education, Arts and Culture, Namibia*

CHAPTER 5

CONCLUSION

Going forward, the region will need to prioritize the following:

There has been enormous investment by a range of partners which has led to all 2015 targets being met and exceeded. However, the outcomes in terms of HIV knowledge, behaviour, and GBV will take several years while these initial inputs translate into service delivery and education for all young people. The ESA region can achieve the 2020 targets if there is continued commitment and adequate investments towards adolescents' and young peoples' SRHR. Revitalizing the Commitment and aligning it with the 2030 goals will ensure that this critical age group receives the attention and resources needed to overcome the challenges they face in realizing their health and well-being. The following recommendations are derived from regional and country consultations with ESA Commitment stakeholders, including young people.



GOVERNMENT

- Take the lead and own the ESA Commitment as a key joint platform for addressing the needs of young people, supported closely by the RECs, COMESA, EAC and SADC.
- Prioritize increased access to CSE and SRH services for all girls and boys – in and out of school, regardless of marital or pregnancy status – to address the disturbingly low HIV and AIDS knowledge levels among young people and the challenges they still face in accessing SRH services.
- Recognize the strategic significance of working across sectors (education, health gender, justice, and youth) to support joint action, while increasing domestic financing for young people's SRH programmes.
- Invest in programmes that encourage girls to remain in school; ensure that schools are safe and equitable places for learning; support access to SRH services for young people; enforce legislation to eliminate child marriage; strengthen child protection systems, with an emphasis on legal reform; and strengthen norms and standards that eliminate discrimination based on gender.
- Prioritize filling the gaps in knowledge and evidence around adolescents' and young people's health, education and rights. To ensure that interventions and resources are well targeted, there is a need to strengthen data collection mechanisms at all levels while ensuring that data is finely disaggregated by sex, age economics status, and geographical location.
- Continue working together towards a common vision of a young African, a global citizen, who is empowered, educated, healthy, resilient, and socially responsible – an autonomous decision-maker who has the capacity to reach their full potential and contribute to the development of their community, country, and the region.



YOUNG PEOPLE

- The ESA Commitment belongs to young people. It is critical that the most marginalized and vulnerable are factored into relevant policies and programming related to their health.
- Programmers and other stakeholders should consider young people as a heterogeneous group with different needs and situations which are taken into account in programming.
- There is a need to bring to light the changing realities of young people and work with key stakeholders to eliminate barriers to access SRH and HIV services at all levels.
- There is a need to innovate around the use of different and relevant forms of media (both traditional and digital) to ensure diverse groups of young people are sufficiently connected and continue to be engaged with in the policy-making processes that impact on their lives.
- New and effective mechanisms need to be found to reach young key populations and marginalized adolescents, for example those who are living in extreme poverty, married at a young age, sell sex for economic survival, or living with disabilities.



COMMUNITIES

- Develop creative strategies for working 'with' and 'through' i.e. working with young people to reach their parents; partnership and engagement with religious leaders for programmes; and engaging in dialogue around key religious principles.
- Develop and implement programmes that encourage communities to promote the delay of marriage and pregnancy, including by addressing cultural barriers, traditional laws, and other actions that promote early marriage and pregnancy.
- Mobilize communities to promote egalitarian gender norms, engage men and boys, and end gender-based, sexual, and intimate partner violence.
- Empower parents and guardians to talk to young people about sexuality, their responsibilities, and their rights as early as possible using accurate and appropriate language that they can understand.
- Engage religious and traditional leaders so that they are supportive of all young people accessing good quality CSE and SRH services.



DEVELOPMENT PARTNERS AND OTHER STAKEHOLDERS

- Harmonize and coordinate existing programmes targeting young people, such as DREAMS, All In!, and the ESA Commitment to ensure better alignment and more efficient use of resources.
- Support communities and civil society, including youth-led organizations, to ensure increased access to good quality CSE delivered by well trained teachers and mentors.
- Support programmes to protect adolescent girls' rights, in particular delaying age at marriage and child-bearing and empowering the most marginalized girls to negotiate the use of contraceptives, including condoms for dual protection against HIV.
- Support HIV programmes that engage men in identifying ways to reduce violence and empower women.



APPENDIX
COUNTRY PROFILES

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The ESA Commitment has strengthened national initiatives for adolescents and young people, including the resumption of the JIRO Project in 2014 by the Ministry of Youth and Sports, the Ministry of Education strategic plan (2013-2017) for the Mitigation of HIV-AIDS, Tuberculosis and Malaria; and the formulation of the National Comprehensive Care Strategy for AYFS (2015-2019) by the Ministry of Health. The ESA Commitment has strengthened inter-sectoral coordination and a harmonized ESA plan is under development.

Coordination of the ESA Commitment

The Ministry of Education leads a task team structured to harmonize efforts to achieve ESA Commitment goals, meeting monthly. The task team includes the Ministries of Health, Education, Youth and Sports, Family and Women Promotion, Welfare and Social Reintegration, and Social Communication, as well as UN agencies, World Health Organization (WHO) and Joint United Nations Programme on HIV and AIDS (UNAIDS), CSOs, and youth organizations. The task team operates under a clear terms of reference which guides monitoring and implementation of the ESA Commitment. The framework for operationalization of the ESA Commitment includes funding contributions from each partner.

Demographics	Value
Estimated total population (all ages) ¹	25,789,024
Estimated population of young people (10-24) ¹	7,723,080
Number of schools ²	Primary: 64,600 Secondary: 17,522
Number of in-service teachers ²	Primary: 64,600 Secondary: 17,522
Number of health workers ³	16,054

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS


TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Angola's policy environment for CSE comprises several recently finalized policies, including the National Education Sector Strategic Plan for HIV, TB and Malaria Prevention and Mitigation (2013-2017). This policy framework targets learners in school between the ages of 6-24. Although CSE has been delivered within the secondary school curriculum since 2005, by missing earlier integration into primary school, the high school dropout rates, particularly among girls, means a huge number of young people never receive adequate CSE. Nearly three out of every four girls do not complete primary school. Of those that do, only 14% make it through the first grade of secondary school and receive CSE (UNESCO, 2013). Through the ESA commitment, 30 curriculum designers were trained on curriculum review to ensure integration of cross-cutting issues, with a focus on CSE and reproductive health issues. Training on ASRH for 360 school teachers will be carried out in 2016. During these trainings the number of schools delivering CSE will be updated.

a) CSE out of schools

Angola has mainstreamed health education approaches for out-of-school youth into various policy instruments and strategies such as the Plano Nacional de Desenvolvimento da Juventude (National Youth Development Plan) and Estrategia Nacional de Saude Integrada para Adolescentes e Jovens (National Integrated Health Strategy for Adolescents and Youth).

Indicator	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	Data collection will take place in 2016	-
Does this country have a costed CSE strategy for out-of-school youth?	Yes	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

There have been no teacher training courses for pre-service teachers on CSE or any course developed for pre-service teachers in Angola. However, the Ministry of Education will now be using the newly developed online course on CSE for teachers by UNESCO and UNFPA, and training of the first cohort of participants will start in 2016. In 2015, 18 in-service teachers who received master training in CSE trained 300 teachers resulting in a pool of well-trained teachers who can comfortably teach CSE in the classroom. These teachers will in turn train youth peer educators that will disseminate information on CSE and SRHR in schools.

b) Training of health workers

Although Angola has not implemented training programmes for health workers on the delivery of YFHS, the recently launched National Comprehensive Care Strategy for AYFS has created a conducive environment for establishing training programmes. Challenges include insufficient health workers and teachers, with a majority located in urban areas. High staff turnover has implications on maintaining trained staff in YFHS.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The National Comprehensive Care Strategy for AYFS (Estrategia Nacional de Saude Integral de Adolescentes e Jovens) 2016-2020 focuses on increasing access of young people aged 10-24 to youth-friendly SRH services.

b) Youth-friendly SRH services

Only 7 of the 11 recommended ASRH services are provided to young people in Angola. The services exist in general health services, while specific SRH services for adolescents and young people are only available on a small scale in the provinces of Luanda, Bengala, and Huila. In 2014, these provinces reached 41,009 adolescents (34,447 girls and 6,562 boys) aged 15-19 years old.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

Despite an overall decline, the number of new infections among girls aged 15-24 remains disproportionately higher than their male counterparts. A multi-sectoral response to address the vulnerabilities of adolescent girls and young women is underway. Furthermore, the Ministry of Health, UNFPA, and UNICEF are designing a school-based programme to promote adolescent girl health led by the Huila Province Government.

The number of young people that have tested for HIV is still low (14.9%), as of 2010⁴. Interventions promoting risk reduction behaviours for HIV prevention among young people include mass information/prevention campaigns.

Reduce early and unintended pregnancy

Angola experiences high rates of early and unintended pregnancy. In 2014, a campaign to eliminate early pregnancy and marriage among young people was launched by the Ministry of Family and Women Promotion focusing on strengthening the provision of health information to adolescents and young people. Currently, there is no policy or strategy that supports pregnant learners.

Eliminate GBV

Angola has two main GBV policy frameworks that cover adolescents aged 10-19 years: the 2015 Campaign to Eliminate Teenage Pregnancy and Child Marriages and the National Policy on Domestic Violence. The frameworks provide tools for advocacy and amplify the need for more reliable evidence on GBV. Key stakeholders have been trained on GBV, including basic GBV screening and use of gender tools.

Eliminate child marriage

The legal age for marriage in Angola is 18 years (Family Code, article 24^o, 1988). However, the law permits boys to marry at 16 and girls at 15 with the permission of a person of authority. There is no law on the minimum age of consent to sex.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁵	4,901	2,662	7,563	4,794	2,613	7,407
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁶				20.2%	17.7%	19.5%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁶				15.4%	14.2%	14.9%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁶				41.9%	48.2%	44.6%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing ⁷	42.5%	N/A	N/A	N/A	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁶			13.7%			
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁶			N/A	9.7%	0.9%	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁶			N/A	48.8%	7.7%	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Collaboration between partners improves coordination of ESA Commitment programmes.
- All interventions need funds.
- There is a need to strengthen the health information system and data on adolescents and youth. The current lack of reliable data is hampering the accurate measurement of impact. Angola must leverage initiatives that seek to coordinate better data collection, analysis, and utilization for programme planning and implementation. Data collection related to HIV and AIDS, sexuality education, and reproductive health will commence in 2016 as a result of the process under the ESA Commitment to include relevant indicators into EMIS.

Challenges

- The main constraints around the establishment of a multi-sectoral team include: the complexity of harmonizing plans that have been developed separately by ministries; the issue of significant staff turnover and absence of some ministries; cooperation and communication between different sectors and aligning various ministerial mandates, including the ESA Commitment targets. Proactive multi-sectoral cooperation requires strong leadership, which has been undermined by the economic climate and conflicting policy priorities.
- It has proven to be challenging for the task team to operationalize the ESA Commitment activities within the context of the economic crisis facing Angola. The crisis has impacted negatively on the availability of funding for the ESA Commitment, which in turn has slowed down the implementation rate.

Sources

1. Population and Housing Census, 2014.
2. MoE, 2015.
3. National Health Development Plan (2012-2025), 2014. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. Recent data will be available from the Multiple Indicators and Health Survey (MIHS) later in 2016.
5. UNAIDS HIV 2016 Estimates.
6. GAPR, INCAPSIDA, 2010.
7. Angola MIS, 2011.


BACKGROUND

Although the Ministries of Health and Education and Skills Development have collaborated on a number of initiatives related to SRHR of adolescents and young people in the past, the ESA Commitment has further enhanced this collaboration.

Coordination of the ESA Commitment

The Technical Working Group responsible for implementing the Commitment is made up of the Ministries of Health and Education, Local Government and Rural Development Youth, Sports and Culture, Labour, and Home Affairs, as well as UNESCO, CBOs, NGOs and other development partners. The group meets every quarter and is guided by clear terms of reference. It has joint work plans and a reporting mechanism guiding implementation. Continuous resource mobilization is carried out under the Prevention Programmes for Adolescents module through the Global Fund Round 7 grants.

Demographics	Value
Estimated total population (all ages) ¹	2,024,904
Estimated population of young people (10-24) ¹	584,287
Number of schools ²	Primary: 821 Secondary: 285
Number of in-service teachers ²	Primary: 14,220 Secondary: 154,713
Number of health workers ³	5,982

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Although LSE is part of both the primary and secondary curricula, not all schools are fully implementing it. However, 100% of schools are delivering CSE. Botswana's achievements in delivering quality CSE are strengthened by meaningful involvement of parents and communities, and Parent Teacher Associations meet every term to address emerging issues, including CSE-related matters. Between 2013 and 2015, various sensitization and education activities on CSE were conducted, reaching 1,106 public and private schools.

b) CSE out of schools

Botswana has no costed CSE strategy, however, development of a manual and guiding documents for CSE for out-of-school youth will be supported under the current funding from the Global Fund.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	70%	100%	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Online and face-to-face pre-service CSE training has been conducted for 39 (25 females and 14 males) college lecturers, who are now training pre-service teachers on CSE, which has been integrated in the following courses: Science, Moral Education, and Guidance and Counselling. A total of 125 in-service teachers were trained on CSE in 2015 through an online training course. This included 39 primary teachers (28 females and 11 males); 54 secondary teachers (39 females and 15 males); and 32 non-teaching staff. A total of 20 lecturers were trained on CSE. Following completion of the Adolescent's HIV Prevention & Treatment Toolkit, 110 trainers of trainers (ToT) were also trained on CSE (30 ToTs and 80 master trainers).

b) Training of health workers

The Ministry of Health has allocated 10% of its budget towards strengthening SRH services. As part of the budget allocation, standard pre- and in-service programmes have helped train health professionals in specific YFHS delivery, and these services have been mainstreamed into the national nursing and allied health professional training curriculum. A national training manual was developed in 2008 to guide the training. As of 2015, 16 Institute of Health Sciences (IHS) curriculum developers, and 486 pre-service and 273 in-service health care providers were trained.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The ASRH Implementation Strategy (2012-2016) guides the scale-up of YFHS by government in coordination with NGOs, and includes standardized training in its delivery. While there are no stand-alone national standards, all eight WHO global standards are covered in other areas, although there are key items in each standard that are not fully implemented.

b) Youth-friendly SRH services

Most ASRH services (10 out of 11) are provided to young people by both government and non-governmental youth-friendly centres. However, facilities differ in the provision of services and use referrals for services that cannot be offered at youth-friendly facility level.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	 <i>referrals for post-abortion care</i>
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

Despite an overall decline, the number of new infections among girls aged 15-24 remains disproportionately higher than their male counterparts. A multi-sectoral response to address the vulnerabilities of adolescent girls and young women is being implemented through programmes such as the Safeguard Young People programme.

Risk reduction behaviours among young people

HIV testing in the general population remains low and has seen little improvement, as revealed in Botswana AIDS Impact Survey (BAIS) reports, with 61.7% and 62.9% of the population ever testing for HIV in 2008 and 2013 respectively. HIV testing rates across gender and most age groups were under 70% in the BAIS IV results, with the exception of females aged 20-24 years, at 74.3%. While Botswana has prioritized programmes for HIV prevention among adolescents and young people, these have not improved risk perception or increased comprehensive knowledge, which is below 50%. However, through the CONDOMIZE! Campaign, the country has enhanced access to condoms, distributing a total of 104,200 male condoms in four districts in 2015, and information and skills-building for adolescent and youth on HIV prevention.

Reduce early and unintended pregnancy

Although Botswana has a high percentage of learners that have ever been pregnant, there is no clear guidance on managing re-entry of pregnant learners once they have given birth. School manuals do, however, indicate that learners who drop out of school due to pregnancy can be re-admitted six months following birth, at the discretion of the school head.

Eliminate GBV

Two-thirds of women in Botswana have experienced GBV, in their lifetime. Botswana has policies that address GBV such as the Domestic Violence Act and Health Sector Response to GBV, however, effective implementation remains a challenge. Efforts have been made to train educators, non-teaching staff, and facilitators in schools on GBV matters, including basic GBV screening and school response protocols.

Eliminate child marriage

Botswana's legal age of marriage is 18 years old, nevertheless, anecdotal data show that child marriage remains high in certain cultures and tribes. There have been programmes addressing this in some districts, however, comprehensive programming on prevention of child marriage has not been instituted.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁴	3,186	1,351	4,537	2,789	1,641	4,430
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁶				65.9	80.9%	72.4%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁵				74.3%	71.1%	73.3%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁶			42.1%	47.4%	47.1%	47%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷		N/A	N/A	9.7	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁶			13.7%			
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage?			No			No

LESSONS LEARNED AND CHALLENGES

Lessons learned

- While collaboration between partners improves coordination of programmes, improved networking and joint planning and implementation of planned activities is needed to avoid duplication and encourage prudent use of funds that have been mobilized for the ESA commitment activities.

Challenges

- To date, funds have been mobilized from the Global Fund, rather than locally, and inadequate resources continue to hamper the scaling-up of interventions.
- There is limited data collection, analysis, and use to guide programming.
- There is no high level reference group led at Ministers level to provide oversight for the implementation of the ESA Commitment.
- The lack of a coordinated youth network has resulted in limited youth engagement in youth programmes.

Sources

1. Population and Housing Census, 2011.
2. Education Stats Brief, 2013.
3. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. UNAIDS HIV 2016 Estimates.
5. BAIS IV data.
6. YPTT report, BAIS IV report, 2013.


BACKGROUND

Prior to the ESA Commitment, the Ministry of Education developed a Civics Education curriculum that included practical general life skills and was complemented by sexuality education interventions in partnership with CSOs and development agencies. At the time the ESA Commitment was endorsed, government was revising the national youth strategy which focused on scaling up better multi-sectoral coordination, education and health services.

Coordination of the ESA Commitment

Burundi has established a multi-sectoral coordination mechanism which includes the ministries responsible for education, health, youth, and gender, and CSOs. The coordinating group organizes and convenes meetings, monitors activities of partners, and conducts advocacy for activities under the ESA Commitment. There is no overarching work plan or implementation strategy, although there are costed activities.

Demographics	Value
Estimated total population (all ages) ¹	11,178,921
Estimated population of young people (10-24) ¹	3,445,272
Number of in-service teachers ²	Primary: 44,662 Secondary: 14,000
Number of health workers ³	133,112

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



Target 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Although CSE is integrated into both primary and secondary school curricula, there are essential gaps in coverage; most notably topics related to SRH and HIV treatment. In the secondary school curriculum, general life skills covers CSE-related topics the most comprehensively, while primary school only covers one main CSE area.

b) CSE out of schools

Burundi has mainstreamed issues related to CSE for out-of-school youth through several policies and strategies, including the National Strategic Plan on Holistic Programming for Condom Use (Plan Stratégique de Santé de la Reproduction) and the Strategic Plan for Reproductive Health (Plan Stratégique Nationale de Programmation Holistique des Préservatifs).

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	100% primary No data for secondary	100% primary 70% secondary	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	Yes	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

There are no pre-service teachers trained in Burundi, however, between 2013 and 2015, 759 in-service teachers were trained.

b) Training of health workers

Burundi currently does not offer training for pre-service health providers on youth-friendly health care delivery. However, there has been a priority to train in-service health care providers with 652 health providers, predominantly nurses, trained between 2013 and 2015.

No. of teachers trained	Baseline 2013			Trained 2014			Trained 2015		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
In-service female and male teachers trained (primary)	10	25	35						10
In-service female and male teachers trained (secondary)	18	37	55			177	175	352	527












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Youth-friendly services are underpinned by six different policies and strategies covering adolescents from the age of 10 years old, such as the Plan Stratégique Santé Adolescents and Jeunes.

b) Youth-friendly SRH services

A minimum package of YFHS have been integrated into Burundi's public health facilities, although only specific health centres offer the services at particular times during the week. Data collected from the health care facilities indicate that the number of adolescents and young people (aged 10-24) accessing the services is steadily increasing from 60,000 in 2013 to just over 91,000 in 2015⁴. Interestingly, the number of boys and young men using YFS is slightly higher than girls and young women.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce early and unintended pregnancy

As of 2007, Burundi has had a policy to support pregnant learners of all ages. However, with the country still facing high teenage pregnancy rates, the Ministry of Education launched the national 'Zero Pregnancies at School' campaign which focused on eliminating all new pregnancies in schools. The nation-wide campaign included the integration of sexuality education in the curriculum, as well as other out-of-school interventions.

Eliminate GBV

While there are national policies against GBV, they do not specifically address school-related GBV.

Eliminate child marriage

Although the legal age of sexual consent in Burundi is 18 for both boys and girls, 20% of girls are still married before the age of 18, despite it being forbidden by both law and the Christian churches⁶.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁵	2,789	1,641	4,430			
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁶						4.85%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁶						16.7%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁶		N/A	N/A	9.6%	N/A	N/A
Target 7: Eliminate gender-based violence						
Does the country have policies that prevent GBV?			No			No
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁶	2.5%	N/A	N/A		N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁶	20.4%	N/A	N/A		N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- There has been positive collaboration across sectors at the local levels, including the coordination and initiation of projects with government ministries and CBOs to improve the provision of health services for adolescents and young people.
- Integrating YFHS into public health facilities has helped maintain financial sustainability.

Challenges

- Data collection has remained a challenge, especially from health centres that do not cater for specific data related to youth and adolescents.
- Progress towards the ESA Commitment targets has been hampered by a lack of financial resources. Furthermore, certain activities that could contribute positively to fast track progress were not eligible for donor funding (for example construction, rehabilitation, fuel, and communication costs).

Sources

1. UN population Division Estimates, 2015.
2. UNESCO. 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa*.
3. DSNIS, 2015. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. DSNIS, 2010.
5. Rapport des centres de santé amis des jeunes.
6. UNAIDS HIV 2014 Estimates.
7. DHS, 2010.
8. www.girlsnotbrides.org Burundi country pages.

DEMOCRATIC REPUBLIC OF CONGO (DRC)


BACKGROUND

The DRC continues to be plagued with post-conflict violence, which has negatively impacted on health infrastructure and resources. This has resulted in major challenges in the provision of quality youth-friendly SRH services. At the time the ESA Commitment was endorsed, DRC had some of the worst SRH outcomes in the world. In order to remedy the situation, the Ministry of Public Health has been working with other cabinet ministries and CSOs to improve sexuality education and health care delivery.

Coordination of the ESA Commitment

Chaired by the Ministry of Public Health, the coordination mechanism takes the form of a working group, which meets quarterly and consists of a number of ministries, including the Ministries of Education, Public Health, Social Affairs, Youth, and Gender, as well as various CSOs. The group has not yet finalized its terms of reference, but is tasked with coordinating, information sharing, and advocacy of the ESA Commitment. A joint two-year work plan has been developed to facilitate effective implementation of activities, and financial resources have been allocated for the implementation and monitoring of the work plan.

Demographics	Value
Estimated total population (all ages) ¹	77,266,814
Estimated population of young people (10-24) ¹	24,966,418
Number of schools ²	Primary: 43,218 Secondary: 22,698
Number of in-service teachers ²	Primary: 339,951 Secondary: 281,324
Number of health workers ³	127,716

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



Target 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

The CSE curriculum model is delivered to both primary and secondary schools, blended with extra-curricular and in-classroom lessons. The joint work plan is intended to support young people with CSE both in and out of school. While some CSE topics are delivered through life skills, there are a number of notable gaps on key essential topics such as decision-making/assertiveness and human rights empowerment; sexual behaviour; and sexual abuse, among others.

b) CSE out of schools

The scope and depth of out-of-school youth programmes in DRC are unclear; a specific costed strategy for out-of-school youth needs to be developed.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	0.5% (350 / 65,916)	1.8% (1,185 / 65,916)	 In progress
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

Target 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

The training of pre-service teachers in CSE has not yet started because CSE has not been integrated into the pre-service curricula training, however, 13,529 in-service teachers were trained in CSE in 2015, although data on the teaching of CSE are not available.

b) Training of health workers

Training of pre-service health providers is not offered in DRC due to a lack of financial resources. However, 15 practicing doctors were trained in 2013 on YFHS delivery. No further training of health providers has been reported since.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Youth-friendly services are supported by two different policies and strategies addressing the issues of adolescents and young people from 10-24 years old: the 2007 National Health Policy and the 2009 National Guidelines on Adolescent Health. In addition, DRC has gender-based discriminatory policies regarding the age of sexual consent, which is 14 years for girls and 18 years for boys. This creates further barriers to accessing SRH services.

b) Youth-friendly SRH services

DRC offers standard YFHS services and has increased its government contributions for contraceptives for 2016 from \$300,000 to \$2.5 million. This increase will greatly facilitate the demographic transition needed to stimulate economic development, improve the health and well-being of women and girls, and reduce the high level of unmet need for family planning, which stands at 28%.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

In DRC, the number of new infections among girls aged 15-24 remains disproportionately higher than their male counterparts. A multi-sectoral response to address the vulnerabilities of adolescent girls and young women is being implemented through various programmes, such as LSE in schools and sports for development programmes for both in- and out-of-school youth.

Risk reduction behaviours among young people

The low use of condoms among both young women and men aged 15-24 in DRC indicates a need to advocate for risk reduction measures.

Eliminate GBV

An estimated 12.8% of girls and women aged 15-24 years have experienced sexual violence, often leaving them stigmatized and rejected by their families, and with devastating health complications. While DRC has a national policy against GBV, and the CSE curriculum covers issues and topics related to GBV, the policy does not specifically address GBV in schools, and only 5% of schools have rules and guidelines for staff and students regarding physical safety, stigma and discrimination, and sexual harassment and abuse.

Eliminate child marriage

DRC has one of the highest child marriage prevalence rates in the world but, despite the challenging realities for many girls and young women, the country has no dedicated national campaign to prevent child marriages. Furthermore, with the ongoing conflict, there is limited rule of law and, coupled with the culture of widespread impunity for perpetrators of child marriage, although the legal minimum age of consent for marriage is 18 years, 37% of girls are married before the age of 18⁷.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁴	3,186	1,351	4,537	2,709	1,125	3,835
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁵				25.6%	28.3%	53.9%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁵				8.9%	6.3%	15.2%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁶	15.1%	20.7%	35.8%	18.6%	24.9%	18.6%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁶	23.8%	N/A	N/A	27.2%	N/A	N/A
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁵		N/A	N/A	10%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁵		N/A	N/A	37.3%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

Strong and shared will and commitment from both government and civil society will be needed to push forward the ESA Commitment agenda.

Challenges

The lack of up-to-date, reliable, and disaggregated data makes it difficult to measure progress.

Sources


1. UN Population Division Estimates, 2015.
2. Annuaire statistique, EPS INC, 2012-2013.
3. Annuaire statistique INS- 2014, Ministère du plan et de révolution de la modernité. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. UNAIDS HIV 2015 Estimates.
5. EDS, 2013-2014.
6. EDS, 2006-2007 and 2013-2014.
7. EDS RDC, 2013-2014.

Although Ethiopia had implemented most of the interventions under the ESA Commitment before the Commitment was affirmed, the country has since placed more emphasis on the delivery of CSE. As a result, Life Skills, SRH, and HIV and AIDS have been integrated into selected subjects of the primary and secondary school curricula, and Life Skills manuals have been prepared for all levels of education: primary, secondary, tertiary, and TVET. In addition, teachers are continuously trained on how to provide LSE.

Coordination of the ESA Commitment

The ESA Commitment coordination mechanism is chaired by the Ministry of Health and consists of a technical working group made up of the Ministries of Education and Health, as well as UNESCO, UNFPA, the Consortium of Organizations for Reproductive Health Activities, Save the Children, and other partners. While the TWG has tried to coordinate the national effort on the implementation of CSE, delays in the approval of a draft CSE guideline outlining the evidence base for CSE, HIV prevention, and SRHR, as well as the roles and responsibilities of various stakeholders, has hindered the process and therefore there is no work plan or implementation strategy in Ethiopia as of yet.

Demographics	Value
Estimated total population (all ages) ¹	99,390,750
Estimated population of young people (10-24) ¹	34,428,505
Number of schools ²	Primary: 32,048 Secondary: 2,333
Number of in-service teachers ³	Primary: 270,375 Secondary: 122,147
Number of health workers ⁴	73,097

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization of the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

The CSE curriculum is delivered in both primary and secondary schools, and mainly within the formal curriculum, and generic life skills are offered both within the formal curriculum and as an extra-curricular activity. HIV and LSE has been integrated into 38.4% of primary and secondary schools⁵. However, there are notable gaps in the CSE curriculum in primary schools, including social and cultural norms, referral systems, and how to seek SRH and HIV services. Following the affirmation of the ESA Commitment, Ethiopia began processes to develop these components, along with several SRH information and service interventions, as part of pilot programmes in three high school subjects. The pilot schools now have clubs led by trained teachers that help to increase the awareness of students on SRH issues.

b) CSE out of schools

Ethiopia does not have a CSE strategy for out-of-school youth, which make up an estimated 3.1 million of the population⁶. However, along with interventions of partners, the government has established more than 1,500 youth centres across the country to address both in- and out-of-school youth with comprehensive SRH information and services.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	38.4%		 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved


TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

There is no specific training of pre- or in-service teachers on CSE, however, Life Skills, including HIV and CSE, are included in the different subjects of teacher training colleges.

b) Training of health workers

Ethiopia provides pre-service training for health service providers which includes SRH, however, the extent to which sexuality education is part of this curriculum is not known. In addition, there are in-service guiding documents and programmes for delivery of YFHS. The Federal Ministry of Health has recently finalized the preparation for the establishment of an institution to train in-service health providers. The extent to which YFHS are part of the scope of the institution is not known.

Indicator	Current data 2015	Progress
% of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year.	100%	 Achieved












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The Ministry of Health is currently finalizing a Comprehensive Adolescent Health Strategy (2016-2020) which will target 100% AYSRH coverage in public health facilities. This strategy includes the Health Sector Transformation Plan 2015/16-2019, the Growth and Transformational Plan (2010-2015 and 2016-2020), and the Strategic Planning and Management of HIV Response (2011-2015), which will also target out-of-school youth.

b) Youth-friendly SRH services

There are more than 1,500 youth centres that provide SRH information and services to adolescents and young people, although many need more investment to be functional. Due to the absence of baseline data, it is difficult to measure the quality of the YFS being provided.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce early and unintended pregnancy

The minimum age for consent to sex is 18 years for both males and females, however, early marriage, lower levels of contraceptive use, and a high unmet need for family planning predispose adolescents to increased chances of teenage pregnancy and motherhood. No policies currently exist to protect the right to education for pregnant learners.

Eliminate GBV

Ethiopia has made enormous progress in reducing harmful traditional practices, including early marriage and FGM. With active participation by religious and community leaders, these practices have been abandoned in many districts and regions. In addition, the country launched the National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in 2013. This strategy is fully endorsed by the government and coordination and leadership mechanisms are in-place. In terms of combatting school-related GBV, a Code of Conduct is being implemented by the gender directorates of each educational institution which covers elements of physical safety, stigma, discrimination, and abuse, however, the level of its implementation and the impact it is making in the school community needs further analysis.

Eliminate child marriage

Early marriage is a deeply rooted tradition in many Ethiopian communities, with 41.2% of girls marrying before the age of 18⁹, despite the legal age for marriage being 18 as of 2004.

The government has a guiding strategy and plan in response to child marriage, including the National Strategy and Action Plan on Harmful Traditional Practices Against Women and Children, which launched in 2013. The government has also committed to taking further action at the Girl Summit in 2014 and 2015¹⁰.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁷						21,000
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁸	10.9%	1.2%				
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁸	23.9%	34.2%	28.4%			
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁸	12.4%	N/A	N/A		N/A	N/A
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁸	16.4%				N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁸	41.2%				N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Dissemination of the ESA Commitment principles has contributed to a stronger common understanding of the seriousness of the HIV epidemic and the protective effect of accessible SRH information and services.
- The issue of CSE has obtained substantial recognition and interventions have been put in place, for example, the Ministry of Health took CSE into consideration while developing the Adolescent and Youth Health Strategy (2015-2025), and the Ministry of Education has taken measures to integrate CSE into curricula of higher education institutions as integrated and/or standalone subjects.
- An advocacy workshop conducted under the leadership of the Ministry of Women, Children and Youth Affairs, where different ministries and youth-focused stakeholders were invited to discuss the coordination of interventions, was attended by the president of the country and led to the establishment of a dedicated Ministry of Youth.

Challenges

Ethiopia considers CSE a particularly culturally-sensitive topic, halting some of the momentum for community and political support. That being said, there is a growing movement of stakeholders involved in the response to HIV and AIDS that recognize its importance. This provides a window of hope for the ESA Commitment to take off in the near future. However, lack of resources to generate solid evidence on CSE has made it difficult to assess the depth of its implementation, even though progress has undoubtedly been made.

Sources

1. UN population Division Estimates, 2015.
2. MOE, 2013/2014.
3. UNESCO, 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa*.
4. MOH, 2012-2013. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
5. Selected 2011 GPS Key Results: Ethiopian Ministry of Education.
6. UNESCO, 2015. Global summary and status of school based comprehensive sexuality education.
7. UNAIDS HIV 2013 Estimates.
8. DHS, 2011.
9. UNICEF, 2015.
10. www.girlsnotbrides.org Ethiopia country pages.

BACKGROUND

Since the ESA Commitment, the country has made great strides in creating an enabling environment for delivery of CSE and access to SRH services to young people, complemented by LSE programmes provided by FBOs and CSOs through extra-curricular interventions.

Coordination of the ESA Commitment

Kenya has established a two dimensional multi-sectoral coordination mechanism which involves government ministries, civil society, development partners, and young people. There is also a Technical Working Group on CSE led by the Ministry of Education, Science and Technology that meets on a quarterly basis. The TWG has so far developed draft guidelines on CSE and a costed work plan of ESA Commitment activities. The TWG also provides technical and financial support to the Ministry of Education, Science and Technology in the implementation of the Commitment. In addition, the National AIDS Control Council convenes and coordinates a multi-sectoral working group on HIV and young people through which the ESA Commitment agenda is addressed. Through both groups, ESA Commitment-related activities have been included in national processes, such as the Fast-Track Plan to End HIV and AIDS Among Adolescents and Young People, the National Adolescent Sexual and Reproductive Health Policy Implementation Plan, and the National Guidelines for the Provision of Adolescent and Youth Friendly Services in Kenya.

2015 TARGETS

TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries**a) CSE in schools**

Sexuality education in Kenya is taught within Life Skills and other carrier subjects, such as Science and Religious Education, in primary and secondary school. However, because it is a non-examinable subject, it is rarely taught in most schools. The current comprehensive curriculum reform process provides an opportunity to address this gap. In line with the education sector policy on HIV and AIDS, which guides the implementation of HIV and CSE programmes in schools, the capacity of 121 out of 125 curriculum developers has been enhanced to ensure that young people receive higher quality CSE information once the curriculum is reformed.

b) CSE out of schools

The 2015 National Adolescent Sexual and Reproductive Health Policy, alongside the policy's costed implementation plan which is currently being developed, will pave the way for provision of CSE to young people out of school, as well as improved coordination and planning among key stakeholders in the delivery of SRH programmes. UNFPA is supporting the Ministry of Health to develop and roll out an SRH information manual targeting young people out of school and those in youth empowerment platforms such as youth polytechnics and the National Youth Service.

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries**a) Training of teachers**

There have been no teacher training courses for pre-service teachers specifically on CSE to date, but the Ministry of Education will use the newly developed online course on CSE by UNESCO and UNFPA to train the first cohort of participants in 2016. In addition, the number of in-service teachers trained has gradually increased since the ESA Commitment was endorsed: from 869 teachers in 2013 to 1,026 in 2015⁶. Initial assessments have shown that the teachers are feeling more comfortable teaching sexuality education after completing training. In fact, some reports have shown an increase in the number of young people accessing health services referred by teachers.


TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV**a) National ASRH policies and strategies**



The ESA Commitment has supported the development of the 2015 Adolescent Sexual and Reproductive Health Policy and the National Guidelines for Provision of Adolescent and Youth Friendly Services, both of which cover the 10-19 years age group. The policy complements the Education Sector Policy on HIV and AIDS, which has rolled out in all 47 counties.

b) Youth-friendly SRH services

Schools and health facilities are currently being mapped in order to link with increased uptake of treatment and other support services. A total of 14,308 young people accessed youth-friendly health services – of which 71% were adolescents between 15-19 years old. This is largely attributed to stronger referral systems over the years.












Demographics	Value
Estimated total population (all ages) ¹	43,000,000
Estimated population of young people (10-24) ²	14,606,090
Number of schools ³	Primary: 29,460 ⁴ Secondary: 8,734
Number of in-service teachers ³	Primary: 270,375 Secondary: 122,147
Number of health workers ⁵	73,097

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization of the ESA Commitment?	No	Yes	 Achieved

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	45% Primary 32% Secondary	51% Primary 39% Secondary	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 In progress

b) Training of health workers

Kenya has implemented specific training programmes for health care professionals on the delivery of YFHS through the Ministry of Health and its partners, such as UNFPA, and reports indicate that a total of 288 health providers were trained between 2013 and 2015. This was aimed at improving the perceptions and attitudes of service providers towards young people, which is often flagged as a key bottleneck to service uptake, and in turn leads to an increase in the number of young people accessing SRH services.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections

The number of new infections among young people aged 15-24 in Kenya has slightly declined over the last three years, but girls are still disproportionately affected. A multi-sectoral response to address this is being implemented through various initiatives such as the Fast-Track strategy, DREAMS, and the All In! Global Campaign to End Adolescent AIDS.

There has been a significant increase in the number of young people testing for HIV from 2008 to 2014, as well as adopting risk reduction behaviours, including delayed sexual debut, reduced number of partners, and increased condom use, among others.

Increase HIV prevention knowledge

There has been a 10% increase in the HIV prevention knowledge levels of young people from 2008 to 2014, but efforts are underway to ensure that knowledge levels increase even more by mainstreaming CSE in the reformed curriculum and designing interventions for out-of-school youth.

Reduce early and unintended pregnancy

According to the Children's Act 8 of 2001, the minimum age of consent to sex for both females and males is 18 years. Kenya has nevertheless provided a return-to-school policy for teenage mothers under the Education and Training Sector Gender Policy. As a result, pregnant learners are not suspended and are given other opportunities to finish national exams.

Eliminate GBV

The data indicates an increase in GBV rates which could be attributed to more cases being reported due to the greater awareness of rights and protective laws as a result of various programmes by government. GBV is addressed in the Kenya Constitution for 2010, the Sexual Offences Act of 2006, Children's Act of 2001, Teacher Service Commission Code of Conduct, Adolescent Sexual and Reproductive Health Policy, and the Education Gender Policy.

Eliminate child marriage

The minimum age of consent to marriage in Kenya is 18 years for both males and females. Yet approximately one in four girls are married before the age of 18⁹. Young women living in rural areas are twice as likely to be married before the age of 18 than those living in urban areas. It is hoped the Marriage Act, which was passed in 2014, together with the ASRH and Education Gender policies will help to address issues such as child marriage and harmful cultural practices such as FGM, which contribute to child marriages.

Indicators	Baseline			Available Data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁷	24,199	13,016	37,217	23,305	12,461	35,764
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁸	24.9%	25.5%		61%	73%	
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁸	40.9%	25.5%		68%	50%	
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁹				57%	65%	
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁹	17.7%	N/A	N/A	18%	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁹			38.2%			40.8%
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁶	6.2%	N/A	N/A	4.4%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁶	26.4%	N/A	N/A	22.9%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

The ESA Commitment does not carry a specific resource envelope and this has impacted on the level of implementation by partners involved. Despite this handicap, there have been effective linkages and partnerships between initiatives such as All In! and DREAMS that build momentum on CSE and ASRH work. To accelerate implementation of Commitment-related activities, it is important to advocate for more resources.

Challenges

Kenya has experienced some challenges in its efforts to provide CSE due to perceptions of some key stakeholders that it could encourage early sex among adolescents and young people. This opposition has to a certain extent affected the implementation of activities. It is therefore important to involve adolescents and young people in the development of CSE content and to promote further dialogue among parents, religious leaders and other key stakeholders.

Sources

1. Kenya National Bureau of Statistics (2014) Projections.
2. UN population Division Estimates, 2015.
3. EMIS, 2014.
4. This includes ECDs, public, private and primary.
5. Africa Health Workforce Observatory, 2010. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
6. Kenya teacher training reports, 2015.
7. UNAIDS HIV 2016 Estimates.
8. DHS, 2008 and 2014.
9. KDHS, 2008 and 2014.
10. UNFPA Child Marriage Profile: Kenya, 2012.


BACKGROUND

Prior to the launch of the ESA Commitment, the Lesotho Government had formulated a number of policies, guidelines and other frameworks relevant to reproductive health and HIV-related education, particularly for young people. However, the Commitment became an important catalyst for galvanizing, harnessing, and enhancing more effective scale-up of both CSE and SRH services for adolescents and young people.

Coordination of the ESA Commitment

Lesotho has established a Technical Working Group to coordinate the ESA Commitment which is jointly chaired by the Ministries of Health and Education and consists of relevant government ministries, school proprietors, teacher organizations, civil society, and UN agencies. The TWG has terms of reference and meets every quarter. It has a joint work plan which draws from the Ministries of Health, Education, and Gender sector plans and resources have been allocated, although specific activities have not yet been costed.

Demographics	Value
Estimated total population (all ages) ¹	2,135,022
Estimated population of young people (10-24) ¹	729,730
Number of schools ²	Primary: 1477 Secondary: 339 Tertiary: 14
Number of in-service teachers ²	Pre-primary: 3,700 Primary: 11,167 Secondary: 5,367
Number of health workers ³	1,301

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Since the ESA Commitment was affirmed in 2013, Lesotho's Life Skills Education curriculum has been reviewed and revised to incorporate CSE and rolled out to Grades 4, 5 and 6 in all primary schools using an integrated approach. This new curriculum means CSE is now examinable. In addition, the curriculum is being piloted in 70 primary schools in Grade 7 in 2016 as a stand-alone subject. To date, it has only been piloted in Grade 8 at secondary school level, however, because the new curriculum is designed to cover the first 10 years of schooling, it will follow young people as they progress through the grades and will build on topics taught in earlier grades.

a) CSE out of schools

Lesotho does not have a specific strategy to reach young people out of school, nor are the issues related to them mainstreamed into the draft school health policy.

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year.	4.75% primary school	100% in grades 4-6	 In progress
<i>(Target: 40% schools to be reached by 2015)</i>	0% secondary school	29.5% in form A	
Does this country have a costed CSE strategy for out of school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Since 2013, 1,900 pre-service primary and secondary school teachers from the Lesotho College of Education, 4,416 in-service primary school teachers, and 100 in-service secondary school teachers have been trained on CSE delivery. With the introduction of the new curriculum, re-orientation was also provided to teachers to help them effectively implement CSE in the classroom. However, the main challenge has been proper in-service training of teachers, and while anecdotal data indicate that teachers need more training than they have received in order to effectively deliver CSE in schools, in-service training comes at a high cost.

b) Training of health workers

Nurses in all health facilities were trained on the National Minimum Standards for Provision of Adolescent-Friendly Health Services, although the exact numbers are not available.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Lesotho has the following policies and strategies in place: Sexual Offences Act, Child Protection and Welfare Act, National Minimum Standards for Provision of Adolescent-Friendly Health Services, National Action Plan for Women, Girls and HIV and AIDS, HIV Testing Services Policy, Behaviour Change and Communication Strategy, National HIV and AIDS Strategy, Elimination of Mother to Child Transmission Plan, draft School Health and Nutrition Policy; and draft Adolescent Health Strategy.

b) Youth-friendly SRH services

Lesotho experienced an increase in the uptake of antenatal clinic services by teenage mothers in some health facilities as a result of the training and capacity-building of health providers.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

Coverage of HIV testing services among young people who are sexually active has improved dramatically over the last four years, with young males accessing HIV testing more than their female counterparts. In addition, there has been an increase in uptake of voluntary medical male circumcision (VMMC), which is also used as an entry point for other services, such as HIV testing and condom distribution.

Reduce early and unintended pregnancy

Although the age of consent to sex is 16 years, 19% of adolescent girls aged 15-19 have begun childbearing.

Eliminate GBV

Data on GBV are limited, and there is very low reporting of GBV cases, however, a recent study by Gender Links revealed that 86% of women experienced some form of violence at least once in their lifetime and 62% experienced intimate partner violence. The draft School Health and Nutrition Policy and draft Adolescent Health Strategy guide the response to GBV, teenage pregnancy, and child marriage, however, progress is limited due to the fact that both the policy and the strategy are yet to be adopted and approved by the relevant authorities. There is currently no legal or policy instrument to address school-related GBV.

Eliminate child marriage

The minimum age of consent to marriage in Lesotho is 18 years, however, there are still many children, particularly in the rural areas, who are married at a very early age. The Ministry of Social Development is currently undertaking campaigns across the country to sensitize communities about child marriage and how to prevent them. The Ministry of Education and Training is also working on new strategies to address high school dropouts, which are highly prevalent in rural areas and a major contributing factor to child marriages.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁴	4,148	2,491	6,640	4,003	2,386	6,388
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁵				7.8%	22.1%	12.2%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁵				58.0%	36.4%	51.8%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁵	28.7%	38.6%		37.6%	30.9%	35.5%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁶	19.8%	N/A	N/A	19%	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁷	28.8% ⁹	51.9%				
% of women who have experienced some form of violence at least once in their lifetime ⁸				86%	N/A	N/A
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage?			Yes			Yes
% of women (age 20-24) who were first married or in union before they were 15 years old ¹⁰		N/A	N/A	2%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁸		N/A	N/A	19%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

Under the ESA Commitment there has been a notable increase in adolescent-friendly service delivery, with adolescents dominating as the most common age group receiving health services at facilities (86%) in some districts.

Challenges

- Lesotho has noted major challenges in adequately and consistently reaching children, adolescents and young people out of school. Currently, 19% of children (primary school age) are out of school. This calls for urgent interventions from both health and education sectors to respond to the needs of out-of-school youth in Lesotho.
- The main challenge with regard to classroom delivery of CSE is inadequate training for in-service teachers.
- The number of health providers trained is not yet sufficient to achieve the required results for the ESA Commitment. Lack of human resources and flexibility in service delivery after school and over weekends have created two major challenges in providing adequate services to young people.
- Disaggregated data collection continues to be a challenge, particularly with regard to training of teachers and health professionals as well as number of adolescents and young people accessing YFHS.

Sources

1. UN Population Division Estimates, 2015.
2. Education Statistics Report, Ministry of Education and Training, 2014.
3. WHO Fact Sheet on Lesotho. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. UNAIDS HIV 2016 Estimates.
5. GARPR report, 2015.
6. DHS, 2009 and 2014.
7. DHS, 2010-11.
8. Gender Links Study, 2015 (including partner and non-partner violence).
9. Percentage of women and girls aged 15 to 49 who have ever experienced physical or sexual violence.
10. UNICEF, 2015.


BACKGROUND

Before the ESA Commitment was endorsed, Life Skills training was integrated and examinable in the Madagascar school system. However, there are notable gaps in its coverage and quality. In addition, despite a very low HIV rate, comprehensive knowledge rates on topics such as HIV and AIDS are low, levels of teenage pregnancy and children out of school, especially girls, are high, and levels of child marriages are increasing.

Coordination of the ESA Commitment

Madagascar has not established a coordinating mechanism and has no terms of reference guiding the ESA Commitment implementation. However, supported by UNFPA and UNESCO, the government sector work plans are currently being validated and the sector plan for the Ministry of Education is in a conceptual phase.

Demographics	Value
Estimated total population (all ages) ¹	24,235,390
Estimated population of young people (10-24) ¹	7,988,954
Number of schools ²	Primary: 31,071 Secondary: 5,279
Number of teachers ²	Primary: 115,640 Secondary: 48,033
Number of health workers ³	17,604

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	No	 Not achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Although Madagascar has already included life skills aspects in the school curriculum, a new CSE curriculum is currently being tested for the 2015-2016 school year in two pilot sites with the support of UNFPA. This CSE curriculum for both primary and secondary schools will serve as an educational tool for the implementation of the official school program. This new CSE curriculum integrates all topics outlined in the International Technical Guidance including communication, human rights empowerment, condom use, human growth and development, and prevention of HIV and STIs.

b) CSE out of schools

Since the ESA Commitment was endorsed, Madagascar has piloted several aspects of CSE into health services in order to reach more adolescents and young people, especially those out of school. Furthermore, issues related to out-of-school youth have been mainstreamed into various policy instruments, plans and strategies, including the Plan National de Lutte contre le Sida, Stratégie de communication de lutte contre le VIH/Sida and Politique nationale de la Jeunesse.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	6.0%	28.2%	 Not achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 In progress


TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Training of pre-service teachers is in a pilot phase and limited in scope and impact due to financial constraints. In-service teachers received training as a pilot training and schools are establishing targets. The trained teachers shared their achievements in their institutions as a way of cascading. A total of 776 female teachers and 402 male teachers were trained in service in CSE by the DSS (School Health Direction). Additionally, 38 primary and secondary school educators were trained in CSE by the Curriculums Development Direction (DCI MEN) in two pilot sites. Those educators have trained 120 other educators. As a consequence, 3,135 young people were reached by the CSE integration⁵.

b) Training of health workers

Political instability has hampered the training of health providers at both at pre- and in-service training level. The delayed enactment of the National Health Policy has further challenged training in the health sector.

Indicator	Current data 2015	Progress
% of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year. <i>(Target: 40% schools to be reached by 2015)</i>	7.0% ⁶	 In progress












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to sexual and reproductive health (SRH) services, including HIV.

a) National ASRH policies and strategies

Even though there is no specific costed national strategy or framework on youth-friendly SRH services, YFS are underpinned by the 2015 National Health Policy for Adolescents and Young People.

b) Youth-friendly SRH services

Some YFHS have been established across the country, however, they are yet to be scaled up significantly.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Increase HIV prevention knowledge levels

With the support of the African Development Bank and UNFPA, head teachers have been trained to integrate HIV prevention topics into primary and secondary school classrooms. These efforts are part of the implementation of the Educational Program in Health of the Reproduction of Pupils and Teenagers.

Reduce early and unintended pregnancy

Madagascar does not have a specific policy or strategy on teenage pregnancy, but the Politique Nationale de Sante des Adolescents et Jeunes and the Politique Nationale de la Jeunesse help to address issues related to discrimination in health facilities for teenage mothers. The minimum age of consent to sex is 14 years. Furthermore, activities such as the set-up of 15 youth spaces (espaces jeunes and maisons des jeunes) and the SRH training of peer educators in those youth spaces were conducted by the Ministry of Youth with the support of the UNFPA.

Eliminate GBV

In June 2015, the government of Madagascar launched the African Union Campaign to End Child Marriage in Africa. The campaign plans to work with partners, the police, policy-makers, women's associations, local communities, and traditional leaders in order to raise awareness on, and end, gender-based violence, including child marriage.

Eliminate child marriage

In addition to the Campaign to End Child Marriage in Africa, Madagascar has programmes that prevent and mitigate against child marriage. Madagascar has one of the highest child marriage rates in the world, with as many as 48% of girls married before the age of 18, and 1 in 10 married by the age of 15. In 2007, the government changed the minimum age of marriage to 18 for both girls and boys, from 14 and 17 respectively.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁷	896	1,104	2,001	1,136	1,518	2,654
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁸	9.1%	17.6%				
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁸	4.2%	3.6%		3.8%	1.9%	
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁸	28.7	38.6%	47%	23.0%	26.0%	
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁸	31.7%	N/A	N/A	N/A	N/A	N/A
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage?			No			Yes
% of women (age 20-24) who were first married or in union before they were 15 years old ⁸	14.4%	N/A	N/A	N/A	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁸	48.2%	N/A	N/A	N/A	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- The ESA Commitment has enabled Madagascar to focus on issues related to the targets, such as age of consent to sex, prevalence of obstetric fistulas, which are one of the consequences of teenage pregnancy, maternal mortality rate among teenagers and young women, and family planning for young people. It has also helped the country to develop tools to meet the real needs of the population.
- CSE curriculum training accompanied by formal monitoring and controls reinforce its acceptability of the trainings (stakeholders ownership and social acceptability).
- Because topics of sexuality are still taboo, strong communication and engagement with the community is crucial to support CSE implementation.
- Meetings with educators, parents, educational administrators, and community leaders is essential to getting ownership and involvement.

Challenges

- Political instability and the shortage of human resource capacity have hindered the launch of the ESA Commitment, the roll-out of quality CSE, and the establishment of YFHS.
- Up-to-date disaggregated data related to young people proved to be a major challenge.
- Collaboration between the Ministries of Education and of Youth has been a challenge.

Sources

1. UN population Division Estimates, 2015.
2. Statistical Yearbook MEN/DCI, 2014-2015.
3. MINSAN (National Health Development Plan, 2012-2025), 2014. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. Educators include teachers, proximity supervisors, educational advisors, monitors, and school principals in the region and districts.
5. DCI/MEN.
6. The 7% only concerns public schools. Data was not available for others outside of the public school system. However, Madagascar is in the process of gathering this data.
7. UNAIDS HIV 2016 estimates.
8. DHS, 2008-2009.
9. DHS, 2008-2009. Report 2012 of the National Survey of Monitoring the Millennium Development Goals (ENS OMD).


BACKGROUND

The ESA Commitment in Malawi has created the space for communities and policy-makers to engage on how best to address the wide-ranging needs of young people. Programmatic and policy options are considered within the political context and are underpinned by available data and evidence.

Coordination of the ESA Commitment

Malawi's coordination mechanism brings together the Ministries of Health, Education, and Youth, as well as UN agencies. It is endorsed by government, but the ESA Commitment processes are led by the UN agencies. The team meets once a quarter to coordinate participatory planning, implementation, and evaluation of Commitment activities and to coordinate various activities related to programming for young people. The activities under the ESA Commitment have been included in the sector work plans and costed, but allocating resources has been a challenge. The targets are being met by existing programmes, which are implemented jointly by government and development partners.

Demographics	Value
Estimated total population (all ages) ¹	17,522,000
Estimated population of young people (10-24) ²	5,755,050
Number of schools ³	Primary: 5,738 Secondary: 1,354
Number of teachers ³	Primary: 71,363 Secondary: 14,497
Number of health workers ⁴	18,374

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Malawi has integrated CSE into the Life Skills Education and it is examinable in the secondary school curriculum, however, primary school only covers topics related to life skills. A recent review and revision of the secondary school curriculum has created a strategic opportunity to simultaneously address gaps in content, including sex and sexuality, as well as linkages to quality SRH services. Efforts are ongoing to complement in-school CSE with engaging out-of-school young people. Through the Ministry of Labour, Youth, and Manpower Development, an in- and out-of-school training curriculum on CSE was developed. As the new secondary school curriculum has just been finalized, partners in the ESA Commitment have started engaging the Ministry of Education and advocating for the introduction of CSE in primary schools.

b) CSE out of schools

Following the launch of the National Youth Status Report early this year, Malawi is developing a costed CSE strategy and plan for out-of-school youth. This will, among other things, address emerging issues, including CSE for all youth, including out-of-school youth.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year ⁵	100% (5641 primary schools)	100% (5,700 primary schools)	 Achieved
(Target: 40% schools to be reached by 2015)	65% secondary school (660 schools)	80% secondary school (1,083 schools)	
Does this country have a costed CSE strategy for out-of-school youth?	No	In progress	 In progress

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Training of pre-service teachers is coordinated by the Department of Teacher Education and Development (DTED), with additional training support by development partners and NGOs. CSE delivery takes place within LSE and covers all essential topics. In 2015, 9,157 pre-service teachers were trained on life skills-based CSE.

The Ministry of Education has also led the training of more than 60% of secondary school LSE in-service teachers on CSE. However, to ensure that the teachers received additional skills in the delivery of CSE, ESA Commitment partners provided supplementary training to 470 secondary school teachers. In total, between 2013 and 2015, 30,086 pre- and in-service teachers were trained, improving their confidence in the delivery of CSE at classroom level.

b) Training of health workers

Training for health providers is guided by the revised YFHS standards and the Youth Friendly Health Strategy. Pre-service training is taking place, although the data on numbers of health providers trained are not available. However, approximately 52% of community-based distribution agents reported having received training in YFHS. In addition, through a specific YFHS programme, more than 68% of health care providers and 73% of those in hospitals said they had been trained to offer YFHS.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

To support ASRH needs, Malawi has the following in place: National Youth Policy, Reproductive Health and Rights Policy, HIV Policy, Gender Policy, and the National Youth Friendly Health Strategy (2015-2020).

b) Youth-friendly SRH services

As of 2007, the Government of Malawi, with support from UNFPA, UNICEF, WHO, and other stakeholders, began implementing the YFHS programme as a strategy to make all health services more acceptable, accessible, and affordable. Although, only 7 out of 11 required services are provided to young people, Malawi health facilities also address cases of gender-based violence (physical) and sexual assault through one-stop centres, which is not part of the standard package.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

Despite an overall decline, the number of new infections among girls remains disproportionately higher than their male counterparts. Programmes to address the vulnerabilities of adolescent girls and young women are being implemented, such as the UN Joint Programme on Adolescent Girls and the EU-funded Gender Equality and Women Empowerment programme, which are implemented with government's leadership.

The number of young people that have tested for HIV is still low, despite the increase from 28% in 2012 to 40% in 2014. However, young people aged 15-25 are adopting a number of HIV risk reduction behaviours, including condom use for safer sex and uptake of voluntary medical male circumcision.

Increase HIV prevention knowledge levels

The existing data indicates a slight increase in the knowledge levels of young people for HIV prevention, from 43% in 2010 to 47% in 2014.

Reduce early and unintended pregnancy

Almost 26% of girls have become pregnant or given birth before the age of 18 in Malawi, with incidences of teenage pregnancy increasing. Accelerated interventions focused on teenage pregnancy will be needed in working towards the ESA Commitment 2020 targets.

Eliminate GBV

The GBV rates among young people stand at 21% (physical abuse) and 18% (sexual abuse) in Malawi. Poor implementation and gaps in laws and cultural attitudes that condone violence against women are major challenges in preventing GBV.

Eliminate child marriage

Malawi has one of the highest rates of child marriage in the world, with one out of two girls married by the age of 18¹¹. Conflicting legislation makes the minimum age of marriage ambiguous in Malawi. In 2015, Parliament adopted the Marriage, Divorce and Family Relations Bill, raising the minimum age of marriage without parental consent to 18. However, the new provisions cannot overwrite the country's Constitution. The constitution does not specifically prohibit child marriages, but merely directs the government to discourage them.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁶	8,105	3,314	11,419	6,748	2,749	9,497
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁷				14.3%	22.1%	18.2%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁸			28%	41.7%	43.3%	40.0%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁹			43%	44.2%	51.1%	47.7%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷		N/A	N/A	25.6%	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds			44.9% ⁷			21% (physical abuse) 18% (sexual abuse)¹⁰
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁷	11.7%	N/A	N/A	5%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁷	49.6%	N/A	N/A	33%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Teachers often find it difficult to deliver relevant content appropriately for both LSE and CSE because of factors such as their comfort level with the content, misconceptions of the topics covered, and an overcrowded curriculum. To address these issues, the Ministry of Education has led a massive campaign to orient and train all teachers on how to integrate CSE into LSE. A resource for teachers was also developed in 2015 to build the capacity of schools to engage with communities on CSE.
- Progress has been less than optimal in certain areas in the country due to the lack of designated resources. Although the ESA Commitment complements many of the milestones set out by government ministries, they are not prioritized in a highly competitive resource environment.
- Engagement of stakeholders, community members, traditional leaders and religious groups following the new Marriage, Divorce and Family Relations bill has been crucial to reducing the number of child marriages. It also led to one of Malawi's traditional chiefs annulling more than 300 child marriages and sending the girls back to school.

Challenges

To many stakeholders, including members of governments and community groups, the ESA Commitment is perceived as a UN-led initiative that runs alongside other initiatives. This undermines the significance of the ESA Commitment acting as a platform for sharing resources and collaborating across sectors, utilizing already existing initiatives and projects that fit local contexts. This has impacted all levels of ownership and sustainability. The coordinating team has therefore commenced working on adjusting this perception and bringing the ESA Commitment milestones more clearly in line with the Government's milestones.

Sources

1. Ministry of Gender 2015 Annual Report.
2. UN population Division Estimates 2015.
3. Ministry of Education, Education Management Information Systems (EMIS) Unit.
4. WHO website. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
5. Ministry of Education EMIS 2012 and EMIS 2015 reports.
6. UNAIDS HIV 2016 Estimates.
7. DHS - National Statistical Office (NSO), 2010. Note: The 2014 MDG Endline survey did not capture data on this indicator. We have therefore used 2010 DHS data.
8. MDG Endline Survey - NSO, 2014.
9. SAQMEC, 2009 and MDG Endline Survey NSO, 2014.
10. Malawi Youth Data Sheet 2014, Population Reference Bureau.
11. UNICEF, 2015.


BACKGROUND

Since the ESA Commitment was affirmed, the Ministry of Education and Human Resources has shown strong political will to scale up sexuality education and great strides have been made in introducing it into primary and secondary school curricula. In addition, the Ministry of Health and Quality of Life has concentrated a large portion of its efforts to support key populations in reducing HIV, STIs and other vulnerabilities. However, further work will be needed to break down barriers in young people's access to SRH services, to harmonize laws and policies on age of consent to sex and marriage, and increase inter-sectoral collaboration to address cross-cutting issues such as teenage pregnancy.

Coordination of the ESA Commitment

While there is no designated technical working group to coordinate activities related to the ESA Commitment, the Ministries of Education and Health continue to work together towards the achievement of the ESA Commitment targets. For example, existing structures and frameworks, such as the National Multi-sectoral HIV and AIDS Strategic Framework (2013-2016), 2006-2015 National Curriculum Framework for Primary Sector, and 2009-2016 National Curriculum Framework for Secondary Sector, focus on addressing issues around CSE, HIV and SRH services for young people, including key populations.

Demographics	Value
Estimated total population (all ages) ¹	1,273,212
Estimated population of young people (10-24) ¹	297,409
Number of schools ²	Primary: 320 Secondary: 177
Number of teachers ³	Primary: 28,029 Secondary: 3,231
Number of health workers ⁴	12,765

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	No	 Not achieved

2015 TARGETS


TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Based on standards set by the International Technical Guidance on Sexuality Education, life skills-based HIV and sexuality education is addressed in the Health Education subject at primary school level and integrated into subjects such as Science and Home Economics at secondary school level. CSE has also recently been introduced into secondary schools, particularly for Form I students (first year of secondary school).

b) CSE out of schools

Mauritius does not have any national policies and/or strategies related to sexuality education for out-of-school youth, making it difficult to reach them with CSE.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	100%	100%	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

In the two years since the ESA Commitment was affirmed, the Ministry of Education and Human Resources has trained a total of 677 pre-service teachers and 687 in-service teachers (589 primary and 98 secondary school teachers)⁵. As part of newly revised curricula, components related to sexuality education and life skills have been updated in teacher training programmes, and a teachers' manual on SRH was also recently produced and is used as supporting material for teacher training across the country.

b) Training of health workers

While Mauritius does offer in-service training programmes for health service providers, there are few reliable records on the current numbers trained each year, but 80 doctors and 80 nurses were identified as having been trained specifically in YFHS delivery since the ESA Commitment was affirmed. The government does not provide a pre-service training programme on YFHS delivery, and












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The Ministry of Health and Quality of Life has two main policy frameworks that focus on the health and well-being of young people in and out of school: the National Sexual and Reproductive Health Strategy and Plan of Action (2009-2015) and the National Sexual and Reproductive Health Policy (2007).

b) Youth-friendly SRH services

A total of 1,649 adolescents and young people accessed YFHS from 2014 to 2015, however, no disaggregated data by age or gender is available. Interestingly, there was a drop in youth accessing services in 2014 – moving from 905 in 2013 to 697 in 2014. However, by 2015, it had risen again to 952. There has also been a notable increase in young people aged 15-24 who have had an HIV test in the past 12 months and know their status, from 6.9% in 2011 to 20.8% in 2014⁶.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

Although Mauritius has a relatively low HIV prevalence compared to other countries in the region, and new HIV infections among young people have decreased, this group remains especially vulnerable to HIV infections and teenage pregnancy due to notable high-risk behaviours in the country. This includes early sexual debut and drug use⁷.

A multi-sectoral response to address the vulnerabilities of adolescent girls and young women is therefore being implemented through various sensitization and SRH programmes in youth centres, women centres, paediatric clinics, antenatal clinics, and programmes with FBOs.

Increase HIV prevention knowledge levels

The existing data indicate a decrease in young people's knowledge about HIV prevention by 7% for both females and males from 2011 to 2014.

Reduce early and unintended pregnancy

In 2014, teenage pregnancy rates stood at 12.1%⁸ and 19.6% of young women reported having either spontaneous or induced abortion, putting them at severe health risk; hospitals reported dealing with an average of 2,000 cases per year of complications arising from unsafe abortions⁹. As of 2013, government decriminalized abortion, which provides doctors with some discretion to carry out the procedure if necessary. However, current legislation still upholds strict criteria for eligibility, which limits abortion by choice for many young women.

Eliminate GBV

Specific data on GBV are not available, however, evidence across the ESA region has shown that compared with adult women, adolescent girls and young women (age 15-24) experience the highest incidence of intimate partner violence. To exacerbate this further, there is no specific law that makes marital rape a crime.

Eliminate child marriage

The minimum age of consent to marriage in Mauritius for both males and females is 16-18 years (with parental consent). Currently, there are no specific policies that address child marriage. Governments have recognized that this is an area that requires stronger inter-sectoral collaboration in order to ensure young people – and in particular, young women and girls – are adequately supported. That being said, Mauritius is part of key international treaties, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

Indicator	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ¹⁰	29	36	65	28	28	56
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse	3.0% ¹¹	N/A	N/A	7.3% ¹²	N/A	N/A
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ¹⁰			38.3% ¹¹			31.8% ¹²

CHALLENGES

- There is a real lack of research and baseline data for Mauritius to support certain aspects of sexuality education, including research on its impact on in- and out-of-school youth.
- Notable challenges in the first year of implementation have been inadequate time slots to complete the provision of CSE and the lack of locally adapted resources to support teaching and learning the programme in the classroom.
- There are major inconsistencies in the standard of health professionals' training – many go abroad for training with varying standards of education.

Sources

1. UN Population Division Estimates, 2015.
2. Statistics of Mauritius under aegis of Ministry of Finance & Economic Development.
3. Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa UNESCO, 2015.
4. Health Statistics Report, 2014, MOH & QL. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
5. Academics from MIE, 2014-2015.
6. BSS, 2011-2014.
7. UNAIDS, Country Progress Report 2015, Republic of Mauritius.
8. Contraceptive Prevalence Survey, Mauritius, 2014.
9. Government Gazette of Mauritius, 2012. Criminal Code (amendment) Bill, second reading.
10. UNAIDS HIV 2016 Estimates.
11. KABP, 2011.
12. BSS, 2014.

MOZAMBIQUE


BACKGROUND

Since affirming the ESA Commitment, the Ministries of Health and Education, together with CSOs and other development partners, have intensified their efforts to reduce new HIV infections and teenage pregnancy among the youth of Mozambique.

Coordination of the ESA Commitment

Mozambique's ESA Commitment activities are coordinated by the Ministry of Education through the Directorate of Nutrition and School Health. Within this Ministry, the National Institute for the Development of Education (responsible for curriculum development), the National Directorate for Teacher Training, and the Directorate for Cross-sectoral Issues (Gender) also take part. Other institutions that are part of this mechanism include the Ministries of Health; Gender, Children and Social Action; and Youth and Sports; as well as various CSOs (AMODEFA, COALIZÃO, and N'weti) and UN agencies.

Demographics	Value
Estimated total population (all ages) ¹	25,727,911
Estimated population of young people (10-24) ¹	8,412,901
Number of schools ²	Primary: 12,211 Secondary: 659
Number of in-service teachers ³	Primary: 104,821 Secondary: 19,655
Number of health workers ⁴	2,009

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	No	 Not achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Prior to the ESA Commitment, life skills had been introduced in the formal education system with a special focus on the primary school level where enrolment levels are high. SRH-related content has been integrated into the subjects of Biology and Portuguese for Grade 8, while content related to HIV, including prevention and stigma and discrimination, has been integrated into the (intra- and extracurricular) Grade 5 syllabus and taught through the subjects of Portuguese, Moral and Civic Education, and Natural Sciences. In addition, 6,456 students have carried out awareness-raising activities aimed at their peers on SRH, HIV and AIDS, and other STIs in the framework of the Geração Biz and Reducing HIV Among Adolescents Programme. Mozambique has also invested in the joint preparation of a methodological manual of CSE for 1st and 2nd cycle primary education teachers. This manual will strengthen the quality and efficacy of the CSE syllabus and ensure it is evidence-based and age- and culturally-appropriate.

a) CSE out of schools

Mozambique has not only developed a costed CSE strategy for out-of-school youth, it also broadcasts radio and TV programmes dealing with SRH and HIV and AIDS topics aimed at youth.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year. <i>(Target: 40% schools to be reached by 2015)</i>	100%	100%	 Achieved
Does this country have a costed CSE strategy for out of school youth?	Yes	Yes	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

All health professional training institutes have a training module on Sexual Reproductive Health of Adolescents and Youth (Saúde Sexual e Reprodutiva de Adolescentes e Jovens) and training of trainers is focused on sustainable solutions for the education system in Mozambique. A total of 325 trainers and 811 in-service teachers were trained through various programmes and partnerships, including UNESCO, the Reducing HIV among Adolescents Programme, and the Geração Biz Programme.

No. of teachers trained	Trained 2014			Trained 2015		
	Female	Male	Total	Female	Male	Total
In-service female and male teachers trained (primary) ⁵	14,807	13,648	28,455	14,842	13,683	28,525

TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Interventions for SRHR are guided by the National HIV and AIDS Strategic Plan IV (2015-2019), which gives priority to vulnerable population groups, among which are adolescents and youth. The Strategic Plan for the Busy Generation (Geração Biz) Programme (2014-2017) is also aimed at strengthening ASRH services through multi-sectoral coordination for better integration of services.

b) Youth-friendly SRH services

The Youth-Friendly Services Package is provided in health units at all health facilities or clinics specifically for adolescents and young people. In addition, programmes such as Geração Biz offer youth-centred services with a multi-sectoral approach. Furthermore, in the last few years there has been an increase in the investment to speed up initiatives that help to prevent early marriages and pregnancies and give young people better access to YFHS in schools, communities, and health centres. According to the annual report for 2015, there are 170 specific YFHS facilities in the country and in that year, approximately 2 million young people were attended to, 490,717 of whom were tested for HIV, of which 18,018 tested positive.

Indicator	Baseline 2013	Current data 2015	Progress
Does this country offer a standard minimum package of youth friendly SRH services?		Yes	 Achieved

2020 TARGETS

Reduce new infections among young people

Mozambique has one of the highest rates of HIV prevalence among youth aged 15-24 years in the region, with 29,418 new infections in 2015 alone. Although there has been a reduction of about 16% in new infections from 2013 to 2015, on the current trajectory this will not be enough to eliminate new HIV infections by 2020⁶.

Reduce early and unintended pregnancy

It is estimated that 25% of adolescents in Mozambique are sexually active by the age of 15, with the median age of first sexual contact 17.1 years for males and 16.1 years for females, and there is a high incidence of teenage pregnancy⁷. Early pregnancies in the country are strongly related to early marriages.

Eliminate GBV

Teenage pregnancies are also related to sexual abuse and violence against adolescent girls and young women: in Mozambique, 36% of girls and women aged 15-49 believe that a husband has the right to beat his wife in specific circumstances⁸. The Ministry of Education and Human Development Gender Strategy 2016-2020, with its respective action plan, is in place to deal with GBV at schools.

Eliminate child marriage

The minimum age of consent to marriage for both males and females in Mozambique is 18 years without parental consent, or 16 when there are circumstances of recognized public and family interest and there is consent of the parents or legal representatives. However, on average, one out of two girls marry before the age of 18, and almost one out of five before the age of 15. Nevertheless, although reliable statistics on the prevalence of early marriages are often not available due to the informal nature of many marriages in the rural areas, the number of early marriages seems to have been decreasing over the last decade. With the help of the National Plan for the Advancement of Women and the National Strategy for Combating Early Marriages (2015), Mozambique has put programmes in place for the prevention and mitigation of early marriages.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁹	21,820	13,317	35,140	18,226	11,194	29,418
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁷	45.5%	45.9%				
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁷	25.7%	11.4%				
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁷	30.2%	51.8%				
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷	37.5%	N/A	N/A		N/A	N/A
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ¹⁰	14.2%					
% of women (age 20-24) who were first married or in union before they were 18 years old ¹⁰	48.3%	N/A	N/A		N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Teacher training and capacity building has been the result of enhanced coordination between the Ministry of Education and UN partners, as well as the focus on sustainable solutions by the Institute for Teacher Training.

Challenges

- Training of managers of the Education System on School Health, with emphasis on CSE.
- Integration of CSE into all curricula, teaching programmes and school books.
- Strengthening of the Interest Groups (Círculos de Interesse) and Counselling Corners (Cantos de Aconselhamento) in schools as platforms for the extracurricular implementation of CSE activities.
- Online training of trainers of the Institute for Teacher Training and of in-service teachers on the content of CSE.
- Investing in the collaborative development of a CSE methodological manual for teachers within the first and second cycle of primary school will strengthen the quality and effectiveness of CSE curricula and ensures it is evidence-based, gender-transformative, and age- and culturally-appropriate.

Sources


1. INE population Projection, 2015.
2. Education Statistics, 2016. Ministry of Education and Human Development.
3. Ministry of Education and Human Development, Planning Document, July 2015. Document number 2.2/RP2015. Stagnation in the pupil-teacher ratio in 1st Cycle Primary Education (EP1).
4. RH MISAU. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
5. School census.
6. UNAIDS HIV 2014 Estimates.
7. IDS/DHS 2011.
8. MICS 2008.
9. UNAIDS HIV 2016 Estimates.
10. Republic of Mozambique. *National Strategy for the Prevention and Combating of Early Marriage in Mozambique, 2016-2019*, approved at the 42th SOCM on 1 December 2015.

Prior to the ESA Commitment, the Ministry of Health and Social Services (MoHSS) and the Ministry of Education, Arts and Culture (MoEAC) collaborated on a number of initiatives related to SRHR of adolescents and young people through school health programmes. The ESA Commitment has been launched in all 14 regions of Namibia, and has proven to be a catalyst in enhancing and intensifying collaboration between the two ministries and other line ministries, as well as CSOs working with young people and other youth-led organizations.

Coordination of the ESA Commitment

The ESA Commitment is coordinated by an existing committee, the National School Health Task Force. The committee is co-chaired by the MoHSS and MoEAC and made up of the Ministries of Sports, Youth and National Services; Gender and Child Welfare; and Agriculture, Water and Forestry; as well as GIZ, CSOs and UN agencies. The committee is guided by clear terms of reference and meets on a monthly basis to provide policy guidance on the implementation of the school health policy and programme and coordinate the implementation of the ESA Commitment. In addition, coordination mechanisms have been established within the 14 regions and are at various levels of functionality.

Demographics	Value
Estimated total population (all ages) ¹	2,113,077
Estimated population of young people (10-24) ²	789,583
Number of schools ³	Primary: 1,018 Combined: 498 Secondary: 196
Number of in-service teachers ⁴	24,660
Number of health workers ⁵	9,899

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

CSE in Namibia is integrated into the Life Skills, Biology, and Environmental Studies subjects. Life Skills is compulsory from upper primary to secondary level. In 2012/13, the LSE curriculum was reviewed and sexuality education content strengthened. The monitoring of CSE in schools was also strengthened by integrating HIV and AIDS indicators into the EMIS, including orientation of EMIS focal persons at regional, circuit and school levels on collecting and reporting of the new indicators. In addition, the Star For Life NGO conducts a school-based HIV and AIDS prevention programme in selected schools in Khomas and Ohangwena.

b) CSE out of schools

Namibia does not have CSE strategy for out-of-school youth. However, different interventions targeting out-of-school youth are in place, for example, the Sports for Development Galz & Goals Programme. This initiative creates a space for girls to play football while delivering life skills messages, including prevention of HIV and teenage pregnancies. Through this programme, over 3,000 adolescent girls have been reached in the past year, totalling a cumulative number of 15,000 since the inception of the programme.

Indicator:	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	80% primary 100% secondary	100% primary and secondary	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

A selection of CSE content has been integrated into the Guidance and Counselling module, which is compulsory for all pre-service teachers across the country. Continued efforts to advocate for full integration of CSE at pre-set level will continue in 2016.

For in-service teachers, capacity development interventions have been implemented to strengthen their skills for the delivery of CSE. In 2015, 439 upper primary life skills teachers were trained on the revised LSE curriculum and 120 Life Skills teachers from eight regions completed the online CSE module. Scripted lesson plans have also been piloted to enhance the delivery of CSE. In addition, a training manual on integrated school health, including CSE components, was developed by the school health task force under the leadership of the MoHSS and MoEAC.

b) Training of health workers

Namibia is one of the few countries in the region to have fully integrated youth-friendly SRHR services in the health workers training curriculum. Despite the integrated approach to training health providers, the provision of increased access to YFS remains a challenge. Some health facilities in Namibia do provide YFHS, however, the monitoring system to collect data on the number of young people accessing the services is not yet well developed. Furthermore, low supervisory support on YFHS implementation from sub-region and national levels makes it difficult to offer the necessary quality in a consistent manner.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Namibia has a well-developed policy framework which guides the provision of youth-friendly SRH services, including the National Standards for Adolescence Friendly Health Services 2011, HCT guidelines 2013, National Policy on Reproductive and Child Health 2012, and National Guidelines on Family planning 2011.

b) Youth-friendly SRH services

Namibia implements a coordinated approach between government and NGOs to scale up YFHS, including standardized training in its delivery, which provides comprehensive SRH information and services to young people aged 10-24 through its eight clinics in the country, which have reached 28,037 adolescents and young people since 2014.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections

The number of new HIV infections remains disproportionately high among girls and young women. As part of the collective response to reduce new infections among young people, the MoEAC has piloted school-based HIV testing and counselling in selected schools. This will generate evidence to inform national policy on the best adolescent and youth-friendly HTC approaches to take nationwide. Over 500 adolescents and young people were reached through the initiative, of which 83% were first time testers. The National HTC Strategy, which integrates the WHO Guidance for HIV Testing and Counselling and Care for Adolescents, has since been implemented. The strategy also aims to involve adolescents and young people in developing the training content for care providers.

Increase HIV prevention knowledge levels

While there has been a decrease in the knowledge levels of young people about HIV prevention, ongoing CSE and HIV education programmes for adolescents and young people are being strengthened to ensure knowledge levels are increased.

Reduce early and unintended pregnancy

Teenage pregnancy has increased in recent years and is a major concern, however, there are a number of interventions and strategies in place to address the issue, including the introduction of a policy on prevention and management of learner pregnancy, which allows learners who fall pregnant to continue with their education.

Eliminate GBV

The government has enacted several laws to protect survivors and punish perpetrators of GBV in a bid to reduce the rising number of domestic violence cases in the country. These include, among others, Combating of Rape Act (No. 8 of 2000), Combating of Domestic Violence Act (No. 4 of 2003), and Children Status Act (No. 6 of 2006). In addition, the National Gender policy (2010-2020) and National Plan of Action on GBV (2012-2016) are also in place to guide the GBV response.

Eliminate child marriage

Namibia has a framework in place for addressing child marriage, including the newly enacted Child Care and Protection Act, No. 3 of 2015 which prohibits child marriage in traditional unions and civil marriages. In addition, the Married Persons Equality Act sets a clear minimum age of 16 years and procedures for civil marriages involving children.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁶	1,653	928	2,581	1,678	944	2,622
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁷				68%	82.6%	75.3%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁷				80%	55%	67.7%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁸	64.9%	61.9%	63.4%	61.6%	51.1%	56.3%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷	15%	N/A	N/A	19%	N/A	N/A
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage?			Yes			Yes
% of women (age 20-24) who were first married or in union before they were 15 years old ⁷	1.6%	N/A	N/A	N/A	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁷	6.9%	N/A	N/A	N/A	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- The ESA Commitment has strengthened the partnership of key ministries working on issues related to adolescents and young people, as well as the coordination of Commitment-related activities.
- Political commitment is important and plays a key role in the success of any given programme.
- The UN agencies have established a trusted relationship with government counterparts and local CSOs, and are often called upon to provide technical support in the implementation of Commitment-related activities.
- Partnership with key ministries and NGOs creates ownership and buy-in of young people's programmes.

Challenges

- Poor M&E systems to monitor and collect data at all levels of implementation is a challenge.
- Young people who are out of school are difficult to identify and often not motivated to participate in behavioural change programmes. As a result, bringing about sustained behaviour change among this group is a challenge and requires building partnerships with youth networks, health facilities where they access services, and other community-based youth programmes.

Sources

1. Population and Housing Census, 2011.
2. UN population Division Estimates, 2015.
3. Education Management Information System, 2012.
4. Education Management Information System, 2012. Number includes both primary and secondary school teachers.
5. MoHSS Annual report, 2012/13. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
6. UNAIDS HIV 2016 Estimates.
7. DHS, 2013.
8. DHS, 2006 and 2013.


BACKGROUND

Although Rwanda was not present when the ESA Commitment was affirmed and endorsed by ministers, the country has benefitted from using the Commitment as a platform for scaling up CSE and SRH services for young people. The Commitment provided an opportunity for the country to reflect on a wide array of policies, strategies, and legal frameworks focusing on the needs and rights of girls, adolescents, and young people. Strengthening the collaboration between the Ministries of Education and Health, together with other relevant ministries, such as Gender and Family Promotion, Youth, and East African Community Affairs has created better coordination and tracking of progress on implementation of CSE and ASRH.

Coordination of the ESA Commitment

The Government of Rwanda Social Cluster brings together these ministries once a month to coordinate partners, provide strategic direction, and monitor progress on set targets including HIV, ASRRH, and gender. CSE activities have been included in costed sector work plans for both the Ministry of Health and Ministry of Education. Allocation of resources is currently in progress. In addition, through the Maternal Child and Community Health Division, the Ministry of Health leads a Technical Working Group on ASRRH, which brings together representatives from government and civil society to share updates, good practices, and emerging issues in the areas of education and adolescent health. From 2015, CSE has been included in the discussions points.

Demographics	Value
Estimated total population (all ages) ¹	10,515,973
Estimated population of young people (10-24) ¹	3,406,530
Number of schools ²	Primary: 2,711 Secondary: 1,521
Number of in-service teachers ²	Primary: 41,192 Secondary: 14,477
Number of health workers ³	2,716

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries⁴

a) CSE in schools

CSE has been integrated into the newly revised primary and secondary school curricula and is examinable in two subjects in primary (Elementary Science and Technology and Social Studies) and three in secondary (Biology and Health Sciences, General Studies and Communication Skills, and History and Citizenship) across 30 districts. Extracurricula activities are also used to reinforce CSE in school health clubs.

b) CSE out of schools

While Rwanda does not have a costed CSE strategy for out-of-school youth, the National Adolescent and Sexual Reproductive Health Policy does cover this group. Through a partnership with the Health Development Initiative, 10 schools have been selected to engage communities on CSE and an additional 90 schools with messages on prevention of teenage pregnancies. Local radio programmes have also hosted community dialogues on CSE in collaboration with the Network for Young People Living with HIV (Kigali Hope Association).

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year (Target: 40% schools to be reached by 2015)	0.5% (350 / 65,916)	1.8% (1,185 / 65,916)	 In progress
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

The Ministry of Education has developed a comprehensive Teachers' Training Manual based on the School Health Guide to support the implementation of the new National School Health Programme. Training has commenced for pre-service teachers at primary and basic education levels on how to deliver the information covered in the school health programme in an appropriate manner. At in-service level, almost 3,000 master trainers and 1,327 Deans of Studies from secondary schools across 30 districts have been trained in CSE, with plans underway to extend this training to subject teachers. Primary schools and all subject teachers have yet to be reached.

b) Training of health care professionals

Rwanda does not offer pre-service training for health care providers on YFHS as the concepts of the youth-friendly package have not yet been integrated into the curriculum. However, training is provided to in-service health providers on the Adolescent Sexual and Reproductive Health and Rights Policy, and the related strategy and minimum package of services have been disseminated.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

In 2011, the Ministry of Health developed the Adolescent Sexual and Reproductive Health and Rights Policy (2011-2015), which led to the dissemination of a strategy and minimum package of services for all health service providers. Plans are now underway to review the strategic plan.

b) Youth friendly SRH services

Guided by the minimum package of services, health centres are mandated to establish youth corners for provision of ASRH services. The concept of youth corners has just begun and currently 50% of health centres in Rwanda are providing youth-friendly services⁵. The government has also partnered with CSOs to provide health care and family planning services for adolescents and young people and has also led nationwide awareness raising campaigns that focus on sexual health for young people, which have helped mobilize and involve communities in supporting better access.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections

The country has maintained a national HIV prevalence rate of 3% over the past 10 years and dramatically reduced HIV and AIDS-related mortality due to increased access to HTC and HIV treatment and care. However, a gender analysis of the epidemic (2010 DHS) shows that young women (15-24) are five times more infected than boys of the same age (2.5% and 0.5% respectively). School-based sexuality education coupled with increased access to SRH information and services for adolescents and young people are some of the strategies in place to curb this trend.

Trends on the reduction of risky sexual behaviours among young people, especially the use of condoms and testing for HIV, show Rwanda has made tremendous progress. Nevertheless, it is crucial to revitalize and continue HIV prevention efforts by all partners in the country.

Increase HIV prevention knowledge

The proportion of young people with comprehensive knowledge about HIV prevention increased significantly from 23% in 2000 to 51% in 2009 and 64% in 2014. Factors include ongoing expansion of access to services through youth corners and access to information through education, national campaigns, and so forth.

Reduce unintended pregnancies

The number of adolescents who had begun childbearing by the age of 19 has slightly increased since 2010. However, the strengthening of co-curricular sexuality education activities, increase in the number of youth-friendly centres and health facilities that deliver youth-friendly services, and concerted efforts to engage the community with targeted messages related to teenage pregnancy are positive developments that will help reduce teenage pregnancy.

Eliminate GBV

Several policies are in place to support action against GBV, teenage pregnancies, and child marriages, such as the 2014 School Health Policy, 2012 Legal and Policy Framework for Children's Rights in Rwanda, and 2007 Girls Education Policy. However, it remains challenging to disseminate and operationalize the existing policies and frameworks.

Eliminate child marriage

In Rwanda, currently 1% of girls are married before the age of 15 and 8% before the age of 18. The legal age for marriage is 21 and age of sexual consent is 18. This implies that young people below 18 years old have no legal status to access contraceptives, despite the fact that they may be sexually active.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁶	1,357	724	2,081	1,259	647	1,906
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁷	3.8%	11.3%		51%	70%	65.4%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁸	38.6%	37.7%		60%	49%	
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁷	52.6%	47.4%	51%	64.6%	64.3%	64%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷	6.1%	N/A	N/A	7.3%	N/A	N/A
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁷	0.8%	N/A	N/A	N/A	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁷	8.1%	N/A	N/A	N/A	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

The successful implementation of national policies and strategies related to the ESA Commitment calls for significant investments in the education and health sectors. For successful programming, strong partnership and collaboration with the different stakeholders is needed, particularly in building the capacity of the education sector for delivery of CSE, implementing interventions for out-of-school youth, and providing ASRH services by the health sector.

Challenges

There is limited data on adolescents, which makes evidence-based policies and programming challenging in the context of HIV and AIDS and the provision of CSE.

Sources

1. Rwanda 4th Population and Housing Census, 2012. Rwanda Education Statistical Year Book. <http://www.mineduc.gov.rw/resources/statistics/>.
2. Education Statistical Year Book, 2014. <http://www.mineduc.gov.rw/resources/statistics/>.
3. WHO, 2010. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. Although Rwanda was not among the 20 countries that affirmed the ESA Commitment, the country has been, and continues to be, a part of the Commitment process and has made several strides in the integration of CSE and scaling-up of SRH services for young people.
5. Mid Term Review of the Health Sector Strategic Plan.
6. UNAIDS HIV 2016 Estimates.
7. DHS, 2010, 2015.
8. RDHS, 2010.


BACKGROUND

Awareness of the ESA Commitment only picked up in 2015 when the Ministries of Education and Health began a coordination process. However, under a growing conducive policy environment, the Seychelles has developed policy objectives aimed at scaling up CSE and YFHS.

Coordination of the ESA Commitment

Initially the Seychelles faced communication challenges between the Ministries of Health and Education, which, combined with the postponement of the launch of the Commitment, delayed the coordination process. However, in the last quarter of 2015, the country witnessed growing momentum in implementation. A multi-sectoral team has been set up, whose main task has been to develop a specific 2015-2020 road map focusing on the Commitment, and a coordinated work plan is currently being developed.

Demographics	Value
Estimated total population (all ages) ¹	93,419
Estimated population of young people (10-24) ¹	11,596
Number of schools ²	Primary: 8,659 Secondary: 7,109
Number of teachers ²	Primary: 656 Secondary: 603
Number of health workers ³	1,551

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	No	 Not achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

The main mode of delivery of sexuality education in the Seychelles is through the Personal and Social Education (PSE) Curriculum, which was introduced in all public schools in around 2001. It consists of four prongs: National and International Understanding, Careers Education, Health Education, and Citizenship Education. These prongs have integrated components of CSE, particularly in Health Education, which is taught in both primary and secondary schools. The Health Education prong is currently being reviewed, in turn providing an opportunity for revised CSE content. In addition to primary and secondary school, a 30-hour CSE unit is provided in post-secondary schools and professional centres, which has been institutionalized in the school curriculum since 2006. This means that in the previous academic year, all of the primary and secondary schools have had CSE scheduled and taught by teachers who are specialized and trained in life skills-based HIV and sexuality education.

a) CSE out of schools

The Seychelles does not have a costed CSE strategy for out-of-school youth health services.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year	100% primary schools	100% primary schools	 Achieved
(Target: 40% schools to be reached by 2015)	100% secondary schools	100% secondary schools	
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

No pre-service teachers were trained in CSE in the period under review, however, up to 2010, the training of pre-service teachers was done annually by the National Institute of Education. In 2010, this institution underwent structural reforms which consequently prevented any training of pre-service teachers between 2013 and 2015. The Seychelles Institute of Teacher Training has since been reinstated with a teacher programme at diploma level that will resume in 2016. Nevertheless, in-service training was conducted by the Centre for Curriculum Assessment and Teacher Support in collaboration with specialists from Ministry of Health.

b) Training of health workers

The National Health Training Institution does not offer pre-service training, and health courses for nurses and midwives are very generic, partially because the country faces a shortage of human resources to lead the development of course material and teaching methods, including on the delivery of YFHS. However, in-service training of nurses and midwives on the provision of YFHS is conducted through development partners.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The Commitment acts as a platform across three key country plans: the HIV/AIDS Strategic Plan 2013-2017, African Union Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Road Map 2012-2016, and GBV Work Plan 2012-2016.

b) Youth-friendly SRH services

Operating since 1994, the Youth Health Centre, based in the country's capital, is the only government-owned institution offering YFHS. Between 2013 and 2015, the centre provided services to 23,964 adolescents and young people. Records indicate that young people make minimal use of district health facilities. This could be attributed to the issue of confidentiality because of the islands' small population. Training health workers on approaching these challenges with confidentiality in a youth-friendly manner may therefore lead to increased use of services by youth.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce early and unintended pregnancy

The Seychelles' Teenage Pregnancy Policy 2005 allows young pregnant learners to continue their schooling to a certain stage in their pregnancy and return to school after delivery. Re-entry policies such as this set a great example for the region and ensure young girls are given ample opportunity to access education despite their circumstances.

Eliminate GBV

The Working Together Manual covers procedures for all stakeholders in relation to child abuse. Evidence, although dated, indicates that as many as one in four women experience some form of moderate physical violence by their intimate partner at some point in their life .

Eliminate child marriage

The legal age of consent to marriage and sex is 18 years, which implies that young people below this age have no legal status to access contraceptives, despite the fact that they may be sexually active.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁴				7	12	19
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁴						4.6%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁴						72.3%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁴						88%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁴		N/A	N/A	6.9%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Allocating adequate financial and human resources to ESA Commitment-related initiatives is crucial to the success of implementation.
- Further training of health care workers will help improve challenges around confidentiality in a youth-friendly manner.
- The data on GBV, child marriages, and teenage pregnancy is often not available or reliable for the Seychelles. Further evidence is needed to help provide policy guidance, develop programming, and design activities that respond to these issues.

Challenges

- The miscommunication between the Ministry of Education and the Ministry of Health, combined with the postponed launch of the ESA Commitment, resulted in a delay of almost two years. The country now needs to accelerate action to achieve the short-term ESA Commitment targets.
- With the National Institution of Education undergoing structural reforms, training of pre-service teachers came to a standstill, which has created challenges for the provision of CSE in the classroom.

Sources

1. National Bureau of Statistics, Seychelles.
2. UNESCO, 2015. Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa.
3. National Bureau of Statistics, Seychelles. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
4. IBBS, GARPR, 2015.
5. CSW, 2006. Statement by H.E. Mrs. Marie-Louise Potter, UN HQ.

SOUTH AFRICA


BACKGROUND

Prior to the ESA Commitment, the Departments of Basic Education, Health, and Social Development had been collaborating through the Integrated School Health Programme (ISHP) to provide access to a package of health services in schools, including SRH services for older adolescent learners. The ESA Commitment has acted as a platform for stronger collaboration across sectors in South Africa as efforts intensify not only in the HIV response, but also in combating teenage pregnancies and more broadly in championing SRHR of every young person.

Coordination of the ESA Commitment

Although the country has yet to formalize an ESA Commitment coordination mechanism, there are several existing structures to coordinate the implementation of CSE and SRH services, such as the ISHP Task Team, South African National AIDS Council (SANAC), and Inter-Ministerial Committee and Technical Task Teams led by the National Development Unit of the Department of Social Development (DSD), which is responsible for the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. These structures are duplicated at provincial and district level and drive coordination between the Departments of Health, Education, and Social Department, as well as with Civil Society.

Demographics	Value
Estimated total population (all ages) ¹	54,960,000
Estimated population of young people (10-24) ¹	15,565,087
Number of schools ²	23,905 ³
Number of in-service teachers ²	Primary: 197,258 Secondary: 143,862 ⁴
Number of health workers ⁵	198,549 ⁶

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Partial	 Partially Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

CSE is delivered through the Life Orientation subject in the school curriculum for both primary and secondary schools. A draft Department of Basic Education (DBE) National Policy on HIV, STIs and TB has been developed aimed at enabling access to HIV prevention and SRH services in schools, including the provision of condoms and contraception. With partnerships such as loveLife, peer education programmes have served as another mode to deliver CSE, leading to more than 16,500 schools being reached across the country. Between 2014 and 2015, a total of 460,585 learners and educators and 488,399 school community members, including parents and other key stakeholders, were reached with CSE.

b) CSE out of schools

The National ASRHR Framework Strategy was approved by Cabinet in February 2015 and commits to developing innovative approaches for delivering SRH education and services to adolescents and young people, including those out of school.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	100%	100%	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

There is currently no pre-service teacher training on CSE. However, over the past two years, there has been a major focus on capacity development for in-service teachers, with approximately 54,730 teachers trained on the delivery of life skills. In total, nearly two million sets of learning and teaching support material were distributed to 23,129 in the 2013-2014 school year and 16,905 in the 2014-2015 school year. In addition, the DBE recently piloted a teacher training programme on newly developed CSE scripted lesson plans. UNFPA and UNESCO are working together with the DBE to formally introduce online CSE training, with 53 Life Skills Coordinators trained in the Eastern Cape in 2015.

b) Training of health workers

The Departments of Health and Higher Education together with the South African Nursing Council (SANC) are in discussions to mainstream pre-service training in AYFS for health care workers. A total of 6,371 primary health care nurses were trained in subdermal implant insertion and in 2014, 206 school health nurses were trained to keep up to date with new developments in SRH services. In 2015, in-service training on AYFS was provided by loveLife for 461 health professionals, 31 assessors, and 48 master trainers.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

A number of national policies and strategies guide the provision of ASRH services, including the National Strategic Plan on HIV, STIs and TB (2012-2016) and the National ASRHR Framework Strategy 2014-2019, among others. These policies and frameworks are aligned to the National Development Plan, the overarching country strategy.

b) Youth-friendly SRH services

Under the Children's Act (2008), children can access contraceptives, other than condoms, independently from the age of 12 and youth-friendly SRH services are provided as part of the primary health care system. In addition, a national HCT campaign is in place to encourage early access to treatment, care and support services for adolescents who test HIV-positive, as well as providing prevention information and services.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce early and unintended pregnancy

Teenage pregnancy is a significant challenge in South Africa, with an estimated 99,000 pregnant teenagers reported in 2013⁷, including a notable percentage of primary school learners. The high number of terminations of pregnancies performed per annum (89,126) suggests the need to accelerate access to contraceptives for women⁸. South Africa is currently developing policies on the prevention of teenage pregnancy and the management of pregnant learners in school. Efforts have been made to halve the number of teenage pregnancies through the Young Women and Girls Campaign, led by the Presidency.

Eliminate GBV

According to the Centre for Justice's Crime Prevention Study (2012), a total of 22.2% of high school learners had either been threatened with or were a victim of an assault, robbery and/or sexual assault at school. To ensure safety in schools and address issues of GBV, the DBE is guided by the South African Schools Act of 1996 as well as the Regulation for Safety Measures in Public Schools. Furthermore, the DBE has developed a number of advocacy materials that addresses violence in schools.

A number of initiatives, policies, and legal frameworks also exist that are aimed at eliminating GBV, including the Domestic Violence Act (Act 116 of 1998), 16 Days of Activism for No Violence against Women and Children, and the Population Policy for South Africa (April 1998), among others.

Eliminate child marriage

Children in South Africa are protected against child marriages under the Children's Act, Marriage Amendment Act, and Bill of Rights. The incidence of child marriage in South Africa is low compared to other countries in the region, however, an estimated 1% of children are still married by the age of 15, and 6% by the age of 18.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁹	10,2786	42,207	144,994	102,699	41,553	144,253
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁸	49.8%	67.5%	58.4%			
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁸	29.0%	28.2%	28.6%			
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ⁹	1.1%	N/A	N/A		N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁹	7.9%	N/A	N/A		N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Since 2009, the South African government has made significant strides in scaling up the HIV response. Data has shown that these efforts have made an impact on young people aged 15-24, halving the number of AIDs-related deaths (from 26,508 in 2000 to 11,629 in 2014), and significantly reducing the number of new HIV infections, with 98,000 fewer infections in 2013 than in 2010 (UNAIDS Gap Report, 2014).
- The Integrated School Health Programme is a best practice model for the region. It showcases how strong multi-sectoral collaboration can achieve provision of essential health services to learners in school.
- Through the Department of Health, South Africa has developed a mobi site which uses information communication technology (ICT) to engage and educate young people about SRHR and how to better access services. The average weekly registration on the mobi site in 2015 was 2,238, and the numbers are gradually increasing.
- Member states must be allowed to customize the ESA Commitment to local context to promote ownership, participation and reporting.

Challenges

- Despite the decline of HIV infections, South Africa still has the highest new HIV infection rates by far in the ESA region, with 97,408 new infections among 10-24-year-olds in 2014 alone (HSRC 2012). Women are especially vulnerable to HIV, with twice as many living with HIV compared to their male counterparts (8.1% and 4% respectively). This is combined with the high rates of unintended teenage pregnancies among school going teenagers. Both trends underpin the relevance of the ESA Commitment and the need for CSE and access to SRH services. Though multi-sectoral structures exist, coordination between government departments and civil society still needs to be strengthened.
- Adolescent and youth health data needs to be disaggregated and aligned to the ESA Commitment targets to improve reporting, although the DHIS is now incorporating age-disaggregation in the National Indicator Data Set. There is also a need to improve data disaggregation and standardization across the departments and all sectors according to age and gender.
- There is still a major HIV transmission knowledge gap between teachers and learners as noted in the latest SACMEQ Study (2014), where knowledge among grade 6 learners was less favourable when compared to the teacher knowledge.

Sources

1. Statistics South Africa, mid-year populations estimates 2015.
2. Education Statistics, 2015.
3. Total number of public schools (School Realities 2015).
4. Total educators in public schools: 379,613 (School Realities 2015).
5. Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.
6. SANC and HPCSA (By 31 Dec 2015: Professional nurses: 136 854; Enrolled nurses: (EN): 70 300; Enrolled nursing assistants: (ENA): 71 462; Doctors and Psychologists: 61,695).
7. Statistics South Africa, 2013.
8. DHIS, 2015.
9. UNAIDS HIV 2016 Estimates.
10. HSRC, 2012.
11. DHS, 2008.

SOUTH SUDAN


BACKGROUND

South Sudan has faced decades of conflict, which has been severely detrimental to every facet of the lives of millions of young people in the country. With limited capacity in both education and health provision, and as many as 59% of primary school age children out of school, the country has had to develop unique and innovative interventions that ensure young people, both in and out of school, are being reached with CSE and are linked to appropriate services.

Coordination of the ESA Commitment

South Sudan has recently approved the formation of an ESA Commitment committee, bringing the Ministries of Health and Education together to develop a road map to implement Commitment-related activities. Meeting on an ad hoc basis, the committee will be chaired by the Deputy Minister of Education with assistance by the two undersecretaries from the Ministries of Education and Health. A technical team, comprising of focal persons from the two ministries, UNESCO, and other partners, including young people organizations (YPOs), is expected to provide regular updates on progress. In addition, the team will develop a position paper on the Commitment that is intended to engage and guide education stakeholders and the general public on issues concerning sexuality education and SRH services for adolescents and young people in South Sudan.

Demographics	Value
Estimated total population (all ages) ¹	12,339,812
Estimated population of young people (10-24) ¹	4,032,178
Number of schools ²	Primary: 3,351 Secondary: 272
Number of teachers ³	Primary: 29,089 Secondary: 3,630
Number of health workers ⁴	2,025

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS

TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Following the endorsement of the ESA Commitment, the Life Skills curriculum was revised to reflect quality CSE. The curriculum was approved in 2015 and will be implemented in 2016. The 2016 national census report is expected to reflect the extent to which life skills-based sexuality education is being rolled out in education institutions. Furthermore, CSE has been integrated into the EMIS tools, Life Skills curriculum guidelines, and the development of teaching and learning materials for in- and out-of-school youth.

b) CSE out of schools

A Life Skills curriculum has been developed for out-of-school youth and development of teaching and learning materials is ongoing. An Adolescent SRH Strategy, currently being drafted, places emphasis on providing CSE to out-of-school youth, and training and sensitizing journalists and other members of the media on CSE has had a huge impact on garnering stronger community and government support for CSE as well. With the vast majority of the population relying on the media for information – especially radio (75%) – it has become a crucial intervention in educating parents, teachers, health workers, young people, and the broader public on topics related to CSE.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year	No	To be collected in 2016	N/A
<i>(Target: 40% schools to be reached by 2015)</i>			

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

The current pre-service teacher training curriculum has some components of sexuality education and life skills, but South Sudan needs to embark on a process that includes the topics with the revised Life Skills curriculum. That being said, 13 Technical Vocational Education Training Centres have already provided Life Skills training for teachers, and teaching and learning materials, which were developed in 2015, will be piloted in 2016. In late 2015, 26 in-service teachers participated in online training, however, the planned targets for teacher training proved to be unattainable as many teachers do not have the required computer skills to complete the online training. Security concerns and weak internet infrastructure across the country further hampered progress.

b) Training of health workers

South Sudan does not provide training on YFHS to pre-service health providers, but training of in-service health providers has started on a small scale, with a total of 41 health workers trained over a two-year period. In 2015, the Ministry of Health, with the support of partners, reviewed the nursing and midwifery curriculum to integrate the provision of ASRH services.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The groundwork has been completed in South Sudan for creating a supportive policy environment to accelerate efforts to provide SRH services and CSE for young people through the newly developed National Sexual Reproductive Health Policy and Adolescent Sexual Reproductive Health strategy. The current provision of youth-friendly services is limited and data on availability, access, referral, and coverage is not reliable.

b) Youth-friendly SRH services

UNFPA is supporting two youth-friendly centres, as well as assisting the Ministry of Health to integrate YFHS in six health facilities. In 2015, 3,179 adolescents and young people accessed services, 282 young people were trained as peer educators in two humanitarian settings, and 63 health workers were trained on provision of youth-friendly SRH and HIV and AIDS services⁵.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

In collaboration with partners, the Ministries of Health and Education developed strategies and policies to increase access to SRH, including HIV, services which contribute to the realization of the ESA Commitment 2020 targets. Nevertheless, their operationalization continues to be a challenge due to insecurity and inadequate social and physical infrastructure.

HIV education was delivered to 45,940 young people in humanitarian and non-humanitarian settings across the country. Through youth peer educators, 499,548 male condoms were distributed to young people in HIV education outreach activities in the largest camps for internally displaced people in Juba and Bentiu, as well as to the general population in Juba and Terekeka.

Increase HIV prevention knowledge levels

While current data was not available for this target, in 2012, just 11% of young people demonstrated knowledge about HIV prevention. A KAP survey was conducted in Greater Bahr El Ghazal in 2015 to measure young people's knowledge about HIV prevention at present, however the results of this survey are not available as yet.

Reduce early and unintended pregnancy

The 2008 Child Act explicitly states that no girl can be expelled from school due to pregnancy, and that the young mother must be allowed to continue her education. Nevertheless, the 2015 EMIS statistical report shows that approximately 5.5% of school dropouts were attributed to pregnancy. Several outreach and extracurricular activities are being carried out by school management committees, partners, and youth organizations to sensitize and educate young people in and out of school on preventing early and unintended pregnancies, such as the Teen Voice quarterly newsletter.




Eliminate GBV

GBV involving armed personnel and civilians continues to rise across the country, while civil unrest has contributed to increased risk behaviours among young people, sexual and gender-based violence, and child marriage. The situation is exacerbated in a country where gender imbalances are pervasive and reinforced by culture norms. In 2009, a study by UNIFEM (now UN Women) revealed that 70% of respondents reported to have known someone who experienced GBV, and 49% of these experienced one form of GBV in the previous year. The South Sudan Health Survey (2010) also estimates that one in every five women has experienced GBV. A number of policies and strategies have been developed to address GBV but the response capacity is inadequate for addressing its high prevalence, especially in terms of the provision of services in emergencies, although more emphasis is placed on prevention.

Eliminate child marriage

Evidence shows that close to half of all South Sudanese girls aged 15-19 are married, with some marrying as young as 12 years old. Girls are especially vulnerable in South Sudan, where the majority do not complete their education after getting married, or attend school at all.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24)*	2,828	1,571	4,399	2,888	1,606	4,494

Indicators	Baseline	Available data	Progress
Target 6: Reduce early and unintended pregnancies among young people by 75%			
Does the country have a national policy/strategy on pregnant learners?	No	No	 In progress
Target 7: Eliminate gender-based violence			
Does the country have policies that address school-related gender based violence?	No	No	 In progress
Target 8: Eliminate child marriage			
Does the country have programmes that prevent and mitigate against child marriage?	No	No	 In progress

LESSONS LEARNED AND CHALLENGES

Lessons learned

Identification of strategic partners and networking are crucial in providing opportunities to harness resources and technical expertise. South Sudan experienced the benefits of joint work when government officials, NGOs, and UN agencies collaborated in developing guidelines, training journalists, and developing life skills materials for schools.

Challenges

The pace of implementing the ESA Commitment in South Sudan has been slow and challenging, requiring tenacity and diplomacy to secure government buy-in. Following the approval by the ministers to implement the ESA Commitment, participation within the ministries has been guaranteed after aligning policies, strategies, and programmes. This has also led to improved collaboration between the Ministries of Health and Education, as well as other ministries such as Youth and Gender. Policies provide an opportunity to solicit increased funding and improved implementation from partners and donors.

Sources

1. UN population Division Estimates, 2015.
2. South Sudan EMIS Statistical Reports, 2015.
3. MOH, 2012 (Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff).
4. BBC Media Action. 2012. *Country Case Study: South Sudan. Support to media where media freedoms and rights are constrained.*
5. UNFPA Reports 2014-2015.
6. UNAIDS HIV 2016 Estimates.


BACKGROUND

The ESA Commitment in Swaziland is benefiting from significant political support and strong collaboration across the Ministries of Education, Health, and Youth. As a result, CSE and SRH activities are well planned for and implemented, and achieving positive results for young people in and out of school.

Coordination of the ESA Commitment

Swaziland has a multi-sectoral working group to implement the ESA Commitment. The group is comprised of government ministries, the UN, and civil society, and is convened by the Ministries of Education, Health, and Youth on a rotational basis. The core team meets quarterly and has a clear terms of reference that help in the coordination and implementation of the Commitment; provision of technical guidance and evidence on CSE and SRH; and monitoring and evaluation. The Commitment implementation plan is directly derived from the Commitment targets and aligns with Swaziland's multi-sectoral development frameworks. All activities have been costed, included in sector work plans, and allocated financial resources. Implementation of the Commitment is coordinated by the Adolescent Sexual Reproductive Health Technical Working Team and is guided by the group's joint work plans and reporting mechanisms.

Demographics	Value
Estimated total population (all ages) ¹	1,132,657
Estimated population of young people (10-24) ¹	377,461
Number of schools ²	Primary: 620 Secondary: 276 Tertiary: 11
Number of in-service teachers ²	Primary: 8 601 Secondary: 6 097
Number of health workers ³	1,118

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

The ESA Commitment has resulted in the recent development of the new secondary school LSE-based CSE curriculum, launched in 2015, which ensures CSE is taught to learners aged 13-24 in a dedicated period during school. Currently, 10% of secondary schools have adopted the new mode of delivery, and the remaining 90% will implement it in 2016. CSE is also delivered through extracurricular activities in secondary school. Children of primary school age are covered under the Education Sector Policy, developed in 2011, with all 620 primary schools in Swaziland delivering integrated HIV content in all school subjects.

a) CSE out of schools

Currently, Swaziland is only implementing ASRH activities for out-of-school youth using the national ASRH policy and strategy. However, the country has developed a draft CSE framework which awaits approval of the Cabinet Paper on CSE.

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year. <i>(Target: 40% schools to be reached by 2015)</i>	100% primary 10% secondary	100% primary 10% secondary	 In progress
Does this country have a costed CSE strategy for out of school youth?	No	No	 In progress

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Currently, training on CSE delivery is only being conducted at in-service teacher level, however, dialogue has commenced to introduce it at pre-service level. The Ministry of Education and partners have identified and implemented e-learning as the most relevant mode of effective capacity-building of teachers in preparation for the roll-out of the curriculum in 2016 and has, thus far, trained 70 teachers and 19 master trainers through this facility⁴.

b) Training of health workers

As with teacher training, there is no structured training on delivering youth-friendly services for pre-service health care providers in the country, however, there are 227 health facilities (SAM 2013) that provide continued family health services support and training for in-service health care providers.











TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Provision of YFHS is guided by the Adolescent Sexual Reproductive Health Policy (2013-2018), which is tied to the strategy, plan and guidelines covering young people aged 10-24.

b) Youth-friendly SRH services

Between 2013 and 2015, 245 nurses across all health facilities were trained in the provision of YFHS delivery. However, it remains challenging to monitor the level of youth-friendliness of the health facilities due to lack of standards and a minimum package for YFHS delivery.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

The number of new infections in Swaziland is disproportionately higher among girls and young women. A multi-sectoral response to address this group's vulnerabilities is therefore being implemented through frameworks such as the Extended National Strategic Framework. While HTC is available, services like these need to be promoted more to young people, as well communicating risk reduction behaviours for HIV prevention.

Increase HIV prevention knowledge

The existing data indicates that more needs to be done to increase young people's HIV prevention knowledge. The scaling-up of the new LSE-based CSE curriculum for secondary schools will hopefully go a long way towards meeting this need.

Reduce early and unintended pregnancy

Swaziland's ASRH strategy and LSE-based CSE curriculum is in place to support the reduction of teenage pregnancy, which currently stands at 16.7%.

Eliminate GBV

A recent study on the prevalence of violence in schools in Swaziland revealed that 86.5% of learners experienced verbal violence, 74.6% physical violence, and 22.1% sexual violence in school settings⁵. Furthermore, evidence outside the formal school setting indicated that 33.2% of girls experienced sexual violence before they reached the age of 18, with the most common perpetrators being men and boys from their neighbourhood, and the first incident most often taking place in the victim's home⁶.

Eliminate child marriage

Swaziland has developed policies and strategies towards the elimination of GBV, teenage pregnancy, and child marriages. According to the Children's Protection and Welfare Act of 2012, any person under the age of 18 has the right to refuse any practice which is likely to negatively affect them.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁷	4,228	2,103	6,331	3,661	1,778	5,438
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁸				7.8%	22.1%	12.2%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁹				58.0%	36.4%	51.8%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁹	28.7%	38.6%		37.6%	30.9%	35.5%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁹	19.8%	N/A	N/A	19%	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁹	28.8%	51.9%				
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ¹⁰		N/A	N/A	2%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ¹⁰		N/A	N/A	19%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Swaziland has one of the strongest CSE curricula in the region with an impressive added feature of linking the curriculum to a detailed set of broader social and legal changes required to reach the same aims.
- The importance of linking CSE to SRH services for adolescents and young people has been well conceptualized, prioritized, and institutionalized under the ESA Commitment in Swaziland. The progress made between 2013 and 2015 highlights that both areas are mutually dependent on each other. Positive results can be attributed to the sustained efforts of the Health, Education and Youth sectors.

Challenges

- Despite the curriculum being strong, there are gaps. For example, while topics like gender and human rights are part of the syllabus, they are only addressed in a cross-cutting manner in the teachers' handbook. In order for CSE to be more effective, it needs to be firmly linked to these topics.
- The ESA Commitment demands strong linkages between schools, local clinics, and communities in Swaziland. Teacher classroom support is key to this, including provision of tools such as reference materials, learner books, and ongoing mentoring.
- Continuous training of health care workers on YFHS delivery promotes uptake of services by young people. In addition, the exposure of adolescent girls to CSE helps to empower them to delay sexual debut and negotiate safer sex.

Sources

- Swaziland Population Projections 2007 to 2030.
- Annual Education Census 2014.
- Service Availability Mapping 2013. Health workers include 215 physicians, 215 nurses and 903 midwifery staff.
- The total number of teachers trained refers to training following a structured curriculum that supports teachers to deliver CSE in classroom settings. It does not consider CSE training as an information package only.
- UNESCO, 2015. *Regional Study on Addressing Gender, Diversity and Violence in Schools in Southern Africa*.
- Reza A et al. 2009. *Sexual violence and its health consequences for female children in Swaziland: a cluster survey study*.
- UNAIDS HIV 2016 Estimates.
- SDHS, 2006-07.
- MICS, 2014.
- UNICEF, 2015.


BACKGROUND

Tanzania has one of the youngest populations in the world, with 45% under the age of 15¹. Prior to the ESA Commitment, the country already had several initiatives relating to CSE, YFHS, GBV, teenage pregnancy, and child marriage in place, however, the Commitment has acted as a platform to increase government ownership and buy-in, strengthen collaboration across sectors, build on quality education and health service provision, and propel sustainable interventions for young people forward.

Coordination of the ESA Commitment

The ESA Commitment is coordinated by the Adolescent and Young Adult Stakeholder Group under TACAIDS. The working group, which meets quarterly, comprises of 31 institutionally appointed members, including representatives from government, development partners, and civil society. The group is guided by clear terms of reference and is co-chaired by the Director of Higher Education and the Assistant Director of Reproductive and Child Health Services, with a funded work plan for 2014/2015. There is no costed plan for 2015/2016, however, partners have managed to raise funds to support activities related to ESA Commitment interventions.

Demographics	Value
Estimated total population (all ages) ²	46,510,631
Estimated population of young people (10-24) ²	14,851,602
Number of schools ³	Primary: 16,343 Secondary: 4,451
Number of in-service teachers ⁴	Primary: 189,487 Secondary: 73,407
Number of health workers	Data not aggregated

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Sexuality education, with the exception of sexual diversity, is provided in schools to learners across the school cycle and is integrated into identified core-carrier subjects. With support from partners, the Ministry of Education and Vocational Training (MOEVT), through the Tanzania Institute of Education (TIE), has adopted life skills-based SRH and HIV education into the new primary school curriculum, and is in the process of reviewing the secondary school curriculum. TIE has also developed guidelines for the teaching of sexuality education within the primary education curriculum, including course content and teaching time.

b) CSE out of schools

Implementation of CSE in and out of schools is limited. Challenges include a lack of resources, limited teacher and peer educator training, and very little awareness at the school and community level about the importance of CSE for youth. Local government authorities and schools themselves are often not familiar with the strong national policies, guidelines, and syllabi supporting CSE, and controversy about the sensitive issue of discussing sexuality with adolescents remains high both in the education sector and in broader communities.

Indicator:	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year	4.1% ⁵	78% ⁵	 Partially Achieved ⁶
<i>(Target: 40% schools to be reached by 2015)</i>			
Does this country have a costed CSE strategy for out-of-school youth?	No	Yes	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Between 2014 and 2015, 14,560 pre-service teachers were trained through the Teacher Educator Programme (TEP), which is a professional course for tutors and pre-services teachers offered in collaboration with the Ministry of Education and the Open University of Tanzania. Despite being rolled out to all government teacher training colleges, implementation of the programme faces challenges.

According to the 2013-2014 TACAIDS National HIV and AIDS Response Report, 13,183 in-service teachers were trained in Life Skills Education for HIV and AIDS. Additionally, the TIE and UNESCO trained 1,300 primary and secondary school teachers from eight districts on practical skills and effective models to provide reviewed components of CSE to learners.

b) Training of health workers

Under the ESA Commitment, efforts have been consolidated to strengthen pre- and in-service training of health care professionals, including the adaptation of global check lists for national and regional health workers. Additionally, the Ministry of Health has worked with several partners that support relatively small geographic areas, and specific types of youth-friendly service interventions. The ESA Commitment process has made it clear that there is a need for more systematic, large-scale and long-term funding and training for this to have a meaningful impact. Between 2014 and 2015, a total of 155 in-service health professionals received training, including medical doctors, midwives, and nurses, on CSE delivery.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Tanzania has a national strategy on youth-friendly SRH services, however it is currently not costed. The present ASRH guidelines specify that adolescents should have access to the same SRH services in an integrated manner as adults. The services should be delivered at the same delivery point to allow for ease of access for adolescents and youth.

b) Youth-friendly SRH services

Many challenges remain in the quality and coverage of training and implementation of YFHS. Only 30% of private and public health facilities are currently providing adequate YFHS, highlighting critical areas where greater investment is needed.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new HIV infections

There has been a reduction in the number of new HIV infections among young people in Tanzania, which may be the result of some of the HIV interventions at increasing risk reduction behaviours.

Reduce early and unintended pregnancy

Teenage pregnancy is a major concern in Tanzania, with almost 25% of girls bearing children between the ages of 15 and 19, of which less than 1% successfully return to school, according to a recent five-country study on the education sector response to teenage pregnancy, in which Tanzania ranked the highest in terms of young girls ever pregnant who are now out of school⁶. Supportive policies for girls, including plans for learners to re-enter school, will be crucial moving forward.

Eliminate GBV

Although data on GBV in Tanzania is only disaggregated by age, not by gender, various studies⁷ note that women and girls continue to be victims of sexual abuse and GBV, where many are socialized to accept, tolerate, and even rationalize domestic violence. This includes being silent when they experience this violence or witness it happening around them⁸. Nearly three out of every ten females aged 13-24 reported experiencing at least one incident of sexual violence before turning 18⁹. Tanzania has committed to addressing GBV and violence against children through the development of a National Plan of Action to Prevent and Respond to Violence Against Children. Following two years of implementation after the affirmation of the ESA Commitment, the Ministry of Health has worked to train health workers to better identify, manage, and report cases of abuse. Additionally, the Ministry of Health has developed standard operating procedures for one-stop centres. The Department of Social Welfare is taking the lead in establishing child protection systems, which inform all key stakeholders about their legal obligations to protect and support children and to address all violence and abuse cases against children, including child marriage.

Eliminate child marriage

According to the Tanzania Law of Marriage Act (1971), the minimum age of consent to marriage is 18 years for males and 15 years for females. However, early marriages are allowed by law in communities that adhere to customary or Sharia law.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ¹⁰	13,091	7,144	20,235	10,922	5,975	16,897
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ¹¹	12.8%	6.9%				
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ¹²				39%	25%	
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ¹¹	46.7%	40.1%				
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ¹¹	22.8%					
Target 7: Eliminate gender-based violence						
Prevalence of Sexual Violence 15 - 19 ¹³	13.2%					
Prevalence of Sexual Violence 20 - 24 ¹³	18.6%					
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ¹¹	6.6%	N/A	N/A	N/A	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ¹¹	36.9%	N/A	N/A	N/A	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

The current funding climate tends to support novel, small-scale, and time-limited initiatives. Insufficient attention has been given to introducing, implementing, and monitoring best practice, sustainable programmes at scale. There is a tremendous need to YFHS with high quality, wide coverage, and long-term sustainability.

Challenges

Implementation remains a significant challenge in Tanzania. Many policies and guidelines are not widely disseminated, understood, or implemented within the respective sectors, from national to local levels. In addition, several key stakeholders have not been exposed or trained in how to supervise or implement programmes related to CSE and YFHS.

Sources


- 2014 World Population Data Sheet.
- NBS: 2012 census projections for 2014.
- BEST 2014, MOEVT.
- UNESCO. 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa*; MOEVT, BEST 2014.
- Numbers based on a specific UNESCO project funded by Sida which targeted 685/16,538 primary schools and 172/220 secondary schools with life skills-based HIV and sexuality education within previous academic year. In 2013, the content of CSE was implemented partially, which means all schools had partial provision of CSE. The new curriculum has started as of 2015 in primary education.
- UNAIDS, UNESCO and UNFPA, 2015
- TGNP, Gender Profile of Tanzania, 2007, HakiElimu documentation on Girls education, FAWE
- Country Report on the Review and Progress Made and Challenges Encountered in Implementation of the Beijing Declaration and Platform for Action and Outcomes of the Twenty Third Special Session of the General Assembly, Beijing +20, 2014.
- Violence against children in Tanzania: Findings from a National Survey 2009.
- UNAIDS HIV 2016 Estimates.
- DHS, 2010.
- UNAIDS HIV 2014 Estimates.
- TDHS, 2010.

The ESA Commitment has helped to catalyse and accelerate the coordination and leadership of governments, young people, and CSOs through joint interventions on CSE and YFS across Uganda. Furthermore, it has helped create robust linkages between sexuality education and SRH services for young people. This joint approach secures sustainability and continued engagement of various stakeholders in achieving healthier outcomes for young people.

Coordination of the ESA Commitment

Uganda's coordination mechanism of the ESA Commitment consists of various government sectors, UN agencies, CSOs, CBOs, and young people and is chaired by the Ministry of Education and Sports (MoES). The team meets on a quarterly basis and a clear terms of reference guides their work to advocate for an increased focus on ASRH services, report on progress made towards the ESA Commitment targets, and jointly mobilize resources. Working in a coordinated manner has improved Uganda's response to the delivery of CSE and strengthened the consensus and understanding on clarifying the benefits of good quality CSE.

Demographics	Value
Estimated total population (all ages) ¹	34,634,650
Estimated population of young people (10-24) ¹	12,052,858
Number of schools ²	Primary: 18,118 Secondary: 2,836
Number of in-service teachers ³	Primary: 169,503 Secondary: 55,843
Number of health workers ⁴	42,530

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization of the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Although Uganda has policies and programmes in place that support the scale up of CSE, such as the School Health Policy and the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) programme, implementation in the classroom has been limited. This is partially due to the majority of teachers lacking knowledge and skills to deliver CSE and having limited resources to implement lessons in the classroom. In addition, Uganda has an already crowded school programme, which makes it even more difficult to find space in the curriculum to prioritize CSE. Currently, the delivery of CSE is taking place in the secondary school curriculum. The MoES is in the process of revamping the PIASCY programme (primary school), and the Life Skills curriculum has been revised to cover most of essential topics within CSE, although gaps remain evident in the area of sexual behaviour, gender equality, sexual diversity, HIV treatment, and services for HIV counselling and testing.

b) CSE out of schools

The Ministry of Gender, Labour and Social Development is developing a terms of reference for development of a sexuality education curriculum for out-of-school youth.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	100% (5641 primary)	100% (5641 primary)	 Achieved
	65% (660 secondary)	80% (1083 secondary)	
Does this country have a costed CSE strategy for out-of-school youth?	No	No	 Not achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Between 2013 and 2014, the Ministry of Education trained tutors and lecturers from teacher training institutions on the integration and delivery of CSE and in 2015, three large pre-service teacher training events were completed in various parts of the country, which resulted in the training of 1,344 pre-service teachers. However, the Ministry has indicated that more adequate training and regular follow-ups with teachers will be needed to ensure greater and long-lasting impact. In addition, as part of the planned roll out of the lower secondary curriculum across the country, which includes components of sexuality education as part of the LSE learning area, the Ministry has also planned to re-equip teachers from 2017 onwards.

b) Training of health workers

Pre-service training programmes for health care providers are conducted by the health training institutions which fall under the MoESTS. In-service training falls under the Ministry of Health and is supported by development partners. Uganda stipulates that at least two health providers per facility must be trained as a prerequisite for accreditation as a facility offering youth-friendly services. In 2015, a total of 330 health workers from 15 districts were trained in sexuality education to improve their capacity in AYSRH service provision in health facilities.













TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Uganda has the following policies in place to support AYSRH: the National Adolescent Health Strategy (2004-onwards, currently being reviewed); Adolescent Health Policy Guidelines and Standards; National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights (updated in 2015); National Adolescent Girl Agenda; and the National Adolescent Health Roadmap, which is currently under development.

b) Youth-friendly SRH services

A total of 37,346 adolescents and young people between the ages of 10-24 years accessed youth-friendly SRH services in 2015. Adolescent health services, including for SRH, are provided in 32% of facilities⁹, and offered up to Health Centre III level (which administratively is located at sub-county level).

Standard package on ASRH, 2015 (UNFPA)	Provided ⁵
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care ⁶	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear) ⁷	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B ⁸	
Any other – Clinical care for sexual gender-based violence	

2020 TARGETS

Reduce new HIV infections

The number of new HIV infections among young people aged 15-24 has slightly declined over the last three years, but girls are still disproportionately affected.

Uganda has undertaken various measures towards improving HIV risk reduction behaviours among young people, including major campaigns in collaboration with youth NGOs, such as Reach a Hand Uganda, Reproductive Health Uganda, and Sexual Reproductive Health Alliance Uganda, which focus on peer-to-peer HIV prevention awareness, creating linkages with youth-friendly SRH services, and engaging with policy-makers to legislate on favourable SRH policies.

Reduce early and unintended pregnancy

An estimated 25% of girls fall pregnant before age 19 in Uganda. To address this, Guidelines for Prevention, Management of HIV/AIDS and Teenage/Unintended Pregnancy in School Settings was published in June 2015, in addition to the 2009 MoESTS directive to allow pregnant girls to return to school and sit through their exams. However, reinforcement of the directive is challenging and the default education sector response to pregnant learners is suspension or expulsion.

Eliminate GBV

The rates of GBV in Uganda have increased since 2011, fuelled by harmful cultural practices like early marriage and social tolerance to violence against women. The government has put specific laws in place to address GBV, including the Domestic Violence Act (2010), among others. Uganda has also executed prevention programmes such as mobilizing communities to act on violence against women and girls through male action groups, FBOs, and traditional and cultural institutions.

Eliminate child marriage

Although the age of consent to marriage in Uganda is 21 years, the traditional practice of child marriage persists. In 2013, the country was ranked 16 among 25 countries with the highest rates of early marriages (World Vision 2013). The government has made considerable progress in improving the status of the girl child and in 2015 launched the National Strategy to End Child Marriage and Teenage Pregnancy, developed in partnership with CSOs, bilateral partners, and UN agencies.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ¹⁰	20,946	11,775	32,721	18,894	10,615	29,509
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ¹¹	15-19yrs: 53.6%	15-19yrs: 54.9%				
	20-24yrs: 53.5%	20-24yrs: 71.3%				
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ¹²	38.1%	39.5%	38.1%	35.2%	34.8%	
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ¹¹		24%				
Target 7: Eliminate gender-based violence						
Prevalence of gender based violence among 15-24 years olds ¹³	15-19yrs: 57.6%	15-19yrs: 55.9%		75.2%	72.4%	
	20-24yrs: 64.2%	20-24yrs: 62%				
Target 8: Eliminate child marriage						
% of women (age 20-24) who were first married or in union before they were 15 years old ¹⁴	12%	N/A	N/A	10%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ¹⁴	46%	N/A	N/A	40%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

Community resistance to CSE and the provision of some SRH services is largely due to the limited information available on their benefits for young people. A well-planned intergenerational dialogue can provide an opportunity to engage in constructive discussions that will address the fears of parents and other community members and equip young people with the information they need.

Challenges

- Monitoring the progress of the ESA Commitment has proven to be a major challenge, especially since the integration of Global HIV indicators into the EMIS did not take place as planned due to technical limitations in the software set-up. While there are no plans to implement this, an alternative approach to capture data through other M&E platforms is currently being explored.
- A lack of resources to implement ESA Commitment-related activities has also been a challenge. The Ugandan government's budget and funds allocation is rather rigid due to highly competing priorities. In most cases, these programmes end up being financed by development partners, which is not sustainable in the long-term.

Sources

1. National Population and Housing Census 2014 main report.
2. UNESCO. 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa*; ESSAPR 2014; EMIS 2014.
3. EMIS 2011.
4. Annual health sector performance report 2014/15, MoH (2015) (Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.)
5. As outlined in the Adolescent Health Policy Guidelines and Service Standards (2012), "Components of adolescent friendly health services."
6. Uganda does not provide abortion services, only post-abortion care services.
7. Services should include breast examination and information on cervical cancer. However, coverage of these services is low.
8. Services should include HPV immunization. In practice, however, these services tend to be offered through outreach programmes.
9. UNICEF Rapid Assessment, Feb 2016.
10. UNAIDS HIV 2016 Estimates.
11. DHS 2011.
12. DHS 2011 and UNFPA (2016) National AYSRH Assessment.
13. Ibid.
14. UNICEF (State of the World's Children, statistical tables 2015) and World Vision 2013.


BACKGROUND

The ESA Commitment has accelerated the ongoing activities being implemented by government and CSOs in Zambia, including strengthening the collaboration between the Ministries of Education and Health and taking a strong leadership role in championing implementation of the Commitment by developing sound policy guidelines. This has provided an opportunity for many players – including civil society and UN agencies – to work within this agenda and meaningfully contribute to attaining healthier outcomes for young people across the country.

Coordination of the ESA Commitment

Zambia's coordination mechanism for the ESA Commitment functions under the joint leadership of the Ministry of General Education and the Ministry of Health. The technical working group consists of representatives from government, UN agencies, CSOs, and young people. The group meets every quarter and their activities are structured by a bi-annual action plan which is costed, included in other sector work plans, and allocated financial resources.

Demographics	Value
Estimated total population (all ages) ¹	16,211,767
Estimated population of young people (10-24) ¹	5,355,341
Number of schools ²	Primary: 3,217,872 Secondary: 801,594
Number of in-service teachers ²	Primary: 78,395 Secondary: 22,418
Number of health workers ³	42,530

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	Yes	 Achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

The Ministry of Education has recently rolled out a nationwide curriculum that integrates CSE into both primary and secondary schools. Subjects include: Integrated Science, Biology, Social Studies, Civic Education, Home Economics and Religious Education. In addition, the Curriculum Development Centre (CDC) has developed learning and teaching materials for grades 5, 6, 8, 9, 10 and 11 to support the delivery of CSE in the classroom. The curriculum ensures that CSE is part of national examinations and learner assessment tools. This has resulted in over 1.3 million learners being taught in CSE.

b) CSE out of schools

The recently developed Out-of-School Comprehensive Sexuality Education (OSCSE) framework was established as a result of the ESA Commitment. This framework aims to equip out-of-school children and young people with the knowledge, skills, attitudes, and values that will enable them to build a positive view of their sexuality in the context of their emotional and social development.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	100% Primary 100% Secondary	100% Primary 100% Secondary	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No	Yes	 Achieved


TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

Zambia has scaled up efforts to include CSE training for both pre- and in-service teachers across the country. Over 34,000 in-service teachers have already been trained in effective CSE delivery⁴, and the new curriculum for pre-service teacher training, which includes CSE delivery, was introduced in January 2015. The first cadres of graduates are expected in 2018.

b) Training of health workers

Mirroring a similar approach to teacher training in the country, a scale-up of training for both pre- and in-service health care providers is well underway. Inclusion of AYFHS provision into the nursing and midwifery curriculum was finalized in 2015 and will be rolled out to pre-service nurses and midwives in 2016.

Indicator	Current data 2015	Progress
% of schools with teachers who received training and taught lessons in life skills-based HIV and sexuality education in the previous academic year. <i>(Target: 40% schools to be reached by 2015)</i>	100% Primary 100% Secondary	 Achieved
Number of In-service health care providers trained in AYFHS	826	-












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

The provision of services for adolescents and young people in Zambia is guided by the National Standards and Guidelines for Adolescent Friendly Health Services, which covers adolescents and young people aged 10-24.

b) Youth-friendly SRH services

All Zambian health facilities offer services for adolescents and young people, but in many areas, the provision of health services is still not youth-friendly: there is a lack of physical space for youth-friendly corners to provide adequate privacy, and many health care providers hold negative attitudes towards youth accessing SRH services. Currently there is no data available on the number of young people and adolescents accessing services.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new HIV infections

Although there has been a decrease in the number of new HIV infections since 2013, twice as many girls and young women are becoming newly infected with HIV than their male counterparts. Efforts are underway to ensure that knowledge levels increase by identifying young people as a key population under great risk of HIV in the Revised National HIV & AIDS Strategic Plan 2014-2016, and strengthening the provision of CSE and SRH services for adolescents and young people.

Reduce early and unintended pregnancy

Zambia does not have a national strategy on teenage pregnancy, however, it has had a re-entry policy since 1997 which allows pregnant girls to go back to school once they have delivered.

Eliminate GBV

Zambia enacted the Anti GBV Act No.1 in 2011 and has also produced a simplified version of the Act that has been translated into seven major local languages and Braille format. An amendment has been made to the Penal Code which criminalizes GBV and has increased the penalty for child defilement from 15 years to life imprisonment. In addition, the revised National Gender Policy was launched in 2014 and the "HeForShe" Campaign, a solidarity movement for gender equality which was developed by UN Women to engage men and boys as advocates and agents of change for the achievement of gender equality and women's rights, was launched in 2015.

Eliminate child marriage

Zambia's legal age for marriage in the amended constitution of 2016 is 21. Furthermore, the country has developed a five-year National Strategy on Ending Child Marriage that will promote and contribute to the protection of the rights of all children; both those affected by child marriage as well as those at risk. This strategy is aimed at accelerating efforts to end child marriage by 2030 through the provision of an operational framework that reflects the current national and global trends and efforts.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁵	13,898	7,788	21,686	13,176	7,358	20,534
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁶	2.12%	14.27%	7.35%	32.72%	39.96%	38.28%
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁶	16.94%	10.19%	13.85%	56%	39%	45.8%
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁶	34%	36%	35%	41.5%	46.7%	43.9%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁶	30%			28.5%		
Target 7: Eliminate gender-based violence						
Prevalence of gender based violence among 15-24 years olds ⁶	16.5%					
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage? ⁶			No			Yes
% of women (age 20-24) who were first married or in union before they were 15 years old ⁶	3.1%	N/A	N/A	5.9%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ⁶	41.6%	N/A	N/A	31.4%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- Integration of CSE and health care services in school programmes, including Parents Teachers Association meetings, sports events and tournaments, and music shows has helped reach more adolescents and young people both in and out of school.
- The exposure of adolescents and young people to health care services through organized clinic visits has helped many gain better information on HIV and AIDS.
- The information provided to adolescents and young people through CSE clubs and peer-to-peer support groups has been beneficial in addressing some of the challenges they face.
- Collaboration and networking among partners working on ASRH issues, both in government and CSOs, has been strengthened which has in turn improved coordination of programmes that are related to the ESA Commitment.

Challenges

- Monitoring and oversight of the implementation of the ESA Commitment remains weak, which has affected the reporting of progress against Commitment targets. Furthermore, it affects the documentation and learning from the implementation process.
- Resources provided by government are insufficient and implementation of the ESA Commitment therefore continues to be supported by UN agencies, bilateral development partners, and CSOs, with government mainly providing technical and policy guidance.

Sources

1. UN population Division Estimates, 2015.
2. Ministry of General Education. 2014. Educational Statistical Bulletin.
3. MoH HR (Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.)
4. Zambia UNESCO Country CSE Annual Report, 2014 & 2015.
5. UNAIDS HIV 2016 Estimates.
6. ZDHS 2007; ZDHS 2013/14.


BACKGROUND

Zimbabwe has made great strides in meeting the ESA Commitment targets. Government and development partners are currently working on strengthening the following essential components of a comprehensive education sector response to HIV and AIDS: quality education; content, curriculum and learning materials; educator training and support; policy, management and systems; and strengthening approaches and illustrative entry points. In addition, the health sector has commissioned seminal studies, for example, the National Adolescent Fertility Study, which will strengthen the evidence base on adolescent pregnancy in Zimbabwe to inform policy and programmes.

Coordination of the ESA Commitment

The coordination of the ESA Commitment between the Ministries of Education and Health, other key line ministries, civil society, and UN agencies remains an area of concern. However, a concrete recommendation has since been made to include the Commitment as a standing agenda for the Adolescent Sexual and Reproductive Health Coordination Forum and the Technical Working Group of the Young People's Network on Sexual Reproductive Health and HIV & AIDS. This will ensure improved coordination, accountability, progress monitoring, and the provision of technical guidance to the attainment of ESA Commitment targets.

Demographics	Value
Estimated total population (all ages) ¹	15,602,751
Estimated population of young people (10-24) ¹	5,096,271
Number of schools ²	Primary: 5,905 Secondary: 2,481
Number of teachers ²	Primary: 73,148 Secondary: 42,585
Number of health workers ³	34,308

ESA Commitment coordination	Baseline 2013	Current data 2015	Progress
Does the country implement a multi-sectoral strategy/framework for operationalization the ESA Commitment?	No	No	 Not achieved

2015 TARGETS



TARGET 1: A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries

a) CSE in schools

Zimbabwe's CSE efforts are supported by several policies and strategies, including the Life skills, Sexuality and HIV and AIDS Education Strategic Plan (2012-2015), which caters for children, adolescents and young people from ages 4-18, both in and out of school. A national curriculum review process has been completed in the following subjects: Guidance and Counselling, Life Skills, Sexuality, and HIV and AIDS. These are compulsory subjects in both the primary and secondary schools curricula and as of 2016 will be examinable at "O" level. Discussions are ongoing on how to handle assessment at primary education level.

a) CSE out of schools

Community-based sexuality education programmes targeting out-of-school youth are being implemented through government and NGOs as per the Adolescent Sexual and Reproductive Health Strategy and the Zimbabwe National HIV & AIDS Strategic Plan 3.

Indicator	Baseline 2013	Current data 2015	Progress
% of schools that provided life skills-based HIV and sexuality education in the previous academic year <i>(Target: 40% schools to be reached by 2015)</i>	No data	87%	 Achieved
Does this country have a costed CSE strategy for out-of-school youth?	No data	Yes	 Achieved

TARGET 2: Pre- and in-service SRH and CSE training for teachers, health and social workers is in place and being implemented in all 20 countries

a) Training of teachers

In 2015, all pre-service teachers from teachers' colleges in the country were trained in CSE, which accounts for over 25,200 pre-service teachers⁴, and a more systematic programme of training was implemented for in-service teachers, training 3,693 primary school teachers and 7,720 secondary school teachers, of which just over 50% were female⁵. Zimbabwe's 14 teacher training colleges provide compulsory CSE under the Health and Life Skills Education subject and as a result of the newly developed Zimbabwe Curriculum Framework (2015-2022), the Ministry of Primary and Secondary Education recently put together a comprehensive syllabus and teachers' manual on life skills, sexuality, and HIV & AIDS education, in line with regional and international standards.

b) Training of health workers

A Standard National Adolescent Sexual and Reproductive Health Training Manual for Service Providers has been developed to guide facilitators in preparing, delivering, and evaluating standard training in youth-friendly SRH service provision for service providers (both pre- and in-service). Zimbabwe has also established community level ASRH committees to support and stimulate community participation, leadership, and ownership of ASRH programmes. However, there is no reliable data available on the number of health care professionals who have been trained between 2013 and 2015.












TARGET 3: Decrease by 50% the number of adolescents/young people who do not have access to SRH services, including HIV

a) National ASRH policies and strategies

Provision of YFHS is guided by four main policies and/or strategies, most of which have reached their lifespan and are due for review and extension in 2016. Policies include the Zimbabwe National HIV & AIDS Strategic Plan, the National Adolescent Sexual and Reproductive Health Strategy, the Adolescent Accelerated Treatment Plan, and the National Youth Policy.

b) Youth-friendly SRH services

The quality of youth-friendly SRH services varies from facility to facility, depending on the service provider or the financial resources available. A total of 2,944,765 adolescents have been reached by youth-friendly SRH services in the previous two years, including those who accessed family planning, HIV and STI services for 2014 and 2015.

Standard package on ASRH, 2015 (UNFPA)	Provided
General health checkups, including checks on your physical development, vision, hearing etc.	
Advice on puberty concerns and help with menstrual hygiene	
Education and counselling on SRH and sexuality	
Contraceptive education and a range of contraceptive methods, including condoms and emergency contraception	
Pregnancy testing and antenatal, delivery (obstetric care) and post-natal care	
Pregnancy options counselling and safe abortion, where legal, and post-abortion care	
STI education, diagnosis and treatment, including partner notification	
HIV education, counselling, testing and referrals for treatment, care and support services, pre-exposure and post-exposure prophylaxis	
Medical male circumcision	
Screening for cervical cancer (Pap smear)	
Immunizations, including for human papillomavirus (genital warts) and hepatitis B	

2020 TARGETS

Reduce new infections among young people

While the number of new infections among young people aged 15-24 is declining, adolescent girls and young women are still disproportionately affected. A multi-sectoral response to address their vulnerabilities is being implemented through programmes such as Safeguard Young People, H4+ (a UN Joint initiative), DREAMS, and the Health Development Fund.

Coverage of HIV testing services among young people has improved dramatically over the last four years, although overall, women are much more likely than men to have been tested for HIV and received test results (85% and 59%, respectively). This is almost double the baseline figures reported in the 2010-11 DHS (45% and 24%, respectively).

Increase HIV prevention knowledge

Comprehensive knowledge of HIV among both young female and men has increased by 5%. However, more work still needs to be done for both in- and out-of-school CSE programmes.

Reduce early and unintended pregnancy

Pregnant learners are protected under Policy Circular 35, which provides that the young mother (former pupil) may be re-enrolled at the same school, in the same grade/form in which she was before she took leave to deliver. Efforts are also underway to eliminate early/child marriages through legal interventions and community mobilization against child marriage and adolescent pregnancy.

Eliminate GBV

In line with the National GBV Policy, prevention efforts are aimed at capacitating targeted communities to address negative social norms that perpetuate GBV. Efforts have also focused on strengthening service availability through health, legal, and psychosocial support. The piloted one-stop centre concept has also been replicated following successes reported in ensuring a multi-sectoral approach in service provision.

Eliminate child marriage

Approximately 25% of adolescent girls enter into marriage or union before the age of 18, and because religious and cultural beliefs are deeply engrained in many areas of the country, change will continue to be a slow and challenging process. Zimbabwe has nevertheless made promising progress with the Constitutional Court's outlawing of child marriage.

Indicators	Baseline			Available data		
	Female	Male	Total	Female	Male	Total
Target 4: Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections among adolescents and young people aged 10-24						
New HIV infections (aged 15-24) ⁶	15,272	8,815	24,089	13,648	7,815	21,460
% of never-married women and men aged 15-24 who had sexual intercourse in the past 12 months and used a condom at the last sexual intercourse ⁷	49	73		59	75	
% of sexuality active women and men (15-24) who have been tested for HIV and received results in last 12 months ⁷	45	24		85	59	
Target 5: Increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels						
Young people's knowledge about HIV prevention (% of young people who can correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission) ⁸	52%	47%	49.5%	56%	52%	54%
Target 6: Reduce early and unintended pregnancies among young people by 75%						
% of adolescent women (age 15-19) who have begun childbearing (have children or currently pregnant) ⁷	23.5%	N/A	N/A	24%	N/A	N/A
Target 7: Eliminate gender-based violence						
Prevalence of gender-based violence among 15-24-year-olds ⁹			13.7%			
Target 8: Eliminate child marriage						
Does the country have programmes that prevent and mitigate against child marriage?			Yes			Yes
% of women (age 20-24) who were first married or in union before they were 15 years old ¹⁰	3.9%	N/A	N/A	5%	N/A	N/A
% of women (age 20-24) who were first married or in union before they were 18 years old ¹⁰	30.5%	N/A	N/A	33%	N/A	N/A

LESSONS LEARNED AND CHALLENGES

Lessons learned

- The institutionalization of CSE within the Guidance and Counselling Learning Area entrenches sustainability, ownership, and accountability.
- The provision of adolescent and youth-responsive services has to be matched with efforts to address socio-cultural, institutional, and legal barriers limiting use of essential ASRH services.
- There is a need for focused school-based, community-based, and health-facility interventions and strategies promoting treatment literacy and adherence to lifelong ART among adolescents and young people.

Challenges

- The coordination of the ESA Commitment needs to be urgently formalized by implementing the recommendation on establishing a standing agenda in the Adolescent Sexual and Reproductive Health Coordination Forum and the Technical Working Group meetings of the Young People's Network on SRH, and HIV and AIDS, and updating the terms of reference accordingly.
- The enabling environment needs to be strengthened further, focusing particularly on policies, strategies and action plans, resource mobilization, and monitoring and evaluation.

Sources

1. UN population Division Estimates, 2015.
2. EMIS, 2015.
3. MoHCC, 2016 (Health workers include physicians, nurses and midwives, dentists and technicians, pharmacists and technicians, environment and public health specialists, laboratory technicians, community health workers and other management and support staff.)
4. NAC, UN agencies, MoHTESTD.
5. MoPSE, NAC, UN agencies.
6. UNAIDS HIV 2016 Estimates.
7. DHS, 2010-11, MICS, 2014.
8. Zimbabwe National Statistics Agency (ZIMSTAT). 2014. Multiple Indicator Cluster Survey 2014, Key Findings. Harare, Zimbabwe: ZIMSTAT.
9. Proxy indicator: percentage of women and girls aged 15 to 49 who have ever experienced physical or sexual violence.
10. Percentage of people who were first married or in union before age 15 (women age 15-49 years); Percentage of people who were first married or in union before age 18 (women age 20-49 years).



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