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Cover photo: Sarah Holtz, Dakar, Senegal
### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACI</td>
<td>Africa Consultants International</td>
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<td>ARH</td>
<td>Adolescent reproductive health</td>
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<td>ASBEF</td>
<td>Association Sénégalaise pour le Bien Etre Familial (Senegalese Association for Family Well-Being)</td>
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<td>ASC</td>
<td>Association Sportives et Culturelles (Sport and Culture Association)</td>
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<td>AWA</td>
<td>Association d’Aide aux Femmes à Risque face au SIDA (Association to Help Women at Risk of HIV/AIDS)</td>
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<tr>
<td>BSS</td>
<td>Behavior Surveillance Survey</td>
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<td>CSID</td>
<td>Centre de Sensibilisation et d’Information sur les Drogues (Center for Drug Awareness and Information)</td>
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<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
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<td>CNJS</td>
<td>National Council on Youth</td>
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<td>CTA</td>
<td>Mobile Treatment Center</td>
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<td>EDS III</td>
<td>Enquête Démographique et de Santé (Demographic Health Survey - DHS)</td>
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<tr>
<td>ENDA</td>
<td>Environnement et Développement en Afrique et le Tiers Monde (Environment and Development in Africa and the Third World)</td>
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<tr>
<td>FGC</td>
<td>Female Genital Cutting</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>OOS</td>
<td>Out of School</td>
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<td>PDEF</td>
<td>Plan de Development de d’Education et de la Formation (Education and Training Development Plan)</td>
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<td>PE</td>
<td>Peer Educator</td>
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<td>PLWHA</td>
<td>Persons Living with HIV/AIDS</td>
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<td>PNLS</td>
<td>National Program Against AIDS</td>
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<td>PPJ</td>
<td>Projets pour la Promotion des Jeunes (Youth Promotion Project)</td>
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<td>PTIP</td>
<td>Plan d’Investissement Triennal Prioritaire (Triennial Priority Investment Plan)</td>
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<td>RABEC</td>
<td>Réseau des Associations pour le Bien Etre des Communautés (Association Network for Community Well-Being)</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWAA</td>
<td>Society of Women and AIDS in Africa</td>
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<td>UNAIDS</td>
<td>United Nations Joint Program on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
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<td>WHO</td>
<td>World Health Organization</td>
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I. Executive Summary

This study was conducted both as a response to a request from the United States Agency for International Development (USAID) to outline the strategies currently in use in Senegal for the prevention of sexually transmitted infections (STIs) and HIV/AIDS in youth and as a preliminary step in developing the CEDPA Youth and HIV/AIDS Initiative. This study identifies the most efficient strategies regarding adolescent reproductive health (ARH) with an emphasis on STI/HIV/AIDS. CEDPA aims to build on the success of past programs by using similar strategies.

The study’s main objectives are to:

- Identify the best practices amongst the strategies employed to improve ARH in Senegal with particular focus on STI/HIV/AIDS among out-of-school (OOS) youth.
- Identify the key factors that contribute to these successes.
- Formulate recommendations for the strategic direction of CEDPA and its Youth Initiative on STI/HIV/AIDS.
- Identify organizations working with youth in regards to STI/HIV/AIDS.

Two methods were used: 1) materials review, and 2) a qualitative study consisting of focus group discussions in target areas, as well as semi-structured interviews.

Definition of Best Practices

Throughout this study, two definitions of best practices were used:

1. Best practices according to the United Nations Joint Program on HIV/AIDS: A process of apprenticeship, feedback, reflection, and analysis of the successes as well as failures and the reasons for these.

2. Best practices according to the youth participating in target groups of CEDPA/Senegal: Planned strategies, following set objectives developed in cooperation with the beneficiaries to promote ownership and sustainable behavior change.

Materials Review

The materials review identified and analyzed the main themes surrounding ARH based on the strategies implemented by various projects and programs in Senegal. The review was conducted by analyzing the lessons learned from field interventions; this allowed for an evaluation of both the pros and cons of the projects.

The observations made in the course of the document/materials review are as follows:

- ARH covers a variety of subjects including unwanted pregnancies and/or complicated births, drugs, female genital cutting (FGC), and HIV/AIDS.
• The research did not cover all aspects related to reproductive health (RH); therefore, there are points that were inadequately covered.
• The various studies compiled in this review are not necessarily comprehensive, but more often are partial and do not cover all aspects of ARH.
• The study does not cover all regions of the country; therefore, it only addresses the specific problems in those areas studied.
• Several documents are not focused solely on Senegal, but also concern other countries.
• Despite the different reports, several studies covered similar themes resulting in identical conclusions.
• The strategies and content of these projects/programs could be more thoroughly reviewed using the study’s conclusions.

Discussion Group and Interview Themes

In total, the evaluation team selected 46 organizations in seven of Senegal’s ten regions to participate in discussion groups and then compiled the themes from interviews and discussions. Based on these discussions, the three strategies identified to improve ARH are as follows:

1. Increase the knowledge and capacity building of youth to produce positive behavior change;
2. Increase access to and use of RH services and programs; and
3. Improve the social environment surrounding youth so that they feel empowered to make informed decisions concerning their health.

Conclusions

Following an analysis of the study results, the following recommendations are presented for CEDPA to use when developing youth strategies in its programs:

• Promote life skills training.
• Integrate information concerning HIV/AIDS and RH into educational programs.
• Increase efforts to help improve communication and dialogue between parents and youth.
• Address stigmas at various levels.
• Integrate gender into the project.
• Improve project monitoring and evaluation.
• Increase the impact of peer educator projects.
II. BACKGROUND

Improving quality of life is a constant concern for all those involved in development. This includes a variety of factors such as education, health, employment, culture, and peace. Health, however, is one of the greatest links and CEDPA has built on this through its USAID-funded ENABLE project, which focuses on strengthening the capacities of health organizations.

ENABLE’s first task was to collaborate with women’s organizations to improve/increase their ability for informed decisionmaking regarding their own RH, their participation in local affairs as well as their overall economic status. In Senegal CEDPA worked through a partnership with four women’s organizations to establish a link between women’s economic power and the demand and use of health care systems, especially for RH.

The ENABLE/Senegal Youth Initiative was the project’s second task. It addressed STI/HIV/AIDS with a focus on out-of-school (OOS) youth. The goal was to focus on capacity building of youth and youth organizations to better address the HIV/AIDS pandemic in their communities. The Youth Initiative also contributed to:

- Improved access to quality services;
- Increased knowledge of the benefits of RH services;
- Increased participation by opinion leaders in social mobilization; and
- Increased demand for services.

This Youth Initiative was implemented in Senegal’s Dakar, Kaolack, and Thiès regions.

III. CONTEXT AND JUSTIFICATION

Socio-Cultural Conditions of Youth in Senegal

According to the most recent census, Senegal has a population of 9 million; more than 57 percent of its population are under the age of 20. It is this group that is most affected by the socio-economic problems that the country faces such as poverty, illiteracy, and lack of education, and the consequences that these problems have on health and individual behavior.

According to a 1999 household survey, 54 percent of Senegalese households live beneath the poverty line. This contributes to the fact that 56 percent of women and 28 percent of men are illiterate (Direction de la Prévision et de la Statistique/Office of Forecasting and Statistics). Despite efforts over the past few years to retain students in school, the dropout rate remains high. In elementary education, 68 percent of youth are enrolled, which means that more than one-third of the children who should be in school are not. In 1998-1999, only 28 percent of school-age youth were attending junior high, and only 9 percent of these students continued on to high school. The result is a high unemployment rate. In fact, 37 percent of those unemployed are youth aged of 15-24. Nearly 64% of those unemployed are aged 14-34, and the majority are young women. While all these factors increase the potential for risky sexual behavior, it must also be noted that Senegalese society is strongly influenced by traditional beliefs and culture.
Traditional Norms and Beliefs and Reproductive Health

Many of Senegal’s traditional norms regarding sexuality are based on gender, such as the incentive for girls to remain virgins until they are married and the propensity for marriage at a young age. Young girls are often faced with strong moral and religious condemnation regarding sexual relations outside of marriage. In the case of boys, abstinence until marriage is recommended in the Muslim religion, however, there is simultaneously an unspoken tolerance for sexual relations outside of marriage for men.

Other factors, such as poverty and urbanization, are beginning to impact on the traditional norms and have resulted in a somewhat delayed age of marriage among women and therefore an increase in the number of those participating in premarital sexual relations. According to a 1997 demographic study, the age of first sexual encounter has decreased; at age 15, 16 percent of girls had already had sexual relations, and at the age of 18, this percent rose to 55 percent. Whatever their age, sex, or marital status, youth need access to quality RH services to maintain good health and avoid unplanned pregnancies.

Generally, adolescents do not frequent the same RH service providers that adults do, and RH information tends to come from informal sources, such as friends, parents, teachers, and other community members. The 1997 study in Senegal showed that both men and youth have a difficult time accessing family planning (FP) services. A 1995 study found that adolescents did not have the appropriate knowledge to make informed decisions regarding contraception. A few years later, the Behavior Surveillance Survey (BSS) showed that a large gap existed between youth RH knowledge and actual practices. In fact, 90 percent of students surveyed knew about protection methods against STIs and HIV, but did not use them. At least 50 percent of youth did not use condoms when having occasional sexual encounters. The consequences of this knowledge-behavior gap can result in early sexual encounters, unplanned pregnancies, STI transmission, and sexual violence.

Youth Responses

Some of those interviewed in the study concluded that it is this vulnerability that has increased youth interest in RH issues. Many youth associations and youth are sponsored by the government or non-governmental organizations (NGOs) involved in RH. Most of these associations are generally located in Dakar, but also in other regions. In fact, these youth groups have been a formative factor in the success of the National Program Against AIDS (PNLS) as well as in the campaign to fight HIV/AIDS. There is a notable presence of youth in planning health-related activities, as well as in HIV/AIDS prevention campaigns. At the World AIDS Day 2001 Forum, for example, youth participants recommended increasing their participation and collaboration in PNLS. This increase will be accomplished through already-recognized youth organizations, such as the Sport and Cultural Associations (ASC-Association Sportives et Culturelles). These associations are found throughout Senegal, and young people are frequent visitors. Even if these
associations tend to be more focused on sports, they also incorporate cultural, social and economic activities.

Along with the ASCs, the National Council of Youth (CNJS), an umbrella organization for 3,000 groups and youth movements, is another way to involve young people.

The 60 political parties recognized in Senegal also have youth movements, not including school/student associations; several of these associations have incorporated HIV/AIDS education into their activities. However, although potential exists within these youth organizations, they have received only sporadic donor support over the past several years.

**Response by the Senegalese Government to the Situation of Youth and Their RH Needs**

Since the first cases of AIDS in 1986, Senegalese authorities have been educated on the extent of the situation. This information led to the development of the National Committee on the Fight against AIDS, which was established on October 23, 1986. This group later became the National Program in the Fight Against AIDS (PNLS).

In December 2001, the president of the Republic signed a decree based on the creation of the National Council for the Fight Against AIDS. Led by the prime minister, this group brings together members of the government, NGOs, persons living with HIV/AIDS (PLWHA), as well as development partners to support the fight against AIDS. Youth are represented in this forum by the CNJS and participate in the conception, coordination, follow-up, and multilateral negotiations on financial issues of the committee’s programs, and they have now become part of the national strategy 2002-2006 in the fight against AIDS.

With the help of the United Nations Population Fund (UNFPA), the Ministry of Youth has promoted issues that are important to youth since 1990. As a result, it has installed 10 RH centers across the country. These centers address many issues that concern youth, including RH in a more broad scope and STI/HIV/AIDS.

In addition, to protect students against STI/HIV/AIDS, the Ministry of Education has inserted a health and nutrition component in the Education and Training Development Plan (PDEF- Plan de Développement de l’Education et de la Formation). The Ministry has also included a mechanism for evaluating and assessing competencies in regards to the fight against AIDS.

Nonetheless, constraints remain. Young people delay seeking out health care, especially in regards to RH issues, training for health service providers is insufficient to handle RH issues of youth, investments remain weak, and there is insufficient pressure for the development of NGOs and youth associations.
IV. ASSESSMENT

A. Introduction

To assist CEDPA in defining activities for its Youth Initiative, USAID solicited a rapid needs assessment to gain a better understanding of the ARH and HIV/AIDS strategies used in interventions. The HIV/AIDS pandemic has raised awareness of RH issues within the society, and very early on, youth were identified as a focus due to their vulnerability.

This study aims to identify the best strategies developed by, with, and for youth in regards to RH, with a particular focus on STI/HIV/AIDS. The study results will enable CEDPA to develop an effective new program focusing on OOS youth in the Thiès, Kakar, and Kaolack regions of Senegal.

The project’s objectives are to:

- Build the capacity of youth and youth organizations in the planning and management of community-based prevention campaigns;
- Promote behavior change to lower the vulnerability of youth to STI/HIV/AIDS and promote better RH practices in general; and
- Promote communication between parents/children and adults/youth in order to reduce youth vulnerability to STI/HIV/AIDS.

Youth will be involved in all steps of this project to ensure sustainability as well as to build ownership. ENABLE will also collaborate with youth organizations through subcontracts to implement both practical and appropriate interventions.

B. Study Objectives

The study’s main objectives are to:

- Identify best practices among the strategies employed to improve ARH in Senegal with particular focus on STI/HIV/AIDS in out-of-school youth;
- Identify the key factors that contribute to these successes;
- Formulate recommendations for the strategic direction of CEDPA and its Youth Initiative on STI/HIV/AIDS; and
- Identify organizations that work with youth in regards to STI/HIV/AIDS.

C. Study Presentation

Methodology: This qualitative study was done in two parts: 1) a materials review and 2) a field survey with group-led discussions and informal interviews.
Data Collection: The materials review consisted of collecting, reviewing and analyzing documents, reports, studies, and publications relating to HIV/AIDS that emphasized the socio-cultural conditions of adolescents, their RH and knowledge, and existing RH resources. The field survey consisted of semi-structured interviews and discussions with those in the public and private sectors, NGOs, youth associations, and organizations offering services to out-of-school youth.

Tools used for interviews and group discussions were:

1. Interview guides;
2. Questionnaires for NGOs and government agencies;
3. Semi-structured interview sheets; and
4. Presentation sheets for each organization.

Data Analysis: At the end of each discussion, the organization completed a summary sheet with all relevant data: the intervention area, activities, focus areas, results, evaluations, successes and constraints, as well as lessons learned and their ideas on best practices.

The researchers completed an interview sheet after each interview, so as to keep an inventory of best practices. On several occasions, the researchers visited the project sites, which permitted them to see how the organizations functioned and how effective the services were. Although these visits were small in number, they did allow for a number of informal discussions with beneficiaries.

D. Locations of Organizations Interviewed

Information was collected in seven of Senegal’s regions (the 11th region, Matam, was established after the information was collected), in each region’s capital city: Dakar, Thiès, Kaolack, Louga, Diourbel, Saint-Louis, and Ziguinchor. These cities are also the health district headquarters, which is the operational level for the implementation of the national health development plan. In rural settings, one village, Kairé, was covered. In the experimental phase, the Youth Initiative project will be implemented in three regions: Dakar, Kaolack, and Thiès, where HIV/AIDS prevalence is quite elevated. St. Louis and Louga were chosen as collection sites because they both have ARH experience, while Ziguinchor and Diourbel were visited to offer insight into other ongoing projects and programs rather than those that CEDPA focused on. Due to limited resources, time constraints, and the availability of organizations, the team was not able to visit more rural settings.

In all, the research team met with 46 organizations. The criteria for choosing these organizations were:

1. An organization or youth movement that is renowned in the fight against AIDS or in promoting ARH;
2. A leading national program focused on RH and/or HIV/AIDS;
3. Worked in the regions within the study parameters; and

Study Limitations: It is important to note that this study may have been too ambitious, given the short timeframe and limitations of the three researchers. Thus the personal observations of those interviewed constitute a more influential part of the conclusions.

E. Terminology and Definitions Used

Several terms exist to define youth. For the study’s purposes, the term “adolescent” refers to the age group of 10-19; “young adult” signifies 15-24, while “youth” is 10-24. (Please note that in Senegal “youth” is considered to last until age 35.)

- **Out-of-School Youth**: A girl or boy aged 10-24 who is not enrolled in a public or private school.
- **Youth Movement**: National or international associations that have a program of non-formal education or training of youth, such as the Scouts, Red Cross, etc.
- **Support Structures**: All organizations offering support to youth or youth organizations, financial or otherwise.
- **Youth Organizations**: Organizations conducting activities or services for youth.

Best Practices:

According to the United Nations Joint Program on HIV/AIDS, best practices are defined as those with a process of feedback, reflection, and analyses of the successes or failures.

The UNAIDS documents indicate that defining a better practice is based on five specific criteria:

1. **Effectiveness**: Activities that produce results. To determine the effectiveness of activities, one needs to be able to recognize results and changes due to project implementation and causes for these results.

2. **Ethics**: Practice based on respect, awareness, confidentiality, development of capacities—individual as well as collectively—and participation in planning and implementation. Practices should also be based on compassion, solidarity, responsibility, tolerance, equality, and justice.

3. **Pertinence**: For activities focusing on HIV/AIDS, this means remaining aware of the social context where the activities are implemented.

4. **Efficiency**: Producing results with minimal resources.
5. **Durability:** Practices that will remain long-term, allowing replication and assuring sustainability.

According to the youth who participated in the Youth Initiative’s launch from 26-28 March 2002, best practices include planned strategies and following set objectives, with participation from the beneficiaries to promote ownership as well as sustainable behavior change. According to the participants, best practices must also be well planned, valuable, durable, adapted, acceptable, and realistic.

V. RESULTS

A. Introduction

This study is a brief analysis of several experiences in Senegal. The results reflect, for the most part, the same lessons learned and difficulties expressed as in the ARH literature. First, the conclusions are presented as drawn from the materials review, followed by the results from those interviewed. The observations are based on the perspectives of the NGOs, Ministry of Health, and representatives of partner organizations and those involved in the RH field.

Conclusions Drawn from the Documentation/Materials Review

Due to the development of RH research, there is a greater comprehension today of these issues in Senegal as well as in the international community. This section is a compilation of the findings from youth RH studies that were primarily focused on STI/HIV/AIDS. Each study’s major themes were identified and analyzed in relation to the projects and programs already being implemented. The lessons learned from the field were analyzed and evaluated for strengths and weaknesses of the interventions to better understand the needs of youth in terms of RH.

Observations from the reports reviewed were as follows:

- ARH includes many aspects such as early or unplanned pregnancies, drugs, FGC, and HIV/AIDS.
- The studies selected for this review were not necessarily comprehensive, but often partial and did not cover all aspects of ARH.
- The studies seem to only cover certain regions of the Senegal and not the country as a whole.
- Several documents did not focus solely on Senegal and therefore, were not in-depth.
- Considering the number of reports, several studies covered the same themes and drew identical conclusions.

B. Common Themes
1. **Sexuality and Youth:** For a long time, the sexuality of youth was not discussed in Africa, which caused it to become stigmatized and resulted in a tendency toward early marriages among youth. However, the social as well as cultural implications for societies in transition have resulted in significant changes including the emergence of new behaviors. One such change has been in sexual behaviors that previously were considered “illegitimate” and outside of traditional norms are becoming more “mainstream.” If not addressed correctly, this sexual behavior change could cause problems when considering the social, economic, demographic, health, and psychological consequences.

2. **Sexuality and Early Marriage:** According to the DHS III, the average age for first marriages remains low at 18; however, the average age for first sexual encounter is 17. The average age of first marriage also tends to be higher in urban areas compared to rural settings, where 18 percent of girls from 15-19 already have at least one child. This also varies by the education level achieved.

3. **Early Pregnancy:** Sexual relations are only considered legitimate within a marriage, therefore, marriage has naturally occurred at a young age. However, even with the increase in age of first marriage (17.2 years in 1986 to 18.2 years in 1993 and 19.9 in 1997), early pregnancies remain a serious problem.

   A 1998 study by M.G.B.A., IV Moreira, MD and F. Diadhiou showed that the adolescent maternal mortality rate is 8.11 percent of all maternal deaths in hospitals. The complications are wide ranging: asphyxiation, 17.6 percent; premature rupture of the membrane, 12.5 percent; and induced abortions, 3 percent. In the activity reports from the counseling centers for adolescents published in December 1995, it is apparent that the demand for abortions or treatment due to abortion complications was one of the major causes for adolescents to seek consultations.

   In large part, the early onset of sexual relations and pregnancies is directly correlated with the increase in age at first marriage as well as the elimination of certain traditional values. In the study, *Adolescent Fertility in Senegal* (Dakar, April 1996) Dr. Nafissatou Diop of the Population Council revealed that 26 percent of first births take place prior to marriage. Half of these births are generally legitimizied by a marriage soon after.

4. **Female General Cutting:** FGC can have multiple health consequences for its victims. Despite the risks and the various laws banning it that have been adopted in certain African countries, FGC is far from disappearing. FGC is a socio-cultural phenomenon that Senegal shares with 26 other African countries, as identified in the journal, *Bintou’s Choice*. In 11 of these countries, more than half of women undergo FGC; approximately 2 million girls undergo FGC each year. Of the 26 countries, 12 have voted to ban or limit FGC, but there are problems enforcing these laws. According to the report, *Excision in Senegal*, FGC will touch 20 percent of women in Senegal; however, it is believed that the FGC rates are diminishing based on geographic and ethnic considerations.
Although FGC is often thought to be a religious practice, it is not an obligation by Islam and, according to *Bintou’s Choice*, 80 percent of Muslims do not practice FGC. However, in Senegal, FGC is more concentrated in certain regions, as shown in a statistical study by Codou BOP in 1999. The study showed that 80 percent of women in Kolda underwent FGC, as did 100 percent of women in Fouta. Looking at the data by ethnic group, 89 percent of Diolas women, 94 percent of Hal Pulaar, and 3 percent of Wolof women underwent FGC.

5. **STI/HIV/AIDS:** According to available statistical data, it is clear that youth and adolescents are the most affected by the AIDS pandemic in Africa. This situation tends to come from risky behaviors conducted by this group such as multiple partners, unprotected sexual encounters and prostitution. In terms of HIV/AIDS, it is not simply the youth’s health that is affected but also their socio-economic status, as they become orphans after the death of their parents and/or guardians due to AIDS-related complications. According to UNAIDS, 3 million children under the age of 15 are living with HIV/AIDS worldwide. In December 1997, more than 13 million children under the age of 15 lost either their mother or both parents to AIDS, in which 90 percent of these were from sub-Saharan Africa. Senegal has not witnessed these high numbers, but it is important to implement prevention programs immediately before the AIDS pandemic gains a foothold.

6. **Knowledge and Practice:** RH knowledge is still not adequate for youth and adolescents to safeguard themselves against risk. An August 2000 study by the Population Council, USAID, and the World Health Organization (WHO) concluded:

   Knowledge on RH is limited. In large part, adolescents do not recognize the signs of fertility in a boy or girl, the fertility cycle and menstruation, nor symptoms of STIs (not including AIDS).

7. **Tobacco – Drug Addiction:** These two phenomena are important when analyzing the situation of youth and adolescents, as they can influence their mental state and their ability to make informed decisions regarding RH. The consumption of tobacco, drugs, and alcohol is on the rise among youth in urban areas and in school settings in Senegal. According to a 1998 study by M. Thionne, *Tobacco Production, Legislation and Use in Senegal*, the average age for adolescents to begin use of these substances was less than 15. In fact, 24 percent of smokers started between the ages of 10 and 15, and the percent rose to 61 percent among the population aged 16 to 20. Tobacco use has many negative health effects on youth, in addition to the financial costs.

   Drug use in Senegal touches both in-school and out-of-school youth, which makes the situation more complex. There has been an increase of therapeutic drug use for recreation, such as amphetamines, tranquilizers and sleeping pills. However, in more impoverished areas, there is a strong presence of drug sniffing, referred to as “guinze,” where youth can easily gain access to glue, aerosols, cleaning agents, etc. For a long time drug consumption was limited to *cannabis*, which is grown in
Senegal; however, cocaine as well as heroin and other hard drugs began to appear throughout the 1980’s and continue to gain popularity.

8. **Socio-economic Profile**: Although this topic does not directly affect health, it has been shown that there is a direct correlation between the socio-economic situation of youth and their health. Many young girls turn to prostitution for financial reasons in certain tourist zones; male prostitution and homosexuality are on the rise among youth. This has lead to a quick progression of AIDS in certain tourist areas like Mbour, Kaolack and Ziguinchor, where the HIV seropositive prevalence rate is higher than the national average (2 percent vs. 1 percent).

It is also evident that youth are most affected by rising unemployment rates, which can also increase the chances of risky behavior.

9. **Education**: Senegal devotes 30 percent of its budget to education, which is a significant amount in comparison to other sectors. However, the percentage of youth receiving education does not exceed 60 percent in any region of Senegal, and in some areas it is less than 30 percent. In many regions, it also varies by sex, with a higher percent of boys receiving education than girls.

One aspect that is critical to consider is the number of school dropouts. Among the children who are sent to school, most do not reach secondary school and even fewer make it to the university level. Unfortunately, vocational and professional training centers have not filled this gap, even with an administration that has emphasized this for the past several years. Higher educational levels have proven to delay the age of first marriage and reduce unplanned pregnancies; therefore, education is an important factor to address when trying to improve ARH.

C. **Programs/Projects Focusing on Youth**

In response to a variety of RH issues concerning youth, Senegal has implemented a number of projects and programs that focus on issues such as education, family life, prevention of HIV/AIDS, and professional training. Organizations and government bodies at a variety of levels have implemented these projects and programs. The number of projects increased even further with the adoption of the *Plan d’Investissement Triennal Prioritaire* (PITP—Triennial Priority Investment Plan), which put a focus on family life education with in-school activities covering the following themes:

- HIV/AIDS prevention
- Decreasing the number of unplanned and early pregnancies
- Advocating against arranged marriages
- Fighting to eliminate FGC
- Strengthening the economic power of youth
- Decreasing illiteracy and school dropout rates
- Promoting contraception use.
These projects and programs took place throughout Senegal and often focused more on urban areas due to demographic issues (increased population growth, rapid urbanization, etc.). Along with educational sessions and the transfer of information, specific strategies were used regarding ARH such as the creation of an Information/Educational Center on Drug Use in Pikine/Guediawaye on the outskirts of Dakar. There are now 10 adolescent counseling centers, which were started in 1995, and they are situated throughout Dakar, Mbour, Kaolack, Mbacke, Tambacounda, and Kedougou and cover 6 of Senegal’s 11 regions. The counseling centers are structured within “youth centers” that specialize in providing RH services. They have teams of midwives, psychologists, social workers as well as an information, education and communication (IEC) specialist. Services offered include family planning and education as well as counseling regarding unplanned pregnancies, rape, pedophilia and incest.

Various programs have mobilized resources for income-generating activities specifically aimed at youth. One such program had a budget of nearly 7 million CFAs (about US$500,000). These projects and programs have contributed on various levels to the improvement of the youth situation in Senegal, more notably in terms of RH.

Nonetheless, there are still gaps, especially regarding the fight against HIV/AIDS in the youth population. In fact, considering the scarcity of resources and the acuteness of the problem, there needs to be an increased effort as well as a closer look at certain intervention strategies:

- Increased community participation and resources focused toward implementing projects; and
- Better problem identification prior to developing solutions.

Note: Throughout this materials review, there does not appear to be a “best practice” presented, except for UNAIDS. This could be due to two reasons; 1) the concept of “best practice” is new; or 2) the analysis centered more on the quality of institutional structures rather than the quality of activities.

D. Recommendations

In light of these observations, it is clear that some aspects of RH were omitted from this documentation and certain points still need strengthening. Regarding the research, it may be useful to take into account the following issues:

- The community’s involvement in project and program implementation and funding;
- A comparative analysis of the health of youth in rural vs. urban settings;
- The accessibility of services to youth;
- The progress of HIV/AIDS prevention education among youth in terms of behavior change, prevalence rates, and knowledge level and quality;
- The impact that these projects/programs are having on the fight against AIDS;
- An inventory of educational materials used in HIV/AIDS education and their distribution; and
• An analytical review of the strategies implemented in Senegal for HIV/AIDS prevention, most notably for education and how effective it is regarding behavior change.

In Senegal, as in many other countries around the world and in particular, in developing countries, these studies highlight the importance of RH problems of youth. However, with the limited number as well as quality of these studies, it is not always possible to cover the full range of ARH. Therefore, more thorough research is needed to give a clearer reading. This would enable the actors to better adapt strategies and interventions to respond more efficiently to the key group’s numerous and complex needs.

VI. FIELD ANALYSIS AND RESPONSES

A. Driving Forces: Participation, Ownership, and Integration

According to the participants, three key principles were important in determining a program’s success. These were:

1. Youth participation in focus groups from the start of a program to instill a sense of ownership among the youth involved;
2. Participation of a parent or a religious or community leader; and
3. Integration of RH themes into broader programs.

1. Youth Participation: The key to any successful youth program is to have youth participate throughout all the project stages. According to the Society of Women and AIDS in Africa (SWAA Youth), youth need to take control of their own health and well-being, and NGOs need to help build their capacities to be able to take on these responsibilities. Therefore, new techniques are needed to motivate youth to want to become involved and take on project ownership.

2. Parent/Adult Participation: In addition to youth participation, several participants found it essential that there be support from key people such as parents and religious leaders prior to any sort of intervention as well as a dialogue between the youth (clients) and those who run the health services.

For certain NGOs, such as Africa Consultants International (ACI), their role is to facilitate a sense of ownership in the communities. UNAIDS cited ACI as an organization that used best practices in its community mobilization model for HIV/AIDS. It has led to a well-focused process, enabling participants to analyze their own situation as well as to draw conclusions for improved ARH services. By transferring knowledge and providing the necessary tools, the local populations were able to take their health into their own hands, especially their RH needs. In the same vein, ENDA Jeunesse Action, has found it is important to work with the youth in impoverished areas so that they properly understand the situation before offering intervention programs. This is part of ENDA’s philosophy of “savoir, savoir-faire” (know, know-how).
3. **Integration**: All the NGOs interviewed incorporate HIV/AIDS education into their youth programs. For example, the YMCA incorporates HIV/AIDS education and RH into all of its programs: youth clubs, training workshops, and literacy classes. The Centre de Sensibilisation et d’Information sur les Drogues (CSID—Center for Drug Awareness and Information) incorporates RH and HIV/AIDS education into sports activities. These activities are alternatives for youth to risky behavior such as drug use and unprotected sexual relations. The center director believes linking RH/HIV/AIDS education to sports is one of its best practices.

Other organizations have a larger vision. ENDA Graf, for example, uses a socio-economic approach when discussing HIV/AIDS, which incorporates a variety of sectors including health. ENDA Graf believes that poverty is a major contributor to the AIDS pandemic and that all sectors are needed to address the problem.

**B. Three Key Strategies to Improving ARH**

The themes and questions raised during interviews and discussions were categorized into the following three strategic approaches:

1. *Increase knowledge, promote safe behavior, and build capacity*;
2. *Increase youth access and use of health services*; and
3. *Improve the social environment to encourage youth to make enlightened decisions concerning their overall health and RH*.

This classification of strategies is very similar to those used in the field. For example WHO, UNICEF, and the UNFPA implement the following strategies in their ARH programs:

1) Create a safe environment.
2) Educate.
3) Build capacity.
4) Ensure counseling is available.
5) Improve the quality of health services.

And similarly, in Family Health International’s (FHI) AIDS YouthNet project, the following strategies are used: improve the political environment and community support for ARH and HIV/AIDS prevention; increase knowledge; increase the capacity of youth to make informed decisions; delay the first sexual encounter; and improve access to and quality of RH services for youth.

The CEDPA BLOOM (Better Life Options Model) focuses on building the capacity of youth to make their own decisions and choose their own futures by increasing access to RH for adolescents as well as creating a supportive environment. This is the model that the ENABLE Youth AIDS Initiative will be modeled on.

1. **Increase Knowledge, Promote Safe Behavior, and Build Capacity**
Approaches to Increase Knowledge of RH and HIV/AIDS

Several youth interviewed expressed a need to access more RH information. This lack of information affects girls more often than boys, increasing girls’ chances of risky behavior. They need to overcome a variety of myths surrounding RH and sexuality in the intervention communities.

Peer educators (PEs) and health extension agents often disseminate RH information through informal discussions, films, theater productions, skits, school presentations, as well as via larger mobilization activities such as National AIDS Day. NGOs also use posters, t-shirts, brochures, and hats with relevant messages to provide information. In Kaolack, twice-monthly radio broadcasts cover topics such as condom use, FP methods, transmission modes and prevention methods for STI/HIV/AIDS, sexuality, puberty, and FGC.

The training curriculum’s objective is for NGOs to develop and improve the PEs’ IEC capacities. By the end of the training, participants should have gained knowledge of STI/HIV/AIDS transmission modes and prevention methods. They should have also learned to appropriately refer community members and peers to health services, as well as to implement and evaluate HIV/AIDS IEC activities in their own communities.

According to a youth center director, its main goal is to increase the knowledge of youth to avoid risky behavior. He believes that youth have the appropriate information, but wonders if this is enough to change their behaviors. However, he also states that it is the responsibility of the parents as well as the schools to build the capacity of youth to make more informed decisions.

Approaches to Integrate Behavior Change and Capacity Building

Research has tried to answer the question: Is information enough to change behavior? The answer is no. Programs that have focused solely on information dissemination have had limited impact on attitude or behavior changes. However, RH programs that have had a broader focus on life skills, discussion groups, and capacity building have had greater success in changing risky behaviors of youth than information programs.

According to UNICEF, life skills include a strong knowledge base to help youth make informed decisions, the ability to communicate more openly, and negotiation skills to take charge of their own health.

Life skills can lead to behavior change, but also a change in the environment. Regarding HIV/AIDS, life skills consist of:

- How to make informed decisions in a relationship and when to decide to have sexual relations;
- How to recognize a situation that may become risky or violent;
- How to negotiate protected sexual relations; and
• How to overcome peer pressure and avoid taking risks in sexual relations.

Among the 46 organizations surveyed in this study, approximately 6 are familiar with this approach. Organizations such as the YMCA have used this approach for several years. More recently, organizations such as ACI, the U.S. Peace Corps and the NGOs participating in the Improvement of ARH project in Senegal have followed in their footsteps.

The U.S. Peace Corps is planning to incorporate a life skills component when enlarging its STI/HIV/AIDS and health programs. In September 2001, 19 Senegalese nurses, public health teachers, local authorities, professors and midwives from several regions of Senegal, along with seven U.S. Peace Corps volunteers, participated in a four-day workshop based on the life skills manual. This manual is comprised of 50 sessions covering communication, decision-making, healthy relationships, and capacity building.

The Population Council’s FRONTIERS Project, in collaboration with WHO, has been using IEC tools and mass media to educate communities. In addition, the project has developed a life skills curriculum called “Grandir en Harmonie” (Grow in Harmony), which consists of 18 sessions and covers topics such as values, adolescence, the human body, decision-making power, parenthood, STI/HIV/AIDS, pregnancy prevention, and sexual relations. PEs that local NGOs have trained in Saint Louis and Louga are using this curriculum to lead group discussions with adolescents.

**Changing Behavior through Peer Educators or Health Extension Agents**

In Senegal, PEs largely facilitate informal discussions concerning health issues, but they often facilitate life skills classes, speak on the behalf of community leaders, distribute condoms and/or refer people to health service providers. The PEs are most often the same age as their clients, generally between the ages of 18-35; however, older PEs are always welcome since it has been found that they have more influence on adolescents.

PEs, both adolescent and adult, must have strong communication skills, an open mind, counseling skills, and extensive knowledge of RH issues and HIV/AIDS. They must also promote confidentiality and be non-judgmental of people’s values.

While none of the organizations interviewed had concrete information on the PEs’ effectiveness, it is believed that they have had quite an impact, since youth tend to speak more easily when they are with their peers. The FRONTIERS Project learned from its intervention that PEs must have a strong command of the information, be motivated and engaging, courteous and responsible, while setting a good example for other youth. Another factor was that the PE training, using the “Grow in Harmony” curriculum, must take place over at least two weeks to ensure that the knowledge is absorbed.

The general feeling is that the PE dropout rate is too high. It has been noted that, after six months, PEs begin to lessen their activities and, after one year, most of their activities subside. However, it has been found that after two months of activities, though recruited
on a voluntary basis, the PEs begin to request financial reimbursement for the work that they have done.

Several participants made recommendations to reduce the PE dropout rate. In the FRONTIERS Project, the PEs formed an association in which they would take the chairs that they had received (each had received 20 chairs to facilitate educational sessions) and rent them out to their communities. This system apparently was successful judging by the their financial gains. With another NGO project, the health extension agents were able to keep 50 percent of the profits made when selling condoms to reinvest in income-generating activities. One health service employee suggested that an official fund be established by the health extension agents to supply capital for income-generating activities and that these agents also be trained in STI/HIV/AIDS, malaria prevention and treatment, and vaccinations to expand services. It was also suggested that “Volontaires du Service Civique National” (National Civil Service Volunteers) be recruited as extension agents for the National Youth Program. This would create an organization to motivate youth, create an interest in being a volunteer, and develop a system for the long-term advancement of volunteers. Clearly a system is needed to increase the value of volunteers and permit them to advance in their professional lives based on the knowledge and experiences gained through PE work.

2. Increase Youth Access and Use of Health Services

Factors Affecting Access

For youth to adopt safer sexual practices, it is essential that they have access to quality RH services that will not only encourage them to take preventative measures, but also will allow them to be treated in case of transmission. Following discussions among government officials and heads of NGOs, it became clear that there were a number of issues that influenced, both positively and negatively, the use of existing services. These were the:

- Availability of condoms
- High rate of unplanned pregnancies
- Use of such services by young males
- Availability of services available to youth who are HIV positive
- Access to such services for at risk youth.
Access and Availability of Condoms: The majority of surveys showed that condoms are distributed very discreetly. ASBEF is the only NGO that sells condoms. At this point, NGOs, PEs, and health extension agents are receiving and distributing condoms free of charge. However, there is a lingering stigma about condoms. Generally, condoms are linked to promiscuity and illicit sexual behavior. For example, condoms are available at the YMCA, but health extension agents do not distribute them for fear of being stigmatized. SIDA Service (AIDS Service), a Catholic organization, distributes condoms, but only to married couples.

Condom acceptability varies across the regions and contexts. One CNJS member found that condom accessibility for youth was not a problem, and that the constraint was rather religious. However, this may be changing due to a great deal of dialogue among religious leaders over the past 18 months. In Kaolack, health education providers state that community-level condom distribution happens without difficulty and that young men do freely purchase condoms in pharmacies. Health education providers thought that NGO access to condoms via a more official route needed to be conducted with discretion, as communities do not officially approve of it.

The FRONTIERS Project provides valuable lessons learned. The PEs from Louga and Saint Louis did not request condoms directly from the health services centers for fear of being ostracized by the community. Nor do they distribute or even show condoms during their educational sessions. They have learned from experience that it is difficult to discuss condom use with youth as their parents, who can easily watch the sessions, find this shocking. Therefore, PEs refer youth to the health service centers.

Due to social and cultural reasons, it has been difficult for girls to access condoms. A psychologist from the youth counseling center in Ziguinchor confirms that girls never request condoms at the center. However, he is sure that they obtain them via other channels. The female condom was introduced in Senegal, but only in a limited manner. SWAA Youth has contributed to the promotion of the female condom through AWA, a women’s NGO in Tambacounda that works with sex workers.

Using condoms as dual protection against STIs and unplanned pregnancies is a message that is not emphasized enough in ARH. A small book published for the FRONTIERS Project indicates that the reasons for using condoms are to protect against STI/HIV and unplanned pregnancies; however, this information is not published in the Projets pour la Promotion des Jeunes (Youth Promotion Projects - PPJ) literature. In fact, the “dual protection” message suffers from the stigma surrounding condoms. Posters displaying messages about dual protection or condom use were not seen in any of the clinics or NGOs visited. Health agents and FP service providers in Senegal only recently introduced the dual protection concept. There has also been resistance by FP service providers to discuss dual protection, since condoms carry a stigma and are generally not accepted by the population. There is also the fear that condom promotion will jeopardize the progress already made in FP. The Ministry of Health has helped by permitting condom distribution in health centers and discussing them in the health education
services, whereas the Ministry of Education does not permit condom distribution in schools.

**Use of Services by Young Men:** Through the interviews held, it was apparent that adolescent boys tend to use services such as youth centers and ASBEF clinics less than girls. According to those interviewed, this is due to the fact that only midwives provide services in these centers. One agent pointed out that boys also tend to come to the Education and Sports Centers with their girlfriends when they fear the girls may be pregnant; this is a good opportunity to encourage youth to frequent the centers for other reasons. Another key informant remarked that there was a new focus in Senegal regarding ARH needs; however, he could not name a single program in this area.

**Care and Support for Youth Living with HIV/AIDS:** Among the organizations considered in this study, very few offer treatment or care for PLWHA. Among those that do, SIDA Service began offering care and support for PLWHA in 1994, by paying rent for certain patients, distributing free medicine to treat opportunistic infections, and offering a scholarship program for youth affected by HIV/AIDS. SWAA Youth offers care for children who are both infected as well as affected by HIV/AIDS; one of its objectives is to get more youth involved in PLWHA care and support. The youth will participate in a program for women and children affected by HIV/AIDS that consists of accessibility to medicine, including anti-retroviral drugs for children, and psychological and educational support.

One of the most comprehensive service providers is the Mobile Treatment Center (CTA), which started in August 1998. CTA offers consultations, hospital stays, and drug distribution, including anti-retroviral drugs, and diagnosis and treatment for common opportunistic infections to patients (mainly unemployed youth). CTA is also equipped with a laboratory for HIV testing and collaborates with LE Dantec hospital for CD4 tests. Discussion groups are also organized to exchange ideas and to provide support for PLWHA. While these groups promote confidentiality, there are some who fear that their visits will not be confidential. Therefore, CTA offers home visits to check up on a client’s social environment, living conditions, and nutrition to make sure there is no breach of confidentiality. Inter-hospital visits are also conducted to follow-up on patients and to provide counseling prior to and following testing. CTA collaborates with a PLWHA association called “Bock Jeff,” whose members visit people who have been hospitalized.

There are other NGOs that have contact with PLWHA groups and would like to offer assistance, but they do not have sufficient resources.

**Availability of Services for Youth at Risk:** Among those organizations visited, approximately 10 work exclusively with high-risk youth, such as informal apprentices, girls working as housekeepers, shoe repair boys, young men who work at bus/taxi stations, and car washers. Several sources identified girls working as housekeepers as a high-risk group for HIV exposure and unplanned pregnancies because, in these settings, there are a lack of family support and insufficient financial resources. Often the girls will
exchange sexual relations for a sandwich, according to one informant, and this behavior often leads to unplanned pregnancies. ENDA Graf works in Dakar with young girls, using informal discussions as a tool to transfer knowledge. A health extension agent facilitates the group discussions without the use of a curriculum; the group usually consists of 8 to 10 girls who meet in the evenings after work.

The sexual transactions previously mentioned are a form of prostitution among young girls that differs from the state-sanctioned “official” prostitution. Since 1960, there has been a law tolerating prostitution that permits young women (under 21) to subscribe to the health system and, therefore, undergo free medical exams, yearly or monthly, based on the case, that include an HIV test, information, and condom distribution. However, while many girls participate in prostitution, many do not benefit from the health services offered due to the age limit of 21.

3. Improve the Social Environment to Encourage Youth to Make Enlightened Decisions Concerning Their Overall Health and RH

The Social Environment

For youth to develop successfully, programs must look beyond an adolescent’s individual needs and consider families, communities, and the social politics affecting an adolescent’s access to services and information. In interviews, three factors emerged as those most notably influencing the social environment of youth in Senegal:

1. Parent/child communication.
2. Gender.
3. Stigmatization.

Parent/Child Communication: Nine key informants underlined the important role that parents can play in educating youth about RH, as well as offering support during times of crisis. While parents do not generally have the capacity to discuss RH issues with their children, they will often allow an adult they trust to do so. A Health Education Program member said that, in some cases, mothers are able to discuss RH and health issues with their children, but that fathers generally are incapable of doing so. However, the RABEC director found that open communication and dialogue between the parent and child is critical. Thus, RABEC has initiated a new strategy that offers home visits to facilitate these types of discussions among parents and children. The PPJ director explained how they are also exploring new paths to promote parents as community educators to improve parent/child communication.

The FRONTIERS Project has also introduced a parent/child component to its activities. The Scouts are also pleased with the work they have done to include parent participation in their activities. Following church on Sundays, they invite parents and their adolescent children for an open discussion. The Scouts often consult with parents regarding the curriculum being developed from session to session as well as offering ARH discussions.
for parents. While it is recognized that the parent/child dialogue is essential and the above-mentioned groups are developing activities geared at improving this, the majority of NGOs do not do so.

**Gender:** Expectations based on gender often influence the behaviors of both men and women and can limit RH choices. For example, the inequality between the sexes and the low status of women often contribute to prostitution, violence against women, and the continuation of traditional practices such as FGC. Young girls are not well equipped to negotiate condom use with an older partner or one who is wealthier. And girls who married at a young age are not capable of resisting family pressures to begin having children immediately, which often results in health problems.

In the same vein, young men also face pressures based on gender that affect their ability to use safe sexual practices. In some societies, boys are ridiculed for being abstinent or a virgin and are encouraged to be sexually active at a young age with multiple partners.

Gender considerations are critical in the STI/HIV/AIDS context; in reviewing the IEC materials used, it appears that the majority of NGO personnel do have the knowledge to offer ARH services with a gender perspective. Several members even demonstrated notions of stereotypes regarding male and female sexuality, which are the same stereotypes that reinforce risky behavior. For example, one of the Louga Scout agents said that men have more sexually advantages than women. The participants were not aware of the fact that there needs to be some behavior change among men and that certain behaviors are no longer accepted. It also appears that the differences between the needs of girls and boys were not taken into account when planning certain programs.

Recommendations for future programming are to:

1. Increase the awareness of youth, parents, community members and decision makers to create an environment favorable to RH and decisionmaking by youth;
2. Reinforce young girls’ knowledge, self-esteem and ability to make decisions; and
3. Focus on the attitudes and behaviors of boys towards girls and sexuality.

**Stigmatization:** HIV/AIDS and condoms continue to be stigmatized in Senegal. Condom use is strongly condemned by Senegal’s Catholic Church, adding to its association with illicit sexuality. The majority of service providers state that condom distribution among youth needs to be conducted with discretion to avoid community disapproval. While there has been an emergence of PLWHA groups, the stigma against them also remains strong. It appears that none of the IEC tools is used to deliver a message supporting PLWHAs. As one informant stated, “**HIV/AIDS does not have a human face in Senegal,**” as no public figure has openly discussed his/her stand during a prevention campaign.

SIDA Service has decided to rename its headquarters the “Center for the Promotion of Health,” due to a fear of possible stigmatization of its clients who do not want to be labeled as being HIV-positive. A large part of creating a supportive environment in the future will be to address these stigmas.
VII. SUPPORT STRUCTURES FOR FUTURE PROGRAMMING

The research team found two elements that are necessary for effective ARH programs:

1) *Thorough and systematic monitoring and evaluation; and*
2) *Up-to-date strategies.*

Monitoring and Evaluation (M&E)

This study has found a weakness in M&E throughout the organizations, since very few of them have an M&E system in place. For example, the youth centers have not established indicators, baseline data, or evaluation plans, although they collect service statistics that do not appear to be analyzed. This same tendency was found in other organizations such as ASBEF and SIDA Service, which both collect a wealth of information. If analyzed, this information could provide indications of the tendencies for an increase or decrease in the number of people receiving STI consultations, the number of people receiving testing and counseling, or the number of unplanned pregnancies. Analyzing this information would provide extensive feedback for improving programs.

All the organizations collecting statistics tended to focus on quantitative information such as the number of people trained, number of discussion sessions held, and the like. Very few had impact indicators. Nonetheless, several participants understood the necessity of a solid M&E system. As one youth center director stated, “this evaluation system is critical in developing improved and appropriate strategies.”

The most extensive evaluation system that the research team observed was part of the Population Council’s ARH program, which had established a surveillance system with one community that directly benefits from the intervention and, prior to the project, completed a needs assessment and a qualitative and quantitative study.

M&E capacity building should be provided as part of any future project to ensure that data are collected and used to its full potential.

Sustainability

The obstacles surrounding sustainability were most relevant to peer educators. Using PEs is an approach that is financially sustainable, since the health extension agents are volunteers. However, due to the loss of diligence mentioned by the NGOs, the strategies used need to be continuously examined and improved.

VIII. CONCLUSIONS AND RECOMMENDATIONS
This chapter consists of general conclusions from key lessons learned as well as recommendations for the HIV/AIDS Youth Initiative program that CEDPA/Senegal is developing.

A. Conclusions

Participation and Ownership

According to the participants, the NGO’s role is to facilitate:

- Capacity building of youth to enable them to take responsibility for their own RH and general well being;
- Inclusion from project start-up of guardians, parents, community members, and religious leaders to ensure support; and
- Creating a dialogue between youth and service providers by organizing a forum where different viewpoints, constraints, priorities, and needs can be expressed and heard by each group, to better bring quality RH services to youth.

In terms of ownership, among the best practices that NGOs have implemented were:

- Participatory techniques throughout all project stages; and
- Community involvement to allow the community to identify its own needs and priorities.

Integration of HIV/AIDS into All Aspects of Services Provided to Young Adults: To protect youth from HIV infection, one has to take into account the non-medical factors that can affect their vulnerability. The NGOs interviewed in this study used a variety of approaches to account for outside factors. For example, CSID linked sports with RH education, as they believe involvement in sports is a factor that helps youth avoid drug use and other risky behaviors. ARH needs cannot be reduced to HIV protection. For young girls, unplanned pregnancies are a large preoccupation and so services must also provide youth with the knowledge, capacity and behaviors necessary to protect themselves against HIV/AIDS and unplanned pregnancies. These strategies need to be implemented by the Senegalese NGOs in the future.

Promoting Behavior Change: In Senegal, a particular emphasis is put on sensitizing and transferring information to youth regarding health, presuming that this will change risky behavior. In the meantime, research has shown that programs focusing solely on medical and biological information had less of an impact on behavior. However, using curricula that integrate knowledge, attitude, life skills, communication, negotiation and capacity building, RH programs based have had more success in developing safe behavior and changing bad habits among youth. In fact, according to the 1988 BSS, even if HIV/AIDS knowledge is very high among youth, they do not always adopt safer practices, such as using a condom for every sexual encounter.

A life skills development approach, along with other IEC activities, should take into account contextual as well as environmental behaviors that could prevent youth from adopting safe sex
behaviors. For example, an effective program focusing on condom use must consider the following questions:

- Does the young person have access to condoms?
- Does the young person have the knowledge to use a condom with his/her partner? This includes the knowledge of how to put on and remove the condom as well as the capacity to negotiate with his/her partner to use a condom.
- Is the partner in agreement with the decision to use the condom?

The NGOs visited have shown their dedication to improving the health and well being of youth. To accomplish this, they have used several mediums, with a focus on quality IEC tools. In all cases there was a value added to behavior change when they added IEC to a life skills training.

**Stigmatization, Care and Support for PLWHA:** According to a UNAIDS report, the reduction of stigmas towards and discrimination of PLWHA are strategies for improving prevention efforts in zones with lower prevalence rates. This discrimination can lead to a conspiracy of silence or “invisibility” of infected people. Senegal is one example of this. The same report states that care and support are components frequently neglected by prevention programs in countries in this situation. By focusing on prevention, programs assume that there will not be PLWHAs and therefore no need for care and support. The interviews conducted have once again shown a need to address problems facing PLWHAs, although it is also evident that the necessary resources do not exist.

** Appropriation of Interventions Focused on Youth:** As outlined in the “Strategies of Prevention in an Environment of Low Prevalence,” prevention should focus on the following principles:

- Breaking the transmission cycle among high-risk populations;
- From the beginning, focus on those at high risk or high vulnerability, but as the program progresses, spread this focus to include those groups of lower risk; and
- Implement efforts directed at the general population to promote a more favorable environment as well as to reach those at risk who might not be reached by a focused intervention.

Looking at the two last points, it is clear that the NGOs stand by these principles and focus on high-risk youth as well as the general population of adolescents. However, one group that does not receive adequate attention is the young girls who are clandestine prostitutes. According to a 2001 study on clandestine prostitution, these sex workers are those at highest risk in Senegal. These young women are not officially registered in the health system and have less chance of benefiting from HIV/AIDS prevention messages. It also appears that a large part of these prostitutes consist of women who do not consider themselves prostitutes and therefore are not receiving prevention messages.
B. Specific Recommendations for CEDPA’s HIV/AIDS Youth Initiative

1. General Observations

In all the RH programs visited, the Population Council ARH program is the one that uses best practices standards. This program is based on evidence from previous studies and focuses on the development and promotion of safe behavior of youth by combining life skills, IEC tools and promotional items. The project also aims to create an enabling environment for youth by improving parent/child communication. Using the Client Oriented Provider Efficient (COPE) method—a system for improving the quality of service by making them youth-friendly—has reinforced services. Since this is a pilot project, the Ministry of Health is very eager to see if this approach could be reproduced on a larger scale. CEDPA and USAID should also follow the project’s progress in case it could be replicated for other local NGOs.

2. Promote Life Skills

CEDPA is well situated to promote the life skills approach in Senegal on two levels, as follows:

2.1 CEDPA is capable of training lead groups such as the U.S. Peace Corps, ACI, YMCA, and the Population Council that can pass on this behavior change strategy to other organizations that are working with youth. These organizations need training to complete their current IEC efforts.

2.2 CEDPA should chose partners based on the fact that they are willing to incorporate a life skills component into their programs. The U.S. Peace Corps and the FRONTIERS Project both have excellent resources available. CEDPA’s “Choose a Future” manual is already used to promote life skills and could easily be translated into Wolof to reach a larger audience. CEDPA could complete a review of “Choose a Future,” “Grow in Harmony,” and the U.S. Peace Corps “Life Skills” manual to develop a pilot program that could be used by the HIV/AIDS Youth Initiative partners.

3. Integrate RH/HIV Information into All Educational Programs

CEDPA could collaborate with partners to ensure that youth have knowledge of HIV/AIDS and the general functions of the human body, know how to avoid unplanned pregnancies, and translate their knowledge into practice. Abstinence and condoms as dual protection should be promoted as a viable option for both girls and boys.

4. Reinforce Current Efforts to Improve Parent/Child Communication

Several organizations in Senegal are working in this area; however, the interviews conducted did not investigate whether these programs are conducted in a formal manner with training or rather informally. One recommendation is to have CEDPA collect
information and complete an evaluation on existing structures regarding parent/child communication. CEDPA could collaborate with partners to develop a training workshop for parents that would not only provide information on ARH, but would also give them the skills to better communicate with their children. This effort would contribute to reducing the stigmas around condom use.

5. Addressing Stigmas at Various Levels

The Life Skills Program that CEDPA and its partners implement should include a session on stigmas and another on support of PLWHA. Opinion leaders should be involved in this process to promote positive messages in their communities. The UNAIDS 2002-2003 strategy is “the fight against stigmatization,” so more information is available on the UNAIDS website.

6. Promoting Gender in All Project Stages

CEDPA and its partners should conduct a review of all IEC materials and available curricula to identify gender messages to ensure that this concept is promoted and integrated into all programs.

To increase service use by youth, a more in-depth study on gender-related issues should be conducted. Adolescent boys and girls need different services and feel comfortable receiving these in different settings. These preferences should be explored to better cater to their needs and to eliminate discrimination.

7. Better Understand Most Vulnerable Youth

CEDPA should partner with an NGO that is currently working with girls who are housekeepers and may be exposed to clandestine prostitution in urban settings. It is critical that organizations involved gain a better understanding of issues affecting these girls. It is also crucial to understand the sexual network of these young girls to better define appropriate interventions and messages. For example, the IEC manual that the research team reviewed suggests that adolescents have sexual encounters among each other, when in actuality, young girls are partaking in sexual encounters mainly with older men (i.e., sugar daddies).

8. Improve Monitoring & Evaluation

The M&E systems of the local NGOs need to be improved. CEDPA could help to build this capacity among its partners.

9. Strengthen the Effectiveness of Peer Educators

Though the PE system is highly esteemed in reaching youth, it also faces high dropout rates after only a short period of time. This is generally due to the voluntary nature of the work. CEDPA should form a group of local NGOs that are interested in discussing and
analyzing possible ways to make this volunteerism more attractive to youth as well as ways to promote careers for youth based on their PE experience.

The work that this research team completed has enabled the group to draw certain conclusions based on strategies that target youth regarding RH and HIV/AIDS protection. The best practices are those expressed by those interviewed and respond generally to the criteria mentioned in published literature. Despite various limits, it is hoped that CEDPA and its partners will take the study results into consideration regarding future ARH interventions.
### ANNEX A

**ORGANISATIONS INTERROGEES**

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<td>1. USAID/SENEGAL</td>
<td>Ngor Diarama</td>
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<tr>
<td></td>
<td>Tel : 221 869 61 00</td>
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<tr>
<td>2. FNUAP</td>
<td>Immeuble FAYCAL</td>
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<tr>
<td></td>
<td>19, Rue Parchappe</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Phone : 221-839.90.66-823.91.68</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>MINISTERES DU GOUVERNEMENT DU SENEGAL/SERVICES PUBLICS</strong></td>
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<tr>
<td>3. Ministère de la Jeunesse de l’Environnement et de l’Hygiène Publique</td>
<td>Phone : 221 822 45 07</td>
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<tr>
<td></td>
<td>Fax :221 823 52 26</td>
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<tr>
<td>4. Secrétariat Exécutif National de Lutte contre le SIDA</td>
<td>Avenue Blaise DIAGNE</td>
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<td></td>
<td>Polyclinique</td>
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<tr>
<td>5. Centre Conseil pour Adolescents de Ziguinchor - Projet Promotion des Jeunes</td>
<td>BP 354 CDEPS Ziguinchor</td>
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<tr>
<td></td>
<td>Phone : 221 991 10.50</td>
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<tr>
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<tr>
<td></td>
<td>Tél. Mobile: 221 686 10 01</td>
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<tr>
<td>6. Ministère de la Jeunesse - Projet Promotion des Jeunes</td>
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<tr>
<td></td>
<td>Phone : 221 822.12.99</td>
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<tr>
<td></td>
<td>Fax :221 821.85.07</td>
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<tr>
<td>7. Clinique IST Centre de référence</td>
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<td>9. District Sanitaire de Kaolack</td>
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<td></td>
<td>Tel : 22109413969</td>
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<tr>
<td>10. Responsable du centre de référence MST de Kaolack</td>
<td>Centre de Santé Kasnack</td>
</tr>
<tr>
<td></td>
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<td>11. EPS-Thiès</td>
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<tr>
<td>12. Région Médicale de Louga</td>
<td>Tel: 967 10 24</td>
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<tr>
<td>Direction de L’éducation Surveillée et de la Protection Sociale</td>
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<td>14. CDEPS/ Ziguinchor</td>
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<td>17. Région Médicale de Diourbel</td>
<td>Région médicale de Diourbel Tel : 971 11 58 <a href="mailto:madiop@sentoo.sn">madiop@sentoo.sn</a></td>
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<tr>
<td>18. SIDA Service/Centre de Promotion de la Santé</td>
<td>Extension Cité Keur Damel BP 15314</td>
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**ONGS ET ASSOCIATIONS NATIONALES**

<p>| 19. SIDA SERVICE                                                            | Extension Cité Keur Damel BP 15314                                      |
|                                                                            | Dakar Fann                                                             |
|                                                                            | Phone : 221 835 34 07 Fax : 221 835 34 08                               |
| 20. ENDA GRAF                                                                | BP 19141                                                               |
|                                                                            | E-Mail : <a href="mailto:graf_gw@enda.sn">graf_gw@enda.sn</a>                                               |
|                                                                            | Phone : 221 835 34 07 Fax : 221 835 34 08                               |
| 21. ASBEF                                                                    | ASBEF                                                                  |
|                                                                            | BP 185 Kaolack                                                         |
|                                                                            | Phone : 41 10 90                                                       |
| 22. Conseil National de la Jeunesse du Sénégal (CNJS)                        | 18, rue Ramez BOURGI x Béranger FERRAUD                                |
|                                                                            | BP 21791 Dakar Ponty                                                   |
|                                                                            | Phone : 221 822 00 75                                                  |
| 23. Réseau des Associations pour le Bien Etre des Communautés (RABEC)       | Usine Niary Tally BP10568 Liberté                                      |
|                                                                            | Tel: 8642736                                                          |
| 24. Association pour la Sauvegarde et la Promotion des Jeunes (ASPJ)         | BP : 3317 Thiès Tél. 952.19.60/634.48.92 <a href="mailto:aspjied@hotmail.com">aspjied@hotmail.com</a>           |
|                                                                            | Fax : 951.85.76                                                       |
| 25. Centre de Traitement Ambulatoire Organisation Panafricaine de Lutte    | Centre Hospitalier Universitaire de Fann BP 16760 Tél.: 825 06 62       |
| contre le SIDA (CTA/OPALS)                                                  |                                                                       |
| 26. RABEC-Jeunes                                                            | Usine Niary Tally BP10568 Liberté                                      |
|                                                                            | Tel: 8642736                                                          |</p>
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<tr>
<td>27. Scouts du Sénégal - District de Louga</td>
<td>Louga Phone : 221 967 01 72 e-mail: <strong><a href="mailto:scoutslouga@jokkoo.sn">scoutslouga@jokkoo.sn</a></strong></td>
</tr>
<tr>
<td>28. Jeunesse et Développement (JED)</td>
<td>BP 16 566 Dakar-Fann Phone : 221 825 79 29 e-mail: <strong><a href="mailto:jed@refer.sn">jed@refer.sn</a></strong></td>
</tr>
<tr>
<td>29. Centre de Sensibilisation et d’Information sur les Drogues</td>
<td>Route des Niayes X Tally Diallo Pith BP : 20540 Thiaroye, Pikine-Dakar Phone : 221 834 50 19 <strong><a href="mailto:apcsid@sentoo.sn">apcsid@sentoo.sn</a></strong></td>
</tr>
<tr>
<td>30. ENDA Acas</td>
<td>Tel : 221 9911407 Fax : 221 9912494 Ziguinchor <strong><a href="mailto:Acas@enda.sn">Acas@enda.sn</a></strong></td>
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<tr>
<td>31. Mouvement International pour le Développement en Afrique (MIDA)</td>
<td>HLM 1 Villa n°147 BP :10403 Tel : 221 8273857/6321438 <strong><a href="mailto:Mida_sn@yahoo.fr">Mida_sn@yahoo.fr</a></strong></td>
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<td>32. Association AWA</td>
<td>Rue 17 x 22 Médina Tél. 221 823.45.57 <strong><a href="mailto:assoawa@sentoo.sn">assoawa@sentoo.sn</a></strong></td>
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<td>33. JAMRA</td>
<td>Sicap Darabis Tél.: 221 86435 79</td>
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<tr>
<td>34. FARLU CI DIINÉ JI</td>
<td>Cambéréne quartier Kawara LAYE Keur Seydina Rouhou Lahi Tel : (221) 835 06 65 / 820 00 35 /550 51 98</td>
</tr>
<tr>
<td>35. Réseau IEC de Thiaroye</td>
<td>Poste de Santé de Thiaroye Gare Tél. 834.55.23 / Fax : 893.43.16</td>
</tr>
<tr>
<td>36. Réseau des Jeunes Filles/Femmes Leaders (RJFL)</td>
<td>CEDPS KAOLACK, Tél. : 221 941 28 89 P: 553 63 87</td>
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<tr>
<td>37. Association Rurale de Lutte contre le SIDA (ARLS)</td>
<td>BP : 01 Khombole Tel 221 953 19 54</td>
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<tr>
<td>38. Enda Jeunesse Action</td>
<td>Guédiawaye DAKAR</td>
</tr>
<tr>
<td>39. Union Chrétienne des Jeunes Gens(UCJG/YMCA)</td>
<td>Avenue Bourguiba x Ben Tally rue 12 BP 4152 Dakar Tél. 824.13.85 Fax : 824. 24.44 <strong><a href="mailto:Ymcasen@enda.sn">Ymcasen@enda.sn</a></strong></td>
</tr>
<tr>
<td>40. SWAA JEUNES</td>
<td>6, Avenue Bourguiba à côté du FNPJ Dakar Tél. 824.51.78 Fax : 824. 59.20 Email : <strong><a href="mailto:swaaajeunes@yahoo.fr">swaaajeunes@yahoo.fr</a></strong></td>
</tr>
<tr>
<td>41. Alliance Nationale Contre le Sida (ANCS)</td>
<td>Sacré Cœur III Villa 10297 Dakar –Liberté Tel :221 827 94 89 Fax : 221827 95 02 <strong><a href="mailto:ancs@enda.sn">ancs@enda.sn</a></strong></td>
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<td>43. <strong>ONGS INTERNATIONALES</strong></td>
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<td>44. Frontiers in Reproductive Health Population Council</td>
<td>Mermoz Sotrac, 128 BP 21027 Dakar-Ponty</td>
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<td>Phone: 221 824 19 93/94 Fax: 221 824 19 98 e-mail: <a href="mailto:ndiop@pcdakar.org">ndiop@pcdakar.org</a></td>
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<td>45. Projet Santé Maternelle-Planification Familiale - MSH</td>
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<td>Phone: 221 864 14 66 Fax: 221 864 14 65 e-mail: <a href="mailto:osmanefaye@sentoo.sn">osmanefaye@sentoo.sn</a></td>
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<td>46. Décentralisation et Initiatives de Santé Communautaire (DISC)</td>
<td>BP 16 659 Dakar-Fann</td>
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<td>Phone: 221 860 31 21 Fax: 221 860 31 23 e-mail: <a href="mailto:vjoret@disc.sn">vjoret@disc.sn</a></td>
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<td>47. Projet Etude pour l’amélioration de la santé des Adolescents, Frontières/Population Council St Louis</td>
<td>Service Régional de l’Hygiène à Saint Louis Tel : 221.961.54.51</td>
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<td>48. ACI/SARA Project</td>
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<td></td>
<td>Centre de Formation d’Information et de Ressources 989 Bis, Sicap Baobab, Dakar</td>
</tr>
<tr>
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<td>Phone: 221 824.83.38 Fax: 221 824.07.41</td>
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<td>49. Africa Consultants International</td>
<td>Centre de Formation d’Information et de Ressources 989 Bis, Sicap Baobab, Dakar</td>
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<td>50. Corps de la Paix Américain</td>
<td>Allées Papa Gueye FALL</td>
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ANNEX B

Bibliography


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ANNEX C

INSTRUMENTS DE COLLECTEEET D’ANALYSE DES DONNEES

C.1 Questionnaire pour ONG et structures gouvernementales

1. Nom du projet (ou de l’Association)
2. Personne à contacter
3. Adresse et téléphone / Fax/e mail
4. Date de création de votre organisation ?
5. Quelles sont les sources de financement de votre association ?
6. Quelle est la source de financement de votre projet ?
7. Quel est l’objectif / la mission de votre organisation ?
8. Quels sont les domaines d’intervention de votre organisation ?
9. Quels sont les bénéficiaires de vos interventions ?
10. Quelles catégories de jeunes bénéficient de vos interventions ?
   1. élèves
   2. étudiants
   3. non scolarisés
   4. scolarisés et non scolarisés
   5. autres
10.1. quelle est la tranche d’âge de votre cible ?
10.2. quel est le profile socio-économique de votre cible ?
   • Employés
   • Sans emploi
   • En situation difficile
     ➢ Enfants dans la rue
     ➢ En milieu carcéral
     ➢ Filles mères
     ➢ Toxicomane
11. Quelles sont vos zones d’intervention ?

12. Quelles sont les services clefs que vous proposez aux jeunes ?
   1. santé de la reproduction
   2. planification familiale
   3. activités sportives
   4. activités culturelles
   5. informations
   6. formation professionnelle
   7. alphabétisation
8. autres

13. Depuis quand et pourquoi ?
14. comment intégrez-vous :
   ➢ Les activités SR et de jeunesse ?
   ➢ Le VIH/SIDA dans les activités de SR ?

15. Quand avez-vous modifié votre programme ?

16. Quels sont les succès du programme ?

17. Comment expliquez-vous ces succès ?

18. Quels sont les critères de succès du programme ?

19. Comment avez-vous mesuré ces succès ?

20. Quels sont les échecs du programme ?

21. Comment expliquez-vous cet échec ?

22. Quels sont les critères d’échec pour vous ?

23. Comment avez-vous mesuré ces échecs ?
C.2
Guide d’entretien pour responsables d’organismes d’appui et des services de l’état

Thèmes abordés :

• Principaux problèmes des adolescents et des jeunes en général,

• Principaux problèmes en santé de la reproduction (grossesses précoces, grossesses non désirées, IST, SIDA, avortement, sexualité, …),

• Solutions préconisées à ces problèmes,
  ✓ Par les pouvoirs publiques
  ✓ Par les ONG et organismes internationaux
  ✓ L’intégration de la SR et le VIH/SIDA

• Apport des activités des associations à ce sujet,

• Bénéfices retirés de l’action de l’association,

• Moyens pour améliorer l’efficacité des actions menées,

• Lieu (et personne) idéal (e) pour fournir des services en SR des adolescent (es) et jeunes,

• Services à proposer.
C.3 : Fiche d’analyse de l’intervention des organisations

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<td>Personne à contacter</td>
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