



Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)

1.0 Preamble

We, the Ministers of Education and Health from 20 countries in Eastern and Southern Africa¹, gathered in Cape Town, South Africa on 7 December 2013, working towards a vision of young Africans who are global citizens of the future who are educated, healthy, resilient, socially responsible, informed decision-makers and with the capacity to contribute to their community, country and region, hereby:

- 1.1. **Affirm** our commitment to the right to the highest possible level of health, education, non-discrimination and well-being of current and future generations;
- 1.2. **Recognize** the responsibility of the State to promote human development, including good quality education and good health, as well as to implement effective strategies to educate and protect all children, adolescents and young people, including those living with disabilities, from early and unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV, risks of substance misuse and to combat all forms of discrimination and rights violations including child marriage;
- 1.3. **Reiterate** our conviction that the education and health sectors, working jointly, have enormous potential to promote the good health and wellbeing of all individuals and communities, and to prevent early and unintended pregnancy, the transmission of HIV and other STIs and to facilitate access to care and support, particularly for adolescents and young people living with HIV (YPLHIV) or those with heightened vulnerability to STIs including HIV;
- 1.4. **Acknowledge** that our countries are signatories to various conventions at international and regional levels including the Education for All (EFA) Dakar Framework for Action, Maputo

¹ Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

Ministries of education and health in Rwanda were part of the ESA commitment process, but were unable to attend the high level ministerial meeting on 6-7 December due to other commitments.

Plan of Action, Southern African Development Community (SADC) Protocol on Gender and Development, International Conference on Population Development (ICPD) Global Youth Conference, Abuja Declaration and Framework for Action on HIV/AIDS, the United Nations Convention on the Rights of the Child (CRC), the African Youth Charter, the Millennium Declaration and the African Union Second Decade of Education Plan of Action and a range of other regionally focused declarations;

- 1.5. **Recognize** the significant progress made by member states in Eastern and Southern Africa to address the needs of adolescents and young people with respect to ensuring access to life skills-based HIV and comprehensive sexuality education (CSE)² and youth-friendly sexual and reproductive health services;
- 1.6. **Realize** that in demographic terms, the region is experiencing major growth in the youth population which has major implications for education, health and development overall. Young people will drive the development of the region in the coming decades and beyond;
- 1.7. **Recognize** that working in collaboration with relevant ministries including ministries of gender, youth and others will greatly enhance the effectiveness of our efforts and ensure a coordinated, multi-sectoral approach that will benefit adolescents and young people;
- 1.8. **Acknowledge** that Eastern and Southern Africa remains the region that is most affected by HIV despite the positive signs that HIV prevalence is declining among young people in some countries. This region is also more heavily affected by adolescent maternal mortality and morbidity than other regions in the world;
- 1.9. **Commit** ourselves to strengthening HIV prevention, treatment, care and support, and sexual and reproductive health and rights (SRHR) efforts in Eastern and Southern Africa by ensuring access to good quality, comprehensive, life skills-based HIV and sexuality education (CSE) and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country's socio-cultural context.

2.0 Whereas

2.1 Several advances have been made in Eastern and Southern Africa there are still significant challenges:

- 2.1.1 HIV remains an urgent problem, with 430 000 new infections per year among young people aged 15-24³; with young women still more heavily affected and with an increase of 50% in deaths amongst adolescents living with HIV globally⁴;
- 2.1.2 With the advent of antiretroviral (ARV) treatment and care, more children living with HIV are surviving, reaching adolescence and adulthood. Young people living with HIV also require good quality comprehensive sexuality education, services and

² Sexuality Education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. UNESCO (2009) *International Technical Guidance on Sexuality Education: An evidence informed approach for schools, teachers and health educators*, Paris.

³ The CRC protects the rights of children, adolescents and young people below the age of 18 and this Commitment document includes young people up to the age of 24.

⁴ Children and AIDS, 6th Stocktaking Report, UNICEF, New York, 2013.

- psychosocial support to be skilled for life, to make healthy sexual and reproductive health choices and in order to fulfill their potential;
- 2.1.3 Alcohol and substance abuse significantly increase risky behavior and sexual violence resulting in increased HIV and STI transmission, unintended pregnancy and unsafe, illegal abortions;
 - 2.1.4 While trends show increases in HIV-knowledge levels in some countries, overall knowledge levels in the region are low with less than 40% of young men and women demonstrating desirable levels of knowledge about HIV prevention (compared to the agreed international target of 95%);
 - 2.1.5 School completion rates remain low with young people completing an average of less than 6.5 years of education, and low levels of progression from primary to secondary education is a great concern. Fewer adolescents and young people therefore have access to HIV prevention and life-skills based CSE before they become sexually active;
 - 2.1.6 Early and unintended pregnancies in the Eastern and Southern Africa region remain high and by age 17, at least 1 in 5 young women in six countries in the region have started childbearing. This rises to over 35% amongst 19 year olds in 10 countries;
 - 2.1.7 Health risks caused by adolescent pregnancy are high and include higher rates of maternal mortality than for older women. Sub-Saharan Africa accounts for 44% of all unsafe abortions among adolescents between the ages of 15 and 19 in the developing world (excluding East Asia);
 - 2.1.8 Gender inequality continues to limit the potential and the achievement of girls in this region, through lower school completion rates (e.g. 28% of girls enroll in secondary school compared to 32% of boys), child marriage and cultural norms which define the roles of girls and boys;
 - 2.1.9 Gender-based violence, including sexual violence, increases vulnerability to HIV transmission, remains a cause for concern with a high percentage of young women - between 15-35% - reporting having experienced sexual violence in nine ESA countries where data was available. For many girls and young women in this region, sex, marriage and pregnancy remain neither voluntary, consensual nor informed;
 - 2.1.10 Child marriage remains a serious obstacle to the realization of all rights for young people, notably adolescent girls and young women, and has direct and negative impact on their education, health and social status;
 - 2.1.11 All forms of discrimination, including that based on age, sex, health, marital, legal or social status, as experienced by children, adolescents and young people, including marginalized and key populations, undermines their rights and dignity⁵;
 - 2.1.12 Poverty and wealth inequality have a direct and detrimental impact on education and health outcomes, and increase vulnerability to HIV.

⁵ Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. *UNAIDS (2011) Getting to Zero, UNAIDS Strategy 2011-2015, Geneva.*

2.2 We acknowledge that:

- 2.2.1 Investment in quality education that includes comprehensive, life-skills based sexuality education fulfills the right to education whilst also contributing to well-being and future quality of life. Adolescents and young people aged 10-24 make up 33% of the population in the region. Investment in health and education will, together with the resulting reduction in fertility rates, contribute to the realization of demographic dividends in the future;
- 2.2.2 Faith and faith-based teachings on life, family, community, sexuality and reproductive issues play a major part in the beliefs, practices and norms of many communities in the region;
- 2.2.3 Families, carers, guardians and community members play a primary role in the education and guidance available to adolescents and young people as they transition to becoming young adults;
- 2.2.4 Most adolescents and young people in the region reported that they were not sexually active until age 18. However, Demographic and Health Survey data from the region indicate that a significant number of adolescents have their first sexual experience at an early age (ranging from 3.3% to 24.5% of females under age 15), and, in many cases do not use any form of protection to prevent pregnancy or sexually transmitted infections. Young people should be supported to delay sexual debut until they choose to be sexually active and ensure that it is voluntary and protected;
- 2.2.5 Comprehensive sexuality education starting from primary school onwards enables the gradual acquisition of information and knowledge necessary to develop the skills and attitudes needed for a full and healthy life as well as to reduce sexual and reproductive health risks. The most recent scientific evidence demonstrates that comprehensive sexuality education, including education on safer sex and condom use, does not lead to early sexual initiation. Instead, quality sexuality education can help to delay the initiation and frequency of sexual activity, reduce the number of sexual partners, increase the use of condoms and contraception, and reduce sexual risk-taking⁶. When sexuality education includes a strong focus on rights and gender, greater benefits are possible⁷;
- 2.2.6 In order to fully exercise their right to health, including sexual and reproductive health, all adolescents and young people require safe, effective, acceptable and affordable access to a range of commodities and services, regardless of gender. These services include but are not limited to condoms, contraception, vaccinations, pregnancy prevention, ante-natal care, safe delivery and post-partum care, diagnostic testing, treatment and care for STIs including HIV, safe abortion (where legal), post-abortion care and treatment, care and support in response to sexual violence. Restrictive abortion laws lead to many abortions being performed in an

6 UNESCO (2009) Op cit.

7 Population Council (2009) It's All One Curriculum, New York.

unregulated and unsafe environment which threatens the lives of adolescents and young women;

- 2.2.7 In-school and out-of-school life skills-based CSE must be linked to and supported by a comprehensive package of youth-friendly sexual and reproductive health services and commodities. Services delivered by trained youth-friendly health workers are more likely to be used;
- 2.2.8 Quality education and health outcomes which can be achieved through comprehensive sexuality education require us to invest in teachers who are well trained, resourced and supported to deliver programmes in and out of school. At the same time, CSE programmes need to be within the formal curriculum and examinable to ensure effective implementation;
- 2.2.9 A stronger research agenda in the region is necessary to improve the quality and effectiveness of programming for adolescents and young people including research into HIV testing and provision of condoms and other SRH commodities in schools.

3.0 Based on the above considerations, we the ministers of education and health, will lead by bold actions to ensure quality comprehensive sexuality education and youth-friendly sexual and reproductive health services in the ESA region. Specifically, we commit to:

- 3.1 ***Work together on a common agenda*** for all adolescents and young people to deliver comprehensive sexuality education and youth-friendly SRH services that will strengthen our national responses to the HIV epidemic and reduce new HIV/STI infections, early and unintended pregnancy and strengthen care and support, particularly for those living with HIV. Establish inter-sectoral coordination mechanisms led through the existing regional economic communities, EAC, SADC and ECSA. Where such mechanisms already exist they must be strengthened and supported.
- 3.2 ***Urgently review - and where necessary amend - existing laws and policies on age of consent, child protection and teacher codes of conduct*** to improve independent access to sexual and reproductive health services for adolescents and young people and also protect children. Laws, policies and practices regulating access to services and in child protection must recognise the need for a balance between protection and autonomy and the evolving capacity of adolescents as they begin to make their own choices about their education and health needs.
- 3.3 ***Make an AIDS-free future a reality*** by investing in effective, combination prevention strategies to build on current declines in HIV prevalence amongst young people in the region as well as addressing underlying structural factors including poverty and a lack of livelihoods. Concerted effort will be made to build the capacity of teachers, health service providers and young people and to particularly advocate for increasing HIV testing and counselling, treatment access and expansion of agreed essential SRH services especially in marginalised communities and hotspot areas and including in non-formal and out of school settings.

- 3.4 **Maximise the protective effect of education** through Education for All by keeping children and young people in school which reduces HIV risk, maternal mortality and improves gender equality, whilst ensuring access to educational opportunities for those living with HIV or adolescent and young women who may be pregnant.
- 3.5 **Initiate and scale up age-appropriate CSE during primary school education** to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases. Using agreed international standards, ensure that CSE is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills and values as preparation for adulthood: decisions about sexuality, relationships, gender equality, sexual and reproductive health and citizenship⁸. Wherever possible, make in-school CSE programmes intra-curricular and examinable.
- 3.6 **Ensure that the design and delivery of CSE and SRH programmes includes ample participation by communities and families** - particularly adolescents, young people, civil society and other community structures including faith-based organisations. At the same time, adolescents and young people should be guaranteed safe spaces, the right to be their own advocates and agents of change in their own communities, and to recommend good practices and innovations which meet their needs.
- 3.7 **Integrate and scale up youth-friendly HIV and SRH services** that take into account social and cultural contexts to improve age-appropriate access to and uptake of high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HIV counselling and testing (HCT), HIV/STI treatment and care, family planning, safe abortion (where legal), post abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) and other related services for young people in and out of school.
- 3.8 **Ensure that health services are youth-friendly**, non-judgemental, and confidential and reach adolescents and young people when they need it most, and are delivered with full respect for human dignity, including for young people considered most at risk, young people living with disabilities, or young people experiencing any other forms of discrimination. Reliable, affordable commodities must be made available as part of service delivery through public, private and civil society channels.
- 3.9 **Strengthen gender equality and rights** within education and health services including measures to address sexual and other forms of violence, abuse and exploitation in and around school and community contexts whilst ensuring full and equal access to legal and other services for boys and girls, young men and women.
- 3.10 **Mobilise national and external resources** by exploring new, innovative finance mechanisms and seeking technical and financial support from national and international sources to fulfil these commitments.

8 UNESCO (2009) Op cit.

4.0 Targets

To ensure effectiveness, impact and accountability, working together within a multi-sectoral and whole government approach, as education and health ministers we affirm our determination to achieve all of the aforementioned ten Commitments and the following targets by the end of 2015:

- 4.1 *A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries;*
- 4.2 *Pre and in-service SRH and CSE training for teachers, health and social workers are in place and being implemented in all 20 countries;*
- 4.3 *By the end of 2015, decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services including HIV that are equitable, accessible, acceptable, appropriate and effective.*

In the longer term, we will work towards reaching the following targets by the end of 2020:

- 4.4 *Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections amongst adolescents and young people aged 10-24;*
- 4.5 *Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels;*
- 4.6 *Reduce early and unintended pregnancies among young people by 75%;*
- 4.7 *Eliminate gender-based violence;*
- 4.8 *Eliminate child marriage;*
- 4.9 *Increase the number of all schools and teacher training institutions that provide CSE to 75%.*

5.0 Accountability

- 5.1 There is a need for governments to renew, accelerate and improve the implementation of the commitments that they have previously made related to human rights, HIV and AIDS, sexual and reproductive health and the wellbeing of children, adolescents and youth. Strong efforts will be taken to ensure wide awareness among key stakeholders about the existence of the Commitment, its purpose and targets, and to ensure their full opportunity for engagement.
- 5.2 In order to ensure the achievement of the agreed Commitments, we hereby establish an inter-ministerial, multi-sectoral mechanism (aligned with, or utilising existing systems) to strengthen planning, coordination and to monitor the implementation of these Commitments. These country mechanisms will be convened by UNAIDS and will engage key stakeholders including government, civil society, young people, UN and other development partners. SADC and EAC will lead in regional monitoring of these Commitments, with support from development partners.
- 5.3 We agree to review and report on this Commitment annually at SADC and EAC Summits involving the relevant ministers through national status reports.

5.4 We agree to institutionalise monitoring and evaluation systems in our respective ministries and improve on the collection of age- and sex- disaggregated data through existing monitoring and evaluation mechanisms such as EMIS and HEMIS. These will be supplemented by periodic adolescent and youth surveys on the education and health status of adolescents and young people.

Annex A

International and regional commitments/declarations

Education

- Dakar Framework for Education 2000
- Millennium Development Goals 2000
- SADC protocol on Education and Training 1997

Health

- Maseru Declaration 2003
- Maputo Plan of Action 2006
- Africa Health Strategy 2010–2015
- SADC Sexual and Reproductive Health and Rights Strategy 2006-2015
- SADC HIV and AIDS Strategic Framework 2010–2015
- Regional Strategic Plan on Sexual and Reproductive Health and Rights in East Africa: 2008–2013
- SADC Protocol on Gender and Development 2008
- Addis Ababa Declaration on Population and Development in Africa beyond 2014

Human rights

- Convention on the Rights of the Child 1990
- The Protocol to the African Charter on Human and People's Rights on the Rights of Women 2003
- Solemn Declaration on Gender Equality in Africa (SDGEA) 2004
- African Youth Charter 2006
- African Union Plan of Action for the Decade of Youth 2008-2019

Annex B:

The countries affirming this commitment are as follows:

Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe⁹.

⁹ Ministries of education and health in Rwanda were part of the ESA commitment process, but were unable to attend the high level ministerial meeting on 06-07 December due to other commitments.