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<td>Adolescent girls and young women</td>
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<td>AIS</td>
<td>AIDS Indicator Survey</td>
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<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
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<td>AU</td>
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<td>AYFHS</td>
<td>Adolescent- and youth-friendly health services</td>
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<td>AYP</td>
<td>Adolescents and young people</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<td>COMESA</td>
<td>Common Market for Eastern and Southern Africa</td>
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<td>CSE</td>
<td>Comprehensive sexuality education</td>
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<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<td>CSW</td>
<td>Commission on the Status of Women</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<td>EUP</td>
<td>Early and unintended pregnancy</td>
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<td>FDC</td>
<td>Fundação para o Desenvolvimento da Comunidade</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICPD</td>
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<td>ICT</td>
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<td>M&amp;E</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NPO</td>
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<td>O³</td>
<td>Our Rights, Our Lives, Our Future Programme</td>
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<td>PTA</td>
<td>Parent-teacher association</td>
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<td>RAF</td>
<td>Regional Accountability Framework</td>
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<td>REC</td>
<td>Regional Economic Community</td>
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<td>School governance body</td>
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<td>School-related gender-based violence</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>SYP</td>
<td>Safeguard Young People initiative</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TCG</td>
<td>Technical Coordinating Group</td>
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<td>UHC</td>
<td>Universal health coverage</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
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FOREWORD

Young people in Africa, as everywhere, have the right to live healthy and fulfilling lives. It is a right that has been reiterated in numerous regional and global declarations and frameworks. The Sustainable Development Goals (SDGs), anchored in the principle of ‘leaving no one behind’, for instance, remind us of the importance of investing in the ones most left behind; for most countries in the Eastern and Southern African (ESA) region, these are adolescents and young people in all their diversities. The African Union’s Agenda 2063 further builds on and seeks to accelerate the implementation of past and existing continental initiatives for growth and sustainable development and, among others, promises to empower women and youth to fulfil the African Dream. This shows there is no doubt that Africa understands the urgency of the now, and the need to prioritize investment in young people. However, we still fall short of achieving such a reality.

The ESA region has, for example, one of the highest adolescent fertility rates in the world. Many of these pregnancies are not planned. In fact, the rate of unintended pregnancy in Africa stands at 89 per 1,000 overall, and 112 per 1,000 in Eastern Africa, resulting in an estimated 21.6 million unintended pregnancies per year. Adolescent girls continue to experience a disproportionately high burden of poor sexual and reproductive health (SRH). For too many of these girls, early and unintended pregnancy (EUP) signals the end of their educational opportunities. Becoming pregnant can result in their expulsion from home and school, being shamed and stigmatized, increased vulnerability to violence and abuse, and greater poverty and economic hardship.

Furthermore, even though new infections among young people in the region are decreasing, the majority of new HIV infections still occur among young people aged 20-24 years, with adolescent girls and young women remaining disproportionately affected, accounting for at least two-thirds of the new infections. Additionally, less than 50% of young people in the region demonstrate accurate knowledge about HIV prevention and transmission, signalling the need for more information and education on sexual health.

Socio-cultural norms that perpetuate gender-based violence (GBV) are rife and continue to disadvantage young girls and women. This calls for more to be done to shift the norms that justify any form of violence against women. Incidences of child marriage, which is especially damaging to the life opportunities of adolescent girls and young women, are also high, and legal loopholes often leave perpetrators of child marriage unpunished.

In 2013, in response to these challenges faced by adolescents and young people in the region, ministers of education and health from 21 ESA countries therefore endorsed and affirmed their commitment to better health outcomes for adolescents and young people in a historic declaration, which is now known as the ESA Commitment. The Commitment, which recognizes the importance of sexual and reproductive health and rights (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 EUP; reducing GBV; and eliminating child marriage.

Significant progress has been achieved since 2013 by most countries in developing political and policy support for:

- Comprehensive sexuality education (CSE) and access to SRH services;
- Integrating sexuality education in school curricula;
- Building the capacity of teachers and educators;
- Working with non-governmental and civil society organizations, including youth networks, to reach out-of-school adolescents and young people; and
- Intensified resource mobilization to fast-track the various ESA Commitment targets.
To pursue the aspirations of the ESA Commitment, the United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), Save the Children, and the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) are supporting countries to roll out a regional multimedia campaign on EUP among adolescent girls. The campaign will be launched in 21 countries across the region in July 2019 and will run until December 2020. The overall objective of the campaign is to reduce and prevent EUP and afford girls who fall pregnant an opportunity to continue with their education, thus advancing the ESA Commitment target of reducing EUP by 75% by 2020.

As we reflect on five years of ESA Commitment implementation, and celebrate 25 years of the International Conference on Population and Development (ICPD), we must recognize and amplify the benefits of CSE not just for attaining positive health and education outcomes for young people, but also for securing a brighter future for our continent. The onus is on governments, development agencies, civil society, community leaders, and parents to work with young people and their movements in order to fulfil our moral duty of securing this future, and empowering adolescents and young people with the information and skills they need to make safe and healthy decisions about their life and future, reach their full potential, and contribute to the development of their community, country and region.

Collectively, we can achieve more!

Dr Catherine Sozi
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Prof Hubert Gijzen
Regional Director & Representative
UNESCO Regional Office for Southern Africa
Our stories may be different, and yet our paths are similar. On our way to adulthood, we want to be independent, and responsible and be able to reach our full potential. We want to follow our dreams and fulfill our ambitions. We want to fit in and be unique at the same time. Sometimes we are confident about ourselves. Sometimes we doubt our choices. Sometimes we celebrate our choices, and sometimes we regret our actions … We feel pressure coming from all sides; from outside and from within… Yet, through this journey we fight to gain a footing in our lives. To shape our future and make a mark.

Our life lessons come in many, often unstructured forms. For instance, many of us learn about the changes our bodies go through a little too late. Not all available information is relevant. And not all relevant information is available. Many of us have unprotected sex at an early age, get pregnant, go through unsafe abortions, contract HIV, face gender-based violence, get discriminated against, drop out of school and miss the opportunity to fulfill our dreams.

Our perception of sexuality itself is often distorted, incomplete and obscure. Biology teaches us about the physiology of it; religion orients us towards abstinence; our parents and society tell us not to do “anything”; and the Internet opens before us a boundless world of exposure to various definitions of sexuality.

That is why we strongly believe that Comprehensive Sexuality Education is essential for us to build a wholesome image of the changes our bodies go through, and for us to make informed decisions. CSE makes us understand that our self-worth does not lie in how attractive we are or in the number of Facebook Likes we may get. Our self-worth comes from the fact that we are full individuals. CSE teaches us that our bodies are our own — not shared commodities; that we have the power to make decisions about how we should use them, and when.

We are not just young people, but we are opportunities and the only hope for a developed Africa. But our success and that of the continent depends on how prepared we are today. We will succeed if we learn. We will learn better if we are healthy. And we will be healthier if we benefit from well implemented CSE programmes.

We strongly believe that every young person in Africa has the right to CSE, which empowers them to make the right choices. It is a belief so strong that it resonates with our desire to help build a, healthier and more sustainable future. A future going far beyond our time. A future that far surpasses the aspirations of the Agenda 2030 and Agenda 2063.

― Voices of African youth and adolescents on CSE

“CSE teaches us that our bodies are our own… that we have the power to make decisions about how we should use them, and when.”

Testimonial by African youth and adolescents
1. Executive Summary

Introduction

In December 2013, ministers of education and health from 21 Eastern and Southern African (ESA) countries1 endorsed and affirmed their commitment to better health outcomes for adolescents and young people in the region. In what is now known as the ESA Commitment, ministers agreed on a set of mid- and long-term targets which guide national implementation, among them reducing new HIV infections, reducing early and unintended pregnancies (EUPs) by 75%, and eliminating child marriages and gender-based violence (GBV) among young people in the region by 2020. Central to the Commitment is the agreement to scale up comprehensive sexuality education (CSE) and access to sexual and reproductive health (SRH) services for adolescents and young people (AYP).

This report outlines progress made up to 2018 in achieving the ESA Commitment targets, assesses gaps in implementation thus far, and makes recommendations towards fulfilment of the pledges made in the Commitment by the 21 countries.

Background

There are currently 113.2 million AYP aged 15-24 years2 in the ESA region, which represents 23% of the population. With estimates that Africa’s population will more than double between 2016 and 2050, this demographic transition presents an opportunity to reap a demographic dividend. However, the realization of this is not a given, hence it requires investment in education, health, employment, and promoting participation by and inclusion of AYP now. Supporting adolescents to protect their sexual and reproductive health is critical to achieving broader development goals, including reducing poverty and improving educational attainment, and will therefore be central to any investment made towards harnessing the demographic dividend in the ESA region.

The ESA Commitment and targets therein foster an overall approach which facilitates access and equity and strengthens national responses to HIV and adolescent sexual and reproductive health and rights (ASRHR). A Regional Accountability Framework (RAF)3 developed by the Technical Coordinating Group (TCG) provides the basis for monitoring progress, as measured by 20 indicators, with specific year-end targets for 2015, 2017 and 2020. The TCG brings together key government officials from education and health, United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population fund (UNFPA) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) under the leadership of the Regional Economic Communities (RECs), namely the East African Community (EAC), Southern African Development Community (SADC), Common Market for Eastern and Southern Africa (COMESA).

1 Angola, Botswana, Burundi, Democratic Republic of Congo (DRC), Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe.
In addition to some notable milestones since the ESA Commitment came into being, three progress reports have been produced to date in 2013, 2015 and 2017 – the latter being led by civil society organizations (CSOs). This report is the latest effort to track the region’s progress in implementing the ESA Commitment and was co-authored by UNESCO, UNFPA, and UNAIDS on behalf of the TCG.

**Data collection and analysis**

The report used primary and secondary data collected between November 2018 and January 2019 for the period up to December 2018. The following sources were used:

- Data for the outcome and impact indicators are taken from robust population-based surveys which provided national estimates on population and health including Demographic and Health Surveys (DHS), the AIDS Indicator Survey (AIS), and the United Nations Children’s Fund (UNICEF)-supported Multiple Indicator Cluster Survey (MICS). Data collected between July and August 2018 as part of a baseline study commissioned by UNESCO for the Our Rights, Our Lives, Our Future (O3) Programme.
- A questionnaire administered to relevant government officials and other stakeholders soliciting quantitative and qualitative data for each of the ESA Commitment indicators as guided by the RAF.

**Findings**

Overall, the report found that member countries have made huge strides in institutionalizing the ESA Commitment since the last government-led report in 2015, with growing political leadership in many countries and increasing establishment of policies or strategies aimed at accomplishing the Commitment goals. However, many of these are not costed, making it difficult to allocate the necessary resources. In addition, weak and fragmented monitoring and evaluation (M&E) systems inhibit effective tracking of progress in some countries. Although all 21 countries have established coordination structures for implementation, only 10 countries have successfully mobilized resources to fast-track the implementation of the Commitment, and domestic financing remains low.

Findings in relation to individual targets are presented below:

**Target 1: A good quality CSE curriculum framework is in place and being implemented in each of the 21 countries**

At the end of 2018, a total of 14 of the 21 countries were offering CSE in schools and 17 had CSE strategies for out-of-school youth. National coverage ranged from 5% (Madagascar) to 100% in the nine countries that have successfully integrated CSE into the standard education curriculum; an approach which has been shown to yield broad and sustainable reach at low cost. Gaps still exist in quality monitoring, as well as in ensuring that CSE is examinable in all countries. Data quality was cited as a limitation, mainly due to poor record-keeping and orientation of data collectors to collect, analyse, and report sexuality and HIV indicators.

**Target 2: Pre- and in-service CSE and SRH training for teachers and health and social workers is established and being implemented in all 21 countries**

At the end of 2018, 20 of the 21 countries (95%) were implementing pre- and/or in-service CSE training for teachers, an upward trend from 11 (67%) in 2015. This shows that much progress has been made by countries in building the capacity of teachers in CSE, a factor that will go a long way in ensuring the delivery of quality CSE in the classroom.

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4 Data presented in the 2018 report relates to the period between 2016 and 2017, depending on when country surveys took place.

5 DHS programme and MICS data have the advantage that the core content of each round is standard across countries, thus maximizing the comparability of information, and the sampling design is guided by principles of probability sampling.

Notwithstanding this, more can still be done to increase greater coverage of pre-service training, which is important for institutionalization and sustainability. It must also be noted that tracking this indicator is often fraught with data quality challenges – training activities are not well coordinated, and the retraining of some personnel results in double counting. The quality of the training is equally important, but has not been evaluated in most countries to date.

**Target 3: Decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services, including HIV-related services that are equitable, accessible, acceptable, appropriate and effective**

In 2018, all 21 countries reported offering pre- and in-service SRH and CSE training for teachers and health and social workers through a combination of government ministries (mostly health) and CSOs. In addition, six countries reported data on the percentage of health service delivery points offering a standard minimum package of adolescent- and youth-friendly health services (AYFHS), with South Africa reporting 100% coverage. Although this is a national indicator, it unfortunately does not give any information on equitable reach and models for integration and delivery of AYFHS at government, private sector, and civil society levels. In most countries, training is phased in – and underserved areas tend to receive the training last. This may skew the numbers in favour of urban areas. As such, more still needs to be done to assess equitable reach of AYFHS as well as define the minimum package of services and align it to international standards.

**Target 4: Eliminate all new HIV infections among adolescents and young people aged 10-24**

Notably, the number of new infections among adolescents and young people aged 10-24 in the region declined from 366,900 in 2013 to 293,570 in 2017 (UNAIDS, 2018). This reduction could be as a result of increased knowledge about HIV, and consequent change in behaviour among AYP. In all the countries, with the exception of Madagascar, new infections are higher among young women than their male counterparts, with ratio of female-to-male infections ranging from 0.6 in Madagascar to 6.4 in Eswatini. This calls for more focussed programming to ensure that young women and girls are targeted with information, life skills, and services.

Condom use was also tracked to further understand risky behaviour. It ranged from 39% in Ethiopia to 73% in South Africa (UNAIDS, 2018), with all countries reporting an increase in condom use, except Ethiopia, which reported a decline. This upward trend can be attributed to several factors, such as greater availability of condoms coupled with increased social acceptability of using them, greater risk perception, and safer sexual behaviour among AYP. It is important to sustain these gains. Of note is that males were generally more likely to use condoms than females – a factor which can partly be attributed to greater availability of male condoms.

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

There was an overall increase of 4% in the number of AYP demonstrating comprehensive knowledge of HIV, from 36% in 2015 to 40% in 2017 (UNAIDS, 2018). Increased knowledge is an important step in changing practices, and it is hoped that the countries will convert these gains to greater self-efficacy and risk perception. However, the achieved result is still less than 50% of the target, underscoring the need for significant acceleration of progress if countries are to reach their 2020 targets.

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

The adolescent fertility rate ranges from 32 births per 1,000 women in Botswana to 194 births per 1,000 women in Mozambique. This is higher than the global average at 46 per 1,000. Most studies show that the majority of pregnancies among

7 Eswatini, Kenya, Afrique du Sud, Tanzanie, Ouganda et Zimbabwe.
8 [https://data.worldbank.org/indicator/sp.ado.tfrt](https://data.worldbank.org/indicator/sp.ado.tfrt)
adolescent girls are unintended and pose a threat to the health of the mother and infant. In addition, EUP has dire social and economic consequences for the mother.

EUPs were tracked through an indicator focussing on national policies on learner pregnancy and re-admission. By 2018, 16 of the 21 countries had a policy for learner pregnancy and re-admission, an upward trend from five countries in 2013 and nine in 2015. These policies are seen as the first step to ensuring that pregnant learners are not excluded from school and that their re-admission is facilitated. The policies are also important in destigmatizing learner pregnancy. However, more data is required to ascertain the quality of these policies and how human rights-centred they are to ensure that they adequately protect girls from discrimination, harassment, and drop-out. In addition, some implementation gaps remain, including social stigma, lack of awareness by learners and parents, and inconsistent interpretation in various schools.

**Target 7: Eliminate gender-based violence**

GBV, including school-related GBV (SRGBV), which takes place in the school precincts or on route to school, persists at alarming levels in the region and threatens the health, social, and emotional well-being of the victims. Of the 21 countries, 18 reported education sector policies that addressed SRGBV, an upward trend from only seven in 2013 and 12 in 2015. While this increase is indicative of how countries continue to create an enabling policy environment to promote behaviour change, challenges remain in shifting socio-cultural norms and attitudes. For instance, the percentage of women aged 15-24 who believe that wife-beating is justified ranged from 6% in South Africa to 60% in Ethiopia, presenting a mixed trend.

**Target 8: Eliminate child marriage**

Much progress had been achieved towards eliminating child marriages, with 16 countries reporting programmes and policies to mitigate child marriage. This was an upward trend from five and 12 in 2013 and 2015 respectively. Although child marriage refers to unions that involve children below 18 years (male or female), the indicator also tracked education sector policies below 15 years, providing an additional measure of the severity of the problem. The incidences of child marriages (before both 15 and 18 years) were highest in Ethiopia, Malawi and Mozambique. On the ground, the implementation of strategies to eradicate child marriage face several challenges. Despite the increase in the number of countries with laws and policies that prohibit it, legal loopholes that allow for child marriage with parental or judiciary consent exist. Furthermore, in many countries, the statutory laws are overruled by traditional and customary laws that promote the practice. It is also difficult to monitor the prevalence of child marriage because many adolescents are not registered by birth or time of marriage.

**Target 9: Increase the number of all schools and teacher training institutions that provide CSE to 75%**

Adolescents and young people in school are among the most common and theoretically easily reached targets for CSE programmes, given the school provides a direct entry point and CSE programmes can be included in the school curriculum with easy scalability. It is important that age-appropriate CSE is provided in both primary and secondary schools. By 2018, the percentage of schools that offered life skills-based HIV and sexuality education ranged from 5% to 100% across 15 countries.

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10. Aucune donnée n’a été rapportée pour l’Angola, le Botswana et Madagascar.
Lessons learned

The ESA Commitment has been guiding policy, programming, and coordination around ASRHR for five years, and much progress has been made towards reaching the ambitious targets agreed to in 2013. Over this period, there have been critical lessons learned, which need to be taken into account to ensure all targets are met by 2020.

Scale-up of CSE

- Some countries, such as Botswana, Eswatini, Kenya, Lesotho, Mauritius, Mozambique, South Africa, Seychelles, and Zambia, have achieved 100% CSE coverage in schools. However, more still needs to be done to strengthen the curriculum, standardize its delivery, and ensure the reach of out-of-school youth and inclusion of other marginalized AYP, such as the disabled, young mothers, and young key populations.

- The number of teachers trained in the provision of CSE has increased. It is important to track pre- and in-service training separately and to evaluate the effectiveness of the training as well as monitor teacher preparedness.

Improved access to adolescent and youth-friendly SRH services

- The scale-up and successful provision of quality sexual and reproductive health and rights (SRHR) services requires competent and skilled personnel. The training of teachers and health workers in SRHR has the potential to promote positive attitudes among the providers. Pre-service training continues to bear great importance, as the resultant institutionalization ensures efficiency and sustainability.

- Community outreach, school health programmes, and peer-led service provision has been seen to attract more youth, with promising outcomes.

Reduction in EUPs

- EUP is driven by poverty, social norms, gender inequality, sexual coercion, poor access to SRH services, a lack of information, low self-efficacy, and peer pressure. Addressing these factors goes a long way in preventing EUP among adolescent girls and young women (AGYW).

- Much has been achieved by countries by way of enabling policies for managing learner pregnancies. These can be augmented through greater investment in awareness programmes for learners, parents, and school governing authorities, as well as through strong referral systems between schools, parents, and health care workers.

Prevention and mitigation of GBV

- The early detection of abused children, and provision of comprehensive services such as psychosocial support, should be at the heart of GBV policies. To this end, referral systems between schools, community health services, and law enforcement agencies as well as access to justice services need to be strengthened.

Elimination of child marriage

- Review, enactment, and implementation of laws should be improved to ensure the eradication of child marriages. Key custodians of customary laws should also be sensitized on the laws against child marriages, accompanied by increased rights awareness among AGYW, parents, community leaders, service providers, and governing authorities, including those responsible for birth and marriage registration.
Child marriages continue to be driven by religious and cultural norms. This calls for greater investment in social and behaviour change communication (SBCC) programmes and collaboration with traditional and religious leaders in efforts to eliminate the practice.

Creation of an enabling environment

- Leadership and ownership of the ESA Commitment by RECs and governments, including the establishment of national working groups, has been critical to its success. Political leadership is crucial in fostering accountability for the ESA Commitment and mobilizing resources for the realization of its targets.
- Efficient and robust coordination are also critical for ensuring the realization of the Commitment targets. Coordination structures therefore need to be strengthened, with sufficient resource allocation and appropriate decision-making authority.

Cross-cutting

- The passing of enabling laws and policies is inadequate on its own, and more needs to be done to ensure that they are gender-sensitive, based on sound human rights principles, and promote the right of girls to equality.
- In many countries, creative and innovative approaches to CSE were reported. However, these pockets of innovation are rarely documented in any systematic manner, and therefore cannot be meaningfully replicated in other settings. Evidence suggests that programmes that invest in knowledge management are more successful in peer learning, sharing best practices, and replicating them in other areas and settings.
- Youth involvement in the ESA Commitment is essential. More investment needs to be made in coordinating and capacitating youth structures and movements.

Recommendations

The report concludes by making the following key recommendations:

- Strengthen country-level accountability, coordination, and financing for greater impact.
- Improve the review, enactment, and implementation of laws in order to accelerate progress towards eliminating GBV and child marriages, as well as to improve access to SRHR information and services, including contraception.
- Scale up knowledge management to enable learning, sharing of lessons and best practices, and institutionalization within government structures at all levels and across countries.
- Ensure that all strategies and policies aimed at promoting CSE and AYFHS are inclusive in order to foster ownership and be costed and accompanied by robust and detailed operational plans and appropriate budgetary allocations. In addition, M&E systems should be harmonized and reporting centralized.
- Integrate CSE in the mainstream school curriculum and pre-service teacher training for maximum coverage. It should be made mandatory and examinable in all countries.
- Develop robust quality assurance and M&E mechanisms to assess quality of training provided to teachers, social workers, and health care providers, as well as the quality of programmes delivered to AYP.
- Strengthen youth participation and ensure that young people are included in the advocacy for the realization of the ESA Commitment targets and mainstreaming of CSE and AYFHS into governments plans.
- Galvanize information and communications technology (ICT) and social media around sexuality education advocacy.
- Ensure RECs provide regular and structured reporting on the ESA Commitment.
2. Introduction & Background

2.1. The ESA Commitment

In December 2013, ministers of education and health from 21 Eastern and Southern African (ESA) countries endorsed and affirmed their commitment to better health outcomes for adolescents and young people (AYP) in the region in a declaration now known as the ESA Commitment. This was a culmination of efforts led by the United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV and AIDS (UNAIDS), and Regional Economic Communities (RECs) towards charting the path to economic and social well-being for young people through securing their sexual and reproductive health and rights (SRHR).

**BOX 1: ESA Commitment TARGETS**

**By the end of 2015:**
- A good quality CSE curriculum framework is established and being implemented in each of the 21 countries.
- Pre- and in-service CSE and SRH training for teachers and health and social workers is established and being implemented in all 21 countries.
- The number of adolescents and young people who do not have access to youth-friendly SRH services, including for HIV, that are equitable, accessible, acceptable, appropriate and effective has decreased by 50%.
- Eliminate gender-based violence.

**By the end of 2020:**
- 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 child marriage.
- Increase the number of all school and teacher training institutions that provide CSE to 75%.

11 Angola, Botswana, Burundi, Democratic Republic of Congo (DRC), Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe.
Central to the Commitment are time-bound targets which guide national efforts and are aimed at increasing coverage of comprehensive sexuality education (CSE) for both in- and out-of-school youth, increasing access to sexual and reproductive health (SRH) services, reducing early and unintended pregnancies (EUPs), and eliminating child marriages and gender-based violence (GBV) among young people in the region by 2020.

Although the ESA Commitment is not legally binding, it represents a political commitment to advancing the health of young people in the region. Through it, ministers affirmed a commitment to the right to the highest possible level of health, education, non-discrimination, and well-being of current and future generations, and agreed to work collaboratively towards a vision of young Africans, 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.

To date, the ESA Commitment has contributed towards many of the gains made on adolescent sexual and reproductive health and rights (ASRHR) in the region, evidenced by intensified efforts and improved coordination and resourcing, which has seen an acceleration towards attaining the Commitment targets.

This report outlines progress made in achieving these targets, assesses gaps in implementation thus far, and makes recommendations towards fulfilment of the pledges made in the Commitment by the 21 ESA countries.

2.2. Background

The world has a large and growing population of adolescents. In recent years, much attention has been paid to efforts to harness a demographic dividend from this population. In the ESA region alone there are currently 113.2 million AYP aged 15-24 years, representing 23% of the population. It is estimated that Africa's population will more than double between 2016 and 2050, and some studies calculate that sub-Saharan Africa's income per capita could be an additional 25% higher in 2050, solely as a result of the demographic transition. For many countries, this represents the potential to graduate from low- to middle-income status. However, capitalizing on the demographic transition to realize a dividend requires investment in education, health, employment, and promoting participation and inclusion. Supporting adolescents to protect their sexual and reproductive health is critical to achieving broader development goals, including reducing poverty and improving educational attainment, as well as ensuring overall better health and well-being for all people in the region.

Adolescence is a period marked with changes in the body and relationships. It is important that these relationships are supported by access to health information and services in order to empower adolescents to make good decision-making on health matters which form the basis of lifelong sexual health and overall well-being.

Globally, there has been an increased focus on the institutionalization of SRHR within the context of universal health coverage (UHC). In the Sustainable Development Goals (SDGs), SDGs 3 and 5 recognize SRHR as a key strategy to promoting health, well-being, and gender equality. In particular, SDG 3 sets out to reduce global maternal mortality (SDG 3.1) and ensure universal access to SRH services (SDG 3.7); while SDG 5 promotes universal access to SRH (SDG 5.6), the elimination of harmful practices, such as child, early and forced marriage and female genital mutilation (SDG 5.3) and advocates for policies and enforceable legislation that promote gender equality (SDG 5.5). Within the ESA region, these rights are contained in several regional agreements, including the Maputo Protocol, International Conference on Population and Development (ICPD) 2014, African Union (AU) Strategy on Youth Dividends and Agenda 2063, Southern African Development Community (SADC) SRHR Strategy, East African Community (EAC) Health Strategy, and the ESA Commitment.
Despite the growing recognition of the benefits of investing in the SRH of adolescents, and of the costs of failing to do so, adolescents continue to face challenges that undermine their SRH. This is particularly true in developing countries, where adolescents face biological, social, cultural, structural, and legal barriers to obtaining SRH information and services. This has significantly increased their risk to adverse SRH outcomes, including EUP, HIV and other sexually transmitted infections (STIs), GBV, and child marriage.

2.3. Comprehensive sexuality education

Taken together, the factors outlined above underscore the need to invest in relevant, age-appropriate CSE and quality SRHR and HIV services, without which AYP will continue to be disenfranchised.

CSE is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.

**BOX 2: International and regional commitments and agreements in place to promote the roll-out of CSE and promote access to comprehensive SRH services**

- **Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), 1979**: Provides the basis for realizing equality between women and men through ensuring women’s equal access to, and equal opportunities in, political and public life – including the right to vote and to stand for election – as well as education, health and employment.

- **The International Conference on Population and Development (ICPD), 1994**: Developed a set of goals and targets, among them, for SRH services, including family planning.

- **UN Political Declaration on HIV, 2001, 2006**: Challenged the global health community to forge closer linkages between SRH and HIV.

- **AU Continental Policy Framework on Sexual and Reproductive Health and Rights, 2005, and the corresponding Maputo Plan of Action, 2006**: Commitment to ensure universal access to comprehensive SRH services in Africa. All countries in the ESA region have adopted the plan.


- **ICPD Beyond 2014**: Global consensus that investing in individual human rights, capabilities, and dignity across multiple sectors, and through the life course, is the foundation of sustainable development.

- **The Sustainable Development Goals, 2015**: Reaffirmed the global community’s commitments to ending poverty and hunger and promoting health, education, gender equality, and environmental and social justice.

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18 The Global Strategy for Women’s, Adolescents’ and Children’s Health, World Health Organization.


Effective CSE programmes are based on human rights principles and help advance gender equality and the empowerment of young people\(^{21}\). CSE is strategically placed to equip AYP with knowledge and skills that help them to make informed decisions about their sexuality and health. Evidence shows that CSE has a positive impact on safer sexual behaviour and has great potential to change risky behaviours and enable young people to develop adequate capacity to manage their well-being\(^{22}\). Furthermore, CSE with links to SRH services has been identified as best practice for the prevention of EUP\(^{23}\).

The last few years have seen an increase in the delivery of CSE in the ESA region, with most countries developing varied terminologies, strategies, and frameworks to make it a reality. However, many of these strategies are inadequate and ineffective as they either cater mostly to in-school youth, to the exclusion of out-of-school youth, lack operationalization plans, are poorly resourced, lack credible and harmonized monitoring and evaluation (M&E) systems, or adopt ‘selective teaching’ in their curricula\(^{24}\). This means that much still needs to be done to ensure that AYP have access to critical information and services that enable them to live healthy and productive lives.

### 2.4. ESA Commitment targets

The ESA Commitment has time-bound targets agreed to by member states that pave 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 ASRHR.

To track progress on the ESA Commitment, a Technical Coordinating Group (TCG) was established under the leadership of UNAIDS, with support from UNESCO, SADC, EAC, and, later, the Common Market for Eastern and Southern Africa (COMESA) and SADC Parliamentary Forum (SADC-PF). A Regional Accountability Framework (RAF) for monitoring country and regional progress towards the Commitment targets was then collectively developed. The RAF monitors 20 indicators with specific year-end targets for 2015, 2017, and 2020 under the following key areas:

- Scale-up of CSE;
- Improved access to adolescent and youth-friendly SRH services;
- Increase in comprehensive HIV knowledge levels;
- Reduction in new HIV infections;
- Reduction in EUPs;
- Prevention and mitigation of GBV;
- Elimination of child marriage; and
- Development of an enabling environment.

In 2017, civil society also developed a civil society organization (CSO) strategy for the implementation of the ESA Commitment. This was in recognition of the critical role played by civil society in realizing the targets, both through providing complimentary services to government and in advocating for greater commitment and accountability from governments. The CSO strategy was focused on five main objectives linked to accountability, resourcing, partnerships and youth engagement, coordination, and policy and legislation.

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\(^{21}\) UNFPA Operational Guidance for Comprehensive Sexuality Education. A focus on Human Rights and Gender, 2014.


\(^{23}\) World Health Organization, 2011.

\(^{24}\) Some of the curricula remain conservative, with limited reference to sex and sexuality.
2.5. Tracking progress on the ESA Commitment

Since the agreement of the ESA Commitment, several initiatives have taken place, with notable milestones. These include:

- A Regional Symposium on Adolescent SRHR and HIV in Africa held in Lusaka, Zambia, in December 2014 had a youth pre-symposium session which engaged young people specifically on barriers to ASRHR information and services. The symposium also brought issues of child marriage and harmful practices to the fore of the agenda.

- At a convening in Johannesburg, South Africa, in September 2015 of 14 select regional and country level organizations working on ASRHR, CSE and HIV, priority actions, partners, and timeframes were identified. It was further agreed that a regional coordination mechanism be put in place, responsible for implementing the regional level strategy.

- Annual Regional Technical Coordinating Group meetings continue to bring together ESA Focal Points from ministries of education and health, CSOs, UNESCO and other UN agencies. The TCG plays a key role in the management of the ESA Commitment process and the implementation of the accountability mechanism.

- The SADC Commission on the Status of Women (CSW) 60/2 Programme of Action on HIV prevention for women and girls has a strong component on CSE and youth-friendly services.

- In 2017, an EUP campaign was commissioned by the TCG aimed at advocating for the prevention of and response to EUP. The EUP campaign is a flagship campaign of the ESA Commitment and represents a joint priority based on data and evidence from the ESA Commitment countries.

- The development of a SADC SRHR Strategy (2018-2030) and Scorecard, with indicators aligned to the RAF, continue to be used to collect data up to 2030, building on the RAF.

- In 2018, CSOs from 12 countries led the development of a report on progress in the implementation of the ESA Commitment. The process sought to provide a civil society perspective and showcase the work done by civil society in support of the objectives of the ESA Commitment. Consolidated data from the RAF and the country consultations was used in the analysis and report writing.

- In 2018, UNESCO, in conjunction with the South Africa Department of Basic Education, hosted a High-Level Policy Dialogue on CSE in Pretoria aimed at bringing together key policy-makers in the region to reflect on progress, challenges, and opportunities for scaling up CSE. The dialogue offered participants an opportunity to renew understanding and engagement on CSE implementation across sub-Saharan Africa. Ministerial collaboration to promote school and health facility linkages were also discussed.

To date, three reports tracking progress on the ESA Commitment have been produced. The 2013 report provided a baseline for many of the outcome and output indicators in the RAF, while the 2015 and 2017 reports showed how the Commitment had been hugely successful in garnering political support for and increasing inter-sectoral collaboration around CSE and ASRHR. During this period, many governments scaled up the provision of CSE, providing critical training to teachers, as well as ensuring its integration into mainstream curricula and improving its quality and delivery. Despite this progress, only marginal gains were made in HIV knowledge among youth. The majority of HIV infections remained in the 15-24 year age group, with a disproportionate impact on adolescent girls and young women (AGYW). In addition, the levels of EUP remained high, as did child marriages. GBV also remained alarmingly high, with over 60% of school-related GBV (SRGBV) incidences occurring in classrooms.

2.6. Purpose of this report

This report outlines progress made in achieving the ESA Commitment targets in the period since their inception in December 2013 to December 2018. It also assesses current gaps and makes recommendations on how the region can scale up the delivery of CSE for in- and out-of-school AYP as well as integrated adolescent- and youth-friendly health services (AYFHS) in order to achieve the 2020 targets.

Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, South Sudan, Tanzania, Zambia, and Zimbabwe.
3. Methodology

3.1. Data collection

All primary data was collected from countries between November 2018 and January 2019 for the period up to December 2018\textsuperscript{26}. Data for the outcome and impact indicators were derived from robust population-based surveys which provided national estimates on population and health. Most of the data for these indicators came from UNAIDS and is obtained through modelling. These surveys included the Demographic and Health Surveys (DHS), the AIDS Indicator Survey (AIS), and the United Nations Children’s Fund (UNICEF)-supported Multiple Indicator Cluster Survey (MICS)\textsuperscript{27}. The data was supplemented with data collected between July and August 2018 as part of a baseline study commissioned by UNESCO for the Our Rights, Our Lives, Our Future (O\textsuperscript{3}) Programme.

In addition, a questionnaire was administered soliciting quantitative and qualitative data for each of the ESA Commitment indicators as guided by the Regional Accountability Framework. Respondents included UNESCO country offices who consulted with government officials and other stakeholders.

A draft report was then synthesized and countries given an opportunity to validate the data and report through one-day multi-stakeholder validation meetings held in 12 countries\textsuperscript{28} (Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Mozambique, Namibia, South Africa, South Sudan, Tanzania, Uganda, and Zambia).

3.2. Data analysis

3.2.a. Quantitative data analysis

The quantitative data was analysed using Microsoft Excel and compared to that from previous ESA Commitment reports produced in 2013, 2015, and 2017. Trend analyses were done where there were sufficient data points. This allowed for richer understanding of both regional and country-level progress.

3.2.b. Qualitative data analysis

Qualitative data obtained through the questionnaire was thematically analysed and complemented with previous findings on challenges and enabling factors in realizing the ESA Commitment targets. The synthesis of this data is presented as part of the findings.

\textsuperscript{26} Data presented in the 2018 report relates to the period between 2016 and 2017, depending on when country surveys took place.

\textsuperscript{27} DHS Programme and MICS data have the advantage that the core content of each round is standard across countries, thus maximizing the comparability of information, and the sampling design is guided by principles of probability sampling.

\textsuperscript{28} ESA countries with UNESCO national programme officers (NPOs) were able to hold validation meetings.
3.3. Limitations

The data collected from countries was self-reported and its robustness was not tested beyond validation by governments and other partners in 12 countries in which there are UNESCO implementing partners. While this report includes impact indicators (such as reducing HIV infection, increasing knowledge, and eliminating child marriage), it must be noted that achieving these targets requires broader efforts, and thus the progress cannot be attributed to the ESA Commitment alone. In addition, the periodicity of the population-based surveys varied by country, and, in most instances, 2018 data was not available. As a result, some of the data points included in this report date before 2018. In order to mitigate this, survey dates have been carefully noted and, in such instances, no trend analysis has been done. In cases where countries did not provide all the data through the questionnaire, the O3 baseline report data was used. However, some of the indicators are worded differently in the two reports. In spite of these differences, care is taken to ensure that the interpretation remains the same.

29 Baseline study – Our Rights, Our lives, Our future: Making positive sexual and reproductive health and education outcomes a reality for adolescents and young people in sub-Saharan Africa, 13 August 2018.
4. Progress, Achievements & Challenges

The progress is reported based on the ESA Commitment targets. Although the targets relate to the 20 signatory countries, Rwanda has been included in the analysis and reporting, and constitutes an important partner in achieving better SRH outcomes for adolescents and young people in the region.

Target 1

A good quality CSE curriculum framework is in place and being implemented in each of the 21 countries

This target was tracked using two indicators:

1. **Percentage of schools that provided life skills-based HIV and sexuality education in the previous academic year**

Life skills-based education, referred to in this document as CSE, equips children and young people “with knowledge, skills, attitudes, and values that will empower them to: Realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.” In-school youth are among the most common and theoretically easily reached targets for CSE programmes, given the school provides a direct entry point and CSE programmes can be included in the school curriculum with easy scalability. It is important that age-appropriate CSE is provided in both primary and secondary school.

Of the 15 countries\(^3\) that reported data on this indicator, 14 were offering some form of life skills-based HIV and sexuality education in their schools. Ethiopia and Uganda indicated that their current data collection systems did not enable them to track this indicator, and as such had no data to report.

The proportion of schools that offered life skills-based HIV and sexuality education ranged from 5% for Madagascar\(^3\) to 100% for Eswatini, Botswana, Kenya, Mauritius, Mozambique, Seychelles, South Africa, and Zambia. The reason for total coverage in the latter group of countries is that life skills-based HIV and sexuality education is fully integrated in their school curricula.

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30 No data was available for Angola, Burundi, South Sudan, or the DRC.

31 Madagascar is set to integrate CSE into the school curricula in September 2019, and in teacher training thereafter.
High coverage does not guarantee a good quality curriculum, however, as exemplified by countries like Kenya and South Africa, which, in spite of 100% coverage, were reported to have major gaps in their curricula. Similarly, Eswatini, which has a more comprehensive curriculum, reports only 30% CSE coverage in school.

As was explained in the 2015 report, integrating CSE into school curricula ensures broad and sustainable reach at low cost, while the school environment allows for better monitoring and resource allocation. It must be noted, however, that this indicator is often affected by poor record-keeping in schools, which impacts data integrity. Cases of over/under reporting can potentially also occur in part because data collectors, such as school heads, are not always oriented on how to collect, report, and analyse sexuality and HIV-related indicators.

2. **Number of countries that have a costed national CSE strategy or framework for out-of-school youth**

The schooling system provides an opportunity to reach AYP at scale, and evidence shows that the vulnerability of youth to risky sexual behaviour, EUP, HIV, misinformation, coercion, and exploitation increases when they are not enrolled in schools and after they exit school upon completion or due to dropout. Because out-of-school AYP are comparatively more difficult to reach than those in school, there is therefore a need for countries to have a targeted strategy that can be implemented and monitored in order to reach them effectively and ensure that they are not excluded.

### INDICATOR REGIONAL TARGET 2015 REGIONAL TARGET 2017 REGIONAL TARGET 2020 REGIONAL PROGRESS 2018

<table>
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<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
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<td>Number of countries that have a costed national CSE strategy or framework for out-of-school youth</td>
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</tbody>
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32 Baseline study – Our Rights, Our lives, Our future: Making positive sexual and reproductive health and education outcomes a reality for adolescents and young people in sub-Saharan Africa, 13 August 2018; Draft report prepared for UNESCO; Accessed 15/05/2019.
A total of 17 of the 21 countries reported having a strategy to reach out-of-school youth with CSE. This represented an upward trend from only two countries in 2013, and 15 in 2015 (Figure 2). However, most of the national CSE strategies were not costed and took various forms. For instance, CSE provision for out-of-school youth in Eswatini adopted an integrated approach through the national youth menu, guided by the National HIV Strategic Framework of 2018, SRH Policy and Strategy of 2013, Education Sector Policy of 2018, and the yet to be validated draft National Life Skills Framework. Mozambique, on the other hand, has since 1999 incorporated CSE into the Sexual and Reproductive Health Programme for Adolescents and Young People, called “Geracao Biz Programme”, and includes the community component (out of school). In some countries, there is no standalone strategy for out-of-school youth and provision for them is instead made in an integrated CSE strategy. Notably, Lesotho, Malawi, Zambia, and Namibia do have standalone strategies for out-of-school youth.

![Figure 2: Countries that have a national CSE strategy or framework for out-of-school youth]

In most of the countries, the Ministry of Education was the lead ministry in the provision of CSE, but several other ministries were also included, such as Ministries of Health, Youth, and Gender. In Madagascar, for instance, CSE is the responsibility of the Ministries of National Education, Health, and Youth and Sports, with support from UNFPA and UNICEF. In Mozambique, CSE is led by the Ministry of Youth and Sports, while the Ministry of Health is responsible for the provision of SRH services.

Although the data made no specific reference to the dissemination of the strategy, it is important to note that successful implementation depends on wide dissemination. Because civil society is involved in reaching out-of-school youth, it is equally important that the development of the strategy is inclusive of them to foster sector-wide ownership. Zambia has been hugely successful in reaching out-of-school youth through joint efforts from government, civil society, and other players, for example (Box 3).

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33 South Sudan developed a curriculum for out-of-school learners in 2015, but this is not a strategy, per se.

34 No data reported for Seychelles.
In Zambia, there are many AYP currently not in school. Consequently, they are excluded from social and health interventions that are delivered through the formal education system and do not have access to accurate information about SRH. This lack of information may lead to risky sexual behaviour, which in turn puts them at risk of STIs (including HIV), EUPs, and GBV.

Over the last five years, Zambia has seen a growth in its ASRHR programme, with an increased focus on reaching out-of-school youth. While the responsibility of CSE in school lies mostly with the Ministry of Education, reaching out-of-school youth requires more innovative approaches and a multi-stakeholder initiative. To this end, the Ministry of Youth, Sport and Child Development, with support from UNFPA, are jointly implementing activities aimed at strengthening the delivery of CSE to this cohort. This initiative continues to build on AYP’s resilience – a core tenet of the ESA Commitment. Significant strides have been made in advocacy, capacity-building, community outreach, and strengthening referrals and linkages.

National policy advocacy: The programme is anchored on a strong advocacy agenda aimed at creating a more enabling environment for AYP to access CSE and SRH services. In particular, efforts were made to revise the minimum age of consent for SRH services, which continues to impede AYP from accessing services. In addition, focus was put on revising the Reproductive Health Policy to ensure that it addresses the bottlenecks in SRH service provision for adolescents.

Youth-led advocacy: There was also extensive engagement with youth networks to promote and facilitate agency in adopting the advocacy agenda. This was achieved through engagement of young people from selected youth networks with parliamentary committees responsible for the welfare of AYP in order to advocate for improved access to ASRHR. In addition, Members of Parliament committed to advocate for increased resource allocation towards adolescent health programmes, revision of the age of consent to access SRH services, and establishing a routine mechanism for youth networks to make formal submissions on improving service delivery to parliamentary committees.

Capacity-building of teachers and health personnel: Through the development of appropriate content and increasing the capacity of trainers, the programme has successfully trained master trainers who will see to the cascading of the training to more community-based educators. The curriculum has been adapted to the country context to ensure comprehensive, accurate, and quality CSE is provided to young people who are not in school. In 2018, a total of 202 health care providers received training in the provision of adolescent-friendly integrated SRH/HIV/GBV services. The UNESCO country office also supported the Ministries of General Education and Health to build the capacity of 273 teachers and health providers in CSE and ADSRHR service provision in supported provinces.

Peer support: The country office continued to support ASRHR outreach activities using the peer-to-peer methodology in UNFPA-supported provinces. A total of 171 peer educators were trained in CSE for out-of-school youth and went on to form safe spaces to engage young people in their communities. In addition, at health facility level, the trained peer educators provided ASRHR information to young people through youth-friendly spaces, where they incorporated the out-of-school comprehensive curriculum within the health facility static and outreach activities.

Strengthening referrals and linkages: In 2018, UNFPA, in partnership with UNESCO and the Population Council, commissioned an operational study aimed at developing functional linkages between schools and health facilities to improve the referral system for AYPs in two priority districts (Mufumbwe and Solwezi). Although the implementation of the CSE-ASRHR linkages study is still in its early stages, there is emerging evidence of reduced EUP within the participating schools. The study will be implemented over a two-year period and will provide evidence to advance programme and policy actions to improve adolescent health outcomes.
This target was tracked using one indicator:

1. **Number of countries that provide pre-service and/or in-service training programmes on the delivery of CSE**

Building technical capacity of teachers contributes to the successful implementation of quality CSE programmes in schools. Well-trained teachers can engage and facilitate the delivery of CSE in styles and approaches that are effective and comfortable to the AYP.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that provide pre- and/or in-service training programmes on the delivery of CSE</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

In 2018, 20 of the 21 countries[^35], constituting 95% of the ESA Commitment countries, provided pre-service and/or in-service training programmes on the delivery of CSE. This represented a sustained increase from 2013, when 10% (Botswana and Namibia) and 2015 when 67% (Botswana, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe) reported offering the training.

[^35]: Burundi did not report any data.
These great achievements need to be further strengthened by assessing the quality of the training and disaggregating between pre- and in-service. More also needs to be done to improve data quality when tracking the indicator to eliminate double counting, which results from the lack of a well-coordinated system for collecting the data.

**Figure 3: Number of countries that provide pre- and/or in-service training programmes on the delivery of CSE**

<table>
<thead>
<tr>
<th>2013</th>
<th>2015</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>Botswana</td>
<td>Angola</td>
</tr>
<tr>
<td>Namibia</td>
<td>Eswatini</td>
<td>Botswana</td>
</tr>
<tr>
<td>Lesotho</td>
<td>DRC</td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>Eswatini</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>Ethiopia</td>
<td></td>
</tr>
<tr>
<td>Namibia</td>
<td>Kenya</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Lesotho</td>
<td></td>
</tr>
<tr>
<td>South Sudan</td>
<td>Madagascar</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>Malawi</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>Mauritius</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>Mozambique</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Namibia</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Seychelles</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Sudan</td>
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<tr>
<td>Tanzania</td>
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<tr>
<td>Uganda</td>
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<tr>
<td>Zambia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This target was tracked using two indicators:

1. **Number of countries that provided pre- and in-service training programmes on the delivery of AYFHS**

Research shows that one of the critical barriers to adolescents accessing SRH services is the poor orientation to their needs. Adolescent/youth-friendly health services therefore describe those service delivery points that have been purposefully oriented to the needs of adolescents. One of the most important components of AYFHS provision is the capacity and attitudes of health care workers, and it is thus important for health care workers to be adequately trained in the provision of AYFHS.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that provided pre- and in-service training programmes on the delivery of AYFHS</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>

All 21 countries were implementing pre- and/or in-service training programmes on the delivery of AYFHS by 2018, marking an increase from 19 countries in 2015. Most countries were providing in-service training, but fewer had integrated it into their in-service training. Most training was the responsibility of health ministries and was aimed at nurses and doctors, with a few countries training para-health workers, such as community health workers, health promoters, and quality assurance officers. Training of health personnel is structured differently in the various countries. For instance, in Lesotho, the training is conducted by the Ministry of Health with support from UN agencies, such as UNFPA and UNICEF, and the World Health Organization (WHO), and all health service providers in the health facilities are targeted, especially nurses. Currently, 100% of health facilities have trained health care workers. Mozambique, through the Ministry of Health, with support from WHO, UNFPA, and Fundação para o Desenvolvimento da Comunidade (FDC), has also trained practicing health workers in adolescent and youth care as a way to improve SRH service delivery. In Namibia, the Ministry of Health developed the Adolescents Job Aid, which serves as a guide document for health workers in the provision of health services to adolescents. In South Africa, AYFHS training is conducted in all provinces by the Department of Health and targets professional nurses, health promoters, and quality assurance managers, and a few non-governmental organizations (NGOs) are providing mentorship on AYFHS implementation as well. Although most of the training offered was for in-service staff, Lilitha College of Nursing in the Eastern Cape is piloting pre-service training for student nurses on AYFHS. In South Sudan, other cadres included in the training are clinical officers and midwives, while orientation on AYFHS is provided to support staff, such as facility guards and cleaners. The training is facilitated by the Ministry of Health and NGOs, with support from UNFPA. There is also a mentorship programme for trained personnel. In addition, a midwifery and nursing curriculum, which reflects ASRHR content, will be rolled out in 2019.
Although this is a national indicator, it unfortunately does not give any information on equitable reach and models for integration and delivery of AYFHS at government, private sector, and civil society levels. In most countries, training is phased in – and underserved areas tend to receive the training last. This may skew the numbers in favour of urban areas.

Figure 4: Number of countries that provided pre- and in-service training programmes on the delivery of adolescent youth friendly services

<table>
<thead>
<tr>
<th>Country</th>
<th>2015</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>DRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eswatini</td>
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<tr>
<td>Ethiopia</td>
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<tr>
<td>Kenya</td>
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<td>Lesotho</td>
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<td>Madagascar</td>
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<td>Malawi</td>
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<td>Mauritius</td>
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<td>Mozambique</td>
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<td>Namibia</td>
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<tr>
<td>Rwanda</td>
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<tr>
<td>Seychelles</td>
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<td>South Africa</td>
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<td>South Sudan</td>
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<td>Tanzania</td>
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<td>Uganda</td>
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<td>Zambia</td>
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<td></td>
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<tr>
<td>Zimbabwe</td>
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<td></td>
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</tbody>
</table>

2. Percentage of health service delivery points that offer a standard/ minimum package of adolescent/ youth-friendly/sensitive health services

AYFHS are those services that are oriented to the rights and needs of AYP. By providing a comfortable and confidential space and mix of methodologies for outreach to communities, many countries have successfully increased reach and utilization of health services – which AYP tend to shy away from. When compliant with the standards and minimum package of AYFHS, health facilities create an opportunity for AYP to engage with well-trained staff, who can then provide information and counselling on SRH and offer commodities, such as condoms and other types of contraception. It also provides a critical entry point for HIV, tuberculosis (TB), and STI testing, screening, and treatment.
The response rate for this indicator was lower than the others, and many countries reported that the data was not readily available. The six countries that self-reported the percentages of health service delivery points that offer a standard/minimum package of AYFHS are Eswatini (74%), Kenya (23%), South Africa (100%), Tanzania (30%), Uganda (17%), and Zimbabwe (20%). In South Sudan, the Ministry of Health, with support from UNFPA, adapted the WHO Minimum Package and Standards for AYFHS. However, the document has not been disseminated widely to the service delivery points.

It is notable that the defined minimum package differs in each country, with some of them falling short of the WHO recommended standards. Many of the countries have focused on availability of information without ensuring commodities (condoms and contraception) were available, while others have limited individualized care, with no audio or visual privacy when young people accessed services. Continuity of care was often weak, with very few referrals being followed up. Mozambique has defined two packages, one meant for AYFHS specific sites and another for other sites, totalling about 60% of the health units offering standardized services. It is important for countries to align their packages with the international standard for quality assurance and comparability. Data from the countries point to a phased approach to reaching full coverage, with some facilities not fully certified as yet.

Most countries reported that this data is not readily available.
This target was tracked using two indicators:

1. **Number of new HIV infections among adolescents and young people (15-24 years)**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>2013</th>
<th>2015</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new HIV infections among adolescents and young people (15-24 years)</td>
<td>366,900</td>
<td>331,210</td>
<td>293,570</td>
</tr>
<tr>
<td>Number of new infections among adolescent girls (15-24 years)</td>
<td>251,634</td>
<td>228,914</td>
<td>204,013</td>
</tr>
<tr>
<td>Number of new infections among adolescent boys (15-24 years)</td>
<td>115,266</td>
<td>102,296</td>
<td>89,557</td>
</tr>
</tbody>
</table>

There was an overall 20% decline in the number of new infections among AYP in the ESA Commitment countries between 2013 and 2017 from 366,900 to 293,570 (Figure 5). This great progress could be attributed to a number of factors, including the intensified efforts to promote a change in risky sexual behaviour and an increase in large-scale prevention programmes in the region, such as the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) Initiative, supported by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and other partners, the UNAIDS All In campaign, and various other initiatives supported by the Global Fund to Fight AIDS, TB and Malaria.

![Figure 5: Total number of new HIV infections among AYP in selected countries in the ESA region. Source: UNAIDS Estimates 2018.](image)

37 It should be noted that the first three Commitment targets are directly dependent on the actions of the partners delivering on the Commitment, but Target 4 to 6, are a function of the action and investments of many actors, to which the ESA Commitment makes a contribution.

Trends in new infections between 2013 and 2017 for male and female AYP are reported in Figures 6 and 7 respectively, which reveal a general downward trajectory, except for Burundi and South Sudan, where rates of new infections remained more or less static, Ethiopia, where rates increased for both males and females, and Madagascar, where the increase was evident for males only.

A detailed analysis (Figure 8) shows that in all the countries, with the exception of Madagascar, young women reported a higher number of new infections than their male counterparts, with ratios ranging from 0.6 in Madagascar to 6.4 in Eswatini. This is consistent with other data sets that point to disproportionate rates of HIV incidence among AGYW. This can be attributed in part to age disparate sexual relationships with older men, whose chances of being HIV-positive are much higher than boys in their own age group. This calls for more focussed programming, ensuring that young women and girls are targeted with information, life skills, and services.

**Figure 6: Number of new infections among male AYP in 2013, 2015, and 2017 by country**

**Figure 7: Number of new infections among female AYP in 2013, 2015, and 2017 by country**
As depicted in Figure 9, there has been a decline in the number of new infections between 2013 and 2017 in all the countries with data, except for Madagascar and Ethiopia. The average decline for the ESA Commitment countries (with data) is 20%. Notably, the largest declines in HIV incidence were reported in Eswatini, Uganda and Zimbabwe. The regression in Ethiopia and Madagascar is concerning, and it is important that HIV prevention efforts are intensified in these countries.
2. Percentage of never married women and men aged 15-24 years who had sexual intercourse in the past 12 months and used a condom at the last sexual encounter

Condoms are one of the most commonly used and effective methods of HIV prevention, also offering protection against other STIs and pregnancy. Over the years, the campaign to increase condom use in sub-Saharan Africa has been intensified in order to decrease the number of new infections. The success of this campaign is dependent on both the correct knowledge and efficacy to use the condoms as well as their availability to AYP.

Data on condom use was obtained for all countries except Botswana, Mauritius, Seychelles, and South Sudan, and ranged from 39.2% in Ethiopia to 72.5% in South Africa (Figure 10).

![Percentage condom use at last sex by country](image)

**Figure 10: Percentage condom use at last sex by country**

A comparison between 2015 and 2018 showed that most countries reported an increase in condom use at last sex, except for Ethiopia, which reported a decrease (Figure 11).

![Percentage condom use at last sex](image)

**Figure 11: Percentage condom use at last sex**
Condom use was highest among males, except in Mozambique. In Angola, Ethiopia and Tanzania, the percentage condom use among males exceeds that of females by more than 50 percentage points (Figure 12). The trend in the majority of the countries is consistent with other data sets that show that young women are less likely to successfully negotiate condom use due to unequal gender relations. Age disparate sex and transactional sex, both common in this age group, further diminish their power and therefore their ability to negotiate.

Figure 12: Percentage condom use at last sex by gender

This target was tracked using one indicator:

1. Increase to 95% the number of AYP aged 10-24 years who demonstrate comprehensive HIV prevention knowledge levels

A critical goal of CSE programmes is to increase knowledge and critical thinking on HIV and SRHR. Studies have shown how scientifically accurate information equips young people with knowledge and skills to make informed decisions which can potentially decrease risky behaviour. Comprehensive knowledge on HIV prevention was measured by assessing young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Country data analysis showed that knowledge levels ranged from 32% in Angola to 47% in Botswana (Figure 13).

39 The data only includes countries with complete 2015 and 2018 information.
Figure 13: Comprehensive knowledge levels among AYP aged 15-24 years in the ESA region by country

Figure 14 reveals that, on average, comprehensive knowledge levels have increased from 36% in 2015 to 40% in 2018. However, country analysis shows a mixed picture. Three countries (Ethiopia, South Africa and Uganda) reported an overall increase, while Angola regressed, and Malawi remained the same. The lacklustre performance of this indicator underscores the need for significant acceleration of progress if countries are to reach their 2020 targets.

Figure 14: Percentage of young people with comprehensive knowledge on HIV prevention
Figure 15 provides a picture of comprehensive knowledge on HIV prevention by gender for the few countries that have data. Although, on average, young women are reported to have higher knowledge levels (albeit marginally) than their male counterparts, individual country analysis shows an even split, with Angola, Uganda, and South Africa reporting that males had marginally higher knowledge levels than females, while Botswana, Ethiopia, and Malawi reported the opposite.

![Figure 15: Percentage comprehensive knowledge of HIV prevention by gender](image)

This target was tracked through one indicator:

1. **Number of countries with/implementing a policy/strategy/guidelines on learner pregnancy and readmission**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries with/implementing a policy/strategy/guidelines on learner pregnancy and readmission</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

Data includes Rwanda.
The adolescent fertility rate ranges from 32 births per 1,000 women in Botswana to 194 births per 1,000 women in Mozambique (Figure 16). This is higher than the global average at 46. Major drivers of EUP include poverty, social norms, gender inequality, sexual coercion, poor access to SRH services, a lack of information, low self-efficacy, and peer pressure. Most studies show that the majority of pregnancies among adolescent girls are unintended and pose a threat to the health of the mother and infant. In addition, EUP has dire social and economic consequences for the mother, as they tend to drop out of school due to stigma and discrimination, as well as punitive laws. There is therefore an urgent need to prevent and mitigate EUP among adolescent girls.

The ESA Commitment calls for countries to implement policies that enable the pregnant learner to stay in school as long as possible and return after childbirth. The creation of a policy is a huge step towards the institutionalization of CSE programmes and for holding policy-makers in different sectors (education, health, youth, women, and social development) and different institutions accountable. A policy framework signifies government commitment and political will for the programme and facilitates support for the programme from development partners.

By 2018, 16 of the 21 countries had a policy for learner pregnancy and re-admission, an upward trend from five countries in 2013 and nine in 2015. This study did not include a content analysis of individual country policies to ascertain their robustness (Figure 17). However, a model policy would be one which upholds the right of pregnant girls to continue with their education and encourages the provision of facilities that are conducive for them to remain at school. The policy should also protect pregnant girls from discrimination and harassment.

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43 No data was reported for Angola, Botswana, or Madagascar.
Figure 17: Number of countries implementing a national policy/strategy/guidelines on pregnant learners

While some community members and teachers are reported to resist learner pregnancy policies as they perceive them to be promoting learner pregnancy, others are not sufficiently empowered to handle pregnant learners, and in many cases, teachers were concerned about taking responsibility for the health of pregnant learners. Conscientizing teachers, community members, and school governance structures on the good intentions of learner pregnancy policies is used in some countries to foster positive attitudes towards the policy. Another challenge commonly cited by different countries is that policies on learner pregnancy are often not applied uniformly, with too much discretion left to heads of schools to decide how to handle pregnant learners. Social stigma and ridicule are also commonly cited as reasons for pregnant learners to opt not to go back to school.

This target was tracked using two indicators:

1. **Number of countries whose education sector policies address SRGBV**

   GBV, including SRGBV, which takes place in the school precincts or on route to school, persists at alarming levels in the region and threatens the health, social, and emotional well-being of the victims. SRGBV deprives young people of a safe and supportive learning environment, and has been associated with early school dropouts, poor academic performance, withdrawal, and negative emotional impact. Shockingly, 61% of SRGBV takes place inside classrooms, 44%
in the school yards, 35% in school toilets and 44% on the way home. In order to protect young people, particularly adolescent girls, it is important for school programmes to purposefully address SRGBV through evidence-based policies and programmes that identify and address school-associated risk factors and mitigate their impact.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries whose education sector policies address SRGBV</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>18^45</td>
</tr>
</tbody>
</table>

Of the 21 ESA Commitment countries, 18 reported education sector policies that address SRGBV, an upward trend from only seven in 2013 and 12 in 2015 (Figure 18).

SRGBV is often addressed through a combination of factors, including empowerment of young people through awareness-building and dialogue, and creating a supportive environment. To this end, national and school level policies are central to addressing SRGBV.

Many countries report that the effective implementation of SRGBV policies and programmes rests on the effectiveness of school-based governance structures, such as parent-teacher associations (PTAs) and school governance bodies (SGBs), and on the support of other referral institutions, such as the police. Initiatives meant to eradicate SRGBV benefit

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44 ESA 2015 Report.
45 Data includes Rwanda.
from regular training of health workers and teachers to better identify, manage, and report cases of SRGBV, and from sensitization of learners about what constitutes SRGBV and what structures and services are available to them to report such cases.

2. Percentage of women aged 15-24 who believe that wife-beating is justified for at least one of five specified reasons

Socio-cultural beliefs have been shown to drive GBV. There were significant proportions of young women who believed that there could be justification for women to be beaten for at least one of the following five reasons: argues with husband, refuses to have sex, burns the food, goes out without telling husband, or neglects the children. In the countries with data, the percentage of women aged 15-24 who believe that wife-beating is justified (Figure 19) ranges from 6% for South Africa to 60% for Ethiopia. Figure 20 reveals a mixed trend regarding changes in the percentage of women aged 15-24 who believe that wife-beating is justified, with Ethiopia, Mozambique, and Uganda showing a decline and Malawi, Tanzania, and Zimbabwe registering an increase. The reasons for this are not clear, but they still show that more needs to be done to shift cultural norms that justify any form of violence against women.

![Figure 19: Percentage of women aged 15-24 who believe that wife beating is justified for at least one of five specified reasons](image)

![Figure 20: Percentage of women aged 15-24 who believe that wife-beating is justified for at least one of five specified reasons: 2015 and 2018](image)
This target was tracked using two indicators:

1. **Number of countries with programmes to mitigate against child marriage (where prevalent)**

Child marriage violates the rights of children (especially girls, who are disproportionately affected by the practice) to health, education, equality, and non-discrimination, as well as the right to a life free from violence and exploitation. The practice is closely associated with early pregnancy, as girls are pressured to prove their fertility, and in turn pregnancy-related complications, which is the leading cause of death among girls aged 15-19 in low- and middle-income countries worldwide. Once married, inability to refuse sex, or negotiate safe sex, also puts girls at high risk of STIs, including HIV. In addition, girls who marry young are less likely to receive the education they need to access the employment opportunities that will allow them to earn an income and help uplift themselves and their families out of poverty.

In the last 10 years, many countries in the region have outlawed child marriage and several have adopted programmes to prevent and mitigate the impact on AGYW. The existing country programmes vary, from advocacy aimed at changing laws\(^46\) and policies, to life skills-based education, social protection and health sector efforts, and behaviour change communication aimed at shifting social norms that perpetuate the practice.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries with programmes to mitigate against child marriage (where prevalent)</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>16(^47)</td>
</tr>
</tbody>
</table>

In addition, various regional and continental initiatives aimed at ending child marriage have been adopted by many of the ESA member countries, such as the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. In 2016, SADC-PF also adopted the Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, which is being used to inform advocacy legal and policy reform and national strategy development in countries such as Malawi, Mozambique, Tanzania, and Zimbabwe. However, most SADC countries are yet to domesticate the Model Law.

A total of 16 countries reported programmes and policies to mitigate child marriage, an upward trend from five and 12 in 2013 and 2015 respectively. Furthermore, many countries, such as Ethiopia, Malawi, Mozambique, South Sudan, Uganda, and Zambia have issued national costed action plans and strategies. Nevertheless, despite the significant progress that has been made in eliminating child marriage, some countries in the region continue to experience high rates.

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\(^46\) For example, in 2014, Kenya enacted the Marriage Act that criminalized marriage for persons below the age of 18.

\(^47\) Data includes Rwanda.
On the ground, the implementation of strategies to eradicate child marriage face several challenges. In spite of the increase in number of countries with laws and policies that prohibit it, legal loopholes that allow for child marriage with parental or judiciary consent exist. Furthermore, in many countries, the statutory laws are overruled by traditional and customary laws that promote the practice. In addition, it is difficult to monitor the prevalence of child marriage because many adolescents are not registered by birth or time of marriage.

2. Percentage of women aged 20-24 years who were first married or in union before age 15 and age 18

Although child marriage refers to unions that involve children below 18 years (male or female), the indicator also tracked marriage below 15 years, providing an additional measure of the severity of the problem. Significant progress has been made by the continent as a whole towards eliminating child marriages, and by ESA member countries in particular. However, many countries continue to experience high incidences of child marriage with large disparities in child marriages between income quintiles, rural-urban divides, or by education levels. In some countries, such as Zambia, the conflict between statutory and customary laws continues to stifle progress towards eliminating child marriages.

The ESA region continues to experience high levels of child marriage, particularly in Angola, Ethiopia, Malawi, Mozambique, and Uganda, as revealed in a 2018 study of child marriages in 10 countries in sub-Saharan Africa, conducted by the Special Rapporteur on the Rights of Women in Africa. For example, of women aged 20-24, 12% were married by age 15 and 50% by age 18 in Malawi, 14% by age 15 and 48% by age 18 in Mozambique, and 10% by age 15 and 40% by age 18 in Uganda. The primary reasons cited for child marriage include gender inequalities, cultural and religious norms, and poverty.
In South Sudan, a study by Oxfam International48 demonstrates that conflict-fuelled poverty and food insecurity increases the risk of child marriage. The research findings, drawn from a conflict-affected town, estimate that 71% of interviewed women and girls were married before the age of 18 compared to the national average of 45%, while 10% were married before the age of 15. Marriage provides significant resources, as dowry, to the bride’s family.

Figure 22 shows the prevalence of child marriages in the ESA region with reported data, and reveals that they were highest in Ethiopia, Malawi, and Mozambique.

Figure 22: Percentage of women 20-24 years who were first married or in union before they were 15 and 18 years old 2018 data49

This target was tracked using one indicator:

Adolescents and young people in school are among the most common and theoretically easily reached targets for CSE programmes, given the school provides a direct entry point and CSE programmes can be included in the school curriculum with easy scalability. It is important that age-appropriate CSE is provided in both primary and secondary school. By 2018, the percentage of schools that offered life skills-based HIV and sexuality education ranged from 5% to 100% across 15 countries.

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49 Data sources: Angola (DHS 2015-16); Burundi (DHS 2010); DRC (DHS 2013-14); Ethiopia (DHS 2016); Kenya (DHS 2014); Lesotho (DHS 2014); Madagascar (ENSOMD 2012-13); Malawi (DHS 2015); Mozambique (DHS 2011); Namibia (DHS 2013); Rwanda (DHS 2013-14); South Africa (DHS 2013); South Sudan (SHHS 2010); Swaziland (MICS 2014); Uganda (DHS 2011); Tanzania (2015-16); Zambia (DHS 2013-14); Zimbabwe (DHS 2015).
5. Creating an Enabling Environment

One of the main objectives of the ESA Commitment is to strengthen multisectoral coordination and collaboration in the delivery of CSE and SRH services for AYP. To this end, three indicators were used to track progress:

5.1. Number of countries implementing a multisectoral strategy or framework for operationalization of the ESA Commitment

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries implementing a multisectoral strategy or framework for operationalization of the ESA Commitment</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20&lt;sup&gt;50&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

The ESA Commitment calls for comprehensive multi-stakeholder collaboration around CSE and the delivery of AYFHS. Its implementation thus straddles various government ministries including health, education, youth, social development, gender, finance, and justice. It also includes civil society and the private sector. Better coordination of these ministries and their programmes is at the heart of the Commitment. At country-level, coordination is very important for the successful operationalization, monitoring, and reporting of the ESA Commitment. Countries are therefore encouraged to have a strategy or framework for effective coordination and collaboration.

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<sup>50</sup> Data includes Rwanda.
In the last five years, there has been a remarkable increase in the number of countries with a multisectoral strategy in place as the first step towards operationalizing the ESA Commitment. In 2015, 18 of the ESA Commitment countries had developed a strategy (Figure 23), and by 2018, 20 countries had a strategy in place.
5.2. Number of countries with a multisectoral task team established and functional to provide policy and technical guidance

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
<th>REGIONAL TARGET 2020</th>
<th>REGIONAL PROGRESS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries with a multisectoral task team established and functional to provide policy and technical guidance</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>12</td>
</tr>
</tbody>
</table>

For successful execution of a multisectoral strategy, effective coordination is critical. Most countries have established multisectoral coordination structures to operationalize the ESA Commitment, including representation from different sector departments, civil society groupings, and development partners. Some countries have successfully adopted an Inter-Ministerial Committee model comprised of the various ministries and other partners involved in sexuality education. Madagascar, for example, has established one that is directly attached to the presidency and is mainly responsible for HIV and AIDS-related issues. Besides ensuring that key stakeholders are represented, the Inter-Ministerial Committee model has helped promote knowledge sharing.

In 2018, 12 of the 21 countries had established a functional multisectoral task team to provide policy and technical guidance for the implementation of the ESA Commitment (Figure 24). Although these figures suggest improved coordination, there is still room for increased collaboration between the education, health, and social protection line ministries. To realize better outcomes, there is also a need for stronger and more committed leadership, and greater institutionalization of the ESA Commitment with national programmes that are implemented at scale, with strategies for accelerated progress, and accountability. Generally weak commitment by government representatives hampers the performance of these structures. This challenge is often compounded by the fact that some ESA Commitment programme activities reside in different departments or ministries, which results in wasteful overlaps and duplication of activities. Different departments’ M&E systems are often not harmonized either, which gives rise to ineffective monitoring of and reporting on Commitment progress.

![Figure 24: Number of countries with a multisectoral task team established for the coordination of the ESA Commitment](image-url)

- No data reported
- No multisectoral task team established
- A multisectoral task team established and functional
5.3. Number of countries that have identified/mobilized financial resources for the implementation of the ESA Commitment

Successful operationalization of the ESA Commitment requires that adequate resources are allocated to the various programmes and initiatives, and that these funds are ring-fenced.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>REGIONAL TARGET 2015</th>
<th>REGIONAL TARGET 2017</th>
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<tr>
<td>Number of countries that have identified/mobilized financial resources for the implementation of the ESA Commitment</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>12</td>
</tr>
</tbody>
</table>

Efforts to mobilize resources, including harnessing private-public partnerships, are evident in all the ESA Commitment countries, albeit to varying degrees and in different ways, and by 2018, 101 of the 21 countries had identified or mobilized financial resources for the implementation of the ESA Commitment. For instance, Kenya, Namibia, and South Sudan have factored ESA Commitment-related activities into national programmes, while South Africa has implemented them through a direct conditional grant to provinces, which provides a window for a ward-based primary health care outreach programme aimed at standardizing and strengthening the training of community health care workers. These health care programmes play a pivotal role in providing HIV-related training. The Global Fund was also instrumental in CSE funding in Namibia.

Regionally, initiatives such as UNFPA’s Safeguard Young People (SYP) mobilized resources to fully operationalize the ESA Commitment. The initiative supports scale-up of interventions that improve AYP’s SRHR through harmonization of laws and policies, integration of CSE and/or social behaviour change communication (SBCC) programmes for in- and out-of-school adolescents and youth, and institutionalization of youth-friendly health services. It also addresses harmful practices, GBV, gender inequality, boys’ involvement, and youth participation.

51 Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.
6. Lessons Learned

The ESA Commitment has been guiding policy, programming, and coordination around ASRHR for five years, and much progress has been made towards reaching the ambitious targets agreed to in 2013. Over this period, there have been critical lessons learned, which need to be taken into account to ensure all targets are met by 2020.

6.1. Scale-up of CSE

- Some countries, such as Botswana, Eswatini, Kenya, Lesotho, Mauritius, Mozambique, South Africa, Seychelles, and Zambia, have achieved 100% CSE coverage in schools. This has been due to the integration of CSE in the mainstream school curriculum, a model which is more effective and cost-efficient.
- Pre-service training of teachers is cost-effective and ensures sustainability. It is important to track pre- and in-service training separately.
- Given the importance of delivering CSE in schools, there is a need to ensure standardization of quality content, and that teachers understand its relevance. It must also be compulsory, or a core part of the curriculum. This can be done by making CSE mandatory and examinable.
- While the number of teachers trained has increased, more still needs to be done to evaluate the effectiveness of the training and monitor teacher preparedness.
- In the last few years, more countries have developed and are implementing CSE strategies for out-of-school youth. This presents an opportunity to reach youth that did not benefit from CSE while in school and ensure inclusivity for those youth who for various reasons dropped out prematurely.

6.2. Improved access to adolescent and youth-friendly SRH services

- The scale-up and successful provision of quality SRHR services requires competent and skilled personnel. The training of teachers and health workers in SRHR has the potential to promote positive attitudes among the providers. Countries need to sustain the momentum, continuously training and sensitizing health and social care workers to shift norms and prejudices, and make them more inclusive of those most vulnerable and marginalized, such as the disabled, young mothers, and young key populations.
- Pre-service training continues to bear great importance, as the resultant institutionalization ensures efficiency and sustainability.
- Community outreach, school health programmes, and peer-led service provision has been seen to attract more youth, with promising outcomes.
6.3. Reduction in EUPs

- EUP is driven by poverty, social norms, gender inequality, sexual coercion, poor access to SRH services, a lack of information, low self-efficacy, and peer pressure. Addressing these factors goes a long way in preventing EUP among AGYW.
- Much has been achieved by countries by way of enabling policies for managing learner pregnancies. For successful implementation, these efforts should also include greater investment in awareness programmes for learners, parents, and school governing authorities.
- Learner pregnancy management policies should include clear implementation guidelines, and promote programmes that build self-efficacy, decision-making, and self-assertiveness.
- Learner pregnancy policies can be augmented through strong referral systems between schools, parents, and health care workers.

6.4. Prevention and mitigation of GBV

- The early detection of abused children, and provision of comprehensive services such as psychosocial support, should be at the heart of GBV policies. To this end, referral systems between schools, community health services, and law enforcement agencies as well as access to justice services need to be strengthened.

6.5. Elimination of child marriage

- Although the laws and policies that prohibit marriage before age 18 are important to curb the practice of child marriage, the level of awareness of rights among girls is low. This has left girls vulnerable and unable to demand their rights. This calls for greater investment in awareness programmes for girls, parents, community leaders, service providers, and governing authorities, including those responsible for birth and marriage registration.
- Child marriages continue to be driven by religious and cultural norms. This calls for greater investment in SBCC programmes and collaboration with traditional and religious leaders in efforts to eliminate the practice.
- Efforts should be directed towards social protection programmes, such as cash or food incentives for households whose girls are attending school, in order to reduce their vulnerability in poorer communities.
- Review, enactment, and implementation of laws should be improved to ensure the eradication of child marriages. Key custodians of customary laws should also be sensitized on the laws against child marriages.

6.6. Creation of an enabling environment

- Political leadership is critical in fostering accountability for the ESA Commitment and mobilizing resources for the realization of its targets.
- Efficient and robust coordination are also critical for ensuring the realization of the Commitment targets. Coordination structures therefore need to be strengthened, with sufficient resource allocation and appropriate decision-making authority.
- Successful implementation of the ESA Commitment requires coordination and collaboration of various government departments. Lessons learnt so far suggest that it is difficult for one government department to hold another to account. Inter-ministerial committees have been shown to be effective in addressing this challenge.
6.7. Cross-cutting

- CSE, AYFHS, GBV, and child marriage strategies are in place in many countries, pointing to a more enabling environment for scaling up CSE and AYFHS. However, more still needs to be done to ensure laws and policies are gender-sensitive, based on sound human rights principles, and promote the right of girls to equality.

- Most strategies are not accompanied by robust M&E and reporting systems. These are needed to enable increased accountability and effective tracking of achievements or failures.

- In many countries, creative and innovative approaches to CSE were reported. However, these pockets of innovation are rarely documented in any systematic manner, and therefore cannot be meaningfully replicated in other settings. Evidence suggests that programmes that invest in knowledge management are more successful in peer learning, sharing best practices, and replicating them in other areas and settings.

- It is imperative that youth are involved and enabled to participate actively in the ESA Commitment. Despite increased advocacy to promote youth participation, the youth sector remains fragmented. More investment needs to be made in coordinating and capacitating youth structures and movements.
7. Conclusions & Recommendations

Leadership and ownership of the ESA Commitment by RECs and governments, including the establishment of national working groups, has been critical to its success. However, although member countries have made significant headway in institutionalizing the ESA Commitment and establishing policies and strategies in order to reach its targets, weak and fragmented M&E systems inhibit effective tracking of progress in some countries. In addition, lack of coordination hampers effective and efficient implementation of the Commitment.

Recommendations

1. **Accountability, coordination, and financing:** Domestic financing of the Commitment should be strengthened and scaled up. Coordination structures should be representative and led by committed point persons. It is also important for countries to allocate resources to coordination and accountability mechanisms.

2. **Laws addressing GBV and child marriage:** The review, enactment, and implementation of laws should be improved in order to accelerate progress towards eliminating GBV and child marriages, as well as to improve access to SRHR information and services, including contraception.

3. **Drivers of GBV and child marriage:** Programmes focussed on AGYW should invest more in efforts that address drivers and socio-cultural, traditional, and religious norms that promote GBV and enhance the risk of child marriage. Key custodians of customary laws should also be sensitized on the laws against child marriages.

4. **Knowledge management:** Investment in knowledge management should be scaled up in order to enable learning, sharing of lessons and best practices, and institutionalization within government structures at all levels and across countries.

5. **Costed and inclusive strategies:** All strategies and policies aimed at promoting CSE and AYFHS should be inclusive in order to foster ownership and be costed and accompanied by robust and detailed operational plans and appropriate budgetary allocations. In addition, M&E systems should be harmonized and reporting centralized.

6. **Integration of CSE:** CSE should be integrated in the mainstream school curriculum and pre-service teacher training for maximum coverage. It should also be made mandatory and examinable in all countries.

7. **Quality assurance of CSE and AYFHS:** The training of practitioners alone is insufficient for the delivery of quality CSE and AYFHS. There is a need for more robust quality assurance and M&E mechanisms to ensure that quality programmes are delivered to AYP.

8. **Youth participation, leadership, and accountability:** Youth participation should be strengthened and young people included in the advocacy for the realization of the ESA Commitment targets and mainstreaming of CSE and AYFHS into governments plans.

9. **Use of media:** The use of mainstream media, social media, and other information and communications technology (ICT) for galvanizing sexuality education advocacy should be increased.

10. **RECs:** RECs should provide regular and structured reporting on ESA Commitment progress.

11. **SADC SRHR Strategy:** The SADC SRHR Strategy (2019-2030) should be fully domesticated and implemented, and country efforts reported on using the corresponding Scorecard.
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