Advancing Accelerated Action for the Health of Adolescents (AA-HA!) and the ESA Ministerial Commitment on Education for the Health and Wellbeing of Young People

Regional Workshop 14-18 October 2024

Workshop Report

Acknowledgements

Sincere gratitude to all who made this meeting a success. Many thanks to the young people from the UNITED! Movement who honoured the invitation and led some of the most engaging sessions. Congratulations to the organising team: Alice Armstrong, Cynthia Amanda Lungu, Doreen Cheta, Geoffrey K Bisoborwa, Joyce Ouma, Leopold Ouedraogo, Meron Negussie, Ndudzo Rudo, Prossy Nakitandwe, Remmy Shawa, and Tamisayi Chinhengo. The task of shaping a comprehensive programme to speak to the multi-layered nature of adolescence and wellbeing in the region was no mean feat. The result was a series of in depth, diverse and expansive discussions that always kept the young person at the heart of the story.

To the country teams who worked so diligently and shared so passionately, we thank you for your honest reflections and for being national champions for adolescent health and wellbeing. We hope new friendships were formed and existing ones strengthened. A special thank you to our hosts, South Africa, for the warm welcome.

To our technical colleagues from WHO Geneva (Prerna Banati and Regina Guthold) and representatives of the regional economic communities (EAC and SADC secretariats), your support and commitment to this work is deeply appreciated.

A huge thanks to the administrative support team for their logistic wizardry and ensuring everything ran smoothly. We are grateful to the translators who not only ensured we grasped the substantive content of discussions but also moved us towards a common language – making health and wellbeing of adolescents and young people a reality.

And of course, to our young people, who, with enthusiasm and readiness to take up the mantle, consistently remind us of their place at the head and centre of all advocacy and programmatic efforts. They are both tomorrow's leaders and today's changemakers.

The workshop was held through the support of 2gether 4 SRHR, Our Rights Our Lives Our Future (O3), and the Safeguarding Young People (SYP) partnerships. It would not have been possible without the generous financial support of our donors – The Kingdom of the Netherlands, The Norwegian Ministry of Foreign Affairs, The Swedish International Development Cooperation Agency, The Swiss Agency for Development and Cooperation, and the U.S. Agency for International Development. We remain deeply grateful for their demonstrable commitment to adolescent health and wellbeing in Africa.

Abbreviations

AA-HA!	Accelerated Action for the Health of Adolescents
AfriYAN	African Youth and Adolescents Network on Population and Development
AYH	Adolescent and Youth Health
CSE	Comprehensive Sexuality Education
DD	Demographic Dividend
DHS	Demographic and Health Survey
DSS	Department of Social Development
EAC	East African Community
EMIS	Education Management Information System
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
FP	Family Planning
G-SHPPS	Global School Health Policies and Practices survey
GAMA	Global Action for Measurement of Adolescent health
GBV	Gender-based Violence
GRM	Grievance Redress Mechanisms
GSHS	Global School-based Student Health Survey
GTA	Gender Transformative Approach
HCP	Healthcare Professional

HMIS	Health Management Information System
HPS	Health Promoting School
KPs	Key Populations
MoE	Ministry of Education
MoH	Ministry of Health
PLHIV	People Living with HIV
REC	Regional Economic Community
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

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Executive Summary

Background to the workshop

For Africa to make notable progress towards the Sustainable Development Goals (SDGs), and for it to achieve its Demographic Dividend, the health needs of adolescents and young people must be met. Several key frameworks help to realise this. The renewed ESA Ministerial Commitment (2022-2030), as well as the second edition of the Accelerated Action for the Health of Adolescents (AA-HA!) both provide a comprehensive approach to adolescent health and wellbeing.

To increase familiarity with the updated frameworks, and to share lessons and experiences regarding adolescent health and wellbeing on the continent, key stakeholders from 18 African countries came together for intersectoral discussions on country needs and priorities.

Meeting participants included representatives from government departments (mainly those representing education and health), youth-led organisations, UN agencies and regional economic communities (RECs). Countries represented included Angola, Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

The workshop sought to:

- Share relevant regional and continental initiatives for adolescents and young people with the view to identify and understand complementarities, interlinkages, and opportunities for joint monitoring and reporting.
- Discuss in more depth the ESA Commitment in terms of national progress against targets and the Regional Accountability Framework.
- Conduct a rapid stocktake of progress in adolescent health including adolescent sexual and reproductive health and rights (SRHR) programming in ESA countries.
- Orient ESA countries' core teams on AA-HA! 2.0 guidance to capacitate them to advocate and plan for its utilization in improving programming for the health and wellbeing of adolescents in their respective countries.
- Plan regional follow-up actions, including identification of technical assistance needs.

Youth – tomorrow's leaders and today's changemakers

The perspective of youth-led organisations was a deliberate inclusion throughout the programme, reminding us that **inclusive and meaningful youth participation throughout all aspects of an intervention must become the norm**.

Overwhelmingly, young people spoke of staff attitudes at health facilities as one of the main barriers to accessing SRHR services and proposed recommendations for low cost/high impact interventions. These included a differentiated service delivery approach in the communities; investing in young people in the rural areas as a human resource; and improving youth friendliness of health facilities with a focus on the attitudes of healthcare professionals.

Status and trends in the region

The meeting revealed the mixture of upward strides and persisting challenges that characterise efforts to improve adolescent and youth health and wellbeing in Africa. For example, it is encouraging that, according to WHO Global Health Estimates, 2024, there has been an **overall decline in all-cause adolescent mortality since 2000**. However, **unsafe sex remains the highest risk factor for morbidity and mortality among adolescents 15-19 years in sub-Saharan Africa, with girls at a disproportionate risk**.[1]

Similarly, although harmful practices such as early or child marriage are on a downward trend, there are regional variations which highlight the discrepancy between policies and social norms. From the perspective of education, notable achievements regarding policy and legislative developments are clear. Despite this, particular outcomes are concerning such as lower completion rates in post-secondary school as compared to primary schools in ESA.

The workshop also highlighted regional initiatives like health promoting schools (HPS). These provide opportunities for coordinated action with an intersectoral approach, allowing the school, students, staff and communities to work together to promote the health of learners.

1 https://vizhub.healthdata.org/gbd-results/

AA-HA!2.0 training and application

The meeting was successful in building the capacity of country teams to utilise the AA-HA!2.0 guidance. Group work and subsequent sharing of findings in plenary, ensured the workshop maintained a vibrant and participatory tone. Country teams were introduced to the following various steps within the AA-HA! guidance:

- **Needs assessment** – Country teams took stock of the adolescent health and wellbeing situation and trends in their country, noting that one particular gap was data for adolescents between 10-14 years old. It was clear that SRHR and HIV remain key concerns, with maternal health and psychosocial support as well as nutrition/obesity, identified as emerging issues.
- **Landscape analysis** – Teams examined the extent to which adolescent and youth health challenges are addressed in national plans, policies and services. The findings highlighted, among others, the extent to which dependency on donor funds impact the quality and sustainability of interventions.
- **Priority setting** – This was a particularly challenging aspect of the strategy given that defining a health issue can be a nuanced process. Teams were encouraged to use GAMA indicators as guidance.
- **Implementation** – Group work centred on curating initiatives that were high impact and cost effective. Participants were reminded that the revised AA-HA! strategy makes a concerted effort to move away from solely communicating about reducing risk and towards young people's agency and positive health interventions.
- **Monitory & Evaluation** – Prior to setting the targets, countries selected GAMA indicators to track and align to the ESA Commitment. This type of practice allows for exploratory questions on the structure, make-up, function, review and reporting processes of technical working groups.

Tailored interventions

When crafting tailored approaches to ensure no-one is left behind, countries spoke of the **importance of meaningful involvement of key populations (KPs) in the design and monitoring of programmes**. Other examples of tailored programmes were online interventions for young people living with HIV during the Covid-19 lockdown; the use of mobile units to reach young people in emergency situations; and ensuring manuals are translated into sign language and braille.

The workshop discussed the need for **gender transformative approaches (GTA)**. This calls for **a gender analysis on the root cause of inequality** and subsequent interventions that transform gender norms and power inequalities. It remains important to determine if and where a GTA approach would yield the most desired programmatic results.

Key take-home reflections and way forward

Participants agreed the meeting had been insightful and highly participatory, with vibrant levels of engagement by young people.

Participants were asked to strongly consider the following **key messages**:

- Focus on **monitoring the implementation of policies** to ensure no-one is left behind.
- In strategizing to scale up interventions, it is critical to **reach different populations** of adolescents and not only those who are easy to reach.
- **Countries that have not endorsed the ESA Commitment can do so with reservations** by indicating this in their endorsement statement.
- The **needs of adolescents must be prioritised** over programme needs.
- Countries should **maintain the relationships formed and/or strengthened during the workshop**. This could translate to meeting at country or district levels to advance the health and wellbeing adolescent agenda.

To build on the momentum of the meeting, participants agreed on the following **key actions**:

- Countries in need of **technical support** and/or interested in building their capacity to use the AA-HA! guidelines can contact WHO country or regional offices, or relevant technical persons in UNICEF, UNESCO, and UNFPA national or regional offices.
- Countries interested in **participating in any of the digital school-based screening pilots** implemented by WHO should contact their WHO country or regional office.
- Countries interested in building their capacity to **conduct the Global School-based Student Health Survey and/or the Global School Health Policies and Practices survey** can approach their WHO country or regional office.
- Each organisation to **send five learning points from the workshop** to Meron Negussie at UNFPA ESARO.
- Country teams to **refine their draft plans** and upload to the shared Google folder.
- **Prof. Sannassee of the SADC Secretariat will reach out to the relevant individuals within SADC** to consider if AA-HA! is an approach SADC countries would like to mainstream. The topic can be discussed at the next ministers meeting.
- **Morris Tayebwa of the EAC will engage sectoral ministers and additional bodies at the AU** level on the results of this meeting and the overall value add AA-AH!

Setting the Tone

Ms. Angel Babirye AfriYAN President ESA, sent up a vibrant and rallying cry to the room, articulating young people's willingness and capacity to lead. She reminded the meeting that **young people are innovative, tech savvy, and committed to contributing to change**, even as they face numerous challenges including those related to poor mental health, unsupportive environments and lack of sexual and reproductive health (SRH) services. Ms Babirye stressed the importance of meaningful youth engagement and the involvement of young people in every aspect of programme interventions and decision-making processes.

> *Provide us with the space for self expression and empower us to lead initiatives. Let's move beyond tokenistic investment and genuinely prioritise young people's needs. Let's be partners in change. Young people are the experts of our lives and we have insights into policies that impact us. Let's turn commitments into real actions.*
>
> **Angel Babirye AfriYAN President, ESA**

East African Community (EAC) Representative, Mr Morris Tayebwa, echoed these sentiments. He stressed that only by **harnessing the capabilities of young people**, especially during the unique stage of life that is adolescence, can we **harness the potential of the region**. This underscores the importance of national commitments to regional accountability frameworks.

Prof. Vinesh Robin Sannassee of SADC Secretariat noted that while adolescent outcomes such as school enrolment and access to health services have improved, there's a **shared sense of urgency to expedite actions relating to mental health, HIV, malnutrition and in particular, health systems strengthening**. These continue to serve as barriers to access and youth participation. The renewed ESA Commitment offers an opportunity to explore how this new phase of the framework relates to legislation and policy impacting adolescent health. It remains imperative that **a new or existing road map must translate to meaningful results**.

On behalf of the UN family, **Ms. Chinwe Ogbonna, Deputy Regional Director, UNFPA ESARO**, reminded the meeting that it remains **impossible to co-create a positive future without the active input of young people**. She encouraged an intersectional reflection on issues that impact the health and education of young people, such as economic empowerment and social entrepreneurship.

Ms Ogbonna highlighted Pact for the Future, an international agreement signed in September 2024 with a focus on future generations. This is another opportunity for countries to align the tailored actions across the agreement's various objectives, with continental frameworks such as Agenda 2063 and regional SADC and EAC frameworks. The Deputy Regional Director highlighted **five critical points**:

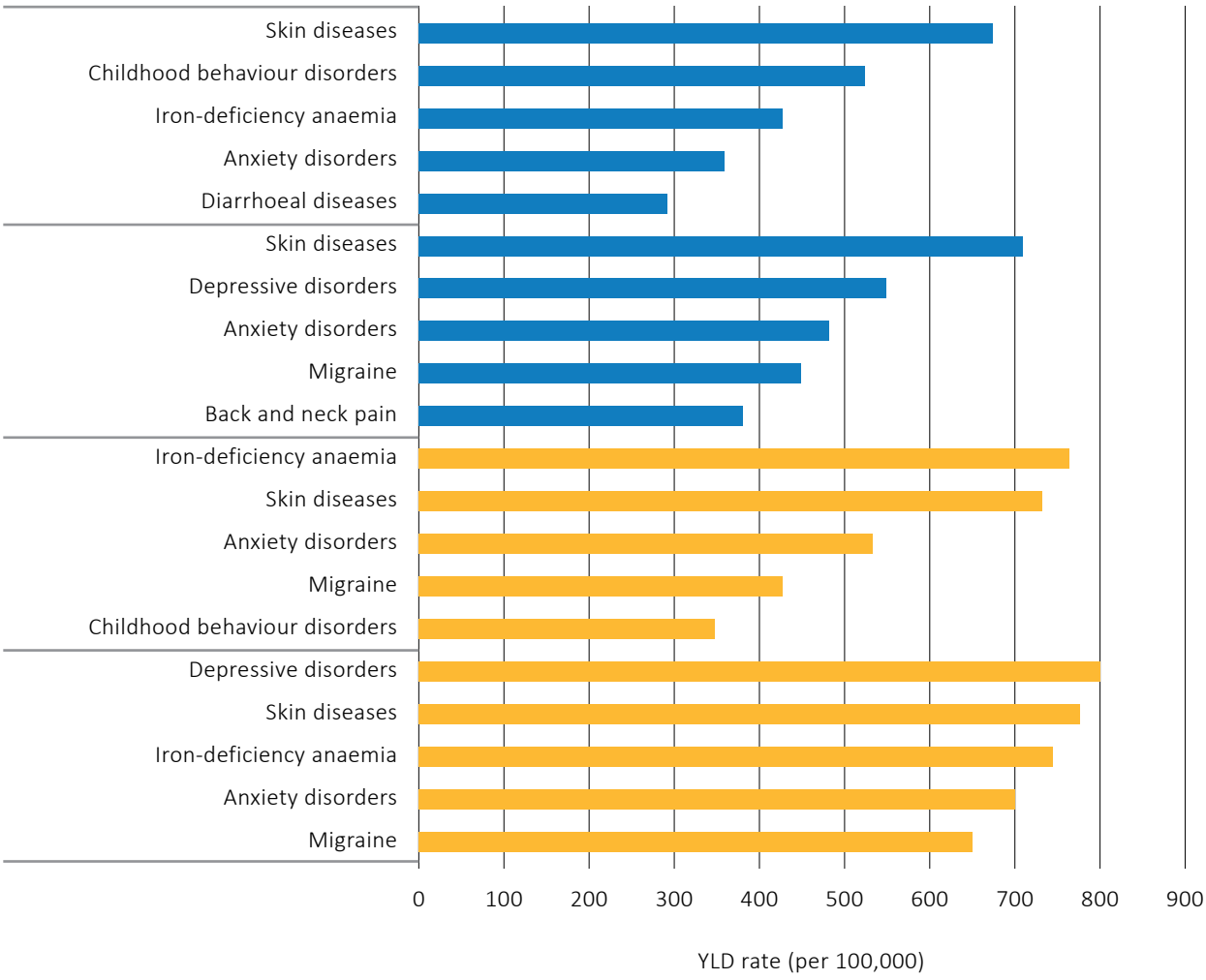
- The importance of **strong narratives informed by evidence**. This should clearly demonstrate how long-term investment will bring about, among others, national peace and security, collaboration and stability.
- **Reimagining and rethinking** which calls on us to step outside our comfort zones and apply fresh perspective to policies, legislation and accountability mechanisms.
- **The power of data** which must speak to intersectionality and hot spot analyses. This includes considering the investments needed for high impact, who's being left behind, and the type of evidence required for scale up.
- **Pace and scale** which forces discussions on the digital divide. It also ushers in critical reflection on the implications of artificial intelligence on human intellectual ability.
- **Raising friends**, a notion that speaks to the increasing move towards collaborations with private sectors partners and international financial institutions. Relationships must be based on shared visions and countries must bring credible ideas and proposals to the table.

Setting the Scene

Status and trends of adolescents health and wellbeing in ESA

Dr. Geoffery Bisoborwa, WHO AFRO, noted that since 2000, **there has been an overall decline in all-cause adolescent mortality**, with the biggest reduction among adolescent boys aged 15 to 19 years. AA-HA!2.0 also considered adolescent morbidity measured as the adolescent's years of life lost due to disability (YLD). Following years of declining YLD rates in Africa, 2019 and beyond saw an increase in YLD, most notably in females aged 15 to 19 years.

Main causes of adolescent YLDs by age, AFR. 2021



Source: WHO Global Health Estimates, 2024

Skin diseases remain prevalent among both genders and age categories in Africa, with iron deficient anaemia notable in young and older adolescent girls. Africa is similar to the rest of the world with school children (aged 11–17 years) not meeting WHO physical activity guidelines. As a result, obesity is now an issue. While the health impacts may not be visible until early adulthood, the seeds of this problem would have been planted during adolescence.

Protective factors for adolescent health and wellbeing:

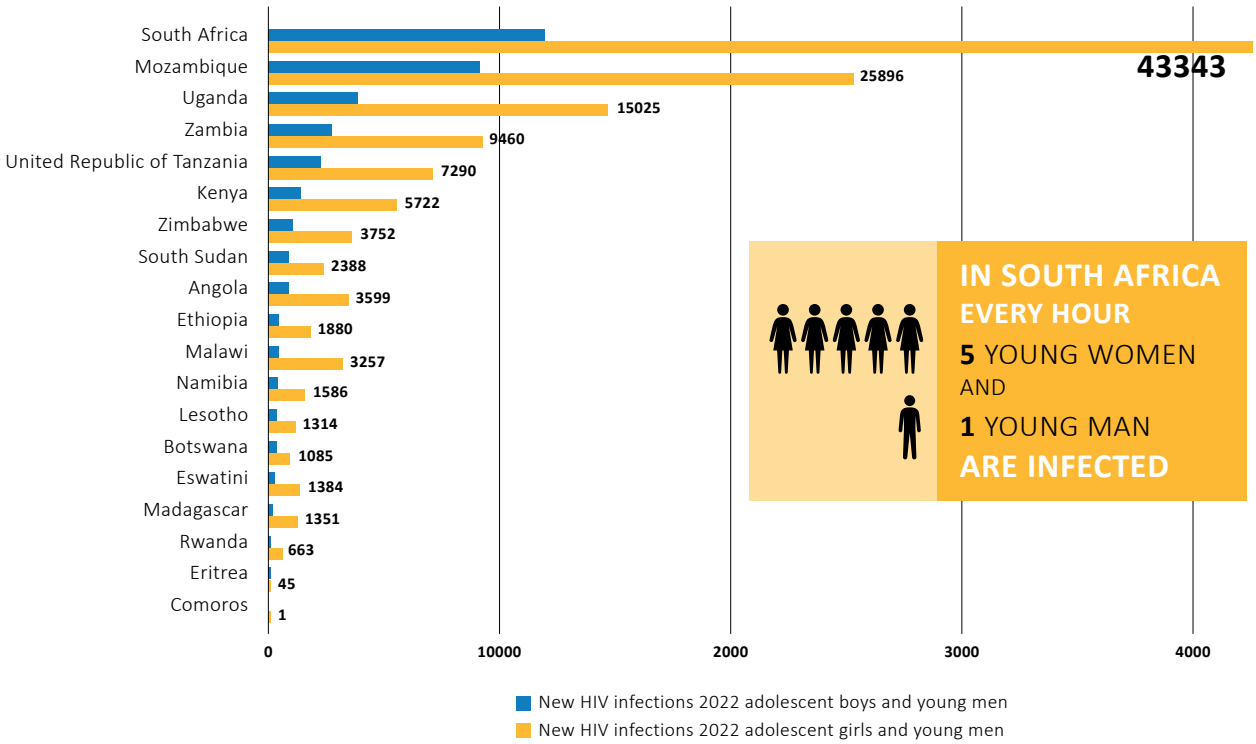
- Healthy diets
- Connectedness, positive values and contribution to society
- Safety and supportive environment
- Learning competency, education, skills, and employability
- Agency and resilience

In addition, **Dr Bisoborwa's** presentation showed that **unsafe sex remains the highest risk factor for morbidity and mortality among adolescents 15-19 years in sub-Saharan Africa, with an evident gendered dimension**: in 2022, 85% of new HIV infections in adolescents 15 to 19 years were girls. Higher infection rates in females as compared to males can be found in all age groups.

Ms. Rudo Mhonde-Chiutsi of UNFPA ESARO, offered a snapshot of some of the interrelated SRH issues affecting adolescents in the ESA region:

- The adolescent birth rate and the unmet need for family planning (FP) among married 15- to 19-year-olds is declining but not nearly quickly enough. An urban/rural divide continues to affect access to information and FP commodities.
- High levels of HIV infections in females are rooted in high levels of transactional and inter-generational sex.
- School completion is lower in secondary than in primary school, especially for girls who experience pregnancy. Lower school completion is linked to higher risk of HIV infection.
- Harmful practices such as being married by age 18 are seeing a downward trend, although there are regional variations.

Estimated number of new HIV infections per week among 15-24 females and males in ESA



Source: Prepared by RST ESA SI Hub based on UNAIDS 2023 estimates

Lerato's Story

Contraception was a word whispered in harsh tones; a concept shrouded in mystery and misinformation. There was a fierce determination in Lerato's young heart. She would not be another statistic, another girl whose dreams were shattered by unplanned pregnancy.

The journey was not easy; Lerato juggled late night study sessions with diaper changes and sleepless nights. Her father motivated her to focus on school and she would enjoy her marriage later. Just one month into university. Lerato found herself pregnant with her second child. The first child was only five months old.

With her father's unwavering support, she chose a different plan. He gently refused the lobola offerings, his eyes filling with a quiet understanding. "Your education is your dowry," he declared. "A gift to yourself, a foundation for your future."

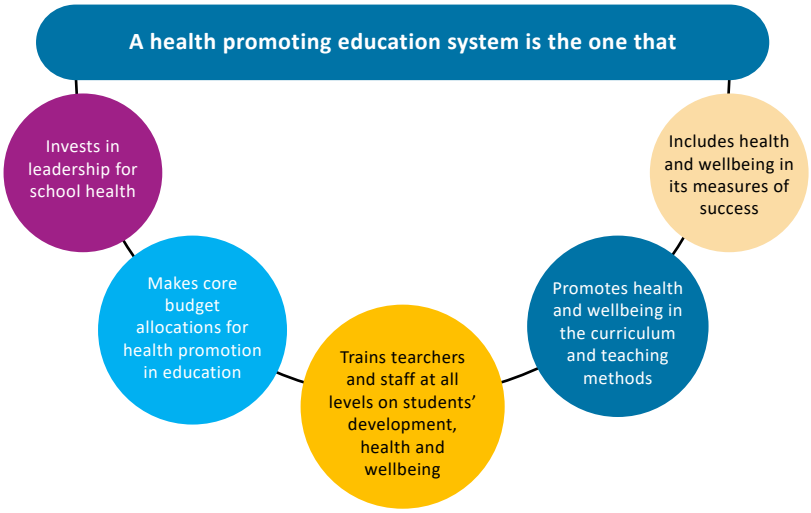
Can you imagine the stress, post-partum depression, enduring whispering and judgements and curious stares? But through it all, a fire burned within her, fuelled by her father's beliefs and by her own unyielding ambition.

Lerato graduated with her degree, even went on to complete her Masters degree at the University of Botswana. Lerato's story is a beacon of hope; a reminder that with determination and support, girls can achieve their dreams, regardless of the challenges that they face.

A personal account shared during the workshop

Making every school a health promoting school (HPS)

From a HPS perspective, schools are institutions that promote holistic, long-term approaches to health among the school, students, staff and communities. Within the HPS approach, the Ministry of Education (MoE) is encouraged to take on more responsibility. In this way, the health department acts as a technical partner in a comprehensive approach to health and wellbeing. In this context, comprehensive refers to what is affordable, rather than a wide bundle of services.



*HPS is a coordinated action with an intersectoral approach. It can be **school-based** with a clinic operating within the school, or **school-linked** where health centres consider schools within their catchment area as part of their population.*

Countries can be supported to build their health promoting education systems. Existing global guidance and standards, implementation guidelines, and country case studies and country experiences can help make this happen. Beyond merely adopting principles, schools will be shown how to move towards systemic strengthening and developing measurable standards. Here, WHO's eight global standards for quality health-care services for adolescents can prove useful.

WHO is currently running several pilots, such as a digital school-based screening programme for young and older adolescents where on-the-spot care is linked to a primary health service. Countries interested in taking part in the pilot should contact WHO.

Mapping of global and regional SRHR commitments and status of domestication

An enabling environment is a critical component of successful AYH programming. In 2022, the regional ***2gether 4 SRHR*** programme, commissioned a study to assess the extent to which global, continental and regional SRHR frameworks have been incorporated into national policies, strategies and frameworks in ESA.

Among the many findings, the study concluded that:

- Countries are performing well regarding the alignment of select SDGs and International Conference on Population and Development (ICPD) provisions.
- Close to half of the countries in ESA have achieved at least 60% of the Maputo Plan of Action policy indicators.
- Many countries are failing to meet the Abuja target of allocating at least 15% of their domestic budget to improve healthcare.
- No policy framework reviewed in the seven EAC countries in the areas of SRHR, HIV and GBV makes direct reference to the EAC Integrated RMNCAH Policy Guideline.
- 12 out of 14 SADC countries have reviewed, improved or enacted new laws to address GBV against women, men, youth, children and adolescents.

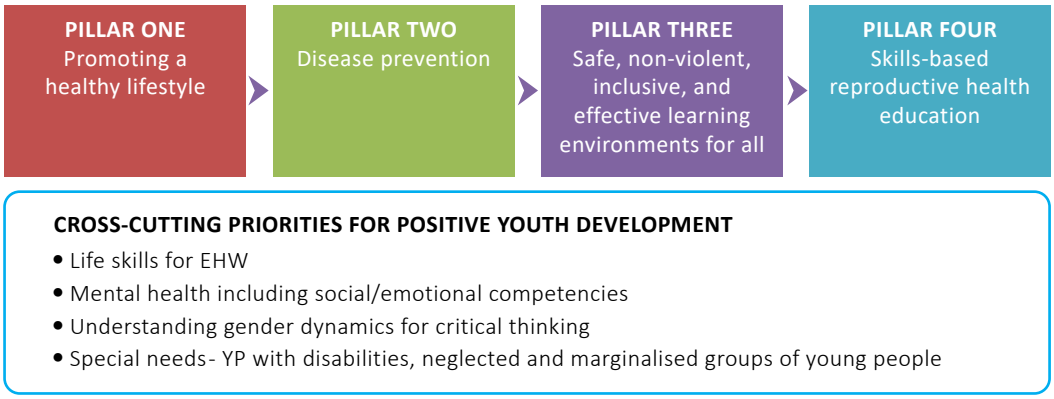
Facilitators to domestication include advocacy from CSOs that keep governments accountable; technical and financial support rendered by CSOs and development partners; and opportunities for countries to engage in peer-to-peer learning.

However, cultural and religious sensitivities, lengthy and complicated policy-making processes, and the perception that international frameworks are informed by foreign ideas remain barriers to domestication.

Continental Frameworks for Education, for Health, and Wellbeing

Remmy Shawa, UNESCO, and **Cynthia Lungu, UNAIDS,** gave an overview of key AYH frameworks. **The AU Continental Strategy on Education for Health and Wellbeing (AU Education, Health and Wellbeing (EHW) Strategy**) serves as a blueprint for the RECs and Member States to implement a collective body of health promotion work for the benefit of learners across the continent. The **renewed ESA Commitment** connects health, education, and social service systems and other support mechanisms, while **Education Plus** works with adolescent girls and young women, using completion of secondary education as an entry point.

AU EHW Strategy

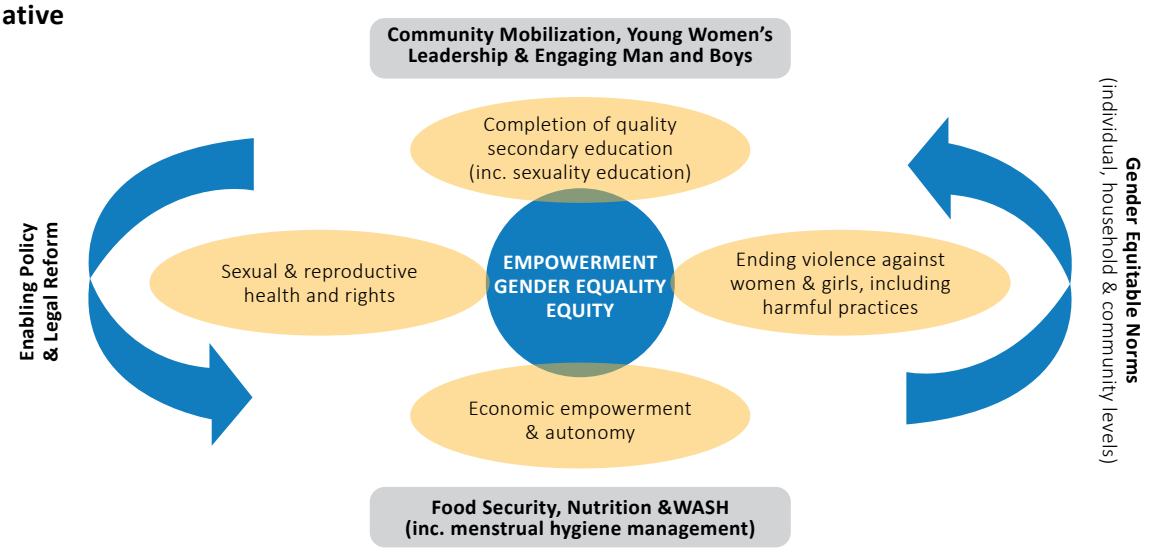


ESA Commitment 2021-2030

Renewed Commitment

- Continue investing in high quality, evidence-based, gender-transformative, and age-appropriate sexuality education.
- Address the structural factors that increase the vulnerability of adolescents and young people and their risk of acquiring HIV and STIs.
- Ensure the inclusion of adolescent SRHR within the national Universal Health Coverage packages.
- Connect health, education and social service systems and other support mechanisms.
- Meaningful involvement of adolescents and young people in decision-making, planning, implementation, and M & E.
- Ensure that interventions at national level are well-targeted and evidence-based.
- Strenthen the role of community organizations and community actors to improve engagement and dialogue.
- Promote the attainment of the ESA Commitment by ensuring that national policy and programme delivery, and related and supporting continental and regional Commitments.
- Coordinate and support the development of national mutisectoral and multistakeholder plans.

Education Plus Initiative



When **Mozambique endorsed the ESA Commitment**, it did so using the HIV sectoral platform. All institutions were represented, including government departments, youth associations, and religious associations. This facilitated a smoother domestication process. The education sector utilised the 2019 UNESCO guide on sexual education, and a communication manual for HIV in the education sector. Extended training for teachers was rolled out, resulting in their increased capacity to teach the subject. In addition to increased knowledge over content, pedagogical skills were sharpened.

In Uganda, under government leadership, the UN family is spearheading harmonized support for adolescent wellbeing. In 2022, Uganda's First Lady launched "The Education Plus Initiative," a high-level advocacy drive to accelerate action and investment for adolescents, supported by multiple UN agencies, led by UNESCO. A framework for action was developed and co-signed by the ministries of education, health and gender, and the Uganda AIDS Commission. The Minister of Gender, Labour and Social Development also called for the integration of elements of Education Plus into the Spotlight Initiative, a global effort supported by the EU and UN to end violence against girls and women. Education Plus is also complemented by activities under 2gether 4 SRHR and UN Women's support to Second Chance Education. Uganda is hosting a symposium later in 2025 to further galvanize funding partners under the important umbrella of holistic, multisectoral action.

The meeting agreed that since endorsement of the ESA Commitment is done in the form of a letter drafted by countries, there is room for countries to include reservations in their statement.

UNITED! Young People Leading Change

In many ways and on many different levels, young people are at the forefront of driving national changes relating to AYH. In a panel discussion with **Angel Ukwishaka Uwimbabazi (Rwanda), Ibrahim Kalimbaga (Tanzania), Stessy Kaze (Burundi), Evelyn Namaiko (Zambia)** and **Seluleko Simelane (Eswatini)**, the meeting learned that:

- AfriYan was successful in helping Rwanda integrate CSE into the national curriculum. The network also translated the guide into local languages and ensured it included a component for out-of-school youth. In general, where AfriYan chapters have been established, there have been increased numbers of youth corners and youth centres designed for peer-to-peer information sharing and learning.
- Young people in Eswatini working in organisations like SAfAIDS, a regional body committed to realising SRHR in Southern Africa, are capacitated to provide reliable and digitally appropriate information to their peers. The country's MoH supports these efforts, and young people are seen as social accountability monitoring champions.
- Young people in Zambia participated in the country's Key Performance interviews and project meetings focused on adolescent girls and young women. This was facilitated via the UNITED! Movement (which strengthens young people's advocacy and leadership capacity in response to HIV and SRHR in ESA) and UNICEF.
- Tanzania's National Council of People Living with HIV successfully advocated for reducing the age of consent for HIV testing in Tanzania from 18 years to 15 years. The organisation currently has a permanent seat in all HIV technical working groups in the country.
- In Burundi, clubs for young people address the lack of information on sexuality education, particularly faced by those in rural areas and those not enrolled in school. The local manufacture of sanitary pads is part of a strategy to support young girls from low-income backgrounds experiencing period poverty.

Panel recommendations for low cost/high impact interventions for adolescent health programming:

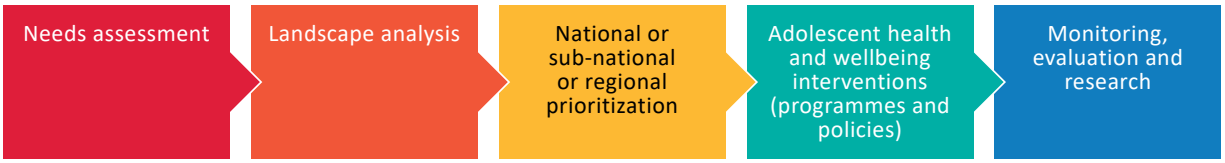
- Develop a differentiated service delivery approach in the communities
- Invest in young people in the rural areas as human capital
- Improve youth friendliness of health facilities, focusing on language used and staff attitudes. This speaks to improving accessibility rather than simply availability of services.

The transition from AA-HA! 1.0 to 2.0 and its applicability

Frameworks like AA-HA! help countries think of programmatic interventions in an incremental, multi-sectoral and cost-effective manner. Dr. Prerna Banati and Dr. Regina Guthold of WHO HQ provided an overview of both versions of AA-HA!, a guidance document which assists governments in identifying priorities and implementation strategies for adolescents.

AA-HA! 2.0 was launched in 2023 and builds on significant political and scientific advances since the initial 2017 version. It also includes learnings from version one, Covid-19 considerations, and new data and trends related to adolescent health and wellbeing.

AA-HA process in a nutshell



Country experiences using the first version of AA-HA! include:

- **Nigeria** used AA-HA! in the development of its 2020 adolescent health flagship programme. The process involved 28 states and 680 adolescents. Technical working groups (TWGs) for adolescents were established at national and subnational levels and a national M&E framework for adolescents was developed and integrated into the national HMIS. The analysis revealed inadequate consideration for adolescents in emergency settings as well as mental health services. One key learning was the importance of capacitating young people to speak to Members of Parliament.
- **Kenya** used AA-HA! to conduct a needs assessment at subnational level. The results revealed the top factors affecting adolescent mortality in girls and boys ages 10-19. The country recently developed the first adolescence TB website which will include all SRH issues, while draft parental guidelines are aimed at assisting religious leaders to better understand adolescents. The involvement of the Judiciary is instrumental in addressing SRHR for adolescents in correctional facilities.
- **South Africa** - Training on AA-HA! proved instrumental to programming around adolescents. The country is now generating disaggregated data for 10- to 14-year-olds and 15- to 19-year-olds. There are youth zones in health facilities and a National Adolescence and Youth Advisory panel which speaks to meaningful engagement. AA-HA! is also facilitating the increased reporting of child abuse since all childbirths by mothers aged 10 to 15 years must be reported as cases of abuse.

The facilitators unpacked the concepts, thinking and principles that underpin each step of the AA-HA! framework. At each step, country teams were given opportunities to practically apply the principles by engaging in group work. Findings were shared in plenary.

STEP 1. Needs Assessment

A needs assessment takes stock of the adolescent health and wellbeing situation and trends in a country. It identifies which conditions have the greatest impact on adolescent health and development, looking at adolescents at all levels of risk.

Groups were required to identify the data sources that would inform a needs assessment, the main adolescent health issues in the country, the adolescent sub-groups in greatest need and the glaring national data gaps. The following country experiences were shared:

- **Malawi** – The team determined that, among others, the Malawi Demographic Health Surveys, the Multiple Inter Cluster Surveys, and information from development partners such as UNAIDS and WHO would serve as key data sources. Top issues identified by the country team included child marriage, teenage pregnancy, high adolescent birth rate and high rates of new incidences of HIV and STIs.
- **Zimbabwe** – The country team identified adolescent sub-groups such as those living with HIV, those pregnant and lactating, and those in farming, informal mining and disaster-prone areas to be in the greatest need. The team stated that lack of coverage on emerging issues such as obesity, and drugs and substance use, as well as lack of disaggregation of data for10 to 14 years olds are notable gaps.
- **South Sudan**- The team identified the main adolescent issues in the country as violence and road traffic injuries, malnutrition and malaria, HIV, and respiratory tract infections. Adolescent sub-groups in South Sudan in greatest need are refugees and internally displaced persons, street children and adolescents in pastoral areas. Along with the inaccessibility of data, the country is challenged with outdated DHS data.

STEP 2. Landscape Analysis

To conduct a landscape analysis, country teams were asked to select one or two needs identified in the needs assessment phase and identify the existing national initiatives to address this need, as well as any notable gaps.

Namibia highlighted the outdatedness of some of its laws. For example, not only has its abortion law remained unchanged since 1975, current tobacco laws do not address vaping. With some pieces of legislation referring to children as 14 year olds, 16 year olds or 18 year olds, this non-alignment can be manipulated when children are abused. On the issue of school dropout, **Tanzania** has several favourable laws and policies on re-entry and completion of education. However, implementation of programmes to realise these laws are on a small scale and heavily dependent on donor funding.

In **The Seychelles**, the harmonisation of the Marriage Law and Age of Consent for Sex has been in Cabinet for over 10 years, awaiting endorsement. While there are several laws and policies that speak to CSE, the lack of adequate budget to undertake programmes is significant, as is the need for capacity building and human resources to undertake M&E.

World Café: Experiences with ESA Commitment and Education Plus

Ethiopia focuses on engaging policymakers, religious and traditional leaders in implementing education for health and wellbeing. While the country has not endorsed ESA, it is still implementing activities to reach targets within the ESA commitment. Even as the term "CSE" received pushback from the MoE and MoH, training for more than 200 federal parliament members was convened. This presented an opportunity for UN and other bodies to present alarming but persuasive findings related to adolescent health. As a result of the weight carried by the scientific evidence, the government committed to providing the necessary support. Religious and community leaders were also trained using the same approach, even as religious doctrines restrict open discussion about AYSRH.

Uganda has not yet endorsed the ESA Commitment but is implementing the Education Plus Initiative. Both are aligned to Uganda's goals to reduce school-related violence, and both promote the cross-sector collaboration aims reflected in Uganda's National Development Plan. A multi-sectoral TWG meets quarterly to address school-based violence. In addition, teachers have received training, and Reporting, Tracking, Referral and Response Guidelines have been developed. Parental and community involvement is notable, even amidst challenges such as deeply rooted cultural, societal and gender norms, weak enforcement of policies and laws, weak capacity and insufficient resources.

In **Zimbabwe**, young people are engaged through the use of the grievance redress mechanisms (GRM) to provide feedback on health services. The GRM is structured so that complaints are completed in triplicate with relevant stakeholders taking responsibility for their area of follow-up. Country level successes include peer-led models such as the Young Mentor Mothers programme and the development of safe spaces for young women selling sex. Youth-led advocacy is demonstrated in the existence of the Junior parliament, and young people serving as members of various parastatals and boards. The "*Not in my Village*" campaign is a youth-community partnership focused on ending adolescent pregnancies.

STEP 3. National Prioritisation

This particularly challenging aspect of the AA-HA! strategy focuses on balancing and prioritising the needs of all stakeholders. Building on the first two steps of the framework, priority setting considers evidence-based interventions identified in step two, and the most vulnerable populations of adolescents identified in step one. Countries were required to prioritise a health issue as well as its related interventions based on magnitude, equity, effectiveness and feasibility.

Country teams found this a useful exercise. For example:

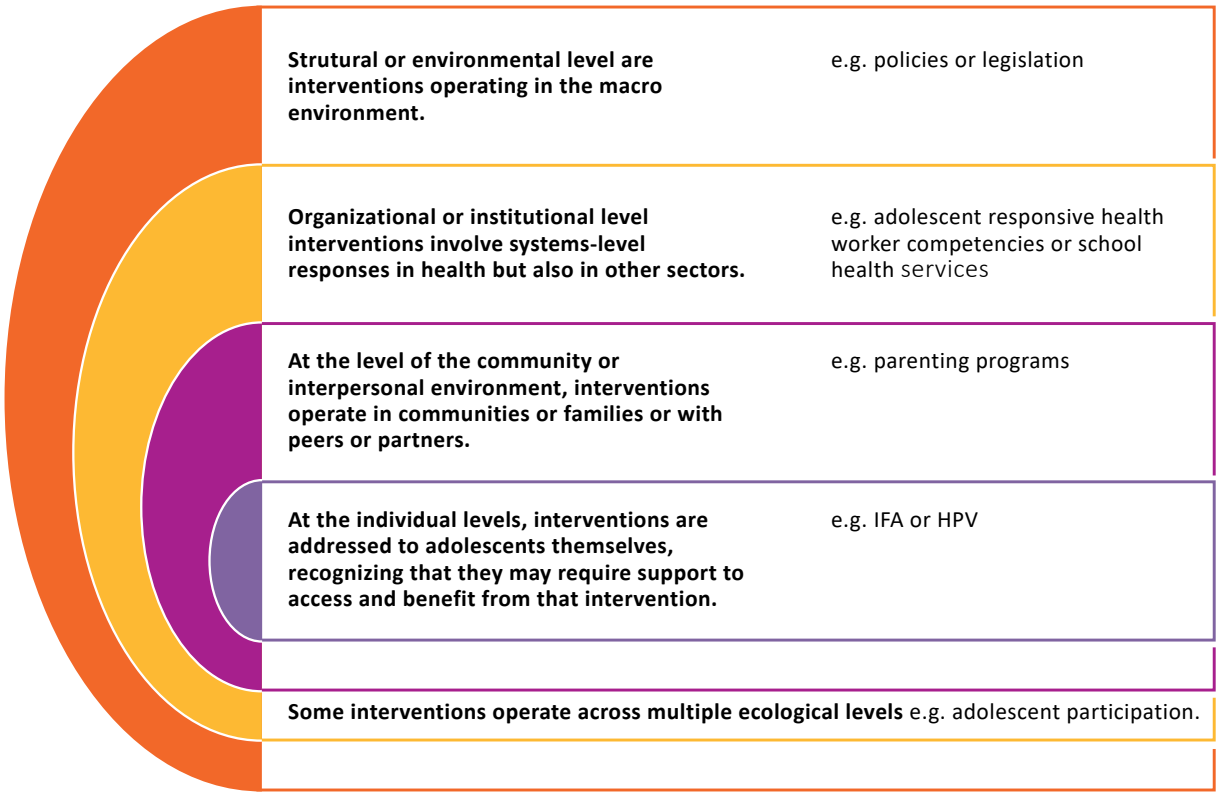
- **Angola** decided on increasing access to SRH information among adolescents and young people to respond to the country's top issue of early pregnancy. The campaign, focusing on providing accurate and up to date information on SRH, would be promoted online and on social media. In addition, through videos and interviews, specialists would be invited to communicate information about SRH and early pregnancy.
- **Eswatini** reported teenage pregnancy a prioritised health issue and opted to focus on developing an intervention integrating school GBV case reporting into the national surveillance system.
- **Madagascar** chose to address the country's high birth rate among adolescents aged 15-19 with a dedicated peer education programme and the establishment of distribution channels for contraceptive products for young people.
- **Ethiopia** also placed teenage pregnancy at the top of the health issues to be addressed. The country team identified various interventions to improve life skills and access to services for adolescents such as the RISE project, the Her Space Programme, the Act with Her Project and Kefeta, an integrated youth programme.

The meeting participants agreed that defining a health issue can be a very nuanced, and therefore challenging, process. **Countries were encouraged to use The Global Action for Measurement of Adolescent health (GAMA) indicators as guidance and to maintain consistency during the process**.

STEP 4. Implementation

Participants discussed what works for adolescent health and wellbeing. When interventions are implemented well, the result is high impact and cost effectiveness. One aspect of the revised AA-HA! strategy is a change of language, a move away from communicating solely about reducing risk, and instead, towards harnessing young people's agency and positive health interventions. Accelerator interventions are combination interventions that, together, amplify effects across multiple domains of adolescent wellbeing.

Interventions operate at all levels of the social ecology



Types of interventions

- Adolescent-specific interventions
- Interventions with wider impacts but with specific benefits for adolescents
- Interventions with wider impacts that need age-appropriate design to be effective for adolescents.

In groups, country teams were asked to identify interventions, packages, or approaches currently being used that effectively improve adolescent outcomes. Next, they provided a short description of the implementation process and highlighted any supporting evidence, data, or references that demonstrated the impact of the strategy.

Rwanda, in discussing an intervention aimed at improving adolescent mental health, spoke of a focus on strengthening health systems and training healthcare professionals on the provision of mental health support services. There are also school-based mental health services and community-based interventions with mental health as an entry point.

Lesotho's efforts to address EUP is centred on CSE in and out of school and works on an individual, interpersonal and community level. In-school focuses on developing the capacity of teachers, reviewing and strengthening the school curriculum and strengthening linkages to SRH services. To increase reach for out-of-school children, Lesotho invests in training peer educators.

South Sudan's efforts to address teenage pregnancy also focuses on scaling up and strengthening CSE. The country's TWG on the ESA Commitment meets quarterly and multisectoral cooperation is evident with religious leaders and CSOs participating in the TWG.

AA-HA! says AWESOME

A **Adolecents** are not simply old children or young adults.

W **Wellbeing** is more than the absence of disease. It means optimum nutrition, good education, connectedness, agency, and supportive environments.

E **Effective** solutions exist, and they should be available to every adolescent.

S **Sector & Stewardship** multisectoral action is crucial, and requires strong stewardship across government.

O **Ownership** by adolescents, for adolescents of decisions affecting their lives is a right!

M **Multiplier effect** throughout life and across generations results from investments in adolescents wellbeing.

E **Equity** means "every adolescent counts!"

Working together: Adolescent Responsive and Health Promoting Systems

Panelists **Aveneni Mangombe (Zimbabwe), Cloudina Venaani (Namibia)** and **Phyllis Mavinda (Kenya)** discussed how they effectively facilitated collaboration among different stakeholders to enhance adolescent health and wellbeing. Country highlights include:

- **Namibia**- After notable backlash, the country re-endorsed the ESA Commitment. As a result of its social contracting policy, the state now supports CSOs in their outreach activities, including the provision of commodities in schools. In a progressive move, HIV testing is allowed in schools and condoms are distributed by Life Skills teachers. Achievements include the #BeFree movement, a youth-led campaign, and the #BeFree Youth Campus launched in 2023. The latter functions much like a one-stop centre.

- **Zimbabwe**- In the past 10 years, an adolescent sexual health and reproductive forum has been operational within the context of school health policy. Although initially SRHR focused, the ministries of women affairs, youth, and other relevant line ministries were subsequently brought on board. Every ministry in Zimbabwe now has a Youth Desk structured according to thematic areas, and young people engaged receive honoraria.

- **Kenya** – The country's interministerial working group responds to what is deemed the triple threat- teenage pregnancy, HIV, and GBV. Some of the country's achievements include the establishment of a Directorate of Policy, Partnership and East African Community Affairs. In addition, the MoH has created an insurance fund for learners in the form of the EDUAFYA Medical Scheme. In this way, learners have access to comprehensive health coverage, as well as referrals. Notable programmes include the Linda Mama (*take care of the mother*) Programme and the Beyond Zero campaign, led by the First Lady, which addresses maternal mortality.

Principles for adolescent health and wellbeing programming

While Africa is performing relatively well regarding leadership for adolescent health, too few governments have specialised budgets for the issue. In addition, young people in many African countries are still required to pay for services such as STI testing and mental health services. Governments can focus on pooling and/or aligning budgets and exploring opportunities for in-kind support. The goal is to maximize the number of adolescents covered and reduce and remove out of pocket payments.

Equity in adolescent health programmes means exploring how gender responsive and/or gender transformative the intervention. There is also a need to take an intersectional approach which considers age, sexuality, disability, and other types of vulnerabilities, something the AA-AH! guidance also includes. While the framework does not assist with setting up a research agenda for adolescents, WHO has a process in place for supporting such work.

In fragile and humanitarian settings, where systems are notable weak, the needs of adolescents often fall away. With adolescence understood as the last growth window, nutrition programmes for adolescents are important and perhaps nowhere more than in emergency settings.

Adolescent-responsive systems have the following components

Leadership for adolescent health in the Ministry of Health and cross government

Adolescent protective laws and policies

Adolescent-responsive financing

Service delivery platforms that maximize coverage and promote quality

Adolescent-competent providers

Adolescent-mindful HMIS

Adolescent leadership and participation in programming for health and wellbeing

Challenges and gaps in AYH Programming in ESA

Panelists **Dr. Wegen Shiferaw (Ethiopia), Stanley Ndlovu (South Africa)** and **Dr. Abigail Tuchili (Zambia)** shared country experiences on the challenges and gaps in AYH programming.

Highlights of the panel discussion include:

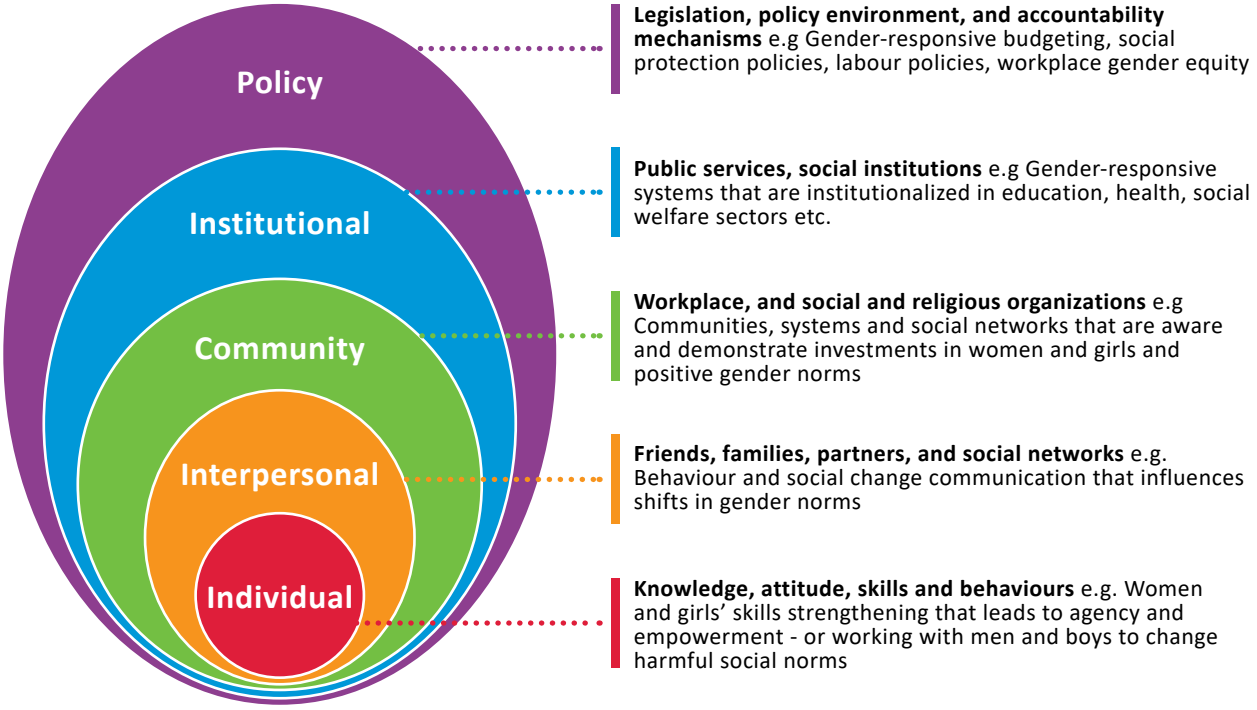
- **Ethiopia** – While the country established a national and subnational AYH council, there are still challenges regarding coordination of the different sectors involved in adolescent health. Lack of quality training of staff is rooted in limited budgets and human resources. In addition, adolescents remain hard-to-reach, restricted by geographic access and social and cultural barriers. Greater efforts are required to improve involvement of adolescents and communities in the design and implementation of health programmes.
- **South Africa** – The interministerial committee on CSE is led by MoE, and out-of-school adolescents are provided with food parcels from the Department of Social Development. The health services offered in schools are guided by Standard Operating Procedures and provided by DoH with the support of partners. Youth zones in every health facility and an advisory panel of young people advising the Minster of Health are examples of meaningful youth engagement. Programming for CSE for children with special needs is currently being developed with support from UNESCO and UNFPA.
- **Zambia** – When implementing the ESA commitment, the country conducted a needs assessment in 10 provinces. Because the term "CSE" received push back, it became necessary for Zambia to clearly communicate that the curriculum content was based on UNESCO materials. This helped dispel doubts and criticism from religious and traditional leaders but still led to changing the programme to *Life Skills and Health Education*. Currently, CSE programmes are taught as part of teacher training courses.

Gender transformative programming for health

Sarah Ries of UNFPA ESARO demonstrated how a gender transformative approach (GTA) can help make progress towards the equal distribution of power, resources, and opportunities/services between women and men. GTAs reinforce human rights approaches, operationalising the principle of leaving no one behind. **GTAs deliberately challenge the underlying factors, social norms and root factors that continue to fuel gender inequality.**

Research on SRHR programmes has shown that working simultaneously on the different levels of the socio-ecological model is more effective than focusing on interventions at a single level.

Conceptual Framework for GTA: the Socia-Ecological Model



GTAs require a gender analysis on the root cause of inequality and subsequent interventions that transform gender norms and power inequalities. While GTA is not prescriptive, it remains the smart choice as it addresses deep seated issues and brings about long term change. Notwithstanding, not all programmes are well suited for GTA. It remains important to determine if and where a GTA approach would yield the most desired programmatic results.

World Café: Experience with the ESA Commitment

71% of **Madagascar's** population is young. However, they are often perceived as immature, leading them to being excluded from the development process. Activities undertaken in Madagascar to transform social norms include intergenerational dialogues between young people and traditional authorities. This has helped to remove stereotypes about young people. The renovation of youth centres and the establishment of innovation rooms are also notable successes. There is collaboration with youth-led organisations as well as an interministerial committee on youth led by the prime minister.

Botswana has several positive experiences operationalising the ESA Commitment. These include policy and legislative development; development of service standards; youth friendly health clinics and corners; and training of health care workers. There is close collaboration between school and health facilities and HCPs schedule visits to schools. Challenges include inadequate harmonisation within the referral system as there is a lack of feedback mechanisms between schools/CSOs and health facilities to determine if adolescents received the desired services.

While **Mozambique** has endorsed the ESA Commitment, more effort is needed to meaningfully involve young people and reach those in hard-to-reach places. There is a focus on girls who are hard to reach due to unplanned pregnancies, displacement, early marriage, emergency situations, disabilities, or being in trouble with the law. Mentorship sessions with girls and boys use community TV and radio stations, and economic empowerment initiatives are among the activities implemented to reach adolescents.

Tailored Adolescent Health Programmes

Panelists shared the following country-level experiences where tailored interventions were required to meeting the needs of particular populations:

- While **Zimbabwe** has achieved epidemic control, HIV sub-epidemics show evidence of a disproportionate burden of disease among KP groups. The government oversees a differentiated HIV clinical service delivery and strategy for those in hard-to-reach places. Demand creation efforts include working with KP peers, KP micro-planners and health assistants, as well as drop-in centres and safe spaces.
- During the Covid-19 lockdown, **Botswana** began developing digital approaches to psycho-social care and converting curriculum content to e-modules. Team clubs for adolescents living with HIV transitioned to a digital platform with young people receiving phones where necessary. The overall results of the pivot to digital were mixed; post training engagement with HCPs and attendance of the club sessions increased. However, while 79% of participants were was able to compete at least one session, only 30% completed all 10 sessions.
- **Lesotho** adopted the social accountability score card to improve engagement of young people. Young people are empowered to provide feedback to peers and service providers and are capacitated to participate in health centre committees. They also serve as liaisons with village health workers and facilitate public dialogues and community discussions on adolescent health and wellbeing. This further increases demand for health services and strengthens community facility linkages. To date, 25 community action plans were developed and monitored based on score card data.
- Some of the emergency issues in **Mozambique** are an ongoing armed conflict in select districts, and Cyclones Idai and Kenneth that both made landfall in 2019. At that time, the closure of healthcare and youth centres gave way to the use of mobile units to provide SRHR, GBV and immunisation services. The national effort involved mapping of partners in the response, capacity building of service providers, and increasing mobile units. Coordinating efforts with a medical unit of armed forces in conflict areas was particularly fruitful. The use of mobile units was also instrumental in addressing the sexual violence during the emergencies.

Implementation considerations – scale, sustainability and quality

Panelists **Kefliwe Koogosotise (Botswana), Mathato Nkuatsana (Lesotho), Joaquim Saquene, (Mozambique),** and **Steady Makunike (Zimbabwe)** discussed the national-level strategies used to reach adolescents with quality programmes.

Botswana is focused on capacity building of HCPs and adherence to service standards. Expansion speaks to service points, reach (particularly for adolescents living with HIV), and programme elements. While 70% of HIV resources are domestic, there are still concerns about how funds are allocated and the absorptive capacity of implementers. Opening times for youth friendly services are currently not ideal, as they are open while learners are in school.

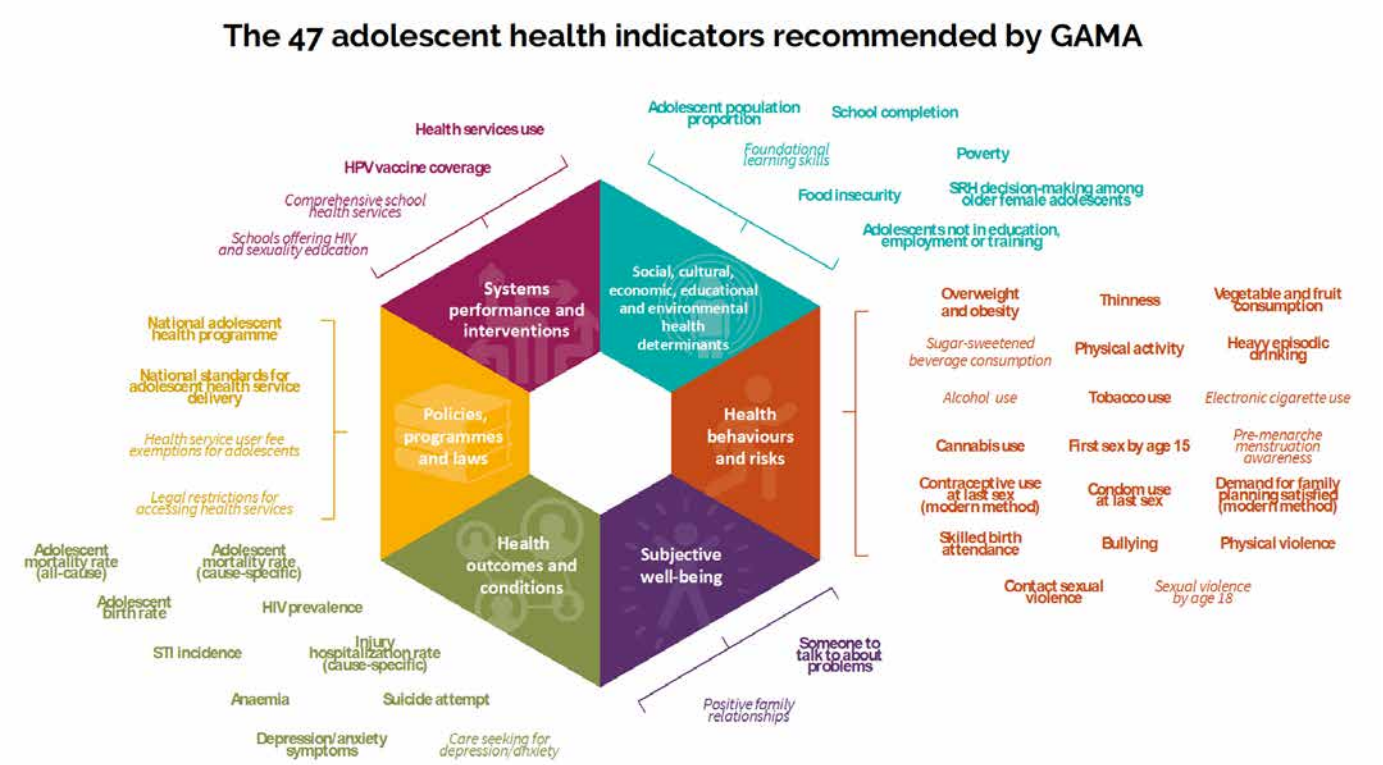
Lesotho is pursuing less off-site training and more on-site training. Capacitating higher learning institutions like nursing institutions to run adolescent health programmes, ultimately translates to the reduction of in-service training. The focus on integrated services is rooted in the fact that cultural and religious gatekeepers are much more likely to welcome integrated services as opposed to, for example, stand-alone FP services.

In **Mozambique**, WHO's eight standards on quality care have been adopted in seven provinces. There are plans to apply these standards to youth friendly services offered by mobile clinics. To address scalability, service providers have been trained to work with the youth. However, while there are over 1,100 mobile units providing healthcare, only 20% are for services to youth. The establishment of school corners where young people can receive SRHR services is imminent. There are also plans to train teachers in SRHR.

In **Zimbabwe**, quality equates to responsiveness. The country's community-led monitoring programme aims to determine the quality of services provided to KPs in hard-to-reach places. The efforts to coordinate and reduce duplication of efforts to meet KP needs in the long term require coordination of donors. To address sustainability, Zimbabwe is considering social contracting modalities for funding of HIV/SRHR programmes, including KP programmes.

Programming: Monitoring and Evaluation (M&E)

The workshop discussions on M&E centred on GAMA Advisory Group indicators. GAMA is a multi-agency collective aimed at improving and harmonizing adolescent health measurement globally. It recommends 47 adolescent health indicators. GAMA indicators build on what currently exists at country level and while they focus largely on health, a select few have been taken from the SDG indicator list. Aligning AA-HA!, GAMA, ESA commitments and other indicators are the basis for the development of one plan, one monitoring and accountability framework.



The meeting noted that the Maternal, Newborn, Child and Adolescent Health and Ageing data portal is a repository for the most recent data on adolescent health. **Global data collection tools include the Global School-based Student Health Survey (GSHS) and the Global School Health Policies and Practices survey (G-SHPPS). Countries interested in conducting one of these surveys can approach their WHO country or regional office**. Typically, there are online training sessions on data collection, sampling, analysing and reporting.

Good TWG practices identified by countries include:

- close engagement with national data collection agencies and capacity strengthening where necessary.
- sharing reporting templates in a timely manner.
- effective communication.
- attending meetings equipped with the relevant information.
- gathering inputs from members to ensure country reporting is representative.
- establishing a small committee to compile the report before presenting to the broader TWG.
- convening validation meetings.

World Café - ESA Commitment and Education Plus

In **South Sudan**, Materials for Life Skills Peace Building Education as well as the Pastoral Education Programme were developed. The concepts of the teacher training manual were also translated to South Sudan sign language and braille. The following materials were produced: 60 copies of the braille version, 100 recorders with soft copies in sound and video format, and 20 copies of the Connect with Respect toolkit for the school violence prevention programme. In addition, 100 guides and scripts were disseminated to assist teachers on using the South Sudan sign language video resource.

Tanzania has endorsed the ESA commitment while the mainland has also endorsed Education Plus. More than 600 schools have been reached by the school security and safety desk initiative. In addition, 30,000 primary and secondary school teachers were capacitated on life skills in relation to CSE. A total of 6,359 schools were reached with the EU-funded Gender Transformative Action Program initiative. Challenges include weak linkages between schools and facilities and the need for better outreach to out-of-school youth.

In **Angola**, while a law against child marriage prevents marriage before the age of 18, marriage remains possible at 16 years with parental consent. In the past, girls who were pregnant were required to attend night classes. However, the implementation of regulation that provided for girls to be in school discontinued that discriminatory practice. Currently, girls who give birth can return to school and those who are older benefit from a specific programme designed to help them catch up academically. Funding from the World Bank helped develop a Learning for All programme for girls to complete their studies.

Although **Rwanda** has not endorsed the ESA commitment, since 2018 it has been implementing the O3 Phase 1 Programme and in 2022 became a focus country. Under the umbrella of the regional Safeguard Young People programme, the country completed a mapping exercise with the AfriYan country chapter. The community score card was also developed, with communities meeting to discuss the issues raised in the score card. Young people are now members of the TWG for implementing ICPD.

After the Covid-19 lockdown in **The Seychelles**, it became necessary to follow-up with school tuck shops and outside caterers. The school staff began preparing dishes in a manner that was both nutritional and attractive for learners. Since not all schools promote personal, social and citizenship education, the issue of drugs, alcohol and nutrition (including obesity) remain challenging. There is currently a call to assign 60 minutes for physical education. Highlights of the school health programme include dental facilities in the schools; a health programme for nurses; a successful immunisation programme; and the initiation of the HPV vaccine for boys.

Country-level planning and roadmap development

Countries were asked to identify the main activities they would be undertaking in the next one to two years. The plans included process leads, the stakeholders involved, how activities will be implemented, proposed timeframe and the technical support required. Country draft plans were uploaded to a shared Google folder.

Key take-home reflections and way forward

The multi-agency organising team congratulated meeting participants on their hard work and active participation during the 5-day meeting. Representatives from youth-led organisations expressed gratitude for their involvement in the meeting, stating that learning from and sharing with such a diverse range of stakeholders was one of the rich takeaways. The AfriYan president, Angel Babirye, expressed gratitude for the significant levels of meaningful youth engagement, calling for the conversion of AA-HA! and the ESA Commitment into bite size, more digestible forms.

Participants agreed that the meeting had been insightful and highly participatory, with vibrant levels of engagement by young people.

Participants were asked to strongly consider the following **key messages**:

- It is essential to **maintain a focus on monitoring the implementation of policies** to ensure no groups are left behind.
- In strategizing to scale up interventions, it remains **critical to reach different populations of adolescents** and not only those who are easy to reach.
- **Countries that have not endorsed the ESA Commitment can do so with reservations** by indicating this in their endorsement statement.
- **The needs of adolescents must be prioritised** over programme needs.
- Countries should **maintain the relationships formed and/or strengthened during the workshop**. This could translate to meeting at country or district levels to advance the health and wellbeing adolescent agenda. The young people and organisations at country level must continue to be engaged.

There was consensus that rich information was yielded from the workshop processes, including the draft country plans. To build on the momentum, the meeting concluded with the following key actions:

- **Countries needing technical assistance or interested in building their capacity to utilise the AA-HA! guidelines** can contact WHO country offices; Dr. Prerna Banati and Dr. Regina Guthold of WHO HQ; or relevant technical persons in UNICEF, UNESCO, and UNFPA national or regional offices.
- Countries interested in **participating in any of the digital school-based screening pilots** implemented by WHO should contact their WHO country or regional office.
- Countries interested in **building capacity to conduct surveys** (Global School-based Student Health Survey and/or the Global School Health Policies and Practices Survey) can approach their WHO country or regional office.
- Each organisation to **send five learning points from the workshop** to Meron Negussie at UNFPA ESARO.

- Country teams to **refine their draft plans and roadmaps** and upload to the shared Google folder.
- **Prof. Sannassee of the SADC Secretariat will reach out to the relevant individuals within SADC** to consider if AA-HA! is an approach SADC countries would like to mainstream. The topic can be discussed at the next ministers meeting.
- **Morris Tayebwa of the EAC will engage sectoral ministers and additional bodies at the AU level** on the results of this meeting and the overall added value of AA-AH! With regional laws binding at the EAC level, engaging the East African Legislative Assembly or bodies such as the East Africa Court of Justice may hold important opportunities for utilising AA-AH!

Annexure A: List of Participants

Country	Name	Ministry/Organization	Designation
Angola	Dr. Ketha Robuz Francisco	Ministry of Health	Chief of Primary Health Care Department
	Elvis de Almeida Cambolo Kambongo	AfriYAN/SYP	Youth Advocate
	Soraya Kalongela	Ministry of Education	National Director of Pre-School and Primary Education
	Dulcineia Gonçalves	UNFPA	SYP National Coordinator a.i.
	Dr Josimar Tavares Dias	WHO	UNV Health Promotion Officer
	Ms Hirondina Cucubica	UNICEF	Health Officer
Burundi	Ms. Stessy Lorraine Kaze	AfriYAN	AFRYAN ESA Committee member
Botswana	Martin Mosima	UNESCO	National Project Officer
		Ministry of Education	
		Ministry of Health	
	Dr. MONYATSI, Ndibo Joyce	WHO	
	Kefilwe Koogotsitse	UNICEF	
Cameroon	Dr Ngalame Alphonse	WHO	
Eswatini	Ms Lindiwe Nana Dlamini	Ministry of Education and Training	Director-Education Training Guidance and Counseling services
	Ms Zandile Masangane	Ministry of Health	ASRH Technical Lead
	Mr Zwelakhe Nsibande	UNFPA	SYP Coordinator a.i.
	Mr Ruben Pages	UNICEF	Chief, Youth and Adolescent Development
	Dr. Angel Dlamini	WHO	NPO
	Mandisa Zwane	UNESCO	National Project Officer
	Thembisile Dlamini	UNAIDS	Equality and Rights for all
Ethiopia	Mr. Segni Dufera Kebebew	Ministry of Health	Adolescent and Youth Health Programme Unit Lead
	Mr. Abebe Tilahun	Ministry of Education	School Health and Nutrition Expert
	Ms. Metsehate Aynekulu	UNFPA	Programme Specialist, Adolescent and Youth Development Programme
	Tiyese Chimura	UNICEF	Health Manager
	Dr. Wegen Shiferaw	WHO	NPO/ CAH _FRH
	Daniel Mekete	UNESCO	National Project Officer
Lesotho	Malesaoana Molapo	UNESCO	National Project Officer
	ZULU, Mosala	WHO	NPO
	Maseretse Ratia	UNFPA	NPA-Adolescents and Youth
	Mpheng Molapo	Ministry of Education	Learner Care and Support
	MAthato Nkuatsana	Ministry of Health	Adolescent Health Manager
	Ms. Terezah Alwar	UNICEF	HIV/AIDS Specialist

Country	Name	Ministry/Organization	Designation
Kenya	Jane Kamau	UNESCO	National Project Officer
	Ms. Kavutha Mutuvi	UNICEF	Adolescent & HIV/AIDS Specialist
	Dr Makeba Shiroya	WHO	NPO
	Phylis Mavindu	Ministry of Education	Assistant Director of Education
	Kigen Korir	UNFPA	SRHR/Youth Advisor
	Dr. Jacqueline Kisia	Ministry of Health	Programme Manager, Adolescent Sexual and Reproductive Health at the Division of RMNCAH
Malawi	Hans Katengeza	Ministry of Health- Reproductive Health Directorate	Deputy Director, Adolescent and Youth
	Yamikani Chiphazi	AfriYAN	Advocacy FP
	Albert Saka	Ministry of Education	Chief Principle Officer, Schools Health, Nutrition and HIV Department
	Cecilia Alfandika	UNFPA	Adolescent and Youth Specialist
	Naomi Mnthali	UNESCO	National Project Officer
	Dr Susan Kambale	WHO	NPO
	Mr. Aaron Mdolo	UNICEF	HIV/AIDS Specialist
	Palikena Kaude	UNAIDS	Equality and Rights for All
Mozambique	Dr. Joaquim Saquene	Ministry of Health	SRHR Coordinator- Prevention for Adolescents and Youth
	Arlindo António Folige	Ministry of Education	Head of the School Health Department
	Patricia Grundberg	UNFPA	Programme Specialist, Gender and Human Rights
	MUTISSE, Néllia	WHO	NPO/CAH
	Dr. Daisy Trovoada	WHO	RMHCAH MCAT
	Faife Jofredino	UNESCO	National Project Officer
	Mr Edilson Matias Zumbulane	AfriYAN Mozambique	Youth Advocate
	Dr. Helga Guambe Dos Anjos	UNICEF	Health Specialist
Namibia	Mr. Ben Muleko	Ministry of Education, Arts and Culture	Chief Education Officer- School Health
	Ms. Kakuna Venokulavo	UNFPA	ASRH Analysit
	Ms. Cloudina Venaani	Ministry of Health and Social Services	Adolescent, Girls and Young Women Coordinator
	Ms. Valerie Uatanavi Mushokabanji	UNICEF	Adolescent Development Specialist
	Aina Heita	UNESCO	National Project Officer
	Dr Tempty Chigova	WHO	NPO
	Miss Puvii Hengari	AfriYAN	Communication FP

Country	Name	Ministry/Organization	Designation
United Republic of Tanzania	Dr. Mariam Ngaeje	UNFPA	Programme Specialist SRHR/A&Y Team Lead
	Gerald William George	Ministry of Education and Vocational Training	Technical officer-School health/life skills
	Mustafa Suleiman Saleh	Ministry of Education and Vocational Training	ESA Focal point
	Mr Alex Mphuru	UNICEF	Immunization Specialist
	Hasina Bukheti	UNESCO	National Project Officer
	Mathias Herman	UNESCO	National Project Officer
	Dr. Nemes Iriya	WHO	NPO/CAH
	Mr Ibrahim Kalimbaga	Network of Young People Living with HIV (NYP+)	Youth Advocate
Uganda	Ismael Mulindwa	Ministry of Education and Sports	Director Basic and Secondary Education
	Dr. Racheal Beyagira	Ministry of Health	Asst Commissioner Adolescent and School Health
	Angel Babirye	AfriYAN	AfriYAN ESA President
	Anne Alan Sizomu	UNFPA	Programme Specialist- AYSRH
	Mr. BODO, Bongomin	WHO	NPO
	Sarah Nakku	UNAIDS	Equality and Rights for all
	ALEMU, Kurabachew	WHO	RMNCAH MCAT
	Teddy Nabwire	UNESCO	National Project Officer
	Dr Barbara Asire	UNICEF	HIV/AIDS Specialist
Rwanda	Ali Ndizeye	UNFPA	Youth Development Analyst
	Angel Ukwishaka Uwimbabazi	AfriYAN	AfriYAN ESA SG
	Ben Alexandre Mpozembizi	UNESCO	National Project Officer
	Ms. Victoria Chuwa	UNICEF	Health Specialist
	Dr Theopista John KABUTENI	WHO	NPO
	Sylvie Uwimbabazi	MOE	Director of the Cross Cutting unit
		MOH	
South Africa	Precious Magogodi	UNFPA	Adolescent & Youth
	Salome Sigida	UNESCO	National Project Officer
	Ms. Boitumelo Morakile	UNICEF	HIV/AIDS Officer
	Ms Hlamalani Nenzhelele	Department of Health	ASRHR
	Roseline DOE	WHO	RMNCAH MCAT
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	Mr Terrence Magoro	WHO	NPO
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Country	Name	Ministry/Organization	Designation
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	Esther Akumu Achire	Ministry of General Education & Instruction	Director General for Gender & Inclusive Education
	Mary Marle	UNFPA	Programme Analyst, SRH
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	Dr. Abigail Tuchili	Ministry of Education	Deputy Director- Curriculum
	Alice Saili	UNESCO	National Project Officer
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	Miss Evelyn Namaiko	Zambia Network of Young People Living with HIV (ZNYP+)	Youth Advocate
	BOBO, Patricia Mupeta	WHO	NPO
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	Ms. Regina Prosper	MoE	Director for Health, Safety and Risk Management Section
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	JOSSO TIANA Tahiriniaina Angelos	Ministry of Youth	Director of Health and Youth Protection
	Randriamanantena Julia	UNFPA	Youth Program Analyst

Country	Name	Ministry/Organization	Designation
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	Ms. Rudo Mhonde-Chiutsi	UNFPA	M&E Specialist
	Ms. Maria Bakaroudis	UNFPA	CSE Specialist
	Ms. Doreen Cheta	UNFPA	Programme Associate
	Ms. Lucetta Takawira	UNFPA	Finance Associate
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	Ms Rudo Ndudzo	UNESCO	Junior Program Assistant
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	BANATI, Prerna	WHO	Scientist AYH
	GUTHOLD, Regina	WHO	Scientist AYH
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	Ms. Jonniah Mollel	EAC	CEO- East Africa Health Platform
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3
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