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Senegal Youth-Friendly Reproductive Health Services Assessment in Six Regions

REPORT | E2A PROJECT

About E2A

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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- The MSAS regional and district executive teams.

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Table of Contents

Acronyms

ASBEF	Senegal Association for Family Welfare
ASC	Community Health Worker
AYRH	Adolescent and Youth Reproductive Health
CCA	Adolescent Counseling Center
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DD	Demographic Dividend
DSME	Directorate of Mother and Child Health
E2A	Evidence to Action Project
EC	Emergency Contraception
FGD	Focus Group Discussion
FP	Family Planning
FGM	Female Genital Mutilation
FP/RH	Family Planning and Reproductive Health
GBV	Gender-Based Violence
GOS	Government of Senegal
GRAG	Global Research Action Group
HC	Health Center
HF	Health Facility
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDI	In-depth Interview
IEC	Information, Education and Communication
IME	Inspection Medicale des Ecoles (school-affiliated health center)
IUD	Intra-Uterine Device
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraception
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	Non-governmental organization
PAC	Postabortion Care
RH	Reproductive Health
SDP	SDP – Service Delivery Points
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YFS	Youth-Friendly Services
YFHS	Youth-Friendly Health Services

Executive Summary

In Senegal, where more than 60% of the population is under the age of 25 years,[17] the government and civil society have implemented a variety of adolescent and youth reproductive health (AYRH) projects and programs since the mid-1990s for youth aged 10–24 years. Since the 1990s, AYRH has been increasingly recognized as a priority by the Senegalese government and civil society. Political commitment to AYRH is evidenced by Senegal's 2005 Reproductive Health law,[2] the current National Health and Development Plan (2009–2018),[3] the National Policies, Norms and Protocols for Reproductive Health,[4] the National Strategic Plan for Reproductive Health (2011–2015),[5] the National Action Plan for Family Planning (2012–2015),[6] and the National Strategic Plan for AYSRH (2014–2018).[7] These policy documents articulate the importance of ensuring access to reproductive health (RH) information and services for adolescents and young people through a multisectoral approach.

While political commitment has contributed to some progress, young people in Senegal still encounter many problems related to RH. For example:

- One third (33%) of women aged 2024 in Senegal were married before age 18, and more than one in ten (12%) were married before age 15.[7]
- The adolescent pregnancy rate (15–19 years) is 78 per 1000, with a particularly high number of births among adolescents in rural areas.[1]
- Only 3% of married adolescents (15–19 years) and 12% of married young women (20–24 years) use a modern method of contraception.[1]
- Unmet need for contraception among unmarried young women is 70% and 31% for married young women.[8]

The current Senegal National Strategic Plan for AYSRH (2014–2018) outlines five quality standards of performance recognized as critical in addressing the RH needs of adolescents and youth (described in the next section). This assessment highlights strengths and weaknesses in currently-offered AYRH services, gauging the degree to which the five quality standards for youth-friendly RH services are being realized from a variety of perspectives (service providers, peer educators, parents, youth who use contraception, etc.). This study was conducted in six regions with the poorest AYRH indicators in Senegal where youth-friendly services are being—or have been—implemented. In addition, five of the six regions are also among United States Agency for International Development (USAID)'s priority regions of concentration (except for Kaolack), presenting an opportunity to concentrate its investments to significantly impact the key drivers of child and maternal mortality, including adolescent and youth FP/RH. Although all reproductive health services are included in this assessment, it focuses more closely on family planning (FP), including contraceptive services and information for adolescents and youth, as this is the area of E2A's specific expertise, and is also an area of specific interest of the Senegal Ministry of Health (MOH) and USAID.

The specific objectives of the evaluation, conducted by Senegal's MOH with the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A), the Dakar-based Global Research Action Group (GRAG), and USAID/Senegal, were to:

1. identify the factors that facilitate or hinder the quality of youth-friendly health services (YFHS) in select sites across Senegal, including the extent to which the National Standards for YFHS are applied;
2. assess the factors that influence the uptake and utilization of YFHS by adolescents and young people, including accessibility, acceptability, and equitability of services;
3. examine characteristics of existing YFHS models that have an influence on potential scale-up; and
4. generate recommendations and practical guidance for the operationalization of the service delivery components of the Senegal National Strategic Plan for AYSRH (2014–2018).

Methodology

The evaluation had two components: (1) a quantitative component that focused on coverage of YRHS, including uptake of YFHS, adherence to standards, and satisfaction with YFHS services provided; and (2) a qualitative component that focused on gaining a deeper understanding of facilitators and barriers to the uptake of YFHS in Senegal. The quantitative component was conducted in a census of all service delivery points (SDPs) offering AYRH services in 12 health districts randomly selected from six regions of Senegal that have the poorest AYRH indicators: Kédougou health district in Kédougou region, Dagana, Richard-Toll and Saint-Louis districts in Saint-Louis region, Kaolack and Nioro health districts in Kaolack region, Kolda and Médina Yoro Foula districts in Kolda region, Matam and Kanel districts in Matam region, and the Sédhiou and Bounkiling health districts in Sédhiou region.

The quantitative component consisted of interviews with:

1. 2,400 young people aged 10–24 years living in YFS catchment areas to determine their knowledge and use of YFHS services;
2. 180 clients aged 10–24 years exiting from the assessed SDPs to determine their satisfaction with services;
3. 50 health service providers to determine their professional training, the quality and breadth of the services they offer, as well as any challenges they face;
4. 150 community-based health workers (e.g., Agents de Santé Communitaire, relais, or "Bajenu Gox" – community outreach volunteers sometimes seen as "neighborhood godmothers") to determine how they conduct outreach and offer services; and
5. 23 SDP management staff/senior YFHS providers on SDP characteristics and service provision, including a review of service statistics from the 12 months preceding the evaluation to assess YFHS uptake.

For the qualitative component, focus group discussions (FGDs) were conducted with two groups of respondents: peer educators in the community (18 FGDs) and parents of youth (24 FGDs). FGDs were conducted in all six regions, in both urban and rural sites, and with both males (fathers) and females (mothers). Each FGD consisted of eight to ten members and the discussions were facilitated by trained persons using pre-tested guides. The FGD participants were recruited by research data collectors using age and gender criteria.

In-depth interviews were also conducted as part of the qualitative component. Interviews with 36 community leaders provided insight into their perceptions of young people, particularly regarding RH. Additionally, interviews with 12 district SRH Focal Points and 30 civil society organization members helped determine adherence to YFHS standards, as well as successes and barriers to the implementation of YFHS. Finally, 36 young women in the community, both married and unmarried, were interviewed about their experiences obtaining and using their preferred contraceptive methods—including the pill, implant, injectables, and IUD.

Key Findings

The key findings are presented in the table below, organized by Standards/Norms 1–5 identified in the Senegal National Strategic Plan for AYSRH (2014–2018). These findings represent overall numbers, percentages, or qualitative findings among the populations interviewed for the six regions. In most of the findings, however, there were some variations by region. Those variations are included in the full report.

Standard/Norm 1: At the level of the SDP, every adolescent or young person, regardless of circumstance, has access to information and advice appropriate to his/her state of health, development, and rights.

- All 23 SDPs in the six regions had at least one provider trained in RH counseling services to offer information and support to adolescents and youth. About half of the 23 assessed SDPs had: at least two providers trained in youth-friendly FP/RH counseling and service provision (16 SDPs), had at least two youth-specific Information, Education and Communication (IEC) materials in the waiting areas (15), and were observed to have a signboard advertising YFHS at the SDP (12).
- Only two SDPs reported they had a program working with attached ASC/relais/ BG/matrons to conduct community-based outreaches for adolescents and youth. These two SDPs reported working with a total of 32 community health workers (ASC/Relais, etc.) trained in AYRH.
- Awareness and use of YFHS is low in these six regions of Senegal, with less than one-fifth (17%) of community youth survey respondents reporting to have heard about YFHS and 12% reporting to have ever used YFHS. Many parents and community leaders who took part in the qualitative assessment also had limited awareness of the RH services available to young people.
- When asked about the main services sought by adolescents and youth, interviewed SRH program managers (District SRH Coordinators/Focal Points and community-based or international organization staff) tended to mention FP, STI testing, prenatal visits, and menstrual pain. In some regions, these respondents reported that adolescents and youth often avoid health services, even in cases of serious illness, mirroring adults in the community.
- In semi-structured interviews, young women did not consistently understand the protections and side effects associated with their chosen FP method. Several individuals who took part in

FGDs or in-depth interviews (IDIs), including parents and community leaders, expressed the belief that use of FP commodities could lead to infertility.

- Participants across the six largely rural regions who took part in the qualitative assessment said YFHS SDPs were difficult to reach due to their geographic distance. The cost of transportation, health services, and especially prescriptions (for obtaining methods in pharmacies) were identified as obstacles to accessing AYRH services in some of the regions.

Standard/Norm 2: Every service delivery point is organized to offer every adolescent and young person quality services adapted to his/her needs.

- Nearly all (21 out of the 23 assessed SDPs) offered sexual and reproductive health counseling for adolescents/young people, and more than half offered diagnosis, treatment, and counseling for the prevention of sexually transmitted infections (STIs) for adolescents and youth. Among the assessed SDPs, 19 reported that they had a functional referral system in coordination with other SDPs offering RH services and other social services, and 18 SDPs reported offering FP, counseling, and at least one contraceptive method (any method, including male condoms) for adolescents and youth.
- However, the infrastructure to actually offer these services was present in just over half of the assessed SDPs: 14 SDPs had water, electricity, toilets, sharps containers, and the required equipment and supplies for appropriate sterilization. In addition, 14 SDPs had not experienced any stock-outs in FP commodities in the past three months of any method usually offered in the SDP. Only nine SDPs were observed to have SDPs with a welcoming and clean counseling room, respecting the standards of privacy and confidentiality for the care of adolescents and youth.
- Fewer than half (10 out of 23) of SDPs reported having an AYRH policy, standards, or protocols document or at least one trained provider who could offer all contraceptive methods (injectables, IUD insertions and removals, implants, etc.).
- Less than one-third (7) of the assessed SDPs had an equipped youth space (corner) for adolescents/youth, and only six SDPs reported offering a complete range of contraceptive methods (including emergency contraception (EC) and long-acting reversible methods) for adolescents/youth.
- Few (4) SDPs offered antenatal care, delivery services, or post-partum care for adolescent/young mothers and their newborns.
- Lack of privacy was one of the most serious barriers raised concerning adolescents' and youths' ability to access RH services. Due to strong taboos around early sexuality and pregnancies outside of marriage, adolescents and youth were afraid to be seen visiting an SDP lest community members conclude they were seeking FP or care for a pregnancy.
- Nearly all (22) SDPs reported their hours of operation (generally 8:00 to 18:00, Monday through Friday) were convenient for adolescent and youth clients. However, there was general agreement among participants in the qualitative assessment across the six regions that the hours during which YFHS SDPs typically operated were not suitable to adolescents and youth; they interfered with school and exacerbated young people's concerns about safeguarding their privacy.

- Stock-outs of FP commodities and other medications were reported to be an issue in some regions according to participants in the qualitative assessment, though it appeared a new program was making some progress in reducing the incidence of stock-outs.
- Participants in the qualitative assessment tended to identify young people without formal schooling, young people not currently enrolled in school, and those living in particularly rural or secluded areas as the least able to be reached by RH services.

Standard/Norm 3: All providers have the knowledge, competencies, and positive attitudes (required) to offer services adapted to the needs of adolescents and youth.

- During SDP audit interviews, one (1) health center (HC) in Kaolack reported to have 25 qualified health personnel (doctors, nurse-midwives, and nurses) who have been trained to offer RH and counseling services to adolescents/youth; this same SDP also reported having 11 support personnel (security, cashier, cleaning staff, etc.) who have been oriented on AYRH. The remaining 22 SDPs reported they had a total of 32 qualified staff who could provide RH services and counseling for adolescents and youth; none of these 22 SDPs reported having any support staff who had been oriented on AYRH.
- Among 50 surveyed providers, nearly three quarters of providers (72%, or 36) reported having formative or in-service training in AYRH counseling, diagnosis/treatment, or prevention counseling for STIs.
- About two-thirds of surveyed providers (64%, or 32) reported having formative or in-service training for confidential Human Immunodeficiency Virus (HIV) counseling and testing for adolescents/youth, and reported having formative or in-service training for offering comprehensive support and care for gender-based violence (62%, 31 providers).
- Less than half of surveyed providers (24 out of 50 providers, or 48%) reported having formative or in-service training to manage and counsel adolescent/youth clients on contraceptive side-effects. Only one third of providers (32%) reported having formative or in-service training to offer a complete range of contraceptive methods, including EC.
- Only a few of the providers (14%) reported having formative or in-service training to offer antenatal (ANC), delivery, or post-natal care (PNC) for pregnant or newly-delivered women.
- Across the six regions, SRH program managers who took part in the qualitative assessment were about evenly split on the question of whether they had received training specifically on RH issues related to service provision for adolescents and youth. However, most of these SRH program managers demonstrated a good understanding of the specific RH needs and concerns of adolescents and youth.
- Clients surveyed upon exiting the assessed SDPs rated nearly all the indicators related to provider interactions, information received, treatment, privacy, and assurance of confidentiality over 90%. Nearly all (99.4%) clients felt they were treated "well" or "very well" by the provider during the visit.
- All providers surveyed at SDP level and most SRH program managers who took part in the qualitative assessment made it clear they generally did not seek parents' permission for treating adolescents and youth. Most said there was no minimum age for accessing RH services in practice; some had seen pregnant girls as young as 12 or 13.

- While many of the SRH program managers interviewed generally had positive comments about the attitudes, skills, and behaviors of service providers, some SRH program managers noted that service providers were judgmental towards adolescents and youth who came to them for RH services, or even gossiped about them. Concerns about providers' professionalism towards adolescents and youth were also voiced by various non-provider participants in the qualitative assessment, most of whom often complained of service providers being moody and temperamental, tired, judgmental, and not respecting clients' privacy and confidentiality.
- Approximately 70% (28) of surveyed service providers mentioned it was important to maintain client confidentiality when offering FP counseling and services to youth. Some participants in the qualitative assessment reported that service providers could not always be trusted to preserve the confidentiality of their clients.

Standard/Norm 4: Members of the community, including adolescents and youth, facilitate the implementation and utilization of health services by adolescents and youth.

- Most SDPs (78%, or 18) reported having an updated list of partner organizations which provide community-based support for increasing use of services by adolescents/youth, and 16 of these SDPs reported having a current community outreach activity plan. However, during the three months prior to the assessment, less than half of SDPs (10) conducted outreach programs (led by providers or ASC/Relais/Bajenu gox) to sensitize and inform youth, parents, community organizations, schools, etc., on the value of health service provision for adolescents/youth.
- As mentioned under Standard/Norm 1, only two (2) SDPs reported they worked with 32 ASC/relais/BG/matrons who had been trained to conduct community-based RH outreaches for adolescents and youth. SDPs more often reported working with peer educators: 11 SDPs reported they trained and supervised adolescent/youth peer educators. These SDPs reported working with 403 peer educators trained in AYRH across the six regions.
- This assessment included 150 quantitative interviews with ASC/relais, though most of these community health workers were not attached to the assessed SDPs included in this study. Of these, 119 ASC/relais reported performing 8,734 community-based promotional activities on AYRH over the past 12 months, reaching 30,283 adolescents/youth. While these numbers could not be validated at the SDPs which supervised the surveyed ASC/relais, clearly there is some level of AYRH community outreach taking place.
- Participants in the qualitative assessment across the six regions held mixed views on whether health service providers engaged effectively with communities. While some mentioned service providers coordinated with local organizations or engaged in outreach campaigns (largely around non-RH issues like vaccinations), others claimed service providers did not properly talk with or educate young people or communities, particularly about RH issues and where adolescents and youth could turn for services.
- Bajenu gox were often among the first (and sometimes only) non-provider resource named by participants in the qualitative assessment when asked if the community benefitted from any AYRH-related outreach activities or service provision by actors other than those directly tied to the SDPs. While their work was described as educating communities, providing basic services and referrals, and serving as an important source of information, many Bajenu gox did

not receive training, and some of the advice they gave and services they provided fell short of the standards that might be expected of a true health service provider (based on their reported knowledge).

- Across the six regions, participants in the qualitative assessment named many local CSOs, as well as several international non-governmental organizations (NGOs) and projects that were engaged in the AYRH space—many in coordination with other organizations, district or national authorities, and/or the health system. Those most often mentioned by participants were Enda (including Enda Santé), Marie Stopes International (MSI), TOSTAN, the Red Cross, and the Neema project.
- CSO respondents were knowledgeable about the range of services available to adolescents and youth.
- Peer educators served as a resource for RH education and referrals for adolescents and youth, while the radio was an important source of AYRH information for adults.

Standard/Norm 5: The system for managing health services takes into account the aspects tied to adolescent and youth RH in an appropriate manner.

- All (23) assessed SDPs reported having registers or other systems in place to collect data on service utilization. However, only 13 SDPs reported sending regular reports (quarterly or monthly) to health districts, including data on the use of specific services by adolescents/youth. Twelve of these SDPs reported using their service delivery data for planning services and implementation of quality improvement initiatives.
- SRH program managers reported systematically collecting data on service provision and engaging in regular reviews of data to improve service delivery.
- About two-thirds (15) of assessed SDPs reported having a functional supportive supervision system or other quality assurance system to improve provider performance.
- Participants in the qualitative assessment involved in AYRH service provision noted that formal supervision structures were in place across the six regions, though this was not consistently described as robust.

Recommendations

- Develop appropriate strategies to **create awareness about YFHS**, particularly in catchment areas surrounding YFHS, including the package of services offered, benefits of services, and intended beneficiaries.

- Promote a **change in social norms regarding communication about family planning, reproductive health and rights** by creating opportunities to stimulate RH communication among families, youth peer groups, schools, mosques, and community settings. Educating parents about FP/RH and family life education in schools and mosques are effective strategies to promote familial communication and increase knowledge.

- Promote **keeping girls in school**. Not only can this advance their economic security and agency, but it can help reduce early marriages and early pregnancies, which jeopardize the health and futures of young women in Senegal.

- **Increase young people's access to the full range of contraceptive options** in both SDP and community settings.
    - The challenge of distance can be partially addressed by mobile service provision at community level (bringing services to where youth live). Adolescents should be actively engaged in programming and outreach efforts, including the distribution of condoms and other contraceptives that are permitted by Senegalese policies.
    - Increasing the ability and willingness of providers to counsel on a wider range of methods can be achieved by periodic training and sensitization (including values clarification) to address misconceptions about married and unmarried adolescents' use of diverse birth control methods.
    - Use existing peer educators, ASC/relais, NGOs, and the media (radio) to engage in health promotion to raise awareness of different contraceptive options and to reduce myths and misconceptions of adolescent users and their parents. A variety of strategies can be used, including home visits, WhatsApp, Click Info Ado, skits, and discussions.
    - Provide training to peer educators and Bajenu gox to counter misconceptions, improve their counseling and referral skills and be more responsive to the needs of adolescents and youth in general.
    - Continue to support efforts to strengthen the availability of contraceptives and other YFHS products.

- **Tailor AYRH services models to the local or regional context.** There really is no one "correct" model of AYRH services which is relevant regardless of context. The selected model should reflect the specific target population, desired behavioral and health outcomes, range of services to be offered, and needs and objectives for scalability and sustainability.

- SDPs should **leverage opportunities to extend YFHS and education to communities** by making consistent use of ASC/relais, peer educators, community leaders, and NGOs. These relationships should not be left to chance; they must be planned, implemented, monitored, and adjusted according to changing circumstances. Given that most AYRH outreach is being conducted at community level by providers not affiliated with designated YFS SDPs, it is important for district-level coordinators to ensure consistency of messages, high quality training (and refresher training), and regular supervision of outreach staff. This is especially important in SDP catchment areas and communities where there is a shortage of health professionals to provide outreach.

- Take steps, considering the available resources, to **organize services to promote privacy for youth** throughout their visit to a YFHS site—from waiting queues to the services themselves. Ensure that awareness-raising campaigns about services emphasize their confidentiality and privacy. Where services cannot be reorganized to provide adolescents and youth with more private access to services, consider other creative approaches, like having

operating hours during which services are only available to adolescents and youth, offering a separate waiting area or entrance/exit, facilitating privacy and access through phone calls, and/or ensuring that no names or details of health appointments are disclosed in waiting rooms or where others might overhear.

- **Raise awareness among young people about their right to quality health services.** Involve young people in mechanisms to monitor and improve SDP and community-based health services.

- **Bring consistency to the training YFHS providers receive** and ensure that it is comprehensive, covering all the essential services outlined in the National Strategic Plan for Adolescent and Youth Sexual and Reproductive Health. Part of the training should also include values clarification exercises to promote unbiased and respectful care.

- **Consistently implement a system for quality assurance in FP and YFHS** to increase the quality and responsiveness of clinical and community-based services to the needs of adolescents and youth. As part of this, support both health care providers and ASC/relais with regular and predictable supportive supervision specifically focused on adolescents and young people.

Introduction

A. Background and Rationale

There remains an unmet need for adolescent- and youth-friendly reproductive health (YFRH) services across the developing world, as sexually active young people frequently struggle to obtain health information, contraceptives, testing, counseling, and more.[9-10] It can be difficult to effectively implement adolescent- and youth-friendly services because most societies frown upon premarital sex,[10-11] and because married adolescents are often no longer considered "youth" and often are under intense social pressure to demonstrate their fertility by becoming pregnant. Unmarried adolescents and youth in developing countries are often hesitant to seek RH services due to the fear of being identified at a clinic and subsequently exposed to their communities as sexually active.[10,12] Furthermore, married adolescents and youth, especially adolescent girls and young women, often experience pressure to have children early and therefore experience discrimination when accessing family planning (FP) services. It is necessary for health care providers to be trained to be comfortable with speaking to both married and unmarried adolescents and youth about their specific needs in a nonjudgmental manner, and to be sensitized about the importance of respecting their confidentiality.[10-12]

In addition to concerns about their privacy, research into adolescents' and youths' access to RH services has identified additional obstacles. These obstacles include adolescents' and youths' busy school schedules during the week, lack of transportation, and lack of income to procure transportation or services. Clinics that are hard to reach, do not have flexible hours, and have costly services may not meet the needs of most adolescents and youth.[10,12-16] Since adolescents and youth might be hesitant to pursue RH services on their own, researchers argue that integrated methods should be utilized; in addition to making clinics more adolescent- and youth-friendly, it is beneficial to organize community outreach efforts and disseminate RH information through school curricula and popular media.[9,12,14]

In Senegal, where nearly two-thirds (63%) of the population is below the age of 25 years,[17] the government and civil society have implemented a variety of adolescent and youth reproductive health (AYRH) projects and programs since the mid-1990s for youth aged 10–24 years. Since the 1990s, adolescent and young people's reproductive health (AYRH) has been increasingly recognized as a priority by the Senegalese government and civil society. Political commitment to AYRH is evidenced by Senegal's 2005 Reproductive Health law,[2] the current National Health and Development Plan (2009–2018)[3] the National Policies, Norms and Protocols for Reproductive Health,[4] the National Strategic Plan for Reproductive Health (2011–2015),[5]the National Action Plan for Family Planning (2012–2015),[6] and the Senegal National Strategic Plan for AYSRH (2014-2018).[7] These policy documents articulate the importance of ensuring access to RH information and services for adolescents and young people through a multisectoral approach.

While the political commitment has contributed to some progress, young people in Senegal still encounter many problems related to RH. The Senegal National Strategic Plan for AYSRH (2014-2018)[7] outlined five quality standards of performance recognized as critical in addressing the RH needs of adolescents and youth (described in the next section). This assessment highlights strengths and

weaknesses in currently offered YFHS in underserved areas of Senegal, gauging the degree to which the five quality standards for youth-friendly RH services are being realized, from a variety of perspectives (service providers, peer educators, parents, youth who use contraception, etc.). This study was conducted in six regions with the poorest AYRH indicators in Senegal where youth-friendly services are being—or have been—implemented. In addition, five of the six regions are also among USAID's priority regions of concentration (with the exception of Kaolack), presenting an opportunity to concentrate its investments to significantly impact the key drivers of child and maternal mortality, including adolescent and youth FP/RH. Although all services are generally included in this assessment, it focuses in more closely on FP, contraceptive services, and information for adolescents and youth as this is the area of E2A's specific expertise, and is also an area of specific interest of the Senegal MOH and USAID.

The specific objectives of the evaluation, conducted by Senegal's MOH with the USAID-funded E2A Project, the Dakar-based Global Research Action Group (GRAG), and USAID/Senegal, were to:

1. identify the factors that facilitate or hinder the quality of YFS in select sites across Senegal, including the extent to which the National Standards for YFS are applied;
2. assess the factors that influence the uptake and utilization of YFS by adolescents and young people, including accessibility, acceptability and equitability of services;
3. examine characteristics of existing YFS models that have an influence on potential scale-up; and
4. generate recommendations and practical guidance for the operationalization of the service delivery components of the Senegal National Strategic Plan for AYSRH (2014–2018).[7]

B. Context

In Senegal, as in many countries around the world with high fertility rates and a youth demographic "bulge", adolescents and youth represent the majority of the population. Based on the 2016 Demographic and Health Survey, 63% of the Senegalese population is under the age of 25, and 48% is under the age of 15.[17] In rural areas, the proportion of the population younger than 15 is higher than in urban areas (50% vs. 38%). While much of the country's population is concentrated in Dakar (23.2%) and Thiès (13.3%), 63.5% of the population lives outside these two most populous cities. The country is split nearly evenly between a rural population (50.9%) and an urban population (49.1%).[17]

There are three preeminent ethnic groups in Senegal: Wolof (42.3%), Fula (28%), and Serer (15.6%). Additional minority ethnic groups include Mandinka (5.2%), Jola (3.1%), and Soninke (0.7%). Senegal is predominantly Muslim (96.2%), with a small minority who identify as Christian (3.4%), and a small minority practicing traditional, indigenous religions (0.3%). In terms of geographic distribution, 40.2% of the population lives in the West (where Dakar and Thiès are located), 27.7% lives in the Center, 17.3% in the North, and 14.8% in the South.[17]

Urban Senegalese are more likely to have formal education than rural inhabitants. In rural areas, 67.4% of women aged 15 to 49 and 60.8% of men in the same demographic age group lack any formal education, compared to 36.1% and 27.9%, respectively, in urban settings. On average, urban men have attained more formal education than urban women and, similarly, rural men are more likely to have advanced further in the educational system than rural women. However, urban/rural residence is also a

critical factor in educational attainment. In the 15 to 49 age group, only 21.5% of rural women and 24% of rural men have some primary education, and 8.8% of rural women and 11% of rural men have some secondary education. The levels of educational attainment improve slightly among the urban population. In urban areas, 32.3% of urban women and 30.9% of urban men have some primary education, and 22.7% of urban women and 24.5% of urban men have some secondary education. The median number of years completed in school is 2.4 for urban women and 3.8 for urban men.[17]

Among children aged 3 to 5 years across Senegal, 34% are enrolled in an educational program. The most common educational model for young children is traditional Quranic schools, or *daaras*. 22% of boys and 16.7% girls aged 3 to 5 attend *daaras*.[17] Human Rights Watch (2017) estimates 50,000 boys across the country attend *daaras*.[18] Students at the *daaras*, known as *talibés*, learn to memorize the Quran from a *marabout,* or Quranic teacher. *Daaras* are most common in urban centers, but also exist in rural areas, dating back to the colonial period. In rural *daara* farms, *talibés* learn agricultural skills, cultivating crops such as millet and groundnuts, in addition to memorizing the Quran. In urban centers, there are multiple types of *daaras*, including costly boarding schools, which tend to attract *talibés* from mid- to high-income families, and "unsupervised" *daaras*, where many *talibés* are forced to beg for money and are exposed to harsh conditions, which can include abuse.[18-19] In recent years, the Government of Senegal (GOS) has been working to create modern *daaras* that teach more than the Quran, since there are few employment opportunities for *talibés* after they graduate.[19]

According to the World Bank (2017), only 5.5% of Senegalese youth aged 15 to 24 are employed.[20] Chronic unemployment in rural areas causes many young people to migrate to urban centers. Even though most rural jobs are agricultural, there are few agriculture-oriented schools, resulting in gaps between youths' skills and the needs of the labor market.[21] Rural women of all ages primarily work in the agricultural sector (50.4%), with others employed as salespeople (26.7%), skilled manual laborers (8.5%), domestic workers (7%), in professional, technical, or managerial positions (3.7%), and as unskilled manual laborers (3.4%). Rural men also tend to work in agriculture (63.4%), with smaller proportions employed as skilled manual laborers (17%), salespeople (8.9%), in professional, technical, or managerial positions (5.3%), and as unskilled manual laborers (4.5%). Unemployment is significantly higher among women than men in rural areas: 38.4% of rural women aged 15 to 49 were employed when they were surveyed for the 2016 DHS, whereas 82.2% of rural men of the same demographic were employed during that period.[17]

Among young women aged 15 to 19, very few (0.9%) report giving birth before the age of 15. For women aged 20 to 24, 1.6% gave birth before the age of 15, 17% gave birth before the age of 18, and 31.4% gave birth before the age of 20. The median age at first birth among women aged 20 to 49 is 20.4 for rural women and 23.3 for urban women. The median age at first birth also varies across regions: 23.4 in the West, 21.2 in the North, 20.7 in the Center, and 19.6 in the South.[17]

Child marriage continues to be an issue in Senegal, with 9% of adolescents married by the age of 15, and 32% married by the age of 18.[22] The mean age of first marriage is 19.9 years for women and 28.9 years for men.[23] In terms of first sex, 8% to 9% of women have experienced sexual debut by age 15, approximately one-third by age 18, and one-half by age 20. Only 5.7% of women reported having premarital sex.[24] Among young women aged 15 to 19, 86% have heard of a contraceptive method. That

proportion increases with young women aged 20 to 24: 95% have heard of a contraceptive method, and the same proportion have also heard of a modern contraceptive method. There is no data available about contraceptive knowledge among young men aged 15 to 19. Among young men aged 20 to 24, 91% have heard of a contraceptive method, and the same proportion have also heard of a modern contraceptive method.[17]

Although contraceptives are not legally restricted based on age or marital status, providers will often refuse to give them to unmarried young women, instead promoting abstinence.[25] Among public-sector providers, 57% impose age restrictions for oral contraceptives, and 44% impose age restrictions for injectable contraceptives, with the average minimum age of 18 for contraceptive provision. Martial restrictions are less common: 12–14% of public-sector providers impose marital restrictions for oral and injectable contraceptives.[26] Abortion is illegal in Senegal, but it is allowed if three doctors confirm that it is necessary to save the pregnant woman's life. Despite the legal restrictions, it is estimated that 24% of all unplanned pregnancies result in induced abortions.[27] The ban on medical abortion has dire health consequences for young women, who are the most likely to have an unmet need for contraception, and the most likely to receive an unsafe abortion.[18,28]

One-quarter of married women aged 15 to 49 use a contraceptive method, with 23% using a modern contraceptive method and 2% using a traditional method. Use of modern contraception is higher in urban than rural areas (31% vs. 17%), and similarly, it is higher in the West than the other regions (33% vs. 20%). The prevalence of modern contraception also increases with educational attainment: 30% of women who completed primary education used contraception compared to 19% of women who lacked formal education. Young women have a much lower rate of contraceptive use: 97.8% of sexually active women aged 15 to 19, both married and unmarried, reported that they did not use any contraceptive method. Among sexually active women aged 20 to 24, both married and unmarried, 86.3% did not use any contraceptive method.[17]

Senegal has nearly universal male circumcision: 98.2% of men aged 15 to 49 are circumcised.[29] Male circumcision is customary for Muslim populations. In Wolof culture, the word for a circumcised man (*njulli*) is closely related to the word for prayer (*julli*), illustrating how circumcision is considered a requirement for pious men. Male circumcision is a religious practice, but it is also associated with cleanliness and health among many ethnic groups. In urban settings, male circumcision is increasingly carried out in medicals centers. In rural areas, male circumcision is generally performed in a large group in the village, viewed as a collective rite of passage for young men.[30]

Across Senegal, 23% of women aged 15 to 49 reported having undergone female genital mutilation (FGM). It is most frequently practiced among Muslim populations in the South and North, and it is particularly widespread among the Fula, Mandinka, Jola, and Soninke ethnic groups. FGM is generally performed before the age of five years old.[17] FGM poses significant health risks, particularly hemorrhage during childbirth. FGM is generally performed by "traditional circumcisers" who use non-medical equipment, increasing the risk of HIV transmission through cross-contamination.[31] Most women and men do not hold favorable views toward FGM, with 80% of both women and men reporting that they do not wish to maintain this custom.[17]

Among young people aged 15 to 24, 0.2% of women are HIV-positive and less than 0.1% of men are HIV-positive. According to a UNAIDS (2017) study, 27.5% of young women and 32.4% of young men are knowledgeable about HIV prevention.[29] Adolescents younger than 15 years old cannot independently consent to HIV testing.

There are no other legal restrictions on the access of adolescents and youth to RH services. Nevertheless, few young people access RH services. International Planned Parenthood Federation (2014) reported the clear majority of young people in Senegal have not accessed RH services, despite the fact that many are sexually active and understand the importance of practicing "safe" sex.[10] Senegalese adolescents and youth explained that health workers and pharmacists often asked for identification to see whether they were 18 years old, and it was common for young people to be denied condoms and other contraceptives due to their age. There was a lack of clarity among adolescents and youth about whether they were legally allowed to obtain contraceptives before they were 18 years old.[10]

However, the cultural definition of adulthood is less dependent on age than on marital status. For example, it is more socially and culturally acceptable for a 15-year-old girl who is married to be sexually active than it is for a 30-year-old woman who is single. Additionally, young women face more scrutiny and judgement for their sexual decisions than young men, since they are more valuable as brides (i.e., can attain higher dowries) if they can "prove" their virginal status.[10] Since female virginity is valorized, it is logical that unmarried, sexually active girls and women would be hesitant to seek RH services if there is a possibility that providers will shame them or expose them to their community.

C. Effective Approaches in Adolescent and Youth Reproductive Health Programming

The World Health Organization (WHO) (2015) recommends providers be trained to be nonjudgmental and nondiscriminatory toward adolescents and youth, to respect their right to information, and to value their confidentiality and privacy.[32] The organization advises that SDPs have convenient hours of operation, such as hours outside of the typical school day and drop-in hours (i.e., the possibility of consultations without appointments). The WHO also recommends SDPs be clean and welcoming, with adequate seating in the waiting areas for smooth patient flow, designed so patients can communicate with reception staff in a private manner, and appropriately staffed with individuals who provide indirect care such as receptionists or secretaries, maintenance workers, and security staff.[32]

Recent studies[13,33] provide evidence that SMS communication facilitates positive patient-client interactions, removing barriers such as issues with access, wait times, and the stigma of being seen at a clinic as an unmarried youth. Other key characteristics of adolescent- and youth-friendly services include greater stakeholder involvement[15,16,34] and free or low-cost services.[12-16] In a report for Advocates for Youth, Moya (2002) recommends involving young people in designing and running programs, as well as the availability of male providers to treat male clients.[16]

Groenhof et al. (2012) identify greater stakeholder involvement as integral to effective service delivery. Young people are rarely consulted in the development of programs meant to address their needs, leading to programs that fail to affect behavior change among adolescents and youth.[34] Groenhof et al.

(2012) endorse including RH experts, young people, and other stakeholders (e.g., teachers and parents) in the development of adolescent- and youth-friendly services. The International Center for Research on Women (2014) reports that RH services that involve adolescents and youth in the program design process tend to be more successful than programs that do not directly consult them.[15]

Integrated programming (where youth and adult services are offered together or at least co-located in the same facility) is also important in considering approaches to service delivery. Stand-alone multi-purpose youth centers have been found to be less effective and more costly than integrated approaches, which may be more impactful and sustainable. Young men tend to frequent youth centers far more than young women, who may be constrained due to domestic duties or whose families may forbid them from visiting the centers. The beneficiaries also tend to be older than the target demographic.[35-36] In a systematic review of 21 studies on 17 youth centers in low- and middle-income countries, Zuurmond et al. (2012) found a significant proportion of clients were young men over the age of 20.[36] Additionally, the cost per beneficiary is higher for youth centers than integrated methods, such as school-based interventions.[35-36]

D. The Senegalese Government's Approach to Youth-Friendly Reproductive Health Services

a. 2014–2018 Strategic Plan for Adolescent and Youth Sexual and Reproductive Health

The GOS takes a multi-sectoral approach to the promotion of AYRH. This approach is justified based on the conceptualization of adolescent wellbeing as resulting from diverse determinants from various spheres of social life, including health, education, employment, the justice system, and social and civic participation. The Strategic Plan makes clear that only working collaboratively and across sectors will help to ensure Senegal is able to take advantage of the 'demographic dividend' (DD)—that is, the economic boost a country can experience from the growing numbers of young people in the workforce relative to the number of non-working individuals. To take advantage of the DD, Senegalese youth must be prepared to become productively engaged in the economic and civic lives of their country. This preparation necessarily requires a multi-sectoral approach.

Despite a long history of working to improve the RH health of adolescents and youth, the Strategic Plan outlines a number of challenges that remain. These include:

- Insufficient access to health services that are responsive to the needs of adolescents and youth
- Insufficient access to quality information enabled by advocacy and communication technologies
- The need to improve the social, legislative, and regulatory environment to be more supportive of adolescents and young people
- The need to promote and strengthen multi-sectoral collaboration and partnership

In response to these challenges, the Strategic Plan envisioned a future where "all adolescents and young people in Senegal, without any distinction or discrimination, will, with their full participation, have universal and equitable access to quality RH services, based on evidence. These services will reach all levels of the adolescent community using appropriate approaches and technologies in accordance with the country's cultural values and beliefs."

To realize this vision, the Strategic Plan takes as its principal objective to promote the RH of adolescents and youth by working to achieve three strategic objectives:

- Increase by 80% the utilization rate of sexual and reproductive services by adolescents and youth by 2018
- Promote a social, legislative, and regulatory environment favorable to the health of adolescents and young people by 2018
- Strengthen multisectoral collaboration and coordination of RH interventions by 2018

Finally, to achieve these objectives, the Strategic plan outlines three strategic approaches:

- Communication, advocacy, and capacity-building
- The establishment of an environment favorable to the promotion of RH of adolescents and youth
- The development of RH services offered in accordance with quality standards

The Strategic Plan sees the introduction of quality standards of performance as a useful tool to accomplish several tasks. These include: 1) making explicit the definition of quality necessary for a service or product, 2) defining clear objectives, and 3) enabling monitoring and evaluation to determine the degree to which the standards have been met and to identify the steps that need to be taken to achieve them.

The quality standards outlined in the Strategic Plan are based on globally recognized standards. They include:

1) Every adolescent or young person, regardless of circumstance, has access to information and advice appropriate to his/her state of health, development, and rights
2) Every service delivery point is organized to offer every adolescent and young person quality services adapted to his/her needs
3) All providers have the knowledge, competencies, and positive attitudes (required) to offer services adapted to the needs of adolescents and youth
4) Members of the community, including adolescents and youth, facilitate the implementation and utilization of health services by adolescents and youth
5) The system for managing health services takes into account the aspects tied to adolescent and youth RH in an appropriate manner

The Strategic Plan clearly states access to comprehensive, integrated, and quality services, information, and education is a fundamental human right. The Plan asserts that in the process of ensuring the right to quality services, priority consideration must be given to the most vulnerable adolescents. These include: very young adolescents (ages 10-14), disabled adolescents and youth, people living with HIV, street children, domestic workers, adolescent mothers, and young people in the justice system. In a ddition, the plan also asserts services should be adapted to the needs of the diversity of adolescents and youth.

b. Organization of Youth-Friendly Services in Senegal

Following the Ministry of Health's YFHS guidelines and standards described above, and with the support of donors and implementing partners, YFHS are currently implemented in at least 16 out of the 34 health districts in Senegal, with the scope of implementation varying across districts. The involvement of different donors and technical partners has resulted in some variation in the way services are provided. In July 2016, the MOH, with input from USAID, United Nations Population Fund (UNFPA), E2A, and other implementing partners, updated existing lists and mapping of YFHS delivery points in the six regions of interest to gain better insight into which services were being delivered. This mapping of service delivery activities was again confirmed in 2017 through phone calls and interviews with the MOH and Dakar-based partners in preparation for field work by E2A's research partner, GRAG. This mapping showed there are six basic service delivery models for YFHS (or combination of elements) in the six regions selected for the study. E2A's *Thinking Outside the Separate Space* tool[41] was used to guide the categorization of these service delivery models. The six service delivery models identified in the regions selected for this study (descriptions are excerpted from *Thinking Outside the Separate Space* tool) are:

Standalone youth clinic: This model of YFS refers to a completely separate HC/clinic dedicated to serving adolescents and youth with a range of clinical services, including RH services. This model is often implemented by the private sector, including NGOs or other private providers, but some countries have implemented this model through the public sector. This model may also include peer educators or counselors available for onsite counseling, as well as measures to promote the services among young people in the catchment area.

Separate Space for YFHS in public health facilities: In this model, RH services for young people are provided in a separate room or separate building (by specifically trained providers) and/or on specific days within a public or private facility. This model can be implemented at all levels of health care facilities but is most common in larger primary HCs or hospitals that have sufficient space for a separate YFS area rather than at the lowest level of health facilities (e.g., health post or dispensary). As with standalone clinics, peer educators may be available onsite for counseling and this model should include demand-side measures to promote the services among young people in the facility catchment area.

Mobile Outreach services: Mobile outreach services, defined here as services offered in strategic locations closer to the people who most need them, can be an effective model to bring RH services to young people. There is a range of different types of mobile outreach mechanisms, including:

- mobile clinics (i.e., a full range of services offered in a specially equipped van/bus)
- satellite clinics (i.e., a full range of services offered in an existing non-health space/tent on a routine basis)
- services offered by a mobile team of health providers at lower level health facilities that don't routinely offer those services (e.g., provider trained in providing IUDs visits a lower-level health facility (HF) where providers don't have this capacity)
- other non-routine outreach events (e.g., immunization days in communities, MCH days).

Community-based services: In this model, peer educators or community health workers are trained and supported to offer a range of RH services, including counseling, select contraceptive methods (e.g.,

condoms, combined oral contraceptives, depending on the legal framework in a given country), HIV counseling and treatment adherence support, and referrals and vouchers for services in schools, youth clubs/groups, homes, and other youth-gathering places.

RH services in non-health settings: In order to reach young people where they are and reach some of the most vulnerable adolescents and youth, YFS can be offered in a range of different non-health settings where there is a large adolescent and youth population including schools, workplaces, prisons, military facilities, areas where young injecting drug users (IDUs) gather, or areas where young sex workers live or work. In these cases, the YFS model will necessarily vary from place to place to accommodate the conditions of the non-health setting and the population to be reached in this setting.

Youth Centers: Youth centers refer to recreational centers which may also offer some RH services. Youth centers are most often separate buildings which house spaces for recreation and/or vocational training and have a space/room staffed by a health provider offering basic, preventive clinical RH services or counseling and referral to services. Sometimes, a youth center (a space offering games, computers, recreational equipment) is located on the property of a HF. Youth centers are a costly and less effective way of increasing use of RH services and have limited scalability. However, youth centers may remain appropriate for addressing the broader development needs of young people, including access to education, technology, and livelihood opportunities.

Methodology

A. Assessment Goal and Objectives

The **goal** of this study is to provide information to strengthen the operationalization of the service delivery components of Senegal's National Strategic Plan for AYSRH (2014–2018) by drawing from lessons learned from implementation experiences with different youth-friendly service models in six regions of Senegal with relatively poorer FP/RH outcomes.

The specific objectives of this assessment are as follows:

1. To identify the factors that facilitate or hinder the quality of YFS in select sites across the identified six regions of Senegal, including the extent to which the National Standards for YFS are applied.
2. To assess the factors that influence the uptake and utilization of YFS by adolescents and young people including accessibility, acceptability and equitability of services.
3. To examine the characteristics of existing YFS models that can influence potential scale-up[a].
4. To generate recommendations and practical guidance for the operationalization of the service delivery components of the Senegal National Strategic Plan for AYSRH (2014-2018).

In alignment with the final objective, this assessment focused on and produced findings and recommendations consistent with the five quality standards of performance recognized by the GOS. These include:

1. At the level of the SDP, every adolescent or young person, regardless of circumstance, has access to information and advice appropriate to his/her state of health, development, and rights
2. Every service delivery point is organized to offer every adolescent and young person quality services adapted to his/her needs
3. All providers have the knowledge, competencies, and positive attitudes (required) to offer services adapted to the needs of adolescents and youth
4. Members of the community, including adolescents and youth, facilitate the implementation and utilization of health services by adolescents and youth
5. The system for managing health services takes into account the aspects tied to adolescent and youth SRH in an appropriate manner

B. Regions Selected for Assessment and Rationale

Six regions were included in this assessment of youth-friendly services. These include: Kaolack, Kédougou, Kolda, Matam, Saint-Louis, and Sédhiou. Consensus on the selection of these regions was reached in dialogue with the Ministry of Health and USAID/Senegal. Two principal criteria were utilized in the selection of these regions: 1) performance on key RH outcomes among young people, ages 15-24

[a] For the purposes of this assessment, "scale-up" will be defined using ExpandNet's definition: "Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis" (ExpandNet, 2010. "Nine steps for developing a scaling-up strategy". WHO: Geneva).

years, and 2) the existence of adolescent-friendly FP/RH services.

The selected regions are among those with the poorest AYRH indicators in Senegal. For example, although there is some variability by region, these areas generally share a high burden of early marriage, adolescent pregnancy, low levels of knowledge regarding HIV (girls, 15–19 years), among the lowest contraceptive prevalence rate (CPR) for married young women (15–24 years), the highest unmet need for FP among this same group, and very high rates of women and girls (aged 15–24 years) who have a husband/cohabiting partner who is 10 or more years older.[37] Five of the six regions are also among USAID's priority regions of concentration (with the exception of Kaolack), presenting an opportunity to concentrate its investments to significantly impact the key drivers of child and maternal mortality, including adolescent FP/RH. These include a focus on increasing the availability of and access to quality, high-impact interventions in RMNCH and nutrition, and strengthening community engagement in health systems management.[38] Finally, youth-friendly services are being implemented in the sampled districts in each of these six regions.

Once the regions were identified, the MOH, with assistance from other partners (MSI, Senegal Association for Family Welfare (ASBEF), UNFPA, etc.), compiled a list of health facilities and other YFHS sites (both governmental and non-governmental) within health districts from the selected regions that were implementing YFHS. Once the YFHS sites were selected, their catchment areas were identified with the help of staff from each of these sites, or service delivery points (SDPs). All interviews and FGDs were conducted in the identified catchment areas of selected SDPs.

a. Site Selection

A total of 12 districts (initially two per region) were purposively selected for inclusion in the study, based on the criteria of having at least one YFHS SDP within the district. During the selection process, it was found that, in the Kédougou region, only the Kédougou health district offered YFHS. To compensate for this, three health districts were selected in the larger Saint-Louis region. Urban and peri-urban/rural representation was also considered, but most YFS SDPs existed in urban and peri-urban sites. The outline below shows the districts which were ultimately selected:

- Kédougou Region
  - Kédougou District
- Saint-Louis
  - Dagana District
  - Richard-Toll District
  - Saint-Louis District
- Kaolack Region
  - Kaolack District
  - Nioro District
- Kolda Region
  - Kolda District
  - Médina Yoro Foula District
- Matam Region

- Matam District
- Kanel District

- Sédhiou Region
  - Bounkiling District
  - Sédhiou District.

The study utilized a mixed methods approach, combining quantitative and qualitative methods. Quantitative methods aimed to capture standardized information across the six regions from a variety of constituencies (detailed below) considered essential stakeholders in the delivery of YFS. Data on the utilization was also collected from both SDPs and community-based services. Qualitative information was gathered from these same constituencies to provide a contextual and nuanced understanding of the dynamics and complexity of the delivery of YFS. Taken together, these methods aimed to address the specific objectives of the study.

C. Components of the Evaluation

b. Quantitative Component

1.1 Target populations

Quantitative surveys were conducted with AYRH service delivery point management staff, service providers, community health workers (ASC/relais/Bajenu Gox). Exit interviews were conducted with clients (adolescents/ young people between the ages of 10 and 24) receiving services at the assessed SDPs.

In order to examine the implementation of YFHS (and the extent to which each of the five YFHS standards have been met) at service delivery points (SDPs), a "facility audit" was conducted with SDP managers. In addition, service statistics by age, sex, and type of service were collected over the past 12 months in order to perform an analysis of data on service provision by region, type of service, age group and sex of clients, and "model" or approach to service delivery. Given the relatively small number of SDPs offering YFS in the 12 districts, a census of all known SDPs (30 in all) offering YFS was included in the study, though only 23 were found to be operating and functioning. A list of these SDPs is included in Annex 1.

Health providers involved on a day-to-day basis with the management or provision of YFS were surveyed in order to assess the extent to which SDPs have met each of the five standards and to examine the extent to which health providers work with communities and youth-serving institutions/organizations (i.e., schools, NGOs, youth clubs) to promote utilization of YFHS. These quantitative interviews were conducted to determine their levels of training in AYRH counseling and service provision, attitudes to young people accessing YFHS, how they use service data to inform services, and whether or not they receive regular supportive supervision and feedback. Information on the service providers' age, sex, education, training in YFHS, number of years on the job, position in the SDP, and association with youth clubs in the community was also collected. While it was intended to interview two providers per SDP (a total of 60 providers), due to the limited number of SDPs assessed,

all YFHS providers present in the SDP on the day of interview were included in the achieved sample for a total of 50 service providers.
Community health workers ("CHWs": ASC/relais/Bajenu gox) work to sensitize adolescents and youth on availability of AYRH services. They educate and counsel on RH and HIV issues, distribute condoms, and-since 2014-have been able to provide oral contraceptives and injectables (both to initiate use and resupply) as well as refer clients to health facilities or other YFHS SDPs for services they cannot offer[b]. CHWs implementing activities in the catchment areas of the 30 target YFHS sites were selected to take part in a survey to better understand the level of implementation of community-based AYRH outreach activities including the numbers of CHWs working in the health districts in AYRH, as well as an annual total of activities conducted, and youth reached. Information on each CBDA's age, sex, education, marital status, number of children, training in YFHS, amount of time they have worked as a CHW, and amount of time they have resided in the communities where they work was also obtained. Due to the limited number of CHWs attached to the 30 SDPs, 150 ASC/relais working in AYRH in the catchment areas-regardless of organization or attached SDP-were targeted and included in the assessment survey of ASC/relais.

Clients aged 10–24 years were surveyed to determine young people's satisfaction with YFHS; interviews were conducted with clients as they left the SDPs (upon exit). Where there were many clients, those interviewed were systematically selected until a maximum of 10 was reached. With the low turnout of clients in some SDPs, all clients who came to the SDPs on the day(s) of the interview were approached for inclusion in the assessment. In a few SDPs, we were unable to reach the maximum number of 10 clients, so other facilities were oversampled to compensate. Of the target 180 clients, 180 were interviewed. In addition to collecting information on a few background characteristics (age, sex, education, marital status, and number of children), each client was asked to provide information on services received at the YFHS SDP, familiarity with the different YFHS offered at the SDP, how they knew about the services, satisfaction with the services received, and adequacy of the services in meeting their health needs. Purposive efforts were made to interview youth of both sexes and of different age groups.

In order to determine at the community level young people's awareness, acceptability, accessibility, and utilization of YFHS, adolescents/young people were selected for interviews as part of a household survey. Adolescents/young people of both sexes, aged 10-24 years, residing in the communities/catchment areas of the YFS SDPs, were included based on sex and five year age group.

1.2 Sampling

SDP-based surveys: Table 1 below shows target sample sizes for SDP-based interviews. YFHS providers, community health workers, and clients associated with all 30 known SDPs were included. For this study, the target sample was all known SDPs (census of 30 SDPs), two YFS providers per SDP, five community health workers per SDP, and six YFS clients per SDP. Total sample sizes are shown in

[b] In 2008, the Ministry of Health supported a pilot initiative to enable matrons and ASCs in rural clinics to provide contraceptive pills. In 2012, the Ministry authorized them to offer injectable methods as a pilot study and supported the introduction of the Sayana press. In 2013, a National Community Health Policy was developed, and in 2014 the Ministry issued a circular authorizing the initial offer of injectable contraceptives at the community level.

the right-hand column in Table 1.

Table 1: Summary of numbers surveyed at the SDP level

Designation	*Sample by category*	*Total number of SDPs*	*Total Target Sample*	*Total Sample Achieved*
SDP audits + statistics collection matrix	All existing (census)	30	30	23
YFS Providers	2	30	60	50
Community Health Workers (ASC/relais/Bajenu Gox)	5	30	150	150
YFS clients	6	30	180	180
Total sample at the SDP level			**420**	**403**

Community-based surveys: To determine sample size for the community youth survey undertaken as part of this evaluation, the primary indicator of interest was the percentage of youth accessing YFHS. For this survey, the baseline value of this indicator was set at 15%, based on a previous study of YFS in Malawi.[39] Because a cluster rather than a simple random design was used, a design effect of 2.0 was applied. The level of precision was set at 95%. The application of a sampling formula yielded a minimum sample size of 413 youths for each of the six age-sex groups of youth. However, because not all youth approached will agree to be interviewed, the sample size was adjusted by a factor that represented the expected refusal rate. By setting the refusal rate at five (5) percent, the desired sample size of 413 was adjusted upward to the effective sample size of 420 for male and female youth aged 15–19 and 20–24 years. The sample size was also adjusted downward to 360 for male and female youth aged 10–14, since this younger group was less likely to be sexually active and seeking services. Consequently, in each region, attempts were made to interview a total of 200 youth aged 10–24 years. A distribution of this sample is shown below in Table 2.

Table 2: Summary of the numbers surveyed at community level

Quantitative component/ household targets	*Sample per region*	*Number of regions*	*Total Target Sample*	*Total Sample Achieved*
Adolescents (10 to 14 years old)	60	6	360	355
Adolescent/young men (15 to 19 years old)	70	6	420	434
Young men (20 to 24 years old)	70	6	420	415
Sub-total men	**200**	**6**	**1200**	**1204**
Adolescent (10 to 14 years old)	60	6	360	363
Adolescent/young women (15 to 19 years old)	70	6	420	416
Young women (20 to 24 years old)	70	6	420	417
Sub-total women	**200**	**6**	**1200**	**1196**
Total adolescents/young people (10–24 years old)			**2400**	**2400**

In each district, five localities (e.g., villages/hamlets in rural areas and neighborhoods in urban areas) were selected for inclusion in the study. The sample frame was obtained from the 2013 General Census of Population, Dwellings, and Agriculture (GCPDA/2013) and organized into a computer file, including 8,081 (localities) located in the six study regions. The localities were drawn using an algorithm to automatically generate a random number corresponding to a locality. In the selection process, each locality was weighted according to its size, (i.e., the number of households in the locality).

In each locality, households were selected using the point of origin, code of the day method. In brief, the supervisor collected information about the locality boundaries from the local authorities (village chief and/or neighborhood delegate), including the number of households. A point of origin in the locality—a place known to almost everyone—was then randomly selected from three candidates. Starting with a household at the point of origin, households were then selected using the code of the day method. The code of the day is determined by adding the digits of the date until you obtain a single digit (Example: if you are on July 17th, then the code of the day is 1 + 7 = 8, if you are on November 29th, the code of the day is 2 + 9 = 11 = 1 + 1 = 2). From the point of origin, the data collection agent moves in one direction (walking north, south, east or west) and skips the number of households equal to the code of the day.
At the household level, if more than one young person met the inclusion criteria, a list of the eligible youth along with their birthdays was made. The young person whose birthday was closest in the future was selected for participation.

Qualitative Component

2.1 Target populations

Parents of youth. The FGDs with parents focused on what parents perceived to be the major health issues among youth in their community, what they do to address these health issues, their awareness and acceptability of YFHS programs, how the YFHS complement/contradict what they (parents) normally do to address health issues among youth, and their attitudes toward their children accessing YFHS. Two separate groups of parents were identified by sex (male and female). In each region, four FGDs were conducted (one with mothers of at least one married adolescent/youth, one with mothers of unmarried adolescents/youth, one with fathers of at least one married adolescent or youth, and one with fathers of unmarried adolescents/youth). Each FGD consisted of 8–10 members and discussions were facilitated by trained qualitative data collectors.

FGDs with peer educators. Peer educators constitute the link between the community and the YFHS SDP. In many instances, they operate within the SDP to provide education and counseling services and refer clients to appropriate places for clinical services. FGDs with peer educators focused on determining what they do (the types of services offered), how they locate/recruit youth for YFHS, where and when they offer services, how they record and report their activities, whether and how they use the data they collect to inform their activities, what they perceive to be working well in YFHS, the challenges they face in the implementation of their activities, and what they think could be done to overcome these challenges. Information on the peer educators' age, sex, education, marital status,

number of children, training in YFHS, how they were recruited, how long they have worked as peer educators, by whom they are supervised, how they are remunerated, and their workload was also collected. Three (3) peer educator FGDs per region were targeted for interviews, for a total of 18 FGDs.

Interviews with young women in the community who use a modern FP method. Young married and unmarried women in the community who reported using a modern FP method at the time of interview, including the pill, implant, injectable, or IUD, were identified during the quantitative survey at the community level and targeted for an IDI. The interview guide was designed to further understand their level of knowledge, particularly their current knowledge about the use of methods, experience (first or recent) of the method currently used, perception of the effectiveness of the preferred method, attitudes to contraceptive methods (in general), social support for the use of a given method, satisfaction and intentions to use FP in the future, beliefs about FP, the determination/ autonomy to use FP and the sources of information on FP. A total of thirty-six (36) interviews were targeted, six (6) per region.

Interviews with community leaders. Community leaders were interviewed to assess their perceptions of youth's major health issues and needs, their awareness and acceptability of YFRHS, how the YFHS complement/contradict what the community has usually done to ensure young people are healthy, and their attitudes toward young people accessing YFHS. Six community leaders per region (a total of 36 community leaders) were targeted for interviews.

Interviews with SRH program managers, including district SRH focal points and NGO staff. Interviews with NGO staff were conducted to determine their YFHS activities in the district where they work, who they support to implement YFHS, the service delivery approach they apply, their level of investment in YFHS, how they are linked to the public health sector, and the challenges they face in the implementation of their activities. Twelve (12) FP district coordinators/focal points and 30 program managers of district-based CSOs or NGOs were targeted for interviews.

2.2 Sampling/Recruitment

The following tables (Tables 3 and 4) give a summary of the critical stakeholder groups targeted for their participation and the selection criteria that were used for recruiting respondents for FGDs and IDIs.

Table 3: Target populations and recruitment approach

Targets	Types of interview	Recruitment approach/criteria
Parents	FGD	1) Parent: any adult with at least one son/daughter aged 15 to 24 and supporting that child 2) Co-resident with one or more married or unmarried children, 15-24 3) Their recruitment (mother and father participants) was carried out at cluster level, following the same process as defined for adolescents 4) To avoid possible biases and to ensure better management of confidentiality, participants (mothers and fathers) should not come from the same households
Peer Educators	FGD	Identified with the support from the district adolescent/youth councils, the Family Welfare Association of Senegal, and Mari-Stopes International among other partners in the field.
Young women in the community who use a modern FP method (pill, implant, injectable, or IUD)	In-depth interviews	Married or unmarried young women identified during the community-based survey who consented for an IDI
Community Leaders	In-depth interviews	Selected based on their knowledge of factors influencing YS utilization, as identified by community leaders
Head of health districts/ SRH focal points	In-depth interviews	The RH coordinator or the Primary Health Care Supervisor (PHCS) facilitated their identification.
Civil Society Organizations	In-depth interviews	Organizations were selected according to the scope of work and activity related to AYRH.

Table 4: Summary of in-depth interviews and focus groups in the regions of the study

Targets	Sample/ Region	Total Number of Regions	Total Target Sample	Total Sample Achieved
FGD with peer-educators	3	6	18	18
FGD with parents	4	6	24	22
In-depth interviews with young married and unmarried women who use a modern FP method (pill, implant, injectable, or IUD)	6	6	36	34
In-depth interviews with community leaders	6	6	36	35
In-depth interviews with heads of health districts/ SHR focal points	2	6	12	11
Semi-structured interviews with civil society organizations	5	6	30	29
Total	**26**		**156**	**149**

D. Data Collection Tools

Questionnaires and interview guides adapted to the targets listed above were designed through a participatory process involving the E2A project team and the Senegal-based research agency, Global Research and Advocacy Group (GRAG). The development of these tools took into account the study objectives and questions, the indicators, and main lessons that emerged from the analysis of documents and data relating to YFS.

Quantitative Instruments

- An audit **questionnaire** for service delivery points, coupled with the AYRH services statistics **collection matrix**;
- A **questionnaire** for health service providers who provide YFS;
- A **questionnaire** for CHWs and/or liaisons involved in YFS service provision;
- A **questionnaire** for **adolescents/young people aged 15–24**, Exit interviews with YFS clients/beneficiaries;
- A **questionnaire** for **adolescents/young men aged 10–24** in communities located in the SDP catchment areas in the different regions; and
- A **questionnaire** for **adolescents/young women aged 10–24** in communities located in the SDP catchment areas in the different regions.

Qualitative Instruments

- An **FGD guide** for peer educators (women and men) in the different regions of the study;
- An **FGD guide** for parents (mothers and fathers) of adolescents/young people. This takes into account parents living with both married and unmarried children;
- An **interview guide** targeting married and unmarried adolescents in the community who have used or are using the pill, implant, injectable or IUD;
- An in-depth **interview guide** for community leaders who will be retained in all study regions;
- An **interview guide** for district focal points and health workers in charge of YS. This tool will help to collect data on the availability and quality of FP/RH services; and
- An in-depth **interview guide** targeting partners, including national civil society organizations and international partners.

E. Data Collection Methods

Recruitment of the data collection team: A total of 42 data collection agents and supervisors were recruited to take part in this study. This group was divided into six teams, one per region. These teams were composed of four quantitative data collection agents and two responsible for the qualitative research. Each team also included a midwife who was responsible for collecting data on YFS services, including the audit of selected service delivery points (including data collection of service statistics), interviews with SDP-based service providers, and client exit interviews. Each team was assigned one supervisor, who monitored both the implementation process and quality of the data collected. The teams worked under the direction of the Activities Coordinator, in close collaboration with the Team Leader/ Principal Researcher.

Recruitment for community-based interview staff focused on the recruitment of "young" data collection agents (men and women) to help reduce the response bias that might be introduced by the involvement of much older investigators. Additional criteria for the selection of data collection agents and supervisors included:

- Field experience in data collection
- Some knowledge of AYRH
- Knowledge of the (geographic) field, including the different regions of the study
- Mastery of the French language and at least one local language
- An excellent reputation for teamwork
- A commitment to quality and confidentiality
- A baccalaureate degree or a state diploma for midwives
- Supervisors must have completed and successfully passed the FHI 360 Research Ethics Training Curriculum

Data entry agents were young professionals (men and women) who received training using CSPro software to handle data processing under the supervision of the Data Specialist.

Data collection team training: Two separate five-day participatory trainings of the qualitative and community-based youth data collection teams were conducted in Dakar by the GRAG technical team with the involvement of E2A. The goal of the training was to ensure the data collection teams would have a comprehensive understanding of the purpose and meaning of data collection tools and their effective and practical implementation in the field while meeting high standards for ethical research.

To ensure data collection agents and their supervisors had a common understanding of the survey and qualitative components of the research, team members received a background orientation to AYRH, reviewed both the quantitative and qualitative tools and their application in detail, and focused on the ethical conduct of research, particularly the importance of informed consent. Special attention was given to the process of obtaining informed consent with minors in both community and clinic settings. In addition, all tools and consent forms were translated from French to Wolof, Pulaar, and Mandingo during the training sessions and involved all the team members. Role plays during the training and the

tools' pre-test process enabled the team to refine the translations to ensure maximum comprehension by research respondents. These steps contributed to the team's understanding of the intent of every question associated with the tools.

Data collection tool pre-test: As part of both trainings, pre-tests of several tools were conducted by the research teams. The pre-test focused on:

- The adequacy of contents of the tools in relation to the objectives of the study;
- Constraints encountered in the selection process of young people, especially those whose participation requires the consent of their parents or guardians;
- The process of informed consent and the questions raised by pre-test respondents;
- Levels of comprehension related to the questions asked;
- Interview duration for each collection tool; and
- Logistical constraints and requirements related to the data collection process.

The results of the pre-test were then used to revise the different tools and the survey support materials.

Data collection and quality assurance procedures: A timetable was developed to collect both quantitative and qualitative research simultaneously in all six regions. Supervisors were responsible for ensuring the research was implemented according to the protocol. Furthermore, they ensured the people selected as respondents met the inclusion criteria.

All qualitative interviews and discussions were recorded using digital voice recorders with prior consent from respondents. In addition, interviewers took notes of the interviews and discussions as a backup. All completed quantitative questionnaires were subjected to a review process in the field prior to their transfer to the GRAG data entry unit.

An E2A-funded consultant traveled to the field on three separate trips to monitor ongoing fieldwork to ensure homogeneity, completeness, accuracy, and consistency of data as well as to ensure adherence to the protocol as approved by the National Health Sciences Committee. Field teams met at the end of each day to review activities and achievements, discuss problems and challenges, explore ways to improve data-collection activities, and plan work for the following day.

F. Data Management and Analysis

Quantitative data: Each completed data collection tool was assigned an identification code to facilitate both its entry and data management. In order to minimize errors, a double entry process was adopted. The data were captured using the CSPro software (Census and Survey Processing System) and the control mechanisms specific to this software were applied. The data were then transferred to the Statistical Package for Social Sciences software for further quality control and analysis and univariate and bi-variate analysis was conducted using Statistical Package for Social Sciences.

Qualitative data: Data collection agents who conducted interviews (in-depth and FGD) were responsible for their transcription and translation into French to mitigate bias and ensure reliability. Once completed, transcripts were reviewed by the data collection supervisor, the interviewer, and the study activities coordinator. A coding system was developed to categorize emergent topics and themes of interest and to facilitate analysis using NVivo software. NVivo was used to carry out a thematic analysis of transcripts from the various respondent groups using standard qualitative analysis techniques, including content analysis and analytic induction.

G. Ethical Considerations

Regarding *data use*, the information collected from respondents for both the quantitative and qualitative components of this study was used solely to achieve the specific objectives outlined in the IRB-approved research protocol developed to guide this study. In addition, the information generated was restricted to the research team and the authors of this report.

Regarding *anonymity and confidentiality*, all participants were informed of their right to remain anonymous. The research team made every effort to guarantee the realization of this right for all participants in the study. First, the survey teams' training sessions highlighted the ethical principles to be respected. Chief among these was ensuring the anonymity of the information provided by research participants. Second, a coding system was established that prevented the linking of individual surveys, individual interviews, and FGDs with specific, individual respondents. Third, in the field, research supervisors ensured the coding system was implemented and utilized effectively. Fourth, the information collected from respondents for analysis was restricted to the research team. Finally, the results documented in this report are presented in aggregate (quantitative components) or in a manner that does not describe personally identifiable characteristics (in the case of the narrative, qualitative results) that could be linked to any specific individual.

Informed Consent

Informed verbal consent was obtained from the various constituencies that participated in the study. Consent forms were adapted to the constituency and context in which the interview was conducted (e.g., a health professional working in a clinic or a parent in the community). The consent form was verbally communicated to the respondent. Though they varied by constituency and context, they all included the following essential components: 1) an invitation to participate in the study, 2) a summary of the project and its objectives, 3) an explanation of the nature of the respondents participation and the kind of information that would be requested, 4) how the information would be handled to ensure anonymity and confidentiality, 5) the potential risks and benefits related to the respondent's participation, and 6) contact information for the research director should the respondent have any concerns or complaints. During the consent process, emphasis was placed on the voluntary nature of the respondent's participation, including their right no to answer specific questions and to stop the interview at any time. Like data collection instruments, consent forms were also translated into local languages to help ensure the respondent understood the nature and consequences of his or her participation.

The inclusion of minors (under the age of 18) warranted special attention. In these particular circumstances, the consent process was adapted to include and procure the voluntary consent of parents or guardians. In the case of clinic-based exit interviews with minors who are eligible for services, the SDP leader served as the 'medical guardian' to ensure confidentiality.

Ethical Review

The final draft of the study protocol was submitted to the national research ethics committee in Senegal (CNERS) and to PATH's research determination committee in the United States in late December 2017. On January 9, 2018, the application was approved by PATH's research determination committee and determined to be "not research", therefore not necessitating any additional review, including PATH/US IRB. After several revisions, GRAG also received approval from the Senegal research ethics committee (CNERS) on March 2, 2018.

H. Limitations of the Evaluation

Although data collection for this evaluation generally went according to plan, some challenges included:

- Unavailability of respondents such as older male youth in agricultural zones, ASC/relais, and MOH/Focal points in some districts;
- Remotely located clusters and SDPs which were difficult to access without regular public transportation; and
- SDPs that did not have registers or could not provide the required information on YFHS statistics.

One major limitation of this evaluation is the small number of SDPs actually delivering AYRH services in the six regions at the time of this assessment. Although the total number of mapped SDPs in these regions was initially small (less than 35), only 23 were located as staffed, distinct service delivery points offering youth-friendly services. As the number of provider and client exit interviews was tied to the number of SDPs, sample sizes for audits and provider interviews were also not met. Additional provider interviews and exit interviews were conducted to ensure adequate measurement of study indicators. SDP-based data presented by region is often presented as numbers (rather than percentages) in the results tables in order to give the reader a clearer understanding of the magnitude and interpretation of the findings.

Additionally, while this study included a comprehensive analysis and triangulation of 12 different respondent types, no observations of provider-client interactions were conducted. For example, no counseling sessions or FP service provision were observed that would give information on provider skills and efforts in these areas. Therefore, indicators on quality of care offered by providers rely on information shared during audit and provider interviews as well as client feedback during exit interviews.

A third limitation involves the sampling methods of households at cluster level and youth at household level. Since the sample was not drawn randomly using enumeration areas from a national frame, but from clusters of different population sizes that form the catchment areas of selected SDPs, estimates of coverage may differ from actual district or national level coverage. In addition, young people's knowledge, attitudes, and utilization of YFHS in the selected districts may not adequately represent the

situation in the *non-selected* districts in each region. Therefore, estimates of coverage from the selected districts might differ from what would have been obtained had all districts in the region been sampled. As a result, while data is presented by region in the report, no statistical comparisons are made for indicators of interest among the six regions. However, we believe this evaluation will yield adequate data to answer all pertinent assessment questions given the objectives of this study.

A fourth limitation pertains to the sensitive nature of the information collected from youth, both at household-level and at SDPs. Many of the questions related to sexual experiences, gender-based violence, post-abortion care, and HIV are highly sensitive and difficult to answer in a face-to-face interview and may result in an underestimation or underreporting of these behaviors, services obtained, or circumstances faced by adolescents and youth. Estimates of some of the findings on these sensitive topics may be lower than in reality due to respondent bias and therefore should be interpreted with caution. The study team sought to minimize respondent bias through design of the study tools, high quality interviewer training, and assignment of same-sex interviewers to respondents (female interviewers with female respondents, e.g.).

Finally, results may vary among different subgroups of youth defined, for instance, by marital status, socioeconomic status, and level of education, but may not be statistically different due to sample size limitations. For instance, the current sample size may not yield statistically significant differences among smaller subgroups of youth, even when such differences exist in the population. To obtain sufficient cases in each youth subgroup for valid comparison, the sample size would have to increase astronomically (with an attendant increase in costs). However, sampling was done in order to ensure adequate estimates by the two most important demographic indicators: age and sex.

Assessment Findings

Characteristics of Service Delivery Points and Respondents Included in the Assessment

In this chapter, we will examine background characteristics of SDPs, surveyed youth (both at SDP level and in the community), service providers (both at SDP level and community-based), and key informants included in this study such as parents, community leaders, and district-level MOH focal points. An overview of which types of SDPs were included in this assessment as well as factors related to the demographic and socioeconomic background of a youth are key in understanding the landscape of services available to youth and youths' need for and exposure to information and services. In addition, the background characteristics of service providers may influence their attitudes to youth and, consequently, the way they provide services to them. Demographic characteristics also provide information on the extent to which different sub-groups of youth were involved in this assessment.

Service Delivery Point Characteristics

Table 5 presents an overview of the 23 SDPs included in this assessment. As noted previously, there were seven (7) SDPs which were initially included in the sample that were not assessed due to closure or other reason. Table 5 shows most SDPs (21 out of 23) were located in an urban or peri-urban area

and most (17) were operated as public by the GOS. Types of SDPs included HCs (4), Adolescent Counseling Centers (CCAs; 7), Inspection Medicale des Ecoles (IMEs, or school-affiliated health centers managed by the MoE in coordination with MoH; 6), fixed facilities operated by ASBEF (3) and MSI (1), and two mobile outreaches implemented by MSI. Five models or types of SDPs to offering AYRH services were found: a stand-alone youth HF (1), youth corners or separate youth spaces within a HF (7), youth centers (7), RH services in non-health settings (6), and mobile outreach services (2). Outreach services operating as independent activities or projects managed by NGOs/CBOs were not interviewed or included as separate SDPs in this study due to the difficulties in establishing the difference between an independent community activity or program and one attached to a facility captured in our assessment. However, CHW activities were captured as part of the community health worker data included in this assessment. Most (11) of the SDPs have been open six years or longer and eight have been newly established within the past five years. Most SDPs operated on normal clinical hours, generally between 8:00 and 18:00, five days a week. Two SDPs reported they offer services 24 hours a day throughout the year.

Table 5: Characteristics of Assessed Youth-Friendly Health Services

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (SDPs)	**n=5**	**n=2**	**n=4**	**n=3**	**n=5**	**n=4**	**n=23**
Service delivery zone:							
Rural	0 PPS	0 PPS	0 PPS	0 PPS	1 PPS	1 PPS	2 PPS
Urban/Peri-urban	5	2	4	3	4	3	21
Sector Type:							
Public	3	2	3	3	3	3	17
Non-public	2	0	1	0	2	1	6
Service Delivery Point:							
Public SDPs							
Health Center	1	0	0	1	1	1	4
Adolescent Counseling Center (CCA)	1	1	2	1	1	1	7
IME	1	1	1	1	1	1	6
Non-Government SDPs (including mobile services)							
ASBEF	1	0	1	0	1	0	3
MSI	1	0	0	0	1	1	3
Youth-friendly service models/ approaches:							
Stand-alone YFHS SDP	0	0	0	0	1	0	1
Youth centers (CCAs)	1	1	2	1	1	1	7
RH services in non-health settings (IMEs)	1	1	1	1	1	1	6
Separate space within the SDP	2	0	1	1	2	1	7

Mobile outreach services	1	0	0	0	0	1	2
Community-based services	0	0	0	0	0	0	0
Number of years SDP has been open:							
Opened in last 5 years	2	0	1	1	3	1	8
Open 6 years or longer	1	2	3	2	1	2	11
Don't know/can't remember	2	0	0	0	1	1	4
Number of days per week SDP is open							
5 days per week	3	2	2	1	2	3	13
6 days per week	1	0	1	1	2	0	5
7 days per week	1	0	1	1	1	1	5
Opening hours of SDP							
8:00	4	2	3	3	3	3	18
8:30	1	0	0	0	1	0	2
9:00	0	0	1	0	0	0	1
Open 24 hours/365 days	0	0	0	0	1	1	2
Closing hours of SDP:							
13:00-16:00	1	0	1	0	3	0	5
17:00-18:00	3	2	2	2	0	3	12
19:00-20:00	1	0	1	1	1	0	4
Open 24 hours/365 days	0	0	0	0	1	1	2

Characteristics of Adolescents Surveyed at Community Level

Table 6 shows the distribution of community youth survey respondents aged 10–24 in the six regions by background characteristics. At the regional level, males and females in three different age groups (10–14, 15–19, and 20–24 years) were equally represented in the survey due to the sampling strategy utilized in the assessment. In addition, about two-thirds (63.3%) of all respondents were drawn from rural areas, mainly due to the sampling strategy at household level. But there is variation by region: in Kédougou, Kolda, Matam, and Sédhiou, more youth were interviewed in the rural areas whereas in Kaolack and Saint-Louis regions, more youth were interviewed in urban areas.

Examining school attendance status is important as it helps differentiate levels of exposure to health information and services. While in-school youth may be exposed to both school-based and community/health facility-based information and services, out-of-school youth may be exposed only to community/health facility-based information and services. Over half (53.4%) of community youth survey respondents were attending school at the time of the survey and 28.2% were former pupils/students (out of school, data not shown); 18.4% had never been to school. For both current and former pupils, the modal highest level of educational is primary in all the zones.

Most (82.0%) of all interviewed male and female youth (aged 10–24 years) had never been married, though there are variations by region. The percentage age never married is highest in Saint Louis (87.5%) and lowest in Kolda (72.2%).
Less than one-fifth (17.1%) of the youth were married at the time of the survey while less than one percent (0.9%) were previously married (separated, divorced, or widowed). Among married youth, nearly half (48.5%, n=426) were married before the age of 18 years and 9.4% weren't sure how old they were when they married.

Employment status and earning money may influence exposure to RH information and services and access to services, with employed youth having an advantage. Unemployment is high among this age group, which is somewhat expected given that over half of youth are still in school and given the high national unemployment rate, especially in these underserved regions; about 84.5% of community youth survey respondents were not working at the time of the survey.

Senegal is a predominantly Muslim country; 98.8% of respondents reported that they were Muslim. In examining ethnic group, the highest proportion of youth in these six regions were Pulaar (49.1%) followed by Wolof (24.8%) and Mandingue (8.7%).

Mass media channels such as radio and television are often used to disseminate Information on YFHS; listening to radio or watching the television increases the likelihood of having access to this information. Access to media is fairly high in these six regions; most youth listen to radio either daily (34.8%) or at least once per week (30.8%), as well as watch TV daily (56.4%) or weekly (21.8%). A large proportion (21.2%) of youth reported to not listen to radio at all. Use of internet is also somewhat accessible for youth; 28.6% access the internet either daily or on a weekly basis with more youth having used the internet in Saint Louis region (39.7%) than any other region. However, 61.9% have never used the internet. About half of all youth own a mobile phone for their own personal use with the highest rate of ownership in Kaolack (55.5%) and Saint-Louis (52.0%) and the lowest rate of ownership in Kolda (44.3%) and Matam (45.8%%) regions.

Table 6: Percentage Distribution of Community Survey Respondents (Youth) by Region and Background Characteristics

Characteristic	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases	**n=400**	**n=200**	**n=400**	**n=400**	**n=600**	**n=400**	**n=2400**
Age:							
10–14	30.0%	30.0%	31.5%	30.0%	28.7%	30.0%	29.9%
15–19	36.0%	35.5%	35.3%	35.0%	35.3%	35.5%	35.4%
20–24	34.0%	34.5%	33.3%	35.0%	36.0%	34.5%	34.7%
Sex:							
Male	50.0%	48.0%	49.8%	52.3%	50.0%	50.0%	50.2%
Female	50.0%	52.0%	50.3%	47.8%	50.0%	50.0%	49.8%

Location of residence:							
Urban/Peri-urban	60.0%	40.5%	30.0%	10.0%	53.2%	20.0%	31.7%
Rural	40.0%	59.5%	70.0%	90.0%	46.8%	80.0%	63.3%
School attendance status:							
Out of School	43.8%	48.0%	50.0%	57.8%	41.7%	41.5%	46.6%
In School	56.3%	52.0%	50.0%	42.3%	58.3%	58.5%	53.4%
Education:							
None	19.5%	9.0%	17.0%	29.3%	14.8%	17.8%	18.4%
Primary	29.3%	31.0%	37.3%	33.0%	36.7%	28.5%	33.1%
Middle	29.3%	43.5%	27.3%	21.8%	26.3%	27.8%	27.9%
Secondary or University	20.0%	14.0%	16.8%	15.5%	20.0%	25.3%	19.1%
Marital status:							
Never married	83.5%	78.0%	74.2%	79.7%	87.5%	84.2%	82.0%
Currently married	16.0%	21.0%	25.0%	19.0%	11.0%	15.5%	17.1%
Previously married	0.5%	1.0%	0.8%	1.3%	1.5%	0.3%	0.9%
For those ever married, age at first marriage:							
10-14 years	7.7%	13.6%	20.8%	24.1%	4.0%	3.2%	13.1%
15-17 years	35.4%	43.2%	29.7%	36.7%	32.0%	41.9%	35.4%
18-19 years	27.7%	11.4%	13.9%	25.3%	17.3%	27.4%	20.4%
20-24 years	27.7%	20.5%	20.8%	11.4%	34.7%	14.5%	21.6%
Don't know age	1.5%	11.4%	14.9%	2.5%	12.0%	12.9%	9.4%
Number of cases	65	44	101	79	75	62	426
Work to earn money:							
Yes	14.3%	21.5%	16.8%	13.0%	18.3%	11.0%	15.5%
No	85.8%	78.5%	83.3%	87.0%	81.7%	89.0%	84.5%
Religion:							
Muslim	99.8%	95.0%	98.3%	99.8%	99.5%	98.5%	98.8%
Catholic	0.0%	2.5%	0.5%	0.0%	0.5%	0.5%	0.5%
Protestant	0.3%	2.5%	1.3%	0.3%	0.0%	1.0%	0.7%
Ethnic group:							
Pulaar	19.0%	37.5%	80.8%	96.0%	33.5%	29.8%	49.1%
Wolof	50.3%	2.0%	3.0%	2.8%	52.2%	13.3%	24.8%
Mandingue	2.8%	40.5%	4.8%	0.0%	.5%	23.5%	8.7%
Sérère	15.5%	1.5%	2.0%	0.0%	4.2%	.8%	4.2%

Diola	.3%	0.0%	2.8%	.3%	1.7%	16.5%	3.7%
Bambara	8.8%	2.0%	1.0%	.5%	.5%	2.8%	2.5%
Maure	2.0%	0.0%	0.0%	0.0%	7.0%	.8%	2.2%
Balante	.3%	0.0%	1.5%	0.0%	0.0%	9.0%	1.8%
Other	1.2%	16.5%	4.3%	0.5%	0.5%	3.8%	3.1%
Frequency of listening to the radio:							
Almost everyday	28.5%	37.0%	41.3%	32.5%	38.7%	30.3%	34.8%
At least once a week	35.0%	24.5%	26.3%	33.0%	26.5%	38.3%	30.8%
Less than once a week	18.3%	10.5%	9.0%	20.8%	6.8%	15.8%	13.2%
Never	18.3%	28.0%	23.5%	13.8%	28.0%	15.8%	21.2%
Frequency of watching TV:							
Almost everyday	56.3%	59.5%	37.8%	57.0%	71.3%	50.5%	56.4%
At least once a week	28.8%	14.5%	24.5%	25.3%	13.7%	24.5%	21.8%
Less than once a week	10.3%	9.5%	10.3%	11.3%	1.7%	12.5%	8.6%
Never	4.8%	16.5%	27.5%	6.5%	13.3%	12.5%	13.3%
Frequency of using Internet:							
Almost everyday	9.8%	16.0%	10.5%	7.8%	19.5%	7.0%	12.0%
At least once a week	20.3%	13.5%	10.8%	12.8%	20.2%	19.0%	16.6%
Less than once a week	15.5%	10.5%	7.3%	15.5%	5.8%	4.5%	9.5%
Never	54.5%	60.0%	71.5%	64.0%	54.5%	69.5%	61.9%
Owns a mobile phone for their own use:							
Yes	55.5%	49.0%	44.3%	45.8%	52.0%	46.3%	49.0%
No	44.5%	51.0%	55.8%	54.3%	48.0%	53.8%	51.0%

Characteristics of Young Women who took part in Semi-Structured Interviews

Young women who had taken part in surveys as part of the assessment and reported using a modern contraceptive method were asked if they would agree to take part in a semi-structured interview. Across the six regions, 34 women aged 18–24 participated in these interviews. Most of the women were married, although two women in Kolda and one in Kédougou were single and one woman in Kolda was divorced. Among the married women, all had married between the ages of 14–22 (the average was 16.9) and many had husbands that were significantly older than them, often 10–15 years or more. Most of the

women were in monogamous marriages, though several noted they were the only spouse at the moment, indicating the husband might marry another woman at a later point. Almost all of the women had at least one child; the average was 1.6 children.

Although quite a few of the women across all six regions had a secondary level of education, most of the women did not work and relied on their husbands for income. Those who did work were mostly domestic servants or engaged in petty trade. Most of the women interviewed had elected to use injectable contraceptives followed by implants.

Table 7: Socio-Demographic Characteristics of Young Women who took part in Semi-Structured Interviews (n=34)

		Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	Total
		n=5	n=3	n=6	n=6	n=8	n=6	n=34
		Range (mean)						
Age		20–23 (21.4)	20–23 (22)	18–24 (21.3)	18–22 (20.5)	19–23 (21.3)	20–23 (21.3)	18–24 (21.2)
Husband's age		35–47 (39)	32–42 (37) n=2	27–34 (31.3) n=3	25–32 (28.8)	23–55 (36.3)	30–50 (36.7)	23–55 (34.7) n=30
Age at marriage		15–19 (17.6)	15 (15) n=1	15–22 (18.3) n=3	14–19 (16.7)	14–20 (17.1)	14–18 (16.0)	14–22 (16.9) (n=29)
Number of children		1–2 (1.8)	1–5 (2.7)	0–2 (0.7) n=3	1–3 (1.8)	1–2 (1.5)	1–3 (1.8)	0–5 (1.6) n=31
		N						
Education	None/religious		1			2	1	4
	Primary	2		2	1	4		9
	Middle	1	2	1			2	6
	Secondary & above	2		2	3	2	3	12
	No information			1	2			3
Marital status	Married: Monogamous	4	2	3	6	6	4	25
	Married: Polygamous	1				2	1	4
	Married: No information						1	1
	Single/Divorced		1	3				4
Type of contraceptive used	Implant	3		3	2		2	10
	Injectable	1	3	2	1	6	3	16
	IUD						1	1
	Pill	1		1	3	2		7
Work to earn money	Yes			3	1	1	1	6
	No	5	3	3	5	7	5	28

Characteristics of Youth who took part in Exit Surveys

This section describes the demographic and socioeconomic profile of exit interview respondents. A total of 180 respondents were interviewed shortly after they received services at the 23 surveyed SDPs. Demographic characteristics were examined to determine the categories of youth who access youth health services including age, sex, type of residence, educational status, marital status, age at marriage, and number of living children at the time of the survey. We also examined the type of SDP in which they were interviewed and the model of service delivery approach adopted. The distribution of respondents by selected background characteristics are presented in Table 8.

Graph 1 below presents information on the kind of service delivery approach adopted in the SDP in which the clients were interviewed.

Graph 1: Types of SDPs in which Clients were Interviewed, n=180

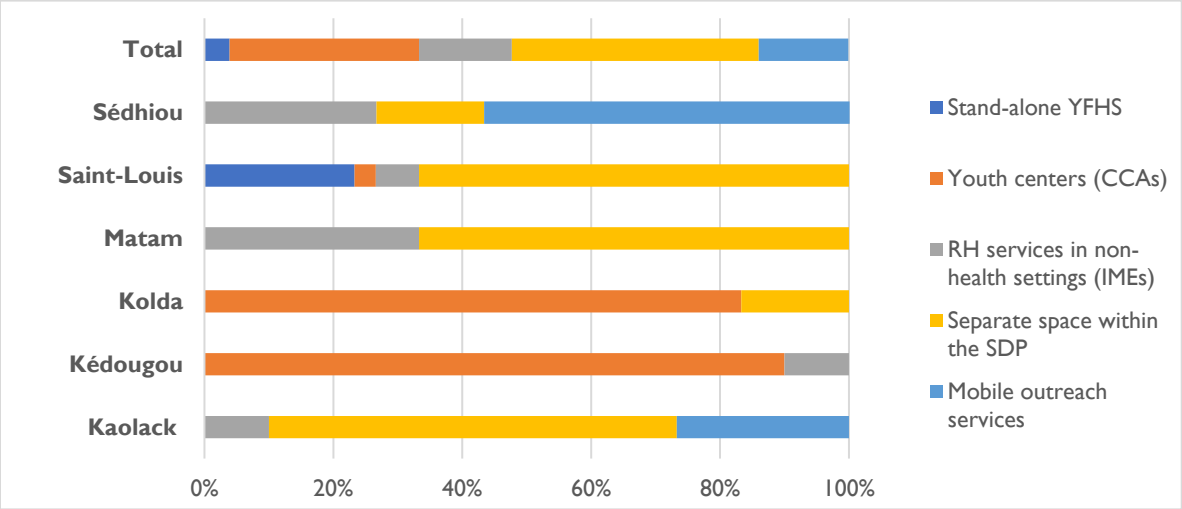


Table 8 shows that, across the six regions, clients were evenly distributed across the ages of 15–24 (by five-year age groups) and very few clients were under the age of 15 (1.1%). The modal age group for all exit interview respondents was 15–19 years (51.7%) with some variations by region; the mean age of clients was 19.3 years. Exit interview respondents were slightly older in Kaolack (21.1 years) and Saint-Louis (20.5 years), and younger in Kédougou (16.6 years) and Kolda (18.3 years).

Most clients were female: of all clients interviewed, 16.1% were males and 83.9% were females, though this varied by region. The percentage of interviewed male clients was highest in Kédougou (40.0%) and lowest Kaolack (3.3%).

Most youth clients had a middle (31.1%) or secondary (29.4%) level of education. A large proportion of clients in Kaolack (33.3%) and Sédhiou (50.0%) had no education at all. In Saint-Louis, most clients had a secondary or higher education (56.7%). These variations may be related to the proportion of male

clients interviewed in these different regions as males tend to have higher levels of education than females.

Across the six regions, clients were slightly more likely to be never married (53.9%) than currently or previously married (45.6% and 0.6%, respectively). However, marital status among clients varied widely by region. In Kédougou, all clients interviewed were never married, whereas in Kaolack, only 13.3% of clients were never married.

More than one-third (37.2%) of interviewed clients had at least one living child at the time of the survey. Again, this varied widely be region with all respondents (100.0%) in Kédougou having no living child and 70.0% of respondents in Kaolack having at least one living child (70.0%). Nearly one-fifth of all respondents had one living child; 17.8% had 2 or more living children.

In addition to describing exit client interview respondent characteristics, Table 8 also shows characteristics of the SDP where the client was interviewed. In this assessment, most clients were interviewed at an SDP located in an urban area (86.7%). At the regional level, only clients interviewed in Sédhiou were likely to be interviewed in an SDP located in a rural area (56.7%).

Most interviews took place in a public SDP managed by the GOS. Over half of clients were interviewed in either a HC (28.3%) or in an Adolescent Counseling Center, or CCA (29.4%)[c]. Only one client (Kaolack) was interviewed in a public health post. SDPs operated by International Planned Parenthood Federation's Senegal affiliate, L'Association Senegalais pour le Bien-Etre de la Famille (ASBEF), and MSI were also included in this assessment. About 9.4 % of clients were interviewed at an ASBEF SDP and 17.8% were interviewed attending an MSI facility or mobile outreach event.

These various SDPs provide RH services to some degree or provide at least some RH services to youth primarily through five different service models: stand-alone youth clinic, youth corners/separate clinic within a main HF, multi-purpose youth centers (CCAs), mobile outreaches, or SDPs in non-health settings (IMEs). Due to the availability of services, most exit interview respondents were interviewed at an SDP that operates a separate space for youth RH services (38.3%); nearly one-third (29.4%) of clients were interviewed at an SDP operating as youth center, and 13.9 % of youth clients were interviewed through mobile outreach services. This varied widely by region as only 23 SDPs were included in the assessment. Clients from mobile services came only from Kaolack (26. %) or Sédhiou (56.7 %), for example.

Exactly 41.1% of all clients were visiting the SDP for the first time on the day of interview and over half (57.2%) had been referred for their current visit on the day of interview. Youth clients reported they were located close to the SDP: 30.6% of clients reported travelling less than 15 minutes to reach the SDP and 36.7 % had travelled less than 30 minutes. Only 11.7reported traveling more than an hour; many of these clients were based in Matam region.

[c] CCAs are managed by the Senegal Ministry of Youth and Sports. They are also not health facilities, but rather recreational facilities with an infirmary offering a limited range of health services.

Finally, Table 8 shows the main reason for the client visit on the day of interview. About one-quarter (25.6%) of clients interviewed reported they had visited the SDP to seek FP services. Other key services sought included antenatal care and delivery services (24.4%), RH counseling and information on menstrual hygiene (20%), and general curative care (17.8%). In Kolda and Matam, a large proportion of clients were visiting the SDP on the day of interview to seek ANC/delivery services (46.7% in Kolda and 56.7% in Matam), whereas most clients in Sédhiou were interviewed after seeking FP services (60.0%). This may largely be reflective of the type of SDP and services offered to youth where clients were interviewed.

Table 8: Percentage Distribution of Client Exit Interview Respondents (Youth) by Background Characteristics

Characteristic	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases	**n=30**	**n=30**	**n=30**	**n=30**	**n=30**	**n=30**	**n=180**
Age:							
10-14	0.0%	0.0%	3.3%	3.3%	0.0%	0.0%	1.1%
15-19	16.7%	96.7%	63.3%	43.3%	40.0%	50.0%	51.7%
20-24	83.3%	3.3%	33.3%	53.3%	60.0%	50.0%	47.2%
Mean age	21.1 years	16.6 years	18.3 years	19.5 years	20.5 years	19.6 years	19.3 years
Sex:							
Male	3.3%	40.0%	13.3%	10.0%	10.0%	20.0%	16.1%
Female	96.7%	60.0%	86.7%	90.0%	90.0%	80.0%	83.9%
Education:							
None	33.3%	0.0%	10.0%	6.7%	13.3%	50.0%	18.9%
Primary	20.0%	0.0%	26.7%	30.0%	13.3%	3.3%	15.6%
Middle	16.7%	63.3%	50.0%	30.0%	16.7%	10.0%	31.1%
Secondary	26.7%	36.7%	10.0%	26.7%	40.0%	36.7%	29.4%
University	3.3%	0.0%	3.3%	6.7%	16.7%	0.0%	5.0%
Marital Status:							
Never married	13.3%	100.0%	76.7%	43.3%	50.0%	40.0%	53.9%
Currently married	86.7%	0.0%	23.3%	56.7%	46.7%	60.0%	45.6%
Previously married	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	.6%
Have living Children?							
Yes	70.0%	0.0%	16.7%	33.3%	46.7%	56.7%	37.2%
No	30.0%	100.0%	83.3%	66.7%	53.3%	43.3%	62.8%
Number of living children:							
0	30.0%	100.0%	83.3%	66.7%	53.3%	43.3%	62.8%
1	20.0%	0.0%	13.3%	20.0%	43.3%	20.0%	19.4%
2	20.0%	0.0%	3.3%	3.3%	3.3%	16.7%	7.8%
3 or more	30.0%	0.0%	0.0%	10.0%	0.0%	20.0%	10.0%
Location of SDP:							
Rural	0.0%	0.0%	0.0%	0.0%	23.3%	56.7%	13.3%

Urban	100.0%	100.0%	100.0%	100.0%	76.7%	43.3%	86.7%
Type of SDP where interview took place:							
Public SDPs							
Health Center	40.0%	0.0%	0.0%	66.7%	46.7%	16.7%	28.3%
Health Post	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	.6%
Adolescent Counseling Center (CCA)	0.0%	90.0%	83.3%	0.0%	3.3%	0.0%	29.4%
IME	10.0%	10.0%	0.0%	33.3%	6.7%	26.7%	14.4%
Non-Government SDPs							
ASBEF	20.0%	0.0%	16.7%	0.0%	20.0%	0.0%	9.4%
MSI	26.7%	0.0%	0.0%	0.0%	23.3%	56.7%	17.8%
YFHS approach adopted in the SDP:							
Stand-alone YFHS SDP	0.0%	0.0%	0.0%	0.0%	23.3%	0.0%	3.9%
Youth centers (CCAs)	0.0%	90.0%	83.3%	0.0%	3.3%	0.0%	29.4%
RH services in non-health settings (IMEs)	10.0%	10.0%	0.0%	33.3%	6.7%	26.7%	14.4%
Separate space within the SDP	63.3%	0.0%	16.7%	66.7%	66.7%	16.7%	38.3%
Mobile outreach services	26.7%	0.0%	0.0%	0.0%	0.0%	56.7%	13.9%
% of adolescents/youth visiting the PPS for first time	50.0%	56.7%	23.3%	43.3%	10.0%	63.3%	41.1%
% of adolescents/youth referred for the current visit	63.3%	100.0%	16.7%	83.3%	26.7%	53.3%	57.2%
Travel time to SDP:							
Less than 15 minutes	10.0%	23.3%	26.7%	36.7%	33.3%	53.3%	30.6%
15–30 minutes	40.0%	56.7%	33.3%	26.7%	46.7%	16.7%	36.7%
30–45 minutes	20.0%	6.7%	3.3%	0.0%	6.7%	3.3%	6.7%
45 minutes – 1 hour	20.0%	13.3%	16.7%	6.7%	10.0%	20.0%	14.4%
More than one hour	10.0%	0.0%	20.0%	30.0%	3.3%	6.7%	11.7%
Reason for visit today:							
Family planning	33.3%	0.0%	16.7%	6.7%	36.7%	60.0%	25.6%
ANC/Delivery	30.0%	0.0%	46.7%	56.7%	10.0%	3.3%	24.4%
Education and/ or counseling on SRH/ menstrual hygiene	0.0%	90.0%	16.7%	3.3%	13.3%	0.0%	20.6%
Curative care/ general consultation	10.0%	6.7%	0.0%	60.0%	6.7%	23.3%	17.8%
Gynecological care	10.0%	3.3%	16.7%	0.0%	13.3%	13.3%	9.4%
HIV/AIDS counseling/testing	0.0%	0.0%	10.0%	0.0%	16.7%	0.0%	4.4%
STI counseling/testing	0.0%	0.0%	3.3%	0.0%	16.7%	0.0%	3.3%

Postnatal care	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%
Vaccinations	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	.6%
Post-abortion care	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	.6%
Other	10.0%	0.0%	0.0%	0.0%	6.7%	0.0%	2.8%

Characteristics of Service Delivery Point-Based Service Providers Surveyed

The distribution of the SDP-based service providers by selected background characteristics are displayed in Table 9. It should be noted that, due to the small number of SDPs which provide youth services in the six regions, the corresponding provider sample size is also small (n=50). Thus, findings regarding providers, especially at the regional level, should be cautiously interpreted.

Across the six regions, the mean age of providers was 34.2 years. Most providers (54 %) were aged 30-39 years. In addition, most providers (78%) interviewed were female. Nearly one-quarter (22%) were male. It should be noted these figures may not reflect the actual sex composition of SDP-based youth-friendly health service providers in the survey regions; rather, they reflect those who were present on the day of interview.

In nearly all regions, the modal level of education for SDP-based service providers is post-secondary (70%). However, in Sédhiou and Matam, about half of providers (40% in Matam and 50 % in Sédhiou) only had a secondary level of education. These percentages in most of the regions show the majority of the service providers have basic post-secondary trainings required for adequate performance of their duties as nurses and midwives, among other providers.

A majority of service providers were married at the time of the survey (72%) and 62% of service providers reported having at least one child. The percentage of service providers with children 10–24 years is highest in Kolda (67.1%) and lowest in Kédougou (0.0%).

Nurse-midwives constitute the largest single group of youth service providers in the assessed SDPs in these six regions of Senegal (58%). Other service providers include nurses (10%), nurse's aide (10%), lab assistants (8%), and other paramedical support staff (14%).

Only one-fifth (20%) of the SDP-based service providers became health professionals within the four years preceding the survey and are relatively new on the job. Most (52%) providers have been working in their profession between 5–9 years. About one-third (32%) of service providers have been in their current service station for less than a year and are thus new in their work station.

Service providers are located in different departments of the SDPs, many working across multiple units. A majority of providers (56 %) mentioned they offered general consultation services and a large proportion of providers reported serving in HIV/STI prevention and treatment (42%), FP (40%), youth corner counseling (40%), and ANC/maternity/postnatal care (32%).

As was observed among exit interview clients, most service providers work in public (government) SDPs: 28% in government HCs, 26% in CCAs, and 18 % in government IMEs. About 14% of the service

providers work in ASBEF sites and 14% in MSI sites (facilities or mobile teams). About 42% work in an SDP with a separate space for youth services.

Table 9: Percentage Distribution of Service Delivery Point-Based Youth-Friendly Health Service Providers by Background Characteristics

Characteristic	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (PPS)	**n=10**	**n=3**	**n=7**	**n=10**	**n=10**	**n=10**	**n=50**
Age:							
15–29 years	20.0% (2)	0.0% (0)	42.9% (2)	20.0% (2)	30% (3)	20% (2)	24.0%
30–39 years	60.0% (6)	66.7% (2)	42.9% (3)	50.0% (5)	50% (5)	60% (6)	54.0%
40 years and above	20.0% (2)	33.3% (1)	14.3% (1)	30.0% (3)	20% (2)	20% (2)	22.0%
Mean age (years)	35.4 years	35.0 years	33.3 years	35.6 years	31.0 years	35.4 years	34.2 years
Sex:							
Male	10% (1)	33.3% (1)	28.6% (2)	10% (1)	10% (1)	50% (5)	22.0%
Female	90% (9)	66.7% (2)	71.4% (5)	90% (9)	90% (9)	50% (5)	78.0%
Type of Residence/locality:							
Rural	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	20.0% (2)	20.0% (2)	10.0%
Urban/Peri-Urban	100% (10)	100% (3)	100% (7)	100% (10)	80% (8)	80% (8)	90.0%
Education:							
Middle	0.0% (0)	0.0% (0)	14.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	2.0%
Secondary	20% (2)	33.3% (1)	14.3% (1)	40% (4)	10% (1)	50% (5)	28.0%
Higher (University)	80% (8)	66.7% (2)	71.4% (5)	60% (6)	90% (9)	50% (5)	70.0%
Marital Status:							
Never married	10% (1)	66.7% (2)	0.0% (0)	30% (3)	30% (3)	30% (3)	24.0%
Currently married	90% (9)	33.3% (1)	100% (7)	60% (6)	60% (6)	70% (7)	72.0%
Previously married	0.0% (0)	0.0% (0)	0.0% (0)	10% (1)	10% (1)	0.0% (0)	4.0%
Number of living children:							
0	40% (4)	66.7% (2)	14.3% (1)	50% (5)	40% (4)	30% (3)	38.0%
1	10% (1)	0.0% (0)	42.9% (3)	10% (1)	20% (2)	20% (2)	18.0%
2	20% (2)	0.0% (0)	14.3% (1)	30% (3)	20% (2)	10% (1)	18.0%
3 or more	30% (3)	33.3% (1)	28.6% (2)	10% (1)	20% (2)	40% (4)	26.0%
Has at least one living child aged 10–24 years:							
Yes	30% (3)	0.0% (0)	67.1% (4)	10% (1)	10% (1)	40% (4)	26.0%
No	70% (7)	100% (3)	42.9% (3)	90% (9)	90% (9)	60% (6)	74.0%
Current Professional Status:							
Nurse	10% (1)	33.3% (1)	14.3% (1)	20% (2)	0.0% (0)	0.0% (0)	10.0%
Nurse-Midwife	70% (7)	33.3% (1)	42.9% (3)	60% (6)	80% (8)	40% (4)	58.0%

Nurse's Aide	20% (2)	0.0% (0)	14.3% (1)	0.0%	10% (1)	10% (1)	10.0%
Lab Assistant	0.0%	33.3% (1)	28.6% (2)	0.0% (0)	0.0% (0)	10% (1)	8.0%
Other*	0.0% (0)	0.0% (0)	0.0% (0)	20% (2)	10% (1)	40% (4)	14.0%
How long provider has been a health professional:							
1–4 years	20% (2)	33.3% (1)	0.0% (0)	20% (2)	30% (3)	20% (2)	20.0%
5–9 years	40% (4)	33.3% (1)	85.7% (6)	50% (5)	40% (4)	60% (6)	52.0%
10+ years	40% (4)	33.3% (1)	14.3% (1)	30% (3)	30% (3)	20% (2)	28.0%
How long provider has been a working in the surveyed SDP:							
1 year or less	40% (4)	66.7% (2)	14.3% (1)	30% (3)	30% (3)	30% (3)	32.0%
2–4 years	10% (1)	33.3% (1)	42.9% (3)	50% (5)	30% (3)	30% (3)	32.0%
5+ years	50% (5)	0.0% (0)	42.9% (3)	20% (2)	40% (4)	40% (4)	36.0%
Type of SDP where interview took place:							
Public SDPs							
Health Center	30% (3)	0.0% (0)	0.0% (0)	60% (6)	30% (3)	20% (2)	28.0%
Adolescent Counseling Center (CCA)	0.0% (0)	66.7% (2)	57.1% (4)	30% (3)	10% (1)	30% (3)	26.0%
IME	20% (2)	33.3% (1)	14.3% (1)	10% (1)	10% (1)	30% (3)	18.0%
Non-Government SDPs							
ASBEF	20% (2)	0.0% (0)	28.6% (2)	0.0% (0)	30% (3)	0.0% (0)	14.0%
MSI	30% (3)	0.0% (0)	0.0% (0)	0.0% (0)	20% (2)	20% (2)	14.0%
YFHS approach adopted in the SDP:							
Stand-alone YFHS SDP	0.0%	0.0%	0.0%	0.0%	20.0% (2)	0.0%	4.0%
Youth centers (CCAs)	0.0%	66.7% (2)	57.1% (4)	30.0% (3)	10.0% (1)	30.0% (3)	26.0%
RH services in non-health settings (IMEs)	20% (2)	33.3% (1)	14.3% (1)	10.0% (1)	10.0% (1)	30.0% (3)	18.0%
Separate space within the SDP	50% (3)	0.0% (0)	28.6% (2)	60% (6)	60% (6)	20% (2)	42.0%
Mobile outreach services	30% (3)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	20% (2)	10.0%
Unit/department where YFHS service provider works (multiple allowed):							
General Consultation	30% (3)	66.7% (2)	71.4% (5)	80% (8)	60% (6)	40% (4)	56.0%
STI/HIV Prevention and Treatment	20% (2)	0.0% (0)	71.4% (5)	50% (5)	70% (7)	20% (2)	42.0%
Family Planning	30% (3)	33.3% (1)	57.1% (4)	40% (4)	60% (6)	20% (2)	40.0%
Youth Corner Counseling	40% (4)	100.0%	14.3% (1)	70% (7)	50% (5)	0.0% (0)	40.0%
Antenatal, Maternity, Postnatal	20% (2)	33.3% (1)	42.9% (3)	40% (4)	50% (5)	10% (1)	32.0%
Mobile Outreach Team	20% (2)	0.0% (0)	0.0% (0)	0.0% (0)	10% (1)	20% (2)	10.0%
Other	30% (3)	33.3% (1)	28.6% (2)	40% (4)	40% (4)	40% (4)	36.0%

* *Other* professional designation includes: social worker, public education teacher, nursing assistant, teacher, and peer educator.

Characteristics of Community Health Workers Surveyed

Table 10 shows the distribution of 150 community health workers ("ASC/relais" in Senegal) working in the catchment areas of the 23 assessed SDPs (though few actively attached to these SDPs) by selected background characteristics. The ASC/relais were generally much older than their potential/actual adolescent and youth clients; nearly three-quarters (74.0%) were aged 30 years and above at the time of the survey.

There were slightly more female than male ASC/relais: 68% of all ASC/relais interviewed were females and, across regions, the percentage ranged from 40% in Kolda to 89.2% in Saint-Louis. Regarding location, less than half (48.7%) of ASC/relais were located in rural areas where outreach services are needed most.

Nearly two thirds (64.7%) of ASC/relais had a secondary or post-secondary level of education; this percentage having secondary education and above ranges from 46.2% in Kédougou to 80 % in Sédhiou. Three in four (75.3%) ASC/relais were married at the time of the survey. The percentage of married ASC/relais ranges from 64.9% in Saint-Louis to 92.3% in Kédougou.

Almost half (48%) of ASC/relais have worked in their capacity for ten or more years, implying, as we noted for the peer educators, a good mixture of old (experienced) and new (less experienced) individuals who could learn from one another. Only 30% of ASC/relais have been working as ASC/relais in the last four years preceding the survey.

The data in the last panel of Table 10 suggests that majority of ASC/relais might have gained a fairly comprehensive understanding of the health conditions in their communities having lived in these communities for ten or more years, most since birth. Nearly all (91.3%) of ASC/relais reported to have lived in the communities where they offer services for ten or more years; 57.3% have lived in the communities since birth.

Table 10: Percentage Distribution of ASC/Relais by Background Characteristics

Characteristic	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (ASC/relais)	**n=25**	**n=13**	**n=25**	**n=25**	**n=37**	**n=25**	**n=150**
Age:							
18–29 years	12.0%	30.8%	28.0%	28.0%	24.3%	36.0%	26.0%
30–39 years	44.0%	23.1%	36.0%	36.0%	21.6%	12.0%	28.7%
40 years +	44.0%	46.2%	36.0%	36.0%	54.1%	52.0%	45.3%
Sex:							

Male	24.0%	46.2%	60.0%	16.0%	10.8%	52.0%	32.0%
Female	76.0%	53.8%	40.0%	84.0%	89.2%	48.0%	68.0%
Type of Residence/ locality:							
Urban/Peri-urban	52.0%	30.8%	52.0%	24.0%	75.7%	52.0%	51.3%
Rural	48.0%	69.2%	48.0%	76.0%	24.3%	48.0%	48.7%
Education:							
None	8.0%	0%	0%	4.0%	0%	4.0%	2.7%
Primary	32.0%	53.8%	48.0%	40.0%	21.6%	16.0%	32.7%
Secondary and above	60.0%	46.2%	52.0%	56.0%	78.4%	80.0%	64.7%
Marital Status:							
Never married	8.0%	7.7%	12.0%	8.0%	24.3%	28.0%	16.0%
Currently married	80.0%	92.3%	80.0%	76.0%	64.9%	72.0%	75.3%
Previously married	12.0%	0%	8.0%	16.0%	10.8%	0%	8.7%
How long respondent has been working as an ASC/relais:							
0–4 years	44.0%	15.4%	20.0%	28.0%	29.7%	36.0%	30.0%
5–9 years	16.0%	30.8%	44.0%	16.0%	18.9%	12.0%	22.0%
10+ years	40.0%	53.8%	36.0%	56.0%	51.4%	52.0%	48.0%
Length of stay in survey community:							
1–9 years	20.0%	0%	8.0%	0%	5.4%	16.0%	8.7%
10+ years	44.0%	23.1%	20.0%	12.0%	27.0%	76.0%	34.0%
Since birth	36.0%	76.9%	72.0%	88.0%	67.6%	8.0%	57.3%

Characteristics of Sexual and Reproductive Health Program Managers Interviewed

SRH program managers, typically focal points or SRH coordinators who worked with SDPs and representatives from a range of civil society and international organizations, including those involved in health, education, local development, youth, and sports, were interviewed across the six regions. In all, 17 women and 22 men took part in these IDIs. In terms of age, many of these participants were in their 30s or 40s. Given that most of those interviewed led organizations or were engaged in health service provision, it is not surprising that most had more than secondary-level education.

Table 11: Socio-Demographic Characteristics of Sexual and Reproductive Health Program Managers and Civil Society Organization Representatives who took part in in-depth Interviews (n=39)

		Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	Total
		n=7	n=4	n=7	n=5	n=10	n=6	n=39
		Range (mean)						
Age		33–60 (45.9)	35–40 (38.3)	32–63 (41.0)	27–56 (40.8)	37–59 (46.7)	33–63 (49.7)	27–63 (44.4)
		N						
Gender	Female	2	1	2	3	7	2	17
	Male	5	3	5	2	3	4	22
Education	None/religious					2		2
	Primary							
	Middle					1	1	2
	Secondary & above	5	4	7	5	6	5	32
	No information	2				1		3

Characteristics of Peer Educators Interviewed

A total of 18 FGDs were held with peer educators across the six regions. Some consisted of only men or only women, and some were mixed; in all, 61 women and 66 men took part in these FGDs. Most participants were between the ages of 15 and 24 (the average age was 20.9 years); most were either high school or college students, though a few engaged in income-generating activities or were in professional training programs. Most of the peer educators were unmarried and had no children. The peer educators had a wide variety of experience in their roles: some had only been peer educators for a few weeks or months while several had been peer educators for many years.

When asked about their motivations for becoming peer educators, many brought up the desire to contribute to their communities' development and to combat harmful trends; additionally, many noted that financial motivations were not a factor. Many female peer educators in Matam, for instance, noted they had decided to become peer educators to try to combat gender-based violence (GBV) in their region. In Kolda, many of the peer educators said they had been motivated to join to sensitize communities about the risks of early pregnancy; as one peer educator explained, "*I became a peer educator to better help alleviate the problems we face in Kolda. We face enormous difficulties in the face of an increase in early teenage pregnancies.*" A peer educator in Kaolack remarked, "*We have become peer educators because we want to participate in the development of our country.*" Many peer educators were affiliated with organizations or health services, including the Centre Conseil Adolescent (CCA), l'Inspection Médicale des Écoles (IME), MSI, and l'Association Sénégalaise pour le Bien-Être Familial (ASBEF).

Table 12: Socio-Demographic Characteristics of Peer Educators (n=127)

		Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	Total
# FGDs		3	2	3	3	4	3	18
# Participants		n=22	n=14	n=19	n=24	n=26	n=22	n=127
		Range (mean)						
Age		16–26 (19.9)	17–15 (24.7)	15–30 (22.0)	15–27 (18.8)	15–27 (21.6)	15–27 (20.2)	15–45 (20.9)
# Children		0–1 (0.05)	0–1 (0.2)	0–1 (0.05)	0 (0)	0 (0)	0–1 (0.1)	0–1 (0.06)
Years of experience as Peer Educator		0.04–6 (2.3)	1–18 (4.1)	0–6 (2.5)	0. –-5 (2.1)	0.25–5 (2.0)	1–6 (2.5)	0–18 (2.5)
		N						
Gender	Female	9	5	13	14	9	11	61
	Male	13	9	6	10	17	11	66
Education	None/religious				1	1		2
	Primary							0
	Middle	5					5	10
	Secondary & above	17	14	19	23	25	17	115
Marital Status	Married	1	1	2				4
	Single	21	13	17	24	26	22	123

Characteristics of Parents Interviewed

Parents of adolescents and youth took part in 24 FGDs (half consisting of fathers and half of mothers) across the six regions. In all, 93 mothers and 88 fathers took part in these FGDs. The parents were predominantly in their 40s and 50s (the average age was 49.6) and most had more than one child who fell into the 10–24 age group. Most of the parents were currently married; 67 of them were in monogamous unions and 92 in polygamous ones. Most of the parents had very little education: 93 had virtually no formal education or only a Quranic education and 60 had only completed primary-level schooling. Most of the women were homemakers or earned an income through petty trade while the men engaged in a wider variety of income-generating activity including farming, fishing, and trade (carpentry, masonry, etc.) among others.

Table 13: Socio-Demographic Characteristics of Parents who took part in Focus Group Discussions (n=181)

		Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	Total
# FGDs		4	2	4	4	6	4	24
# Participants		n=29	n=13	n=26	n=32	n=48	n=33	n=181
		Range (mean)						
Age		35–84 (52.6)	36–73 (51.5)	28–79 (49.2)	25–87 (49.6)	36–67 (50.3)	21–64 (45.2)	21–87 (49.6)
# Children aged 10–24		1–7 (3.1)	1–14 (4.5)	0–10 (3.6)	1–8 (4.0)	1–11 (3.6)	1–8 (4.6)	0–14 (3.8)
		N						
Gender	Female	15	7	13	16	25	17	93
	Male	14	6	13	16	23	16	88
Education	None/religious	14	5	14	26	24	10	93
	Primary	12	4	10	5	13	16	60
	Middle	1	2				4	7
	Secondary & above	2	2	2	1	11	3	21
Marital status	Married: Monogamous	11	4	12	10	16	14	67
	Married: Polygamous	15	2	14	16	26	19	92
	Widowed	2	2		5	2		11
	Single/Divorced	1	5		1	4		11
Income-generating activity	Farmer	1	6	1	6	8	13	35
	Fisher					7		7
	Homemaker				7	13	4	24
	Laborer			4				4
	Maid	8	4	5				17
	Professional position		2	1		1	1	5
	Religious/cultural teacher/ leader	3		2	1			6
	Trader/seller/ businessperson (commerce)	8	1	7	13	8	11	48
	Tradesman	1		2		1	2	6
	Retired	6		1	1	4		12
	Other	2		3	4	6	2	17

Characteristics of Community Leaders Interviewed

Across the six regions, 37 community leaders were interviewed, most aged somewhere in their 50s and 60s. Among the community leaders were village and neighborhood chiefs, Imams, heads of local associations, primary or secondary school directors or principals, elected leaders, and Bajenu gox.[d] Some of the roles community leaders occupied overlapped with those of CSO representatives, though the interview guides for each category of participant was different. Among the 9 women and 28 men who were interviewed as community leaders, most had a secondary level of education or higher, though 9 had virtually no formal education and 7 had only a primary level of education.

Table 14: Socio-Demographic Characteristics of Community Leaders who took part in in-depth Interviews (n=37)

		Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	Total
		n=6	n=3	n=6	n=8	n=8	n=6	n=37
		Range (mean)						
Age		37–63 (55.8)	33–50 (42.7)	32–63 (48.4) n=5	29–80 (42.0)	44–77 (60.3)	35–60 (53.6) n=5	29–80 (51.2) n=35
		N						
Gender	Female	1	1	3	3	1		9
	Male	5	2	3	5	7	6	28
Education	None/religious	1			2	5	1	9
	Primary		1	3	2		1	7
	Middle		1		1		2	4
	Secondary & above	5	1	2	3	3	2	16
	No information			1				1

B. Identification of the Reproductive Health Needs of Adolescents and Youth in the Six Regions

One of the important objectives of this study was to examine factors that influence uptake and utilization of AYRH services. Consequently, attempts were made to examine the perceptions of a wide variety of community members about adolescents' and youths' health needs, acceptability and accessibility of YFHS, support for use of AYRH services, and the extent to which YFHS meet youths' health needs. Because youth, particularly those under the age of 18, require parental consent (or at least tacit support) to participate in some health and social programs, parents' level of knowledge of YFHS—including their perceptions of the need for services, their appreciation of the benefits of services, their perceptions of the cultural appropriateness of services, and consequent acceptability of services—play a

[d] Also referred to as a *badiène gox* or *bajenu gokh*, a Bajenu gox is a community outreach worker, sometimes seen as a "neighborhood godmother," who engages with community members on health issues, including RH issues, and refers those in need of services to health facilities and other YFHS SDPs as appropriate.

major role in determining whether youth will utilize services or not. As custodians of community norms and values, community leaders can work against programs they do not perceive to enhance moral values or benefit the community at large. Consequently, a major strategy of any service or outreach program for youth should be to raise awareness of the parents and community leaders on the benefits of services for youth and society at large. Information for this chapter was collected mainly from FGDs among parents (mothers and fathers) of adolescents and youth and IDIs with community leaders.

1. Perceptions of and Norms Around Adolescents and Youth in the Communities Generally

1.1 The Intertwined Issues of Education and Poverty

When asked about their aspirations for their children, parents and community members who took part in the qualitative assessment across the six regions were nearly universal in expressing the wish that their children finish school or advance as far as possible in terms of their education, often noting this was important to finding employment and ultimately supporting their families. Many parents noted these aspirations applied equally to their sons and daughters. As a mother who took part in a FGD in Sédhiou said, "*We all want our children to go to school to help us in the future. Whether it's boys or girls, it's the studies that must take precedence so that they can honour their parents.*" A mother in a FGD in Matam noted, " *For both girls and boys education is the sure way to aspire to a high social status.*"

In each of the regions, a minority of parents who took part in the FGDs—typically fathers—expressed gendered differences in their expectations for their children, emphasizing marriage as a priority for their daughters. Sometimes, these gendered differences were expressed in subtle ways, such as the expectation that girls who completed their schooling (or who abandoned their studies) get married, such as the case of a father in Kédougou, who noted:

> *My primary goal for my children is education. I want my children to be well educated especially those who are between 10 and 24 years old. They must have religious values (Islam) and moral values [...] For girls aged [less than] 24 years, if they are not studying, they must enter married life. Our wishes are along the lines of finding a good husband for our girls and good wives for boys.*

A mother in Kaolack similarly noted of daughters, "*If she's lucky enough to go to school, yes [she can wait to get her qualifications], if not, she can get married as soon as she's 18 years old*." In other cases, the different expectations for girls and boys were quite stark, as was evident in the comments of a father who took part in a FGD in Kolda: "*Regarding my aspirations for my children, it is that they study, and after their studies that they can find a job for the boys, for the girls that they find a husband so that they can get married*."

The majority of parents and others who took part in the qualitative assessment in the six regions, however, expressed more gender-equitable views about girls' social roles and their education. A mother in Kaolack asserted, "*I am against a girl getting married early, she should at least have a degree and look for work before getting married*." In a FGD in Saint-Louis, a mother similarly stated, "*I am for the schooling of children whether they are boys or girls. The vocation of a child is education; every child must go to school*." A

community leader in Kolda noted that parents had begun to value girls' education much more than used to be the case:

> *Previously, our parents always thought that a girl's purpose was to stay at home, especially in our area. But now they have started to change their minds, they all want their daughters to succeed and become important people in society. They all show awareness on the issue of education.*

Across the six regions, participants in the qualitative assessment observed that the key obstacle to their children's education was poverty. As a community leader in Kolda observed, " *We would like our children to study but we cannot afford it. If you cannot even find enough money for a kilo of rice and your child asks you for an exercise book or he comes back from school but cannot find anything to eat at home, he will not be able to able to focus on his studies*." Participants noted poverty was one of the main reasons children dropped out of school. A father who took part in an FGD in Saint-Louis, for example, observed:

> *In this locality, education is not what it should be. That's why after two, three years, children end up dropping out of school and find themselves without an occupation. In addition, they do not have support. This is essential for continuing studies. Thus, most of those who enter the sixth year leave school because parents cannot afford to finance their studies.*

Many participants in the qualitative assessment noted, as a result of dropping out of school, some young people sought their own forms of income. A community leader and religious figure in Kaolack noted: "*The other thing that also hinders education is the economic situation. You have to stop studying if the parents are in a state of poverty. So that children can look for other ways to support themselves*." A mother in Sédhiou observed, "*Poverty is a real obstacle, we are diminished, our husbands too, so we have no choice, we must all go out to look for something to feed the family. As soon as you have your back turned, they too go to look for some money*." A community leader in Kolda noted when boys dropped out of school, they often did so to take part in income-generating activities that were detrimental to their wellbeing: "*Boys, they leave school to stay in the street, to beg, or do jobs that are not at all advisable*."

In five of the six regions, participants in the qualitative assessment mentioned teacher strikes as further impeding children's ability to learn in school. A mother in Saint-Louis complained, "*We want our children to study but education also does not work because there are too many strikes*." In Kolda, a Bajenu gox explained, "*At school, with endless strikes children do not learn anything*." In the region of Matam, several community members said poverty and strikes led some parents to enroll their children in religious schools. A father who took part in an FGD in Matam asserted that parents felt they also had to do this: "*Education above all, here the boys give school up very early but also for a week now the children did not go to school because of strikes. So parents are forced to send their children to Koranic school and pull them out of the French school.*" A Bajenu gox noted children in daaras faced additional difficulties, even though French schools posed serious economic hardships of their own:

> *Children who are in the daaras do not have enough money and ask for financial support. These are children who are left stranded. They are left on the street and it is the Koranic teacher who takes care of them through begging. Children who are in daaras are neglected*

by families. They support themselves through begging. But those who are in French schools require as much resources and monitoring; it's very expensive this teaching of children. The cost really exceeds our means, but we have no other alternatives.

Despite the emphasis on education, participants in the qualitative assessments noted that a degree was no guarantee a young person would find an appropriate job. A mother in Saint-Louis lamented, "*I have a 23-year-old child who studied and completed competitive exams, he succeeded in almost all his exams, he has his qualifications, but he still cannot get a job*." In an FGD in Kolda, a father cautioned that, given the employment trends in the region, allowing girls to finish their degrees could prove to place a burden on families : "*When a girl is at school it is said let her continue her studies until she finds a job before getting married. She finishes her studies, she does not have a job, eventually she becomes a burden for you*."

1.2 Changing Cultural Norms and the role of Technology

When asked about adolescents and youth in their communities in general, parents and community leaders across the six regions where the qualitative assessment took place expressed great frustration with young people's conduct and their own perceived inability to control young people's behavior or to punish them as they saw fit. Many parents and community leaders complained young people did not have enough respect for them and their elders or behaved in ways that would have been unacceptable in their day. As a father in Kédougou lamented, "*Young people are our only concern. They have become uncontrollable and parents cannot do anything against them. They are a heavy burden for us*." A community leader in Kaolack noted: "*The technological evolution should serve young people, they should have a more advanced state of mind than ours, but they dress badly, they no longer respect their parents, these are all insults*."

Across the six regions, many parents and community leaders brought up a relatively recent amendment to the country's criminal code (which they typically referred to as a new law) that allows for the punishment of a person who causes injury to a child under the age of 15,[40] which they argued hampered their ability to properly raise adolescents and youth. As a father in Kolda noted: "*It's always a problem because we parents, we dare not even correct our children. If we do, there is the law that is there with its sanctions saying that children have their right. That's what worries us the most.*"

Often, this legal change was described in more oblique terms like the "new" or "foreign" concept of "children's rights" or "human rights", though the complaints remained the same. One father who took part in an FGD in Sédhiou lamented:

Another challenge facing our society is how to educate your child with the children's rights, which in my opinion give adolescents/young people more freedom. Today with this right, it is very difficult to succeed in children's education in rural areas. With this right, we are prohibited from hitting children, otherwise you risk going to prison if there is an injury. Yet us, our parents did not educate us this way.

This sentiment was echoed across the six regions. In an FGD in Kaolack, for instance, a mother noted:

The most important thing is to put parental authority back where it used to be. The problem is that there is a lack of respect for this authority nowadays. Human rights are partly responsible for that. The issue is that no one has the right to educate or "raise" the children of others these days without facing challenges.

In a few cases, participants in the qualitative assessment, particularly fathers, argued the rights of children, or even of women, were being elevated to such an extent that the rights of parents to raise their children as they saw fit—or even the rights of men—were being encroached upon. A father who took part in an FGD in Kolda was perhaps the most strident of the participants in expressing his views on the changes he perceived to be taking place in his society:

Today the father's authority is weakened. Today there is an adolescent crisis and also a parental crisis. We talk about children's rights, about women's rights, but there are also men's rights; a man has as much right as a woman, as much as a child. And among these three rights, it is that of man that is in last place. It is forbidden to hit a child, it is forbidden to hit a woman, it is forbidden to marry off your daughter (forcefully), and you, the man whose right in principle should be come first, you are obliged to adapt—this is what created this societal crisis.

Across the six regions, participants in the qualitative assessment saw the change in the law concerning corporal punishment for children, as well as changes taking place culturally in terms of the ubiquity of cellphones and other technology among young people, as a result of outside (Western) influence, which they often viewed with suspicion. As a village chief in Sédhiou commented:

Education has changed a lot, people now tend more towards the Western system, young people want to be free when this is not possible. Children's rights are forced upon us when it is something that does not fit with our values, our realities, our customs, our culture. Because we used to use corporal punishment as a punishment to scare the child. Today all this is banned, that's why children are like this.

There was concern among parents and community leaders who took part in the qualitative assessment that globalization and Western norms had so influenced their communities to the extent young people no longer adhered to traditional social norms. As a community leader in Matam observed, "*We have globalisation and each country has its own culture. We can see that the world is condensed in a single culture [...] It's hard to give good education to children. Children fall under influences outside of the family*." In Kaolack, a community leader complained that young people spent too much time on their phones to talk to their parents, adding, "*Young people have embraced European culture in such a way that they love this culture more than the Europeans themselves*."

As the below quote from Kaolack illustrates, participants often raised the growing use of technology among young people and the perceived influence of Western culture within the same argument when talking about the challenges their communities faced regarding adolescents and youth. The influence of media and technologies—cell phones, the Internet, social media platforms, online videos—and their hold on young people's attention and time was a strong recurrent theme across the six regions in which the

qualitative assessment took place. A father in Sédhiou observed:

> *At the beginning with our ancestors, education was based on tradition. So the children listened to their parents. But unfortunately, with modernization it is really a big problem for children's education, because the media—especially television, the Internet, radio, music and mobile phones—have had a negative influence on children's education. Indeed, with the arrival of these communication tools, children no longer have the time to listen to their parents. Every child is glued to their phone. They do not have time to chat with their parent. As a result, youth education has become a major challenge for parents.*

2. Perceptions of and Norms Around Reproductive Health Problems Adolescents/Youth face and their Consequences

2.1 Perceptions of the most Pressing Adolescent and Youth Reproductive Health Problems and their Causes

In the qualitative data collected across the six regions, the two RH problems identified as the most common among adolescents and youth in the region were early pregnancies (i.e., unplanned pregnancies occurring in young, unmarried girls) and early marriages, which many research participants defined as the marriage of girls younger than the desired age (typically 18, in cases in which participants provided clarification). Many participants in the qualitative assessment, from parents to community leaders, CSO representatives, and peer educators, described adolescents and youth as engaging in sex at younger ages than had been common in previous generations. As a religious leader (Imam) in Saint-Louis commented, "*It has become endemic, now it's rare to find young boys as well as girls who have not experienced sex before marriage*." As a result, participants in the qualitative assessment across the six regions noted the rate of unplanned pregnancies among adolescent girls and young women was a major problem; in the words of a peer educator in Matam: "*The observation I made here in Matam is early pregnancy, the rate is very high, for me it's the first [biggest] problem*." In addition to early sexual activity and pregnancy—and closely tied to these issues—the participants in the qualitative assessment identified early marriage as a major RH issue faced by adolescents and youth, particularly girls. A mother who took part in an FGD in Kaolack noted, "*One of the main problems is early marriage. Here, parents have the bad habit of giving their daughter away in marriage before she turns 18, but that's destroying her life, it's much too early.*"

Participants in the qualitative assessment across the six regions consistently pointed to a number of causes and factors they said contributed to the prevailing RH issues faced by adolescents and youth in these communities in Senegal such as early pregnancy, early marriage, STIs, etc. which are discussed further in the following sections. The roles of technology and poverty came across strongly, as did restrictive social norms and the lack of communication about sensitive issues like adolescents' and youths' RH. These issues are discussed in this section.

2.2 Perceptions of the most Pressing Adolescent and Youth Reproductive Health Problems and their Causes

Across the six regions, participants in the qualitative assessment characterized early sexuality and early pregnancy as large-scale problems among both married and unmarried adolescents and youth. There was general agreement across the assessment sites that unmarried young people had sex at greater rates and earlier ages than in the past, resulting in more unplanned pregnancies, and that this behavior ran counter to cultural norms and was frowned upon. As a mother in Kédougou observed, "*I think here early pregnancies are very frequent because you see a girl who is 14–15 years old who gets pregnant. Even if they are not given away in early marriage, it is very common here.*"

2.2.1 Perceptions Concerning the Influence of Technology on Adolescents' and Youths' exual Activity

Across the regions, technology was frequently identified by participants in the qualitative assessment as playing a major role in what many considered inappropriate or even immoral behavior on the part of adolescents and youth; in the words of one father in Kolda: "*Social networks such as WhatsApp and Facebook are what contributed a lot to the degradation of values among young people, you see them watching pornographic movies or sending dirty pictures to each other.*" The backlash against new technologies was not limited to older generations; peer educators also emphasized the role of television, cell phones, the Internet, and social media in changing the behavior of youth. In Matam, for instance, a peer educator observed, "*There is also the sexual behavior of teenagers, we talked about mobile phones especially with social networks. We must also make the parents understand that their children are not only in school, they are much more on WhatsApp, on YouTube than in the school.*" Cell phones, in particular, were blamed not only for spreading corrupting cultural influences, but also for allowing youth to facilitate encounters outside their families' supervision and for hiding their sexual activity. A father in Saint-Louis remarked,

> *My little brother over there said earlier that because of mobile phones, a girl can have a relationship with a boy until she gets pregnant without anyone knowing anything about it. You can be in the house without being aware of their communications or their outings and company.*

As this last quote indicates, participants in the qualitative assessment often saw technology as an enabling force for what they described as young people's promiscuity or libertinism, terms that many used to describe adolescents' and youths' behavior.

2.2.2 Perceptions Concerning the role of Poverty on Adolescents' and Youths' Sexual Activity

In a myriad of ways, poverty was cited as a cause and exacerbating factor for adolescents' and youths' early sexuality and early pregnancies—and AYRH problems more generally—across the six regions. Poverty affected how parents were able to take care of the sexual and reproductive needs of their children, both in terms of costs of health care and in terms of having the time to raise them in way that would prevent early sexuality. As a community leader in Kédougou observed, "*It's poverty. For example, if a parent has ten children and cannot make ends meet, it will be very difficult for them to provide for the family. They are more concerned with everyday life than really caring to educate their children.*"

Adolescents and youth who dropped out of school due to insufficient means and/or to pursue work not only lost access to information on RH, but were also described as being exposed to more risks because they were in less safe environments. A mother in Saint-Louis explained, "*Today, the general conclusion is that young people leave school very early, face enormous difficulties in finding work and engage in debauchery*." In some regions, participants in the qualitative assessment noted girls who dropped out of school were particularly vulnerable to abuse and exploitation. In Saint-Louis, participants noted many young women ended up working as domestic servants, roles that left them particularly vulnerable to GBV. One mother observed: "*When a mother with three or four children enrolls in college and cannot afford it, this can jeopardise their education. These girls will end up on the street to perform the roles of domestic servants with all the dangers that await them*." In Kédougou, where mining was described as a major industry, some participants noted some young women who could not find work were susceptible to prostitution or exploitation by men, especially foreign men engaged in mining in the region. A community leader in Kédougou observed, "*If young people are trained and cannot find jobs, most of the girls will engage in illicit practices. They are in gold mining sites in search of easy money which leads them to debauchery*." A peer educator in the region stated, "*There is also the problem of prostitution. You know that Kédougou is a border region with Guinea and Mali and there are many foreigners in the 'Dioura' [traditional gold mines]*." Prostitution was also described as common in Saint-Louis, which was said to have a large population of foreigners. One [male] peer educator said of a town in the region: "*It must be said that [this city] is a crossroads, there is a mix of people and there are many ethnic groups, the Diolas and others. There is also prostitution. There are bars, [...] Since our childhood, we hear that not far from here, there are girls who prostitute themselves for 500, 1000 francs*."

The view that some adolescent and young women had sex with men in exchange for money was not limited to Kédougou. Across the six regions, participants in the qualitative assessment observed that some poor adolescent and young girls sought out men (boyfriends or sexual partners) who could buy them things that they could not themselves afford but felt social pressure to own. A mother in Sédhiou remarked:

> *[Poverty] is a factor because young people tend to want the same thing as their peers. So it is up to parents to be vigilant especially when it comes to girls because they are most concerned with these problems. The mother must do everything to make them want nothing, be it a handbag or even the smallest pen, as long as she has the means she must do it. If not, they will look for it all outside and may get it in a way that is not desirable.*

This sentiment was strongly echoed across the other regions. A mother in Kolda, for instance, similarly lamented, "*If I cannot pay for my child's nice clothes and another has the means to do so, my child will want to have the same things as their classmate and will do things that are unpleasant*." There was a tendency by some participants in the qualitative assessment to place adolescent girls and young women at fault for early sexual encounters and early pregnancies, describing these young women as being motivated by materialism and/or libertinism rather than seeing these behaviors as existing within the broader context of poverty, puberty, and social issues like peer pressure. A community leader in Saint-Louis explained, "*What you have here, is that teenagers are getting hold of money very early. Motivated by materialism, boys use money to attract girls to have sexual relations. And sometimes, to protect them, they are called to raise their awareness. But they do not give in*." A peer educator in Kédougou, while recognizing poverty played an

important role in the sex-for-material goods phenomenon, nevertheless appeared to hold adolescent girls and young women culpable for this trend when he said: "*It's poverty because girls are very materialistic. They want to wear nice clothes while their parents cannot afford them. So, they do anything to buy clothes and men do not give money for free.*"

Other participants in the qualitative assessment saw the issue of young women being motivated to own certain material items as intertwined with their perceptions that young women dressed and behaved in ways they viewed as inappropriate and unsuitable to their culture. In these comments, it was also clear these participants held adolescent girls and young women at fault. A community leader in Matam observed, "*What is more noted is that the problems are often attributable to girls. Which is why we insist they dress more modestly*." A father in Kolda commented, "*Today the way young girls dress, they inevitably draw attention to themselves, so it is their behavior that is provocative. A woman must dress properly. When your clothing is provocative, why won't men come to you [one should not be surpised by the male attention that one might attract]?*"

2.2.3 Perceptions Concerning the Prevalence of Early Sexuality and Early Pregnancies and their Consequences

Among unmarried young people, early sexuality was often described as prevalent among both boys and girls. Explanations for this included early marriage and the perception that young people were motivated to have sex and make poor decisions; in the words of a community leader and Bajenu gox in Kaolack:

> *For early pregnancy, this is due to parents who give their children away early in marriage. There are also girls who become pregnant because of debauchery. Just yesterday I saw school girls [lingering] in the streets instead of going home. They ask passers-by to drop them off at home, this can open the way to temptations.*

A peer educator in Saint-Louis observed, "*Nowadays, all young people are sexually active. [...] Everyone is looking for fun and most have girlfriends or friends; it has become banal and commonplace within society.*" In Kolda, a peer educator observed, "*Today, from the age of twelve, all children want to discover the experience of sex*." However, as noted above, some participants in the qualitative assessment argued poor, unmarried young women were more likely to have sex with older men, such as those who worked in the mines (in Kédougou), or other wealthy men who could help them afford the things they wanted. As a peer educator in Sédhiou pointed out, "*Another cause of early pregnancy—parental poverty; when a young girl wants something, she has to ask a person from outside, and we all know how men are, they only blackmail*."

Regardless of circumstance, there was widespread agreement among many participants in the qualitative assessment across the six regions that pregnancies among adolescents and youth were extremely common and a major concern; as an SRH program manager in Sédhiou observed: " *It's as if a 15/16-year-old girl has to get pregnant, the phenomenon is so common. [...] now almost in every house there is a case like this, which is a problem, it is a very serious problem*." Many also pointed out that pregnancies seemed to be happening at earlier ages than in the past. A community leader in Kolda remarked, "*Teenagers/young people worry me a lot because now you see teenagers aged 12, 13 who get pregnant […] There are many cases of early pregnancy*."

The consequences of early pregnancies, particularly for unmarried adolescent girls and young women, could be serious. As a Bajenu gox in Kolda said,

> *There are many consequences, I am unable to mention them all: for example: girls die, they give up their studies, and their future is flouted. And when the baby is born, the baby's father cannot even buy soap for it. There are unmarried pregnant girls and the perpetrators refuse to admit [that they are the father] of the child.*

Across the six regions, one of the most cited consequences of unplanned pregnancies among adolescent girls and young women was that they dropped out of school. As one mother in Saint-Louis explained:

> *The first consequence is that all our children have failed in their studies. It does nothing but spoil the child's education. When a girl becomes pregnant or breastfeeds a baby, she will no longer be able to attend classes. The process from pregnancy to breastfeeding [weaning] will cause the child to lose two years of study.*

This echoed the statements of a mother in Kédougou, who noted that early pregnancies could cause young men to drop out of school as well:

> *If a girl becomes pregnant, after giving birth she will have to leave school and look after her baby. And that's the end of her studies. It's the same thing for a boy who makes a girl pregnant, he knows he has to take care of his child, he will have to give up school and look for work to take care of his baby.*

Aside from lost schooling, the health consequences of early pregnancies for young women and girls were also invoked by many participants in the qualitative assessment across the six regions. As an SRH program manager in Sédhiou noted of girls who were married around the age of 13: "*If she ever gets pregnant, it will be a risky pregnancy and could lead to a lot of complications such as haemorrhaging, caesarean section and even something we do not wish for, maternal mortality*." This was echoed by a peer educator in Kédougou, who said, "*With teenage pregnancy, teenage girls have many problems in childbirth and consequences such as stillbirths and maternal mortality*."

In addition to educational consequences and potential health complications, participants in the qualitative assessment spoke of the ostracization and social consequences boys/young men and girls/young women faced when the girls/young women were impregnated outside of marriage. A mother in Kédougou, for instance, observed: "*Here in the village when a girl becomes pregnant without being in the bond of marriage, the village elders will not take part in the baptismal ceremony. Women will have to manage to baptise the child [themselves]*." A father in Sédhiou explained that if a young unmarried woman became pregnant, she *"loses the opportunity to have a young boy as a husband, she is demoted to second place [as a second wife] with older men.*" A community leader in Kolda explained,

> *With regard to physical health, if the [adolescent] child has been the victim of an early pregnancy, there is a tendency to find that she has deformities. And psychologically,*

compared to society, she is a little frowned upon. Therefore, if she is not monitored, this can create psychological disturbances. In this case the community tends to reject the teenager. She is stigmatized, more or less rejected by her family, or is a burden for her family.

The potential for psychological problems was also raised by the mother in Kédougou who had talked about baptisms, who noted that the financial pressure that young men might face upon learning they had impregnated a young woman or girl could be too much for them to bear:

Imagine a young boy in the prime of his life, who does not even have the means to support himself and who makes a girl pregnant. This act and heavy burden, which weighs on his conscience, can cause psychological disorders in the person. [...] Sometimes, there are young people who die because they cannot control themselves or handle the situation.

Indeed, the financial burden of unplanned pregnancies, especially among unmarried girls and young women, was raised by many participants in the qualitative assessment. Some, like the mother quoted above, highlighted the pressure faced by the young men who had impregnated the young women. Others noted this financial burden often fell to families, who were still responsible for the young women or girls. A peer educator in Matam noted, "*When you become pregnant as a teenager, you cannot [even] buy a piece of bread…and [when] you give birth to a child, we create another problem for the family*." This became even more of a problem if the young man who impregnated the young woman did not want to take financial responsibility for his actions; as a father in Saint-Louis said, "*This is a very difficult situation, the boy will refuse to take responsibility and it will be up to the grandparents to take care of this newborn in addition to his girl*."

Among the many consequences of early sexuality and pregnancies, participants in the qualitative assessment brought up the transmission of STIs and young women's decisions to seek abortions, both of which are discussed in further detail below.

2.3 Perceptions Concerning Early Marriage

When asked about the prevailing AYRH issues in their communities, participants in the qualitative assessment across the six regions identified early marriage as one of the key problems. A number of peer educators even said the high rate of early marriage had convinced them to become involved in outreach efforts to try to change this trend; as one peer educator in Kolda said, "*The frequency of early marriages pushed me to attend the CCA to gain experience to share with the neighborhood in order to reduce misperceptions*." It is important to note that across the six regions, participants who spoke about early marriage were virtually always speaking about girls, as there seemed to be little pressure for boys to get married at an early age.

2.3.1 Perceptions Concerning the Influence of Poverty on Early Marriage

As with early sexuality and early pregnancies, poverty was one of the dominant factors contributing to early marriage, according to those who took part in the qualitative assessment in the six regions. Participants in the qualitative assessment said parents facing economic difficulties often made the

decision to marry off their daughters at an earlier age as a way to reduce the financial burden on their own households; in the words of a peer educator in Saint-Louis: "*Early marriages are often due to parents who give their daughter away in early marriage for financial reasons*." A father in a FGD in Kaolack explained, *"Early marriage exists here. This is due to the lack of means that obliges parents to give their children away very early in marriage. If these poor parents find men who can take care of their daughters, they are forced to give them away early in marriage*." A mother in Matam also described the need to reduce the financial burden on the family as a valid motivation for early marriage: "*Here, there are only poor people, and in this respect, we want girls to be married with better conditions to enable us parents to be able to disengage from costly family expenses. If the girl is between 14 and 18 years old, we give her away in marriage*." In Kaolack, a mother who took part in an FGD described mothers as being largely opposed to early marriage and aware of its potential negative impacts, but said they were unable to stop their husbands due to financial pressure:

> *Early marriage is our most serious problem. Here there are girls who are married at age 13; the body is not yet mature at that age and if the husband is ruthless he will use this little body until exhaustion. It is only the mother of the child who will suffer, the fathers must stop with this practice, we mothers do not agree but we are obliged to accept it, to give in. Life is expensive, and these are additional expenses if I have to buy medicine for my daughter at 5,000 francs while I do not even have 1,000 francs, this poses a problem, we have no income, our peanuts are very difficult to sell at the moment and at a very bad price.*

Many participants in the qualitative assessment pointed out that wealthy suitors were extremely attractive to parents and could cause them to make decisions they might not make under different circumstances. A community leader in Matam observed, "*It is found that parents give their daughters away in forced marriages. We see girls who are in their final year at school but as soon as the parents see an emigrant who has money they give the girl away in marriage*." A peer educator disapprovingly described the same phenomenon in Kolda: "*With regard to early marriages, I will say that the main causes are parents. In a situation of poverty, they are going to marry off their children aged 15 to 18 to rich people and this is what is deplorable*." In Sédhiou, a father used a hypoethical scenario to explain how poverty could motivate a parent who was otherwise opposed to early marriage to give away a daughter in marriage at an early age:

> *Everywhere there is also poverty, [...] you have a young girl, under 20, someone comes from Spain with their millions in front of you to ask you for your daughter, [the father] will use any excuse [he] can for this marriage to happen […but] everyone knows that there is a hidden interest, that is, to [get] money [...]. Giving their daughter away in an early marriage is putting her at risk. I am neither a medic nor a doctor, but I know that at this age the girl's reproductive organs are not fully developed, and this could be dangerous for her body and even cause death.*

2.3.2 The Influence Social Norms Appeared to have on Early Marriage

Across the six regions, social norms appeared be an important factor for early marriages. In particular, sex outside of marriage was deeply frowned upon and said to be embarrassing and shameful for not only those who engaged in it, but also for their entire families. Participants in the qualitative assessment described the stigma against unmarried youth having sex (and potentially ending up pregnant) as a major

driving force behind early marriage. A father in Sédhiou remarked, "*Parents want to prevent their daughter bringing shame on them, which is why girls are given away in marriage when they are not old enough. They want to prevent the girl from bringing shame on her family*." This sentiment was echoed by a community leader in Kaolack, who noted, "*It's the parents' fear, there is a category of parents for whom it would shameful should their daughter be pregnant, that's why they give away the girls very early in marriage*." A father in Kolda noted his desire to avoid a daughter's pregnancy outside of marriage would outweigh consideration of her age: "*If a man came to ask for my daughter's hand I would grant it without considering whether it is early or not, because the parent is afraid that his daughter becomes pregnant illegally (out of wedlock), there is this problem here*." Likewise, a mother in Sédhiou noted she would prefer to marry off her daughter at a young age than have her bring shame upon the family, even though she would have preferred a different future for her.

> *If nowadays we notice high numbers of the early marriages [„„], to terminate the studies of a young girl and to force her to marry, this is because we want to avoid shame and that she brings us problems. And really it is undesirable because you cannot put your child in school from the IC [Introductory Course], buy everything you need to eat, drink, or dress and pay for schooling at the private school – all this under the care of the mother who has only a small trading stall, for a day to come when […] the girl does her a disservice. So it is better to give her away in marriage.*

As the above quotes concerning early marriage and family honor illustrate, some parents and other members of the community who took part in the qualitative assessment held adolescent girls and young women responsible for getting pregnant as minors, describing them as willful or impossible to control. In the words of a peer educator in Kolda: "*For early marriages, I can say that they originate from the parents and us young girls. Since girls are becoming more and more out of control, parents take advantage of young children (12 to 13 years) and give them away in marriage to prevent the irreparable from happening*." Moreover, the mother in Sédhiou who argued that girls were not taking school seriously and were therefore better off getting married was not alone in holding this view. A father in Kolda complained that girls did not take school seriously despite their parents' investment in their education, declaring, "*That's why me if someone comes forward to marry my daughter, whether it's when she has the BFEM [middle school certificate], or the BAC [secondary school diploma], I will marry her off because what girls do, the way they behave, is degrading and it taints the respectability of the family*." A community leader in Kaolack similarly argued only "serious girls" should be allowed to stay in school, whereas those who misbehaved were better off getting married before something bad happened to them, even if this put their health at risk in terms of pregnancies resulting from early marriages:

> *It depends, because for a girl who is obviously going to deviate from the right path, it is necessary to marry her off early so as not to lose her, but the misfortune in early marriage is early pregnancy, because the body is not prepared for a foetus [pregnancy]. So, the best thing is to leave her in school, until she is mature enough to give her away in marriage. But this is for serious girls, but when they head straight for the flood, you have to intercept them in time.*

While the stigma against sex and pregnancy outside marriage appeared to be universal across the six regions, participants in the qualitative assessment also noted there were some cultural contours to

trends and social norms concerning early marriage, pregnancies, and other AYRH issues. An SRH program manager in Kédougou, for instance, said the young people most affected by AYRH problems tended to be young women aged 16–20 years who belonged to the Peulh (Pular) ethnic group:

> *They are, most of the time, married people and more particularly teenagers/young people married to adults. They are sometimes, a second or third wife. Most marriages bring together two teenagers-youngsters where the husband is 24 years old, the wife 14, 15 or 16 years old at most. This phenomenon is very common among our Peulh [Pular] parents.*

SRH program managers interviewed in Kolda similarly observed that adolescents and youth of the Pular ethnic group faced more AYRH issues, and one of them added a second ethnic group to this category: *"Married and unmarried girls aged between 10 and 19 [years], belonging to the Peulh and Sarakholé ethnic groups, are the categories of adolescent/young girls who are most affected by SRH problems*."

A manager in Sédhiou said that he had observed differences in how long adolescent girls were kept in school:

> *Among the Mandingo, if girls go to school, it's just up to CM2 [Middle Course]. Those who pursue their [secondary] studies do so until the third [year of] secondary [school], after which they come home. Which means that there are not many intellectual [well educated] girls coming out of Sédhiou.*

Another manager in Sédhiou noted various ethnic groups tended to promulgate attitudes that could hamper progress on AYRH issues:

> *We were all moulded into a society be it Mandingo, Diola or Wolof…into a very conservative society, we were taught the ways to conduct ourselves. For example, you should not touch a pregnant woman [...]. Sometimes religion [promotes] certain sociocultural values which result in 'blocking' factors. Factors that block evolution, like […] activities related to early marriage, excision, early pregnancy. This is why I say to myself that I give my daughter in marriage at the age of 15, 16 years, because otherwise she will get pregnant. Even if sometimes we can find favourable factors in our customs, they are few.*

In contrast, some participants in the qualitative assessment said the perceived rise in RH problems faced by adolescents and youth were a direct result of Western or other outside influences, arguing cell phones and the Internet had allowed young people to access pornography or become otherwise corrupted by this culture. Some even argued the imposition of Western norms through campaigns to delay marriage had conversely resulted in more early pregnancies by encouraging adolescent girls to have sex outside of marriage; as a father in Kolda remarked:

> *The traditional education inherited from our ancestors has disappeared. Today modern Western education has come to tell us that this is not how we should educate our children, we should not marry off a girl at age 13 years old [...]. With traditional education, the girl kept her virginity until she got married and brought pride to her parents, but today we are*

told that this way of educating is no longer consistent, we must adopt the modern Western system, i.e. to educate girls and not to give them away in marriage before they are 20 years old, and with that as I said, they will have already had 2 pregnancies.

This father's argument had parallels to observations made by an SRH program manager in Matam, who noted having adolescent girls marry at an early age, but delay consummation until after maturation used to be commonplace:

We raise awareness among parents. They say that the Peulh marry very early, but what was done before by the Peulhs was that the girl married early but she was there with the mother-in-law. She grew up [so closely] with the mother-in-law to the point that she could [even pass as] the daughter of the mother-in-law until she became mature. But this is no longer the case today, people get married early, get pregnant and these pregnancies are often difficult. A girl who is pregnant at a very young age and who does not [stay with her mother-in-law] anymore, this becomes very dangerous.

2.3.3 Perceptions Concerning the Prevalence of Early Marriage and its Consequences

Regardless of the causes, there was widespread agreement among the participants in the qualitative assessment across the six regions that early marriage was a major AYRH issue. A peer educator in Kédougou noted, "*We still see girls under 16 who are married. Despite the efforts, it is the parents who are ignorant and continue to do this without considering the consequences of early marriages of 12, 13-year olds*." A community leader in Matam noted,

Early marriage is one of the problems of young people's sexual and reproductive health, because it is common to see in [a pastoral or agrarian zone] that a girl under the age of eighteen is given away in marriage. Girls aged between 15 years and 16 years are given away in marriage, this is a problem because the girl is not mature enough to get married.

While there was agreement that the phenomenon was widespread, some participants voiced their approval of early marriage, particularly as a way to safeguard their financial security and/or their families' honor. However, a larger share of the participants in the qualitative assessment expressed their personal opposition to early marriage. In Kolda, a father remarked, "*No parent would want their child to be married at the age of 12-13, at this age it is preferable that they study*." This sentiment was echoed by a mother in the same region, who said:

Now we prefer to invest in children's education rather than to give them away in marriage at a young age (12, 13 or 14 years), because that will only cause them problems in the future. She may become pregnant while her body is not yet fit to handle this condition, and this will create problems for her. I also tell them to behave and avoid boys, because if they get pregnant, they bring shame to their parents.

As this mother noted, negative health outcomes, particularly in terms of early pregnancies, were a key negative consequence participants identified with respect to early marriage. A father in Saint-Louis said

of the health dangers adolescent girls might face: "*Those who have difficulties have them as a result of early marriages. Because to marry a 13-, 14-year-old girl who gets pregnant, it is certain that she will have problems during delivery*." An SRH program manager in Matam said it was important to educate community members about the potential hazards of early marriage:

> *The girl gets married, [gets pregnant, and] she dies because her organs are this, or that [not mature]. In addition, they do not make antenatal health care visits in remote places. So, all of this means that today we are educating them on these aspects. When the girl's organs are not mature, this could create problems.*

A few parents also pointed to the potential psychological consequences of early marriage, claiming marriage requires emotional and psychological maturity. As a mother in Saint-Louis explained, "*Usually we say that we can marry a girl from the age of 18 years. But we wait until the age of 20, because at that time, they will be ready for marriage. Because marriage is not easy. That's why there is no early marriage*." A peer educator in Kédougou said a classmate who had been forced to marry at an early age had committed suicide.

In addition to the potential health consequences, many participants in the qualitative assessment observed that early marriage typically resulted in adolescent girls dropping out of school. A community leader in Sédhiou noted, "*As an immediate consequence is that the girl will not be able to continue to go to school when pregnant. It is the same for early marriages, even if for the latter case the husband says she will continue these studies, the observation [reality] is that once the marriage is celebrated, the girl no longer goes to school*." A peer educator in Kédougou similarly remarked, "*The stubbornness of parents to give their daughter away in early marriage…still persists [...]. I would say that this is unfavourable, especially for the girl who ends up dropping out of school and who will not know how to do more*."

In the region of Matam, a number of participants brought up divorce as another potential consequence of early marriage. A representative of an organization that implemented sensitization activities for young women in schools explained that young women who were married early, often divorced later: "*We found that most girls in high school are divorced, they get married early, and they divorce early.*"

3. Sexual behavior and use of FP among adolescents and youth in the communitites

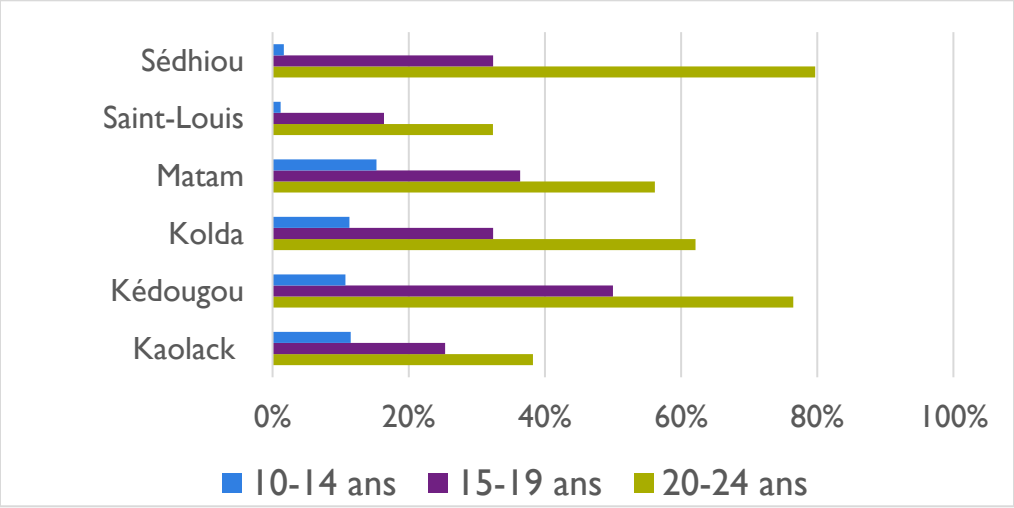
Information on sexual experience was collected from adolescents and youth to highlight their RH needs and to inform existing programs to better meet their health needs. For example, findings showing a significant percentage of youth, aged 10–14 years, as sexually active might encourage policymakers to consider including information about the consequences of unprotected sex in RH education materials for this age group. This section describes the self-reported sexual experiences of youth aged 10–24 years. Table 15 depicts data for males (only) by region, and Table 16 for females (only) by region. Graph 2 depicts the percentage of male youth who have ever had sex by age group and region, while Graph 3 shows the same information for female youth.

Ever heard of sex: Overall, males aged 10–14 years were more likely to report hearing about sex or knowing someone who has had sex than females aged 10–14 years. About 39.7 % of male adolescents

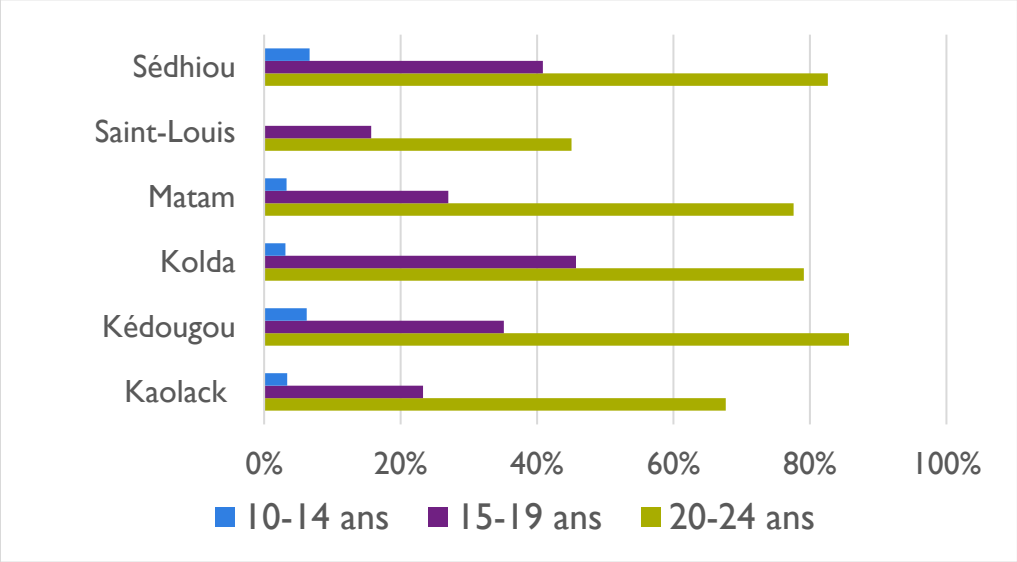
and 39.1% of female adolescents aged 10–14 have heard or talked about sex. The percentage of male adolescents aged 10–14 who have heard or talked about sex ranges from 20 % in Sédhiou to 67.2 % in Kaolack. Among females aged 10–14, the percentage reporting to have heard or talked about sex ranges from 25 % in Kédougou and Kolda (each) to 64.4 % in Kaolack. Among youth aged 10–14 years who have ever heard of sex, 43.3 % of males (n=141) and 21.4 % of females (n=363) reported to know someone of their age who has had sex. Again, there are regional variations with the percentage indicating if the respondents knew someone who has had sex, ranging from 5.0 % in Saint-Louis to 69.2% in Kédougou for males, and 10.7 % in Matam to 50 % in Kédougou for females.

Ever had sex: All youth who had ever heard of sex were also asked if they had ever had sex. As expected, the likelihood of sexual initiation by youth increased with age. Among all males aged 10–14 years, 7.9% reported to have had sex at the time of the survey, with the percentage increasing among youth aged 15–19 years and 20–24 years (29.3and 53.7%, respectively). Males aged 10–14 years in Saint-Louis and Sédhiou were least likely to report ever having sex (1.2% and 1.7%, respectively) while those aged 20–24 years in Kédougou and Saint-Louis were most likely to report ever having sex (76.5% and 79.7 %, respectively). Among females, the percent initiating sexual activity increased from 4.7% among females aged 10-14 years, to 18.6 % among females 15–19 years, up to 26.9 % among females aged 20–24 years. Sexual initiation (ever had sex) among girls 10–14 years ranged from 0.0 % in Matam to 6.7% in Sédhiou. Nearly half (49.3%) of female youth aged 20–24 years in Kédougou reported ever having sex.

Graph 2: Percent of Male Youth who have ever had sex, by age Group and Region (n=1204)



Graph 3: Percent of Female Youth who have ever had sex, by age Group and Region (n=1196)



Median age of sexual debut by urban/rural residence is also presented in Table 15 (males) and Table 16 (females). The median age of sexual debut is about 16 years old for males and 17 years old for female respondents who have ever had sex. Males in rural areas reported having first sex at a slightly earlier age than males in urban areas (15.9 years vs. 16.2 years) as did females (16.5 years vs. 17.8 years).

While 76.5 % of sexually experienced male respondents reported to have partners at first sex who were either younger or of the same age, only 11.3 % of female respondents reported sexual partners who were younger or of the same age; 87.3 % of females reported that their sexual partners were older than them.

For both male and female respondents, the percentages reporting sexual partners who are younger, of the same age, or older than them vary significantly by region. The patterns reflect the traditional practice of males wanting to have a sexual relationship with females who are younger or of the same age and females wanting to have a relationship with older men or males of the same age. An exception was found for males reporting having older sexual partners at first sex; in Kaolack and Matam regions, 39.2% and 28.2% of males (respectively) reported their sexual partner at first sex was older than them.

Among those who reported their partners were either younger or older than them, 9.3% of males and 38 % of females reported their partners were five or more years older than them. In addition, 29.7 % of females who have ever had sex reported their first sexual partners were 10 years or older than them. A wide age gap such as this is important to highlight, as it may indicate a relatively wide prevalence of female child marriage or other relationships with significant power imbalances between adolescent women and adult men.

Sexual Experience in the 12 Months Preceding the Survey: Tables 15 and 16 also show the percentage of community youth survey respondents who reported having had sex in the 12 months preceding the survey, as well as when they last had sex. Sexually active female youth aged 20–24 years reported higher levels of sexual activity in the 12 months preceding the survey than their male counterparts. For males, the percentage having had sex in the 12 months preceding the survey ranged from 5.4% for boys aged 10–14 years, 18.7 % for males aged 15–19 years, to 34 % among males aged 20–24 years. For female youth, the percentage ranged 2.5% among 10–14 years, 23.8% among females aged 15–19 years, and 55.2% for females aged 20–24 years. Most sexually experienced youth reported they had not recently had sex; only 21.8% of males and 41.7 of females reported having sex in the past one month.

Table 15 : Sexual behavoir of Male Youth

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percent of male youth 10–14 years who have ever heard about or talked about sex	67.2%	46.4%	43.5%	47.5%	23.5%	20.0%	39.7%
Number of cases	61	28	62	59	85	60	355
Know people of same age having sex (10–14 years only who have ever heard of sex)	61.0%	69.2%	37.0%	46.4%	5.0%	25.0%	43.3%
Number of cases	41	13	27	28	20	12	141
Percentage of adolescents/ young people who report having already had sexual relations (by age):							
10–14 years	11.5%	10.7%	11.3%	15.3%	1.2%	1.7%	7.9%
Number of cases	61	28	62	59	85	60	355
15–19 years	25.4%	50.0%	32.4%	36.4%	16.4%	32.4%	29.3%
Number of cases	71	34	71	77	110	71	434
20–24 years	38.2%	76.5%	62.1%	56.2%	32.4%	79.7%	53.7%
Number of cases	68	34	66	73	105	69	415
Median age at first sex by residence:							
Rural	14.0	16.1	16.1	15.4	16.0	16.7	15.9
Number of cases	21	21	49	63	20	62	236
Uban/Peri-Urban	15.4	15.5	16.0	15.0	17.4	17.0	16.2
Number of cases	29	20	21	9	32	17	128
Percent of sexually experienced whose:							
Partner was the same age at first sex	43.1%	56.5%	60.6%	47.4%	43.4%	70.9%	54.8%
Partner was younger at first sex	17.6%	21.7%	25.4%	21.8%	34.0%	12.7%	21.7%
Partner was older at first sex	39.2%	21.7%	11.3%	28.2%	20.8%	16.5%	22.2%
Age of first sexual partner is unknown or respondent refused to say	0.0%	0.0%	2.8%	2.6%	1.9%	0.0%	1.4%
Number of cases	51	46	71	78	53	79	378
Partner was 5 years older or greater at first sex	5.9%	6.5%	5.6%	12.8%	9.4%	12.7%	9.3%
Number of cases	51	46	71	78	53	79	378
Percentage of adolescents/ young people who say they have been							

sexually active in the past 12 months (by age, all respondents):							
10–14 years	6.6%	10.7%	6.5%	10.2%	1.2%	1.7%	5.4%
Number of cases	61	28	62	59	85	60	355
15–19 years	15.5%	41.2%	15.5%	22.1%	10.0%	23.9%	18.7%
Number of cases	71	34	71	77	110	71	434
20–24 years	22.1%	47.1%	33.3%	37.0%	20.0%	58.0%	34.0%
Number of cases	68	34	66	73	105	69	415
When last had sex (among those who have ever had sex):							
Within the past one week	3.9%	17.4%	11.3%	6.4%	15.4%	5.1%	9.3%
1–4 weeks ago,	13.7%	13.0%	14.1%	6.4%	11.5%	16.5%	12.5%
1–11 months ago,	33.3%	41.3%	25.4%	51.3%	32.7%	50.6%	40.1%
More than one year ago	41.2%	28.3%	47.9%	35.9%	38.5%	26.6%	36.3%
Don't know/can't remember	7.8%	0.0%	1.4%	0.0%	1.9%	1.3%	1.9%
Number of cases	51	46	71	78	52	79	377

Table 16: Sexual Behavior of Female Youth

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Ever heard about or talked about sex (10-14 years only)	64.4%	25.0%	25.0%	45.9%	40.2%	28.3%	39.1%
Number of cases	59	32	64	61	87	60	363
Know people of same age having sex (10-14 years only, among those who have ever heard about sex)	28.9%	50.0%	37.5%	10.7%	11.8%	35.3%	24.1%
Number of cases	38	8	16	28	34	17	141
Percentage of adolescent/young girls who report having already had sexual relations (by age):							
10-14 ans	3.4%	6.3%	3.1%	3.3%	0.0%	6.7%	3.3%
Number of cases	59	32	64	61	87	60	363
15-19 ans	23.3%	35.1%	45.7%	27.0%	15.7%	40.8%	29.8%
Number of cases	73	37	70	63	102	71	416
20-24 ans	67.6%	85.7%	79.1%	77.6%	45.0%	82.6%	69.1%
Number of cases	68	35	67	67	111	69	417
Median age at first sex by residence:							
Rural	16.76	16.67	15.80	16.34	18.14	16.50	16.54
Number of cases	33	30	70	64	35	74	306
Uban/Peri-Urban	17.91	17.20	17.73	17.29	18.00	18.15	17.80
Number of cases	32	15	15	7	29	13	111

Percent of sexually experienced whose:							
Partner was the same age at first sex	4.6%	8.9%	8.0%	2.8%	4.5%	25.6%	9.9%
Partner was younger at first sex	0.0%	2.2%	0.0%	0.0%	4.5%	2.2%	1.4%
Partner was older at first sex	95.4%	86.7%	90.8%	95.8%	89.4%	70.0%	87.3%
Age of first sexual partner is unknown or respondent refused to say	0.0%	2.2%	1.1%	1.4%	1.5%	2.2%	1.4%
Number of cases	65	45	87	71	66	90	424
Partner was 5–10 years older at first sex	38.5%	48.9%	35.6%	35.2%	39.4%	35.6%	38.0%
Number of cases	65	45	87	71	66	90	424
Partner was >10 years older at first sex	35.4%	17.8%	35.6%	47.9%	16.7%	21.1%	29.7%
Number of cases	65	45	87	71	66	90	424
Percentage of adolescent/young girls who say they have been sexually active in the last 12 months (by age):							
10–14 years	1.7%	6.3%	1.6%	3.3%	0.0%	5.0%	2.5%
Number of cases	59	32	64	61	87	60	363
15–19 years	23.3%	29.7%	32.9%	15.9%	14.7%	32.4%	23.8%
Number of cases	73	37	70	63	102	71	416
20–24 years	61.8%	54.3%	55.2%	58.2%	37.8%	73.9%	55.2%
Number of cases	68	35	67	67	111	69	417
When last had sex (among those who have ever had sex):							
Within the past one week	47.7%	20.0%	24.1%	16.9%	35.9%	26.7%	28.4%
1–4 weeks ago,	13.8%	8.9%	14.9%	14.1%	18.8%	8.9%	13.3%
1–11 months ago,	29.2%	37.8%	26.4%	40.8%	23.4%	50.0%	35.1%
More than one year ago	7.7%	28.9%	29.9%	28.2%	14.1%	14.4%	20.4%
Don't know/can't remember	1.5%	4.4%	4.6%	0.0%	7.8%	0.0%	2.8%
Number of cases	65	45	87	71	64	90	422

Pregnancy and Childbearing

Information was also collected on pregnancy and childbearing experiences of sexually active respondents or their partners (in the case of males). Table 17 shows data on the pregnancy and childbearing experiences of the partners of male respondents and Table 18 shows data on the pregnancy and childbearing experiences of female respondents. It should be noted that very few or no males aged 10-14 years or 15–19 years reported their sexual partners had ever been pregnant or ever given birth; thus, these findings for these two age groups of males (10–14 and 15–19 years) are combined in Table 17.

Only 2.5 % of all male respondents reported their sexual partners have ever been pregnant. The percentage of male youth reporting that their partners have ever been pregnant increases slightly with age (1.0 and 5.3% among the 10–19 and 20–24-year-old youth, respectively), with little variation across regions. Among **all** female respondents, 23.7% reported having been pregnant. The percentage reporting having ever been pregnant also increases with age: 0.3% (one respondent) of all females aged 10–14 years, 14.7% of all 15–19-year-olds, and 53% of all 20–24-year old female youth, respectively); this percentage also varies across regions (from 15.7% in Saint-Louis to 31.7% in Kédougou).

Tables 17 and 18 also show the percent of adolescents/youth who have ever had sex and who have had at least one child. This analysis shows that 4.5% of males aged 10–19 years and 9.4% of males 20–24 years have ever had a child. These results are also presented by marital status: 1.2% of never married sexually active male youth have had a child and 45.3% of ever married male youth have had at least one child. Among sexually active females, 8.3% (one respondent) aged 10–14 years, 46.8% aged 15–19 years, and 75.7% of youth aged 20–24 have had at least one child. By marital status, 24.6 % of never married youth have had at least one child, and 72.2% of married female adolescents/youth have had at least one child.

Among youth who have ever had a child, 88.5% of males and 56% of females reported having one currently living child at the time of interview. One-third (33%) of females with children have two currently living children. Among sexually active youth, 1.1% of males and 8.5% of females report either currently having a partner who is pregnant or being pregnant. While nearly all youth report wishing to have a (another) child (96.6% of males and 96.9% of females), most do not wish to have a child in the near future: 73.5% of males and 71.2% of females wish to wait at least two years (if not longer) to have a child.

Currently pregnant female youth were asked if their pregnancy was desired at the time they became pregnant. This analysis shows that 41.7% of respondents reported their current pregnancy was unwanted; nearly all reported they wished to wait until a later time before becoming pregnant. This finding reinforces the need to make FP accessible and feasible to adolescents to avoid unwanted pregnancies.

Regarding the ideal numbers of children for men and women in their communities, male and female youth expressed social norms that reflect a value for high fertility levels. Only 28% of male youth and 31.1% of female youth reported that women should have four or fewer children; both male and female youth revealed women should have five or six children and men should have seven to ten children in their lifetimes (reflects the modal percentage in both cases).

Both male and female youth would like men to have their first child at an older age than women. Both male and female youth suggested 18–19 years as the mean ideal age at first birth for women, and an ideal range of 20–24 years for men. The ranges of ideal ages for a first child vary by region but do not vary greatly between male and female youth.

Table 17: Pregnancy and Childbearing Experience of Male Youth, 10-24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percent of all male youth whose partners have ever been pregnant (by age):							
10–19 years	0.0%	1.6%	1.5%	2.2%	0.5%	0.8%	1.0%
Number of cases	132	62	133	136	195	131	789
20–24 years	2.9%	11.8%	12.1%	2.7%	2.9%	4.3%	5.3%
Number of cases	68	34	66	73	105	69	415
All Males	1.0%	5.2%	5.0%	2.4%	1.3%	2.0%	2.5%
Number of cases	200	96	199	209	300	200	1204
Percentage of sexually active adolescents/ young people who report having had at least one child:							
10–19 years	0.0%	5.0%	6.7%	5.4%	5.3%	4.2%	4.5%
Number of cases	25	20	30	37	19	24	155
20–24 years	7.7%	15.4%	19.5%	4.9%	5.9%	5.5%	9.4%
Number of cases	26	26	41	41	34	55	223
Never married	0.0%	2.6%	0.0%	0.0%	0.0%	4.0%	1.2%
Number of cases	46	38	53	66	47	75	325
Ever married/in union	40.0%	50.0%	55.6%	33.3%	50.0%	25.0%	45.3%
Number of cases	5	8	18	12	6	4	53
Number of **living** children (among those who have ever had a child):							
1	100.0%	80.0%	80.0%	100.0%	100.0%	100.0%	88.5%
2	0.0%	20.0%	10.0%	0.0%	0.0%	0.0%	7.7%
3 or more	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	3.8%
Number of cases	2	5	10	2	3	4	26
Percentage of sexually active adolescents/ young people who report that their partner is currently pregnant	0.0%	0.0%	0.0%	4.0%	1.9%	0.0%	1.1%
Number of cases	51	46	71	75	53	79	375
Percentage of adolescents/youth who would like to have (a) another child	99.5%	96.9%	96.5%	99.5%	94.3%	94.0%	96.6%
Number of cases	200	96	199	209	300	200	1204
Percentage of adolescents/youth who would like to wait at least two years to have a (another) child	75.5%	74.0%	69.8%	72.2%	70.7%	80.5%	73.5%

Number of cases	200	96	199	209	300	200	1204
Number of children a woman in this community should have:							
One or two children	2.5%	11.5%	5.5%	2.4%	2.0%	6.5%	4.2%
Three or four children	16.5%	22.9%	27.1%	23.0%	28.3%	22.5%	23.8%
Five or six children	33.0%	29.2%	30.2%	31.6%	20.7%	24.5%	27.5%
Seven or more children	26.5%	11.5%	16.1%	23.4%	20.0%	15.0%	19.5%
Don't Know	21.5%	25.0%	20.6%	19.6%	29.0%	31.5%	24.8%
Number of cases	200	96	199	209	300	200	1204
Mean number of children a man in this community should have:							
One or two children	4.0%	8.3%	6.5%	.5%	3.3%	4.5%	4.1%
Three or four children	11.5%	18.8%	23.6%	21.1%	19.0%	19.0%	18.9%
Five or six children	24.5%	22.9%	19.6%	23.4%	17.7%	17.0%	20.4%
Seven to ten children	27.5%	19.8%	22.1%	31.1%	22.0%	16.5%	23.4%
More than ten children	13.5%	4.2%	6.5%	7.2%	7.7%	10.5%	8.6%
Don't Know	19.0%	26.0%	21.6%	16.7%	30.3%	32.5%	24.7%
Number of cases	200	96	199	209	300	200	1204
Mean age at which a woman should have her first child:							
Aged 10–14 years	1.0%	4.2%	3.5%	3.3%	.7%	1.0%	2.0%
Aged 15–17 years	9.5%	18.8%	17.6%	20.6%	7.7%	10.0%	13.1%
Aged 18–19 years	24.5%	35.4%	34.7%	29.2%	26.7%	51.0%	32.8%
Aged 20–24 years	33.5%	19.8%	16.6%	24.4%	28.7%	20.5%	24.7%
Aged 25 years or more	14.5%	3.1%	5.0%	3.8%	9.3%	3.0%	7.0%
Don't Know	17.0%	18.8%	22.6%	18.7%	27.0%	14.5%	20.4%
Number of cases	200	96	199	209	300	200	1204
Mean age at which a man should have his first child:							
Aged 10–17 years	4.5%	2.1%	3.0%	4.8%	1.3%	3.0%	3.1%
Aged 18–19 years	15.5%	15.6%	23.1%	22.5%	10.0%	29.0%	18.9%
Aged 20–24 years	29.5%	36.5%	35.2%	36.4%	19.7%	37.0%	31.0%
Aged 25–29 years	25.5%	19.8%	12.6%	16.3%	31.7%	14.0%	20.9%
Aged 30 years or more	9.0%	5.2%	5.5%	2.9%	12.0%	1.5%	6.6%
Don't Know	16.0%	20.8%	20.6%	17.2%	25.3%	15.5%	19.6%
Number of cases	200	96	199	209	300	200	1204

Table 18: Pregnancy and Childbearing Experience of Female Youth, 10-24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Pourcentage d'adolescentes/jeunes femmes qui rapportent avoir été enceintes:							
10–14 years	0.0%	0.0%	1.6% (1)	0.0%	0.0%	0.0%	0.3% (1)
Number of cases	57	30	62	59	87	56	363
15–19 years	12.3%	21.6%	24.3%	14.3%	7.8%	14.1%	14.7%
Number of cases	73	37	70	63	102	71	416
20–24 years	57.4%	71.4%	53.7%	62.7%	35.1%	58.0%	53.0%
Number of cases	68	35	67	67	111	69	417
All Female	24.0%	31.7%	26.9%	26.7%	15.7%	25.0%	23.7%
Number of cases	200	104	201	191	300	200	1196
Percentage of sexually active adolescents/ young people who report having had at least one child:							
10–14 years	0.0%	0.0%	50.0% (1)	0.0%	--	0.0%	8.3% (1)
Number of cases	2	2	2	2		4	12
15–19 years	35.3%	61.5%	53.1%	52.9%	50.0%	34.5%	46.8%
Number of cases	17	13	32	17	16	29	124
20–24 years	52.8%	51.8%	46.8%	47.3%	48.8%	38.4%	46.8%
Number of cases	72	56	94	93	84	112	511
Never married	25.0%	27.3%	0.0%	100.0%	0.0%	25.8%	24.6%
Number of cases	4	11	8	3	4	31	61
Ever married/in union	67.2%	88.2%	68.4%	70.6%	75.8%	71.2%	72.2%
Number of cases	61	34	79	68	62	59	363
Number of **living** children (among those who have ever had a child):							
1	57.1%	53.1%	55.8%	58.8%	60.9%	50.0%	56.0%
2	28.6%	37.5%	32.7%	35.3%	32.6%	32.0%	33.0%
3 or more	14.3%	9.4%	11.5%	5.9%	6.5%	18.0%	11.0%
Number of cases	42	32	52	51	46	50	273
Youngest child is less than one year old	35.7%	34.4%	36.5%	27.5%	28.3%	42.0%	34.1%
Number of cases	42	32	52	51	46	50	273
Percentage of sexually active adolescent girls/ young women who currently report being pregnant	15.4%	4.5%	8.0%	11.4%	1.5%	8.9%	8.5%
Number of cases	65	44	87	70	66	90	422

Percentage of adolescent girls (who are currently pregnant) who reported having an unwanted pregnancy	60.0%	0.0%	14.3%	87.5%	0.0%	12.5%	41.7%
Number of cases	10	2	7	8	1	8	36
Percentage of adolescents/youth who would like to have another child	98.5%	95.2%	97.5%	97.9%	94.7%	98.0%	96.9%
Number of cases	200	104	201	191	300	200	1196
Percentage of adolescents/youth who would like to wait at least two years to have a (another) child	76.5%	63.5%	63.2%	73.8%	68.0%	80.0%	71.2%
Number of cases	200	104	201	191	300	200	1196
Number of children a woman in this community should have:							
One or two children	3.0%	3.8%	2.0%	4.7%	6.7%	4.0%	4.3%
Three or four children	26.0%	19.2%	25.4%	31.9%	29.3%	24.5%	26.8%
Five or six children	37.5%	37.5%	31.3%	37.2%	28.3%	26.0%	32.2%
Seven or more children	21.0%	7.7%	16.4%	16.8%	13.7%	15.5%	15.6%
Don't Know	12.5%	31.7%	24.9%	9.4%	22.0%	30.0%	21.1%
Number of cases	200	104	201	191	300	200	1196
Mean number of children a man in this community should have:							
One or two children	3.0%	3.8%	2.0%	1.0%	3.3%	3.0%	2.7%
Three or four children	12.0%	8.7%	12.9%	13.1%	17.3%	12.0%	13.4%
Five or six children	15.5%	26.0%	19.4%	24.1%	17.7%	15.5%	19.0%
Seven to ten children	26.0%	12.5%	20.4%	29.8%	19.3%	21.5%	22.1%
More than ten children	13.0%	6.7%	9.0%	9.4%	5.3%	10.5%	8.9%
Don't Know	30.5%	42.3%	36.3%	22.5%	37.0%	37.5%	34.0%
Number of cases	200	104	201	191	300	200	1196
Mean age at which a woman should have her first child:							
Aged 10–14 years	.5%	2.9%	4.5%	1.0%	.7%	1.5%	1.7%
Aged 15–17 years	8.0%	24.0%	17.4%	19.4%	9.3%	15.5%	14.4%
Aged 18–19 years	25.0%	33.7%	32.8%	24.6%	19.7%	53.0%	30.4%
Aged 20–24 years	33.5%	18.3%	18.9%	32.5%	33.7%	18.0%	27.0%
Aged 25 years or more	13.5%	3.8%	4.0%	4.2%	13.7%	.5%	7.4%
Don't Know	19.5%	17.3%	22.4%	18.3%	23.0%	11.5%	19.1%
Number of cases	200	104	201	191	300	200	1196
Mean age at which a man should have his first child:							
Aged 10–17 years	4.0%	1.9%	4.0%	5.2%	3.3%	4.5%	3.9%

Aged 18–19 years	9.5%	11.5%	14.9%	13.6%	10.3%	26.5%	14.3%
Aged 20–24 years	30.5%	36.5%	33.3%	33.5%	17.3%	43.5%	30.9%
Aged 25–29 years	19.0%	9.6%	10.4%	14.7%	23.0%	7.5%	15.1%
Aged 30 years or more	11.0%	9.6%	9.0%	8.4%	12.7%	1.5%	8.9%
Don't Know	26.0%	30.8%	28.4%	24.6%	33.3%	16.5%	26.8%
Number of cases	200	104	201	191	300	200	1196

Ever and Recent use of Contraception

Tables 19 and 20 display findings related to ever and recent use of contraception among male and female youth. As with Table 17 for males, it should be noted that very few or no male or female youth aged 10–14 years or 15–19 years reported they or their sexual partners had ever used a method of FP or used a method at last sex. As shown in these tables, many sexually experienced youth (61.4 % of males and 32.1% of females) reported to have ever used a contraceptive method. Percentages of youth reporting use of contraception varied by region from 47.4% in Matam to 86.1% in Sédhiou for males, and from 12.7% in Matam to 48.5 % in Saint-Louis for females. The dominant contraceptive method reported to have been used by males is the male condom (96.1%) and for females, the injectable (46.3%).

Use at last sex among youth is slightly lower than ever use: 55.1% of sexually experienced males and 18.9% of sexually experienced females used a method at last sex. Both males and females who reported using FP at last sex were most likely to have used a male condom (99% of males and 48.1% of females). Given that most youth expressed a preference to wait at least two years until they become pregnant with a child and given that nearly half of currently pregnant females reported their pregnancy to be unwanted or mistimed, this is significant programming issue/gap to be addressed.

The major two sources of contraceptive methods used during last sex (which is mainly the male condom) are pharmacies and government health posts. Nearly 65% of male respondents and 76% of female respondents reported to have received their method from these two types of SDPs. Only a small percentage (less than six percent) of youth reported receiving their last FP method from a designated youth center (ASBEF, equipe mobile, Centre ADO). ASC/relais or peer educators were not mentioned as sources of condoms or any other contraceptive methods.

Table 19: Use of Family Planning by Male Youth, 10–24 years old

	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of **sexually active (ever had sex)** adolescents/ young men who report having ever used a modern FP method (by type of method):							
10–14 years	14.3% (1)	0.0%	42.9% (3)	33.3% (3)	0.0%	0.0%	25.0%
Number of cases	7	3	7	9	1	1	28
15–19 years	66.7%	70.6%	52.2%	35.7%	27.8%	82.6%	55.1%
Number of cases	18	17	23	28	18	23	127
20–24 years	46.2%	76.9%	58.5%	58.5%	76.5%	89.1%	69.5%
Number of cases	26	26	41	41	34	55	223
All (10–24 years)	49.0%	69.6%	54.9%	47.4%	58.5%	86.1%	61.4%
Number of cases	51	46	71	78	53	79	378
Contraceptive methods ever used (with a partner):							
Oral contraception pill	0.0%	0.0%	2.6%	0.0%	6.5%	0.0%	1.3%
Number of cases	25	32	39	37	31	68	232
Injectable	0.0%	0.0%	0.0%	5.4%	6.5%	0.0%	1.7%
Number of cases	25	32	39	37	31	68	232
Implant	0.0%	3.1%	0.0%	0.0%	3.2%	0.0%	.9%
Number of cases	25	32	39	37	31	68	232
Male condom	96.0%	96.9%	100.0%	91.9%	90.3%	98.5%	96.1%
Number of cases	25	32	39	37	31	68	232
Other method (IUD, permanent methods, calendar method, female condom)	4.0%	0.0%	0.0%	2.7%	3.2%	1.5%	1.7%
Number of cases	25	32	39	37	31	68	232
Percentage of sexually active adolescents/ young men who reported using a modern FP method last time they had sex:							
10–14 years	0.0%	0.0%	42.9% (3)	37.5% (3)	0.0%	0.0%	22.2%
Number of cases	7	3	7	8	1	1	27
15–19 years	66.7%	70.6%	39.1%	32.1%	22.2%	78.3%	50.4%
Number of cases	18	17	23	28	18	23	127
20–24 years	46.2%	69.2%	45.0%	53.7%	67.6%	80.0%	61.7%
Number of cases	26	26	40	41	34	55	222
All (10–24 years)	47.1%	65.2%	42.9%	44.2%	50.9%	78.5%	55.1%
Number of cases	51	46	70	77	53	79	376
Contraceptive method used at last sex (with a partner):							

Male condoms	95.8%	100.0%	96.7%	100.0%	100.0%	100.0%	99.0%
Female condoms	4.2%	0.0%	3.3%	0.0%	0.0%	0.0%	1.0%
Number of cases	24	30	30	34	27	62	207
Among sexually active adolescents/young men who report using FP, **source** of FP:							
Pharmacy	62.5%	36.7%	13.3%	38.2%	81.5%	27.4%	39.6%
Health post	16.7%	10.0%	20.0%	20.6%	7.4%	48.4%	25.1%
Health centre	4.2%	13.3%	23.3%	0.0%	0.0%	3.2%	6.8%
Shop/ Market	12.5%	10.0%	3.3%	23.5%	0.0%	1.6%	6.8%
Health Hut	0.0%	13.3%	20.0%	0.0%	0.0%	3.2%	5.8%
ASBEF Adolescents Advice Center	0.0%	3.3%	6.7%	2.9%	0.0%	4.8%	3.4%
Outreach activities/Mobile team	0.0%	3.3%	0.0%	0.0%	0.0%	1.6%	1.0%
ADO Centre	0.0%	0.0%	3.3%	0.0%	0.0%	1.6%	1.0%
Others (friend, partner, acquaintance)	4.2%	10.0%	9.9%	14.7%	11.1%	8.1%	7.8%
Number of cases	24	30	30	34	27	62	207

Table 20: Use of Family Planning by Female Youth, 10–24 years old

	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of **sexually active (ever had sex)** adolescent/young girls who report having ever used a modern FP method (by type of method)							
10–14 years	0.0%	50.0% (1)	50.0% (1)	0.0%	—	0.0%	16.7%
Number of cases	2	2	2	2		4	12
15–19 years	17.6%	23.1%	15.6%	5.9%	18.8%	31.0%	19.4%
Number of cases	17	13	32	17	16	29	124
20–24 years	28.3%	36.7%	37.7%	15.4%	58.0%	50.9%	38.2%
Number of cases	46	30	53	52	50	57	288
All (10–24 years)	24.6%	33.3%	29.9%	12.7%	48.5%	42.2%	32.1%
Number of cases	65	45	87	71	66	90	424
Contraceptive methods ever used:							
Injectables	50.0%	40.0%	42.3%	22.2%	78.1%	28.9%	46.3%
Number of cases	16	15	26	9	32	38	136
Implants	31.3%	20.0%	38.5%	44.4%	12.5%	42.1%	30.9%
Number of cases	16	15	26	9	32	38	136
Male condom	12.5%	46.7%	15.4%	22.2%	3.1%	36.8%	22.1%
Number of cases	16	15	26	9	32	38	136
Oral contraception pill	31.3%	0.0%	3.8%	22.2%	40.6%	0.0%	15.4%
Number of cases	16	15	26	9	32	38	136
Other method (IUD,	0.0%	0.0%	7.7%	0.0%	0.0%	2.6%	2.2%

permanent methods, calendar method, female condom)							
Number of cases	16	15	26	9	32	38	136
Percentage of **sexually active** adolescents/ young women who report using a modern FP method last time they had sex:							
10–14 years	0.0%	50.0% (1)	0.0%	0.0%	--	0.0%	8.3%
Number of cases	2	2	2	2		4	12
15–19 years	5.9%	38.5%	12.9%	5.9%	12.5%	27.6%	17.1%
Number of cases	17	13	31	17	16	29	123
20–24 years	15.2%	26.7%	23.5%	11.8%	16.0%	28.6%	20.1%
Number of cases	46	30	51	51	50	56	284
All (10–24 years)	12.3%	31.1%	19.0%	10.0%	15.2%	27.0%	18.9%
Number of cases	65	45	84	70	66	89	419
Contraceptive method used at last sex:							
Male condoms	25.0%	50.0%	56.3%	28.6%	0.0%	75.0%	48.1%
Injectables	25.0%	28.6%	6.3%	14.3%	60.0%	12.5%	21.5%
Implants	50.0%	21.4%	31.3%	42.9%	10.0%	12.5%	24.1%
The morning after pill	0.0%	0.0%	6.3%	0.0%	20.0%	0.0%	3.8%
Emergency pills	0.0%	0.0%	0.0%	14.3%	10.0%	0.0%	2.5%
Number of cases	8	14	16	7	10	24	79
Among sexually active adolescents/young women who report using FP, **source** of FP:							
Health post	87.5%	21.4%	43.8%	57.1%	80.0%	66.7%	57.0%
Pharmacies	12.5%	35.7%	25.0%	14.3%	10.0%	12.5%	19.0%
Health hut	0.0%	14.3%	18.8%	0.0%	10.0%	8.3%	10.1%
Health Centre	0.0%	21.4%	0.0%	14.3%	0.0%	4.2%	6.3%
MSI Centres	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	1.3%
Shop/ Market	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%	1.3%
Others (friend, partner, acquaintance)	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	2.5%
Unknown	0.0%	0.0%	0.0%	14.3%	0.0%	4.2%	2.5%
Number of cases	8	14	16	7	10	24	79

As part of the qualitative assessment, young women who had used a FP method and had consented to take part in a semi-structured interview were asked about their motivations for using FP. Across the six regions, the most common response among the young women who were married was that they wanted to space their births. As one young woman in Sédhiou put it, she had chosen a Long-Acting Reversible Contraceptive (LARC) method "*To space births out and ensure children's education.*" These women spoke of wanting to wait between two and five years before conceiving again. Their motivations for spacing

their pregnancies ranged from allowing themselves and their bodies to rest, waiting until their current children were weaned or ensuring they would be able to raise the children well, and financial difficulties. In a few cases, the young women explained the primary motivation was financial; as one young woman in Matam noted, "*At the moment I prefer to wait 5 more years to have another child. My only goal is to have a job*." Also, in Matam, two of the women said they chose to adopt a FP method because they had faced birthing complications with their previous children and one said her mother had encouraged her to space her births so she could continue her education.

In two regions, one or more of the women who took part in the semi-structured interviews were unmarried. When asked about her motivations for using FP, a single woman in Kédougou responded: "*I wanted to stop having children out of wedlock*" and that she might stop using her chosen FP method "*if my situation improves; and I find work*." In Kolda, where three of the women who took part in the semi-structured interviews were single with no children, the young women said that they were using FP to prevent pregnancies.

3.1 Perceptions concerning STIs, HIV, and Gender-Based Violence and their Causes and Consequences

Tables 21 and 22 present survey data for males and females about STIs, HIV, and gender-based violence (GBV), defined as physical, psychological, or sexual violence (including rape), sexual exploitation, or genital mutilation (FGM). About three-quarters (76%) of all 10–14-year-old males and females have never heard of STIs, and about one-third of 20–24-year-old males and females have never heard of STIs. Only 15% of males and 17% of females could name at least one symptom of an STI. Youth were more likely to know about HIV, but they had relatively low knowledge about methods of HIV prevention. While 11% of 10–14-year-old males and 12.7% of 10–14 year-old females had never heard of HIV or AIDS, and less than three percent of 20-24 year old youth had never heard of HIV/AIDS, less than one-third of either male or female youth mentioned abstinence or condom use as methods of HIV prevention. Less than five percent of male or female youth named avoiding multiple sexual partners as a method of HIV prevention.

Reported experience with STIs was relatively rare. Less than 5% of sexually-experienced male and female youth reported ever contracting an STI (1.9% of males and 4.5% of females). Reported condom use among female youth was also relatively low: among youth who were sexually active in the past 12 months, 56% of males and only 12.7% of females reported using a male condom at last sex to prevent an STI, HIV, or unwanted pregnancy.

Finally, male and female youth were briefly asked about any experiences they have had regarding GBV, including physical, psychological, or sexual violence (including rape), sexual exploitation, or female genital mutilation (FGM). Both male and female adolescents and youth reported some experience with GBV, which *decreased* with age (experience with GBV ranged from 17.5% among 10–14-year-old males to 10.8% of 20–24-year-old males, and 14.3 % among females aged 10–14 years to 8.9% among females aged 20–24 years). While one might expect the reverse to be true due to older youth having more time and potential exposure to abusive experiences, perhaps this trend is due to increasing levels of

awareness about GBV among youth, including the notion that FGM and physical abuse are more widely considered part of GBV.

Table 21: STIs/HIV/GBV Among Male Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescents/young men who have never heard of STIs:							
10–14 years	62.3%	78.6%	62.9%	86.4%	77.6%	90.0%	76.1%
Number of cases	61	28	62	59	85	60	355
15–19 years	28.2%	52.9%	52.1%	54.5%	54.5%	39.4%	47.2%
Number of cases	71	34	71	77	110	71	434
20–24 years	26.5%	35.3%	47.0%	56.2%	39.0%	18.8%	37.6%
Number of cases	68	34	66	73	105	69	415
Percent of adolescents/youth who know at least one symptom of an STI:	9.0%	20.8%	15.6%	7.2%	9.0%	35.0%	15.0%
Number of cases	200	96	199	209	300	200	1204
Percentage of adolescents/ young men who have never heard of HIV:							
10–14 years	8.2%	14.3%	14.5%	16.9%	5.9%	10.0%	11.0%
Number of cases	61	28	62	59	85	60	355
15–19 years	1.4%	0.0%	7.0%	6.5%	3.6%	2.8%	3.9%
Number of cases	71	34	71	77	110	71	434
20–24 years	1.5%	2.9%	3.0%	0.0%	1.0%	1.4%	1.4%
Number of cases	68	34	66	73	105	69	415
Percentage of adolescents/young men who can name the ways to prevent HIV:							
Abstinence	30.5%	29.2%	26.6%	28.2%	25.0%	25.0%	27.1%
Number of cases	200	96	199	209	300	200	1204
Use of condoms	35.0%	45.8%	29.1%	30.1%	23.3%	35.0%	31.1%
Number of cases	200	96	199	209	300	200	1204
Avoid multiple partners	0.0%	4.2%	7.0%	2.9%	3.0%	.5%	2.8%
Number of cases	200	96	199	209	300	200	1204
Avoid contaminated sharp objects	10.0%	3.1%	6.5%	10.5%	17.7%	17.0%	12.0%
Number of cases	200	96	199	209	300	200	1204
Percentage of adolescents/young men (who have ever had sex) who report having contracted a sexually transmitted infection	2.0%	4.3%	4.2%	0.0%	0.0%	1.3%	1.9%
Number of cases	51	46	71	78	53	79	378

Percentage of sexually active (last 12 months) adolescents/ young men who report using a condom last time they had sex to prevent STI/ HIV and/ or unwanted pregnancy	56.7%	57.6%	35.1%	42.0%	57.6%	79.3%	56.0%
Number of cases	30	33	37	50	33	58	241
Percentage of adolescents/ young men who report being exposed to gender-based violence in the last 12 months:							
10-14 years	49.2%	0.0%	4.8%	16.9%	17.6%	6.7%	17.5%
Number of cases	61	28	62	59	85	60	355
15-19 years	22.5%	5.9%	5.6%	15.6%	18.2%	7.0%	13.6%
Number of cases	71	34	71	77	110	71	434
20-24 years	8.8%	11.8%	6.1%	23.3%	8.6%	7.2%	10.8%
Number of cases	68	34	66	73	105	69	415

Table 22: STIs/HIV/GBV Among Female Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescent/ young women who have never heard of STIs:							
10–14 years	62.7%	78.1%	70.3%	83.6%	79.3%	81.7%	76.0%
Number of cases	59	32	64	61	87	60	363
15–19 years	35.6%	48.6%	55.7%	50.8%	45.1%	36.6%	45.0%
Number of cases	73	37	70	63	102	71	416
20–24 years	27.9%	40.0%	32.8%	43.3%	33.3%	29.0%	33.8%
Number of cases	68	35	67	67	111	69	417
Percent of adolescents/young women who know at least one symptom of an STI	16.5%	19.2%	17.4%	7.3%	11.7%	33.0%	17.0%
Number of cases	200	104	201	191	300	200	1196
Percentage of adolescent/ young women who have never heard of HIV:							
10–14 years	10.2%	18.8%	18.8%	3.3%	16.1%	10.0%	12.7%
Number of cases	59	32	64	61	87	60	363
15–19 years	1.4%	10.8%	14.3%	4.8%	2.0%	0.0%	4.8%
Number of cases	73	37	70	63	102	71	416
20–24 years	1.5%	0.0%	7.5%	1.5%	.9%	2.9%	2.4%
Number of cases	68	35	67	67	111	69	417
Percentage of adolescents/young women who can name the ways to prevent HIV:							
Abstinence	24.0%	29.8%	36.8%	27.2%	28.0%	28.0%	28.8%

Number of cases	200	104	201	191	300	200	1196
Use of condoms	30.0%	25.0%	15.4%	20.4%	20.3%	30.0%	23.2%
Number of cases	200	104	201	191	300	200	1196
Avoid multiple partners	4.5%	11.5%	5.0%	5.2%	4.3%	.5%	4.6%
Number of cases	200	104	201	191	300	200	1196
Avoid contaminated sharp objects	13.5%	10.6%	7.0%	17.8%	13.7%	15.5%	13.2%
Number of cases	200	104	201	191	300	200	1196
Percentage of adolescent/young women (who have ever had sex) who reported having contracted a sexually transmitted infection	4.6%	4.4%	9.2%	2.8%	6.1%	0.0%	4.5%
Number of cases	65	45	87	71	66	90	424
Percentage of sexually active (last 12 months) adolescents/young women who reported using a condom last time they had sex to prevent STI/ HIV and/ or unwanted pregnancy	3.3%	21.9%	18.0%	7.8%	3.5%	22.1%	12.7%
Number of cases	60	32	61	51	57	77	338
Percentage of adolescent/ young women who report having been exposed to gender-based violence in the last 12 months:							
10–14 years	32.2%	0.0%	3.1%	9.8%	27.6%	1.7%	14.3%
Number of cases							
15–19 years	17.8%	13.5%	5.7%	19.0%	11.8%	4.2%	11.8%
Number of cases							
20–24 years	13.2%	5.7%	9.0%	14.9%	6.3%	4.3%	8.9%
Number of cases							

Across the six regions, data from qualitative interviews, including descriptions of the prevalence of STIs, particularly HIV, among adolescents and youth, was decidedly mixed. In the part, this appeared to be the result of strong stigma associated with STIs, and HIV/AIDS in particular, that kept adolescents and youth from learning about, getting tested for, or talking about these issues; as a result, older members of the community had highly varying views on the scale and intensity of STIs as an AYRH problem.

In Kaolack, STIs were one of the most-commonly identified consequences of sexual activity among adolescents and youth. Others in the region, however, said there were no cases of HIV/AIDS in Kaolack, and one community leader even remarked, "*I really wonder if AIDS exists. [...] the Qur'an talked about AIDS, but I personally do not believe it.*" Many participants in the qualitative assessment in Kolda and Matam, too, noted that STIs were among the most pressing AYRH problems facing their communities, sometimes ranking the issue of STIs and HIV among adolescents and youth as second to early pregnancy. A peer educator in Matam noted, "*In our society there are too many girls who become pregnant without getting married, there are too many sexually transmitted infections that affect teenagers. That's what pushed me to become a peer educator.*" In the same region, however, a community member asked about STIs and HIV

responded, "*Non, je n'ai jamais entendu parler de cela*." In Saint-Louis, most participants in the qualitative assessment denied the existence of STIs and HIV/AIDS in their community or acknowledged they might have existed but were not discussed. In Sédhiou, STIs were brought up as a major AYRH issue by many participants, but they were described as less pressing than early marriage and early pregnancy. The most detailed description of STIs among adolescents and youth in Sédhiou came from an SRH program manager, who noted it was a major consequence of unprotected sex among adolescents and youth: "There are risks because of the transmission of certain diseases, such as STIs/HIV/AIDS. In relation to this, the district is "red" for the prevalence rate of HIV/AIDS, that is to say the rate is high compared to other regions."

Those community members who identified STIs and HIV as major problems tended to highlight the fact that many young people did not get tested, which exacerbated the problem. A community leader who worked in health in Kolda lamented: "*Teenagers/young people here, excuse the term, but as they say, they love sex but do not like screenings. They want to have sex, at a young age, but they never get tested. As a result, I think they need sex education from a very early age*." A SRH program manager in Matam also described adolescents and youth as extremely reluctant to consent to testing for STIs: "*I also take this opportunity to ask them if they got tested, not only for sexually transmitted infections, syphilis, but also for cancer. And it's very rare for young people to tell you that they are going to get tested, sometimes they do not come back*"

Some leaders and program managers on health pointed out that the extent of stigma associated with STIs and HIV, in particular, could help explain why adolescents and youth might be more inclined to hide their problems than seek testing or treatment. A community leader in Kédougou observed that fear and shame prevented young women from getting tested: "*when asked to go to the hospital, she says she is ashamed to go. When asked to get tested for HIV/AIDS/STIs, they say they are scared claiming their future will be in danger. So all these situations are real problems for us.*"

Unmarried adolescents and youth reportedly face additional shame and stigma due to the perception in some regions that STIs were a result of sex outside of marriage. A father in Kolda explained, "*I usually say that sexuality, if it is early and is out of wedlock, the person will have these STI problems*." The intensity of the stigma was apparent in one mother's remarks in an FGD in Saint-Louis: "*You can even contract diseases, as today's men act like wild animals when it comes to sexual intercourse, and these are diseases that may prevent you from getting married in the future*." The belief that STIs were mostly prevalent among and transmitted between unmarried individuals could also have negative consequences for married adolescents and youth who were at risk. As a peer educator in Saint-Louis noted, "*The problem of STIs is very common, too. The misfortune is that in our society, when someone hears 'STI' it is thought that someone who is not married cannot contract them.*"

In Kédougou alone, a few qualitative participants noted an additional obstacle to getting adolescents and youth tested for STIs and HIV: rumors that their blood would be sold. As one peer educator explained: "*I have experienced things with teens/young boys who say," The people who do the screening are here to take our blood and sell it for profit." Currently, many teenagers do not want to be tested because of that.*"

The result of the high level of stigma around STIs appeared to be that adolescents and youth hid their symptoms, refused to see doctors and continued to spread infections and HIV/AIDS to their partners.

This was described as particularly problematic when the infected individuals were in polygamous marriages or with partners who were unfaithful. As a mother in Saint Louis noted about the advice she would give to her daughters: "*If she is married, of course I suggest she go to these facilities for her to be diagnosed. But also to check that they have no sexual diseases, especially if you have a husband who is not faithful to you or who is polygamous*."

3.2 Perceptions Concerning Other Adolescent and Youth Reproductive Health Issues

3.2.1 PerceptionsCconcerning Abortion

Perceptions about the prevalence of abortion and whether it was a significant AYRH issue varied widely across the regions in no small part because Senegal has a highly restrictive law concerning abortion[27] and because there was a strong stigma against the practice. Some participants in the qualitative assessment in Kédougou described abortion as one of the predominant AYRH issues facing the region; some participants in other regions also described abortions as common, though others described it as rare and others stayed silent on the topic. In Kolda, for instance, one community leader involved in health remarked, "*For abortions, I only had one case in the neighbourhood*," whereas another commiunity leader observed, "*We often see cases of clandestine abortions with huge risks mostly caused by unwanted pregnancies. But if it is rape, abortion is tolerated*." Similarly, in Saint-Louis, one community leader said abortions were not a problem in his community. Another community leader, by contrast, said it was common, though information was not reliably available, "*There are many at the local level, sometimes we receive information, sometimes not*." In Sédhiou, a mother in a FGD claimed, "*It is no longer done, there used to be illegal abortions, but nowadays we do not hear more about it because everyone now knows about the hospital, there is family planning there, it is enough just to go to the hospital and tell your concerns to the doctor*."

As the quote (above) from the second community leader in Kolda illustrates, some community members felt abortion should be tolerated in cases of sexual violence, and some even argued that the law should be changed. A mother in Kaolack noted abortion was appropriate if an adolescent girl was too young to safely carry a pregnancy to term: "*Yes there are cases of abortion because if a girl becomes pregnant when her body is not sufficiently prepared, there is a problem, the foetus does not have enough space, so the baby dies before term*." Others expressed opposition to abortion generally or said they had counselled others against pursuing abortions due to health risks.

In the cases in which abortion was discussed, it was clear that adolescent girls and young women were motivated to seek abortions because the stigma against pregnancies outside of marriage was extremely strong. As a peer educator in Matam remarked, "*I think that kicking your daughter out of the house because she is pregnant can discourage the girl and make her do worse, which we do not want*."

Participants also noted that families sometimes took charge of arranging abortions for their unmarried adolescent and young daughters to ensure they did not bring shame upon their families; as a SRH program manager in Matam recounted, "*I get young people who come here because they are afraid of getting pregnant, but unfortunately they come with pregnancy and there is no follow-up thereafter. It is the family who decides to terminate the pregnancy*." A mother in Kédougou spoke to the stigma against pregnancy outside of marriage and how it could spur young women and their families to choose to abort:

It's not easy, personally, I'm talking about our situation as single mothers. If our daughter becomes pregnant, the community can even go so far as to say that she is only following in her mother's footsteps! And hop starts the gossip especially for us who live in a big village where people are not educated enough the conversations will not be positive. [...] These are the kinds of cases that cause mothers to force their daughters to abort because they are scared of being singled out for failing to educate their daughter.

3.2.2 Perceptions Concerning Gender-Based Violence

Perceptions about the existence and extent of physical or sexual GBV varied widely across participants and across the six regions in which the qualitative assessment took place. A major factor appeared to be the culture of silence around GBV, particularly when it took place in domestic settings.

In Kaolack, Kédougou, and Kolda, a number of participants described rape and other forms of domestic violence as common among adolescents and youth in these regions. A community leader in Kolda noted, "*Here the sexual violence persists, and we receive a lot of cases especially young girls*." An SRH program manager in Kédougou noted that sexual violence against young women factored into the high rates of early pregnancy in the region:

It's true that people tend to say that "Yes, it's girls who provoke boys", all in all, there are situations in which the girl has not done anything and ends up the victim, who is left with a pregnancy she does not want.

Across the regions, participants who identified GBV as a problem noted violence was often covert and that adolescents and youth affected by violence were often unable to disclose this due to taboos around discussing these issues openly, even (or especially) with family members. A peer education in Kaolack observed, "*Sometimes a girl may be raped, and her parents may not give her the attention she needs.*" A Bajenu gox in Kolda remarked, "*As far as sexual violence is concerned, it may well exist, but it will be difficult for us to support it. Most of the time, these are facts that remain in the family so as not to denounce certain members*."

Perhaps due to the silence around violence, some participants in the qualitative assessment claimed violence was rare or nonexistent. In Saint-Louis, GBV was very rarely mentioned and spoken of largely in indirect ways, such as dangers that young people might encounter in the street. In Matam and Sédhiou, community leaders tended to discount GBV as a problem, whereas peer educators made the opposite case. Whereas a community leader in Sédhiou said rapes were infrequent and an educator said he had never heard of a case of GBV, peer educators in one FGD observed that GBV was common; as one said, "*In this community violence against adolescents/young people is very common. Similarly, rape and early marriages, and unwanted pregnancies are also common*."

GBV against adolescents and youth was said to happen in a variety of fora: within the home, when young people were in the street or on their way to school, or as was mentioned above, when they fell prey to older or wealthier men. An SRH program manager in Matam noted violence often took the form of older men exploiting younger women:

Even gender-based violence, we see this especially [...] There are young people who do not know anything and there are adults who abuse them. For example, you see a 14–year-old girl or a 16–year-old girl, 18 years old, who knows nothing about sex, they go to a 38–year-old or 30–year-old adult man. This man is going to abuse her conscience, he tells her I love you and in the end, he sleeps with the girl and she gets pregnant without knowing about it.

Another example of exploitation that was raised (infrequently, again, perhaps because of the sensitivity of the issue) across several regions—Kaolack, Kolda, and Saint-Louis—was that male teachers sometimes preyed on their female students. A mother in Kaolack remarked, "*The teachers go out with their pupils, sometimes they even get them pregnant.*" The hesitation seen in a peer educator's description of this phenomenon in Saint-Louis seems to indicate that this issue was difficult to discuss openly:

There are many pregnancies in schools. This is the work of the teachers. [He hesitates a little] ... it is the teachers who sometimes blackmail the students by asking them to come and visit them. And if a girl refuses to give in, the teacher will drop her grades and start to be severe with her.

3.2.3 Perceptions Concerning Female Genital Mutilation

Participants in the qualitative assessment across the six regions differed on whether and to what extent FGM was an ongoing issue in their communities. As with abortion, part of the reason that there were different perceptions of the degree or severity of the problem may be related to the fact that, as participants pointed out, the practice often occurred in secret, as participants noted the government and organizations had been campaigning to reduce the practice.

In Saint-Louis, all participants who were asked about FGM said it did not exist in the region. In Sédhiou, there was agreement that the practice was in decline (though still taking place, often in secret) thanks to community sensitization efforts. A community leader remarked, "…*Excision was done for some time, but with sensitization it decreased a lot and those who do it now do it secretly, they hide from us, the authorities*." In Kaolack, most participants said FGM was very rare or mostly practiced in more rural and isolated areas, and that it was often done in secret. In contrast, one community leader said the practice had been medicalized: "*Excision is not common here because many people are now resorting to health facilities to medicalize the practice. The traditional method is rare now*." In Matam, views of FGM's prevalence were more mixed. A mother in the region claimed the practice no longer existed, and a community leader declared, "*These days it's rare to see an excised girl.*" In contrast, a peer educator asserted "*There are many girls in my community who are victims of mutilation."* As in Kaolack, some participants in Matam said FGM was more common in the more remote agrarian parts of the region. There was also a sense among participants who said FGM remained common that the practice was beginning to decline, although a SRH program manager explained there was a hidden nature to FGM that made it hard to know how common it was:

Yes, people do it, but they say they do not, but, it is done, because when we send a girl of fifteen to maternity, we see that the vulva is removed, we know that this girl is excised. But

when you ask the girl if she is excised, she says no, she does not know. So, it's done at a very young age.

This SRH manager's observation that FGM was taking place in girls at an earlier age than had been common was echoed by others, including another manager in Kédougou, a region where FGM was described as common:

The tradition still favours the practice of female genital mutilation, which in theory (and it remains to be verified), has decreased a lot. Because before, excision was done at a slightly older age and it was difficult to hide, but today, girls are excised very early, even before they reach the age of two years or before they go to school. So, these "breakthroughs" deserve in-depth studies to see the reality, even though numbers are publicized. But, given communities' attachment to their customs and traditions, there may be some truth to the fact that nothing has changed, it's just that girls are excised a little earlier now.

FGM was cited as a major AYRH problem in Kolda, especially in more isolated villages. When asked about the primary AYRH problems in Kolda, one peer educator responded, "*Excision. The latter is very common and is still practiced today in some peripheral areas of Kolda*." As in other regions, participants in Kolda noted the practice was often hidden from view; as another peer educator remarked, "*There is also excision that people continue to practice but secretly. They even practice it now on new-borns barely a month old*."

Participants who spoke about FGM across the six regions held differing views about whether FGM was acceptable and should continue to be practiced. Often, participants referred to the outreach and sensitization efforts that had been made with regard to FGM in their explanations of their support or opposition to the practice, either praising or vilifying them. A peer educator in Matam, for instance, noted the opposition that peer educators faced from others in the community when discussing the issue of FGM: "*We were talking to our parents, but when we talk about the excision risks listed in the course, they tell us that white people are trying to ban our traditional practices. They also argue that Islam allows it.*" In the same region, many fathers in one FGD agreed that FGM was acceptable. As one father explained, "*It is a practice that is part of our culture and the Muslim religion. We found it here and I think that no one can come here to stop us from practicing it ... For example, if the girl is not excised, everything she touches remains stained. When she prepares [food] to eat, no one eats*." In contrast, a father in a different FGD in Matam noted that there were differing views concerning whether religion supported the practice:

Concerning excision, there are differences because there are those who say that excision is prohibited by religion and those who say that religion accepts and demands it. Also, religious authorities claim that this is not a religious constraint; we can say that the opinions are divided.

This father's argument was supported by the words of a religious leader (Imam) in Sédhiou, who remarked, "*Excision is tradition, culture. Because in the Qur'an, it is not written in any verse to excise girls*." When asked to explain why community education efforts were important, an SRH program manager in

Sédhiou also argued the beliefs concerning girls' ritual purity was damaging to adolescent and young girls:

> *It's ignorance that led us to do anything. It is said that if you are a girl and you are not excised, you are not clean. So, you do not have the right to cook. You are considered improper. And when you pray, God will not accept your prayers. But that's wrong; people denied it in the Qur'an. So, they traumatized people like that.*

As this manager's statement illustrates, there were some strong beliefs attached to FGM that could result in social ostracization for girls and women who had not undergone FGM; a peer educator in Matam noted, "*No one argues that we must ban excision; young girls were saying that you should not greet a girl that is not excised. In addition, she may become pregnant before marriage because she is not pure. She could not abstain*."

While not undergoing FGM could result in social isolation and rumor-mongering about adolescent girls and young women, many participants noted that FGM had the potential for severe health consequences. Parents who took part in FGDs in Kolda were without exception opposed to FGM and it appeared that sensitization about the potential consequences had played a large role in forming their option. One mother in Kolda noted, "*And concerning excision, I'm never going to do this practice because of the problems that this involves: infections, complications during childbirth, etc*." A mother in Matam said that in her community, women forbade FGM because of health complications: "*There are too many health complications around this practice, which is why women have banned it*." A community leader in Kédougou observed, " *Excision causes a lot of problems for children during childbirth*." One mother in Kolda even cited FGM as a major cause of divorce in the region: "*Today most marriage breakdowns are due to excision, because there is no pleasure in marriages*."

4. Norms Concerning Communication About Adolescent and Youth Reproductive Health Issues in the Communities

One of the issues explored in-depth in the qualitative assessment was that of communication around AYRH issues. Participants were asked about whether and to what extent AYRH was discussed within families, within communities, among peers, and within couples. Closely related to this issue, participants were also asked about whether they felt it was appropriate to educate adolescents and youth about AYRH issues, to orient them towards RH services, and to offer them FP.

4.1 Communication Among Parents and Adolescents/Youth about Reproductive Health Issues

Across all six regions, participants in the qualitative assessment described strong taboos surrounding the discussion of AYRH issues, and many participants—including parents themselves—said parents did not talk to their children about issues like puberty, sexual curiosity, or FP out of shame or a strongly held belief that it was wrong or counter to their culture to do so. A father in Sédhiou explained: "*In terms of the obstacles, first we have the problem of communication about the sexual life of adolescents/young people at the age of freedom. [...] This is a real problem in our community; parents are often ashamed to discuss this topic with their children. It is a subject that is often taboo*." A SRH program manager in Matam remarked, "*For the*

family, the eldest of the family must communicate with the children, but unfortunately, the eldest cannot talk about it. Because there is this taboo of communication between parents, the parents do not speak, the mother, the father, the aunts, the uncles and the elders do not speak." According to a peer educator in Saint-Louis, talking about AYRH issues was considered such a taboo that an adolescent or youth who brought a problem to the attention of a parent risked being labeled a bad child:

> *The major problem is the lack of sex education that exists between parents and their children. Because one tends to consider this a taboo subject; for example, to speak about vaginal discharge with one's parents as the Westerners do. When they have sexual health problems, they talk about them with their parents, be it mother or father. They explain what happens during puberty. This is not the case in our country ... the parents do not even have that time. Because most of the population is illiterate [...] So, the parent will consider that their child is bad, when he/she is not, but rather, has not had sex education.*

Some parents, particularly in Kaolack and Sédhiou, said they did talk to their children, particularly their daughters, about AYRH issues. Often, these conversations were initiated by the arrival of a daughter's first menstrual period, as parents, especially mothers, wanted to warn their daughters of the potential consequences of sex, particularly early pregnancy and STIs. Many emphasized that they talked to their children about abstaining from sex. As a mother in Sédhiou noted:

> *I talk with my children especially young girls and as soon as they begin to have their periods. I let them know that they have become women and if they ever had sex with a man, they could become pregnant. I also talk with my young boys."*

A mother in Kaolack said she drew on her personal experience to talk to her children:

> *You must educate them, explain things to them, I who speak to you, I had my first child at the age of 13, so I can talk to my child about everything. I explain that if you have sex with a man, you can get pregnant, with early sexuality you can even have obstetric fistula and it is serious as a disease, I talk to my children about the consequences.*

In contrast to the above examples from Kaolack and Sédhiou, some participants in Kolda and Matam observed that even the mention of menstruation was taboo. A peer educator in Matam noted, "*You cannot look at your mother and ask her what to do with your periods. The peer educator who has been trained can help with these issues and can even help other girls who have painful periods, because sometimes the girl sees her period and cannot talk to her mother*." A peer educator in Kolda told a personal story, saying she had sought advice from an older friend when she first had her period because sexual issues were taboo in her household: "*Two years later, my mom asked me if I started to see what girls see at their age. I said to her 'what'? She had problems saying the word 'periods'. I held my head down because I was embarrassed*."

In a few regions, participants also noted the lack of communication went in two directions, observing that, just as parents might not speak to their children, adolescents and youth did not want to listen to their parents. A peer educator in Matam noted, "*With adolescence, we do not listen to the father or the mother, we do not listen to what is said, we only care about our happiness, we do what we want to do*." A

mother in Kedouguo remarked, "*If I take my case I often discuss sex with my children. But the problem is that you talk to them all the time to avoid this or that, but they do not even listen to you*." Perhaps as a result of the silence around AYRH issues in households, adolescents and youth were described as being reluctant to talk to their parents about AYRH issues; as a community leader in Kolda noted, "*In Kolda, there are many taboo subjects, young people, especially young girls, never go to parents to discuss what is happening to them.* A mother in Kedougou lamented, "*My children are ashamed to talk with me, I do not know why*."

In addition to the taboo around AYRH issues, participants brought up several other causes for the lack of communication about this topic within families. In Kédougou and Kolda, a few participants said the lack of communication between parents and children resulted from the loss of traditional forms of education. A community leader in Kolda explained, "*Parents no longer communicate with their children, especially about sex. They are ashamed to talk about sex, and yet it used to be through storytelling and teenagers/young people knew how to protect themselves from certain problems, but this is no longer the case*." A community leader in Kédougou asserted, "*In the old days, our grandfathers used to make 'Pencco' [refers to a political party in Senegal], that is, to collaboratively manage and raise their children through education and discussions about family values. But nowadays we do not have these good practices to prepare our children well*." Participants also spoke of problems created by the impetus to work, especially for families in which the father migrated or both parents were not home for much of the day to supervise and talk to their children. A father in Kolda remarked, "*In the morning, as a father, you leave home early to go to work and you do not come back until late in the evening, and so you will not be able to do as the elders did, sit down and communicate with the children, that's why there is no more communication [...]. I do not have this communication at home*."

Aside from sociocultural taboos, participants most frequently cited parents' lack of knowledge about AYRH issues and how to handle them as a significant barrier to educating young people about their health and opening up lines of communication between parents and children. A Bajenu gox in Matam explained, "*Even parents do not know how to manage the lives of teenagers; they do not have the knowledge to understand their children. So, that does not help, because there is no good communication*." A father in Saint-Louis noted, "*I must admit that we do not have the necessary knowledge to be able to supervise our children. Because we do not have enough education or knowledge in this area.*" For this reason, many participants advocated for educating parents about RH issues, particularly as these related to adoelscents and youth, as a strategy. An SRH program manager in Saint-Louis argued, "*Beyond the teenagers/young people, it is necessary to educate the parents: the mothers, the fathers so that they have a dialogue on the SRH with the former.*" This was echoed by a Bajenu gox in Kolda, who told the interviewer, "*For me, the best method is to educate parents first, then teenagers/young people. As a result, they will understand the why of things and will be comfortable communicating with their children*."

Many participants, including parents, also called on for adolescents and youth to be taught about RH issues at school, given the constraints parents faced in educating their children. As a father in Saint-Louis said:

> *We must understand that there are socio-cultural barriers that mean that today we do not often discuss the issue with our children, and there has been a change in society that we could not adapt in our realities. So, we must go through awareness-raising campaigns,*

communication and advocacy. We must even insert these things into the Senegalese education system. We have a problem with our society.

4.2 Communication Within Communities about Adolescent and Yotuh Reproductive Helath Issues

When participants in the qualitative assessment across the six regions were asked about the extent to which the community as a whole discussed RH issues with adolescents and youth, many said that it was difficult to discuss these issues, especially in public settings; as a community leader in Sédhiou observed, " *As far as the community itself is concerned, not once have I heard that they discussed or communicated with children about a sexual problem*." Yet some regions seemed to be making more progress on engaging on AYRH issues. A father in Matam, for instance, said parents were leading some activities to educate themselves: "*We parents hold conferences. We talk with Imams and relais [CHWs]. We have a commission whose members are elected as city councillors to work as volunteers to help young people.*"

The main ways in which communities seemed to engage on the subject of AYRH to any extent were through awareness-raising activities, which were largely organized by peer educators, health providers, Bajenu Gox, and/or CSOs, or through the transmission of awareness-raising messages via the radio or other media (these are discussed in greater detail in Section 4 under Findings). Some of these actors described facing push-back from community members and having their work misconstrued. A peer educator in Kaolack described having to talk to a friend's mother to convince her to allow her daughter to continue attending activities at ASBEF because the mother had heard from her friend that *"ASBEF only does family planning*" explaining: *"It's like that even between young people, it's crazy. They all say that the girls were all perverted because they attend ASBEF, but each time I correct them telling them never to judge and that there is a youth movement at ASBEF."* A peer educator in Saint-Louis complained, *"We may want to talk to a young person, but as soon as the mother arrives she will say that we want to pervert her child by talking to them about sex. So this is a problem because of the taboo."*

Participants often pointed to culture and religion as factors in hampering public discussion of RH issues with or concerning adolescents and youth. A father in Matam observed:

> *The community does not really help teens/young people, because people take refuge behind tradition or religion so as not to touch on topics that are related to sexuality, especially with regard to young people. Unless some projects/programs take care of this, you will never see anyone taking the initiative to initiate such a public debate, so the problem continues to worsen. For example, in the case of early marriage people argue that it is their customs, or they are in accordance with religion. So the community does not stand with young people in this sense.*

A religious leader (Imam) in Saint-Louis remarked that an unmarried young person should not be given the same information as a married person:

> *We do not give the same speech to a husband as to a young, single man. We just remind them of the recommendations of the Muslim religion. With the bride and groom we discuss*

the duties and conjugal rights but for the others, we just exhort them to abstain by listing the consequences that may arise in if they do not.

A village chief interviewed in Sédhiou, when asked about discussing AYRH issues with members of his community, responded, "*Our culture and custom do not allow us for the moment to discuss this issue. It's a taboo subject.*"

Despite the opposition of some community and religious leaders, participants in several of the regions—particularly Kédougou, Kolda, and Matam—described many community members as actively involved in and supportive of efforts to address AYRH issues and the actors who led them. A SRH program manager in Matam, for instance, spoke approvingly of the many ways in which young people were engaging on AYRH issues: "*The youth clubs that are there, the youth coordinators, the sports and cultural associations (ASC), these are [youth organizations] that we should capitalize on to increase awareness.*" A community leader in Kolda perceived the community to be changing thanks to outreach and education efforts: "*At the moment the NGOs are really helping us with awareness raising, relais too, etc., and the situation is starting to change."* A community leader in Matam described changes he said he had noticed in how religious leaders responded to activities related to AYRH issues:

I think they were the blocking factors, tradition and religion, but now as I told you, even imams tend to come to the meetings that are organised. So that they too can play their part, because you have to integrate them, you have to integrate the imams; you have to integrate the religious leaders, the village chiefs and others so that they can still take charge of the issue.

An SRH program manager in Kolda also perceived attitudes towards AYRH to be shifting. He attributed this to a variety of factors, including higher education levels, more travel and access to information, and outreach efforts:

It is a fact that more and more people in these communities are educated, that is an observation we made. Then in these environments there are many people who have had to travel, either because of immigration or rural exodus and often if they come back, they do so with other ideas different from those that prevail here. And also, more and more in these environments, there is accessibility to information through various communication channels (radio, TV, social networks); and also, there is the involvement of community liaisons and well-informed "bajenu gox" who are in the community. These are the different factors that favour the successful intervention implementation.

4.3 Communication Among Peers About Adolescent and Youth Reproductive Health Issues

There was wide variation in opinions among participants in the qualitative assessment—both within and between regions—about whether adolescents and youth talked to one another about RH issues. Some said peers were an important source of information and confided in one another about problems they could not share with their parents. A peer educator in Kédougou noted, "*When adolescents do not have the recourse to parents to solve their problems, they talk to the people close to them who inevitably will send*

them to districts and health centers or even CCAs. Even when talking with classmates, they may have information about their concerns." A peer educator in Kolda also asserted it was more comfortable for young people to talk to peers than their parents: "*A young person is more comfortable among peers when talking about sexuality and all subjects than with their own parents*." This was echoed by another peer educator in Saint-Louis, who asserted peer educators were more effective at reaching adolescents and youth with information than adults, "*Young people are more comfortable with their peers and they understand each other. With adults there may be a barrier because of the age difference. So, information passes better between young people*." Peer educators described themselves as playing an important role in facilitating communication and raising adolescents' and youths' awareness of RH issues, particularly when young people were too embarrassed to visit YFHS sites themselves, as a peer educator in Sédhiou explained:

> *Sometimes there are young people who use "go-betweens" to communicate or alternative channels of information because they are reluctant to go to the district or CCA [Counselling Centre for Adolescents]. They prefer to go through their girlfriend, or see someone who is familiar with these issues, to ask about their problem, that's why at our level we would like to have peers in each neighborhood.*

Schools and social media were two important fora through which participants said information about RH was shared with and between adolescents and youth. A mother who took part in an FGD in Sédhiou noted that, in the CEM (Collège d'Enseignement Moyen, or middle school), "*Sensitization is always there, either between teachers and students or among the students*." A peer educator in Kédougou remarked, "*The contributions that we try to make at the CCA level is to go to the schools and friendly students because many young people do not have time to travel; we go to them to organize talks*." Peer educators and parents noted adolescents and youth also communicated through WhatsApp, Facebook, and cell phones, learning from and sharing information with one another.

Despite some participants' views that adolescents and youth spoke openly about RH issues, others said the taboos that existed within households extended to the community and made it difficult for young people to feel comfortable talking about issues like puberty, menstruation, sex, and FP. A community leader in Matam called for more work to be done to create spaces where adolescents and youth could speak about RH issues freely because even peers did not talk about these things amongst themselves: "*We have agreed with the Youth Minister that there will be an ADO space in each district so that young people can discuss things that they cannot talk to friends about or that are taboo on the street*." A SRH program manager in Kolda also said young people did not talk to each other about RH issues: "*Talking with people is not easy because there are cases where we meet teenagers who are reluctant to talk about their problems. But we take the necessary time, even two hours so that they can open up and explain their problem*."

A similarly mixed portrait of the extent to which adolescents and youth discussed reproductive health issues emerged from the semi-structured interviews with young women and from interviews with SRH program managers and Bajenu gox. On the one hand, a Bajenu gox in Matam described adolescents and youth as being in constant contact, including about RH issues: "*They are in permanent contact. If any of them have concerns about their sexual and reproductive health, he or she talks confidentially with their peers before seeing the badien gokh*." On the other hand, only one of the young women who had taken part in the semi-structured interviews in Matam said she had spoken with her friends about her decision to use

FP; one of the young women who said she had not talked to her friends about FP explained, "*I do not have information from my friends because women 'hide' [do not talk about such matters]*." In Saint-Louis, very few of the young women knew whether any of their friends were using FP or not, and almost none of them had discussed their decision to use contraception with their friends. In Sédhiou and Kolda, in contrast, most of the young women were aware of what kinds of modern contraceptives their friends used; one young woman said she has received advice "*through friends*" about the "*the best protection to prevent pregnancy*." This echoed an observation by a SRH program manager in Kédougou that adolescents and youth who came to health facilities to seek FP often had some preconceived ideas of what they wanted based on their conversations with peers: "*They are well informed about the costs of FP products. Even with counseling, you clearly see that they have already made their choice of a particular product before coming. And so I think that their girlfriends inform them*."

Some participants in the qualitative assessment condemned adolescents' and youths' communication about AYRH issues, describing this as potentially harmful to their development. A community leader in Kolda commented:

> *Parents are mostly faced with 'street' education. Not only is there basic family education, but also street education with friends, friends who are obstacles. The child can be very well educated at home, but once in the street, there is other information that contradicts and overrides this parental education. So, it's a perpetual fight.*

Parents in Saint-Louis described youth sharing pornography through their cellphones and social media, and a community leader in Kaolack remarked, "*People do not have the habit of discussing sexuality openly in order to get information. Young people discuss these issues but in an oblivious and dangerous way because they discuss them only among themselves. There is not an adult who can guide them and give them good advice*."

4.4 Communication and Decision-Making Regarding Family Planning Among Adolescents/Young Couples

The issues of decision-making regarding FP use and pregnancy spacing was addressed to a very limited extent in the qualitative assessment and was largely limited to the semi-structured interviews with the young women who had accepted a modern contraceptive method. Across the six regions, the women provided a wide variety of responses concerning the extent to which their husbands or male partners were involved in the discussion and decision to use FP, which was typically articulated as desired to space pregnancies.

In Kaolack and Matam, several of the women noted their husbands had asked or suggested to their wives that they adopt a FP method. A young woman in Matam noted, "*During my last delivery, he himself suggested that I adopt a FP method*." In Kolda, several of the women framed the decision to use FP as one in which the husband had to provide his consent or approval. When one had told her husband she wanted to use contraception, she said, he was "*reassuring, he said that's good*." This was also common in responses from women in Matam, Saint-Louis, and Sédhiou. When asked who had ultimately made the decision as to whether or not to use a contraceptive device, many of the women said they themselves had; nevertheless, this decision was in many cases clearly informed by the express support for the

decision they had already secured from their husbands. A young woman in Sédhiou who had sought her husband's consent to use FP said that, in response, "*He told me yes, but not to do it for too long*." One young woman in Matam said when she had broached the subject with her husband, "*He was supportive of my decision and he himself gave the money for to buy the method*," while another noted she had discussed her decision with her husband to obtain his consent: "*Yes, and it was to have his consent so that there was no problem later. And he agreed right away*."

A community leader in Kaolack noted husbands sometime refused their wives' requests to get permission for a modern contraceptive method, noting he felt this was due to lack of awareness about RH issues: *"There are also husbands who refuse to let their wives use family planning. I even saw a teacher who wanted to sue a midwife for allowing his wife to use family planning. All this is due to ignorance*."

Some of the women in Kédougou, Kolda, Saint-Louis said they had not discussed their decision to use FP with their husbands. As one woman in Kédougou explained, when asked why she had not talked to her husband, "*It's my own health.*" In Saint-Louis, one of the women who had not told her husband said this was because she was afraid he would refuse to agree to it; when he later learned of her decision, she said, "*He reproached me for that, but he let me continue*."

A woman in Kolda said she had not talked to her husband due to fear, while also noting "*It depends on me. Because it's my own health*." A SRH program manager in Kolda noted some married women who wanted to continue their education hid their decisions to use FP from their husbands. A mother in Kaolack noted that when a girl was married at a young age, it could be advisable to secure FP without informing the husband of this decision:

> *It is necessary to make the children aware, to show them the path of righteousness. When we marry our daughter off at a young age, the act is already done, but we must advise her discreetly without the husband's knowledge about FP until she reaches a certain physical maturity [and is therefore ready to become pregnant and give birth].. It is important not to inform the husband [about the FP advice or use], as this will negatively impact the relationship [between the husband and the wife's family]. If the parents are wise [well informed about the benefits of delaying childbearing], they can bring their daughter to the FP clinic without the husband knowing.*

A community leader in Matam, in contrast, argued it was a very bad idea not to talk to spouses about the decision to use FP: "*These are not problems that require a discussion with the spouse. If the latter agrees, this is not a problem. The problem arises only when the wife does it without a husband's consent*."

C. Extent to which the Health Service Centers Assessed Across the Six Regions meet the Standards Specified in Senegal's National Strategic Plan for Adolescent and Youth Reproductive Health (2014-2018)

As stated in the introduction, the major objective of this study is to provide information to strengthen the operationalization of the service delivery components of Senegal's National Strategic Plan for

AYSRH (2014–2018), drawing lessons learned from implementation experiences with different youth-friendly service models in six regions of Senegal with relatively poorer FP/RH outcomes.

To ensure YFHS, providers must adhere to a set of standards developed by the GOS. This section focuses on implementation of the YFHS Strategy. In line with this evaluation objective, we assess the extent to which the YFHS Standards have been met at different levels of health care and service delivery points and highlight implementation gaps, with a view to addressing them in the process of scaling up of YFHS. This section focuses on providing data on the following Standards:

1) Every adolescent or young person, regardless of circumstance, has access to information and advice appropriate to his/her state of health, development, and rights.
2) Every service delivery point is organized to offer every adolescent and young person quality services adapted to his/her needs.
3) All providers have the knowledge, competencies, and positive attitudes (required) to offer services adapted to the needs of adolescents and youth.
4) Members of the community, including adolescents and youth, facilitate the implementation and utilization of health services by adolescents and youth.
5) The system for managing health services takes into account the aspects tied to adolescent and youth RH in an appropriate manner.

The key guiding principles of these standards include the following: (i) active participation of young people in the planning, implementation, and monitoring of health services according to their level of capacity; (ii) provision of services based on the development and health needs of young people; (iii) community participation in activities and services provision; (iv) provision of YFHS by trained health worker and community volunteers; and (v) accreditation and certification of all SDPs providing YFHS. The Standards are to be implemented at the different levels of the health care system:community, HC, hospital, district, and national. Operational indicators were used to assess the application of each Standard as presented in the subsequent sub-sections.

For this study, we assessed the implementation of the five YFHS Standards listed above at the SDP, client, and community level. Information on the implementation of the standards at SDP level was obtained through the questionnaires administered at the SDP level and IDIs held with RH Focal Points at the district level, and additionally assessed at the client and community level to determine if SDP efforts to meet various criteria were also experienced by youth at the output level. Only 23 SDPs across the six regions were identified as providing YFHS services, which limits any cross-regional analysis of various indicators or calculating indicators as percentages. For this analysis, level of implementation was defined as the number of SDPs reporting to be implementing a specified indicator within a standard element.

It should be borne in mind this was an assessment to determine the level and functioning of services in these six regions and it was not intended as an evaluation of any particular SDP or organization's efforts. Consequently, given the number of SDPs providing YFHS services during the period of data collection across the six regions, it is not possible to statistically analyze how effective various SDPs or approaches have performed in the implementation of YFHS across the six regions. However, this report will give a critical mapping of current YFHS service implementation at SDP and community level and provide input

on performance of key indicators in the National Strategic Plan.

Standard 1: At all SDPs, every adolescent or young person, regardless of circumstance, has access to information and advice appropriate to his/her state of health, development, and rights

To assess this first standard, the assessment first sought to explore the extent to which adolescents and youth across the six regions in Senegal had knowledge concerning key health issues through quantitative and qualitative methods. This section begins by looking at community youth's understanding of key RH knowledge indicators to understand their needs and levels of awareness on key RH knowledge indicators. Table 23 and 24 describe male and female youth's knowledge of the menstrual cycle and the period of fertility, the percentage of youth who can name at least one consequence of unprotected sex, the percentage who know at least one advantage of spacing children, and awareness of contraception.

1.1 Adolescents' and Youths' Awareness on key Reproductive Health Issues

As shown in Tables 23 and 24, none of the males aged 10–14 and only 1.4 % of females aged 10–14 were aware of the menstrual cycle and the correct period of fertility ("in the middle of the menstrual cycle"). In addition, only 14.1% of females 20–24 years (the group who might have the greatest knowledge of this information) knew about the menstrual cycle and correct period of fertility, with a range of 7.2 % in Saint-Louis to 23.5 % in Kaolack.

Youth were better informed about the consequences of unprotected sexual intercourse. About one-third of male and female youth aged 10–14 years (34.6 % and 28.9 %, respectively) could name at least one consequence (most typically "contracter une grossesse non-desiree") and more than three-quarters of male and female youth aged 15–24 years could name at least one. A similar percentage of male and female youth across the age groups and regions could also name at least one benefit of birth spacing.

About two-thirds of male and female youth (64.0% and 69.8% respectively) had ever heard of contraception, though few 10–14-year-old male and female youth could name at least three methods of contraception (10.1% and 13.5%, respectively). Knowledge of three methods ranged widely across regions and age groups for both male and female youth. For example, the percent of males aged 15–19 years who could name three methods ranged from 25.4 % in Saint-Louis to 56.3% in Kaolack. With respect to individual methods, male youth were most likely to know about male condoms (57.3%) and about 40% named oral contraceptive pills and injectables. Only 8.5% of male youth mentioned EC as a method to prevent pregnancy. Females, however, were more likely to mention injectables (54.5 %), and nearly half of all female youth were aware of oral pills, male condoms, and implants. Female youth in Kaolack had higher awareness across all of the different methods than those from other regions, whereas female youth in Sédhiou had the lowest overall levels of awareness across the regions.

During interviews, male and female youth listened to a series of statements reflecting myths and misperceptions about contraceptive methods and stated if they agreed or disagreed with each statement using a four-point scale (strongly agree, agree, disagree, strongly disagree). A large proportion of youth either agreed with these statements or were not sure about the various myths and misperceptions

related to FP use, such as "contraceptives can result in babies with deformities." Between 70% and 90% of all males and females agreed with or were not sure about ten different common misperceptions about contraception, indicating a very high level of negative perceptions about long-term effects of contraception.

Table 23: Knowledge of Reproductive Health and Family Planning among Male Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescent/ young men who know the menstrual cycle and fertility periods:							
10-14 years	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Number of cases	61	28	62	59	85	60	355
15-19 years	11.3%	2.9%	14.1%	9.1%	6.4%	7.0%	8.8%
Number of cases	71	34	71	77	110	71	434
20-24 years	7.4%	8.8%	16.7%	12.3%	4.8%	4.3%	8.7%
Number of cases	68	34	66	73	105	69	415
Percentage of adolescents/ young men who are aware of possible consequences of unprotected sex (at least one):							
10-14 years	44.3%	64.3%	51.6%	33.9%	11.8%	26.7%	34.6%
Number of cases	61	28	62	59	85	60	355
15-19 years	88.7%	97.1%	70.4%	74.0%	60.0%	77.5%	74.7%
Number of cases	71	34	71	77	110	71	434
20-24 years	94.1%	91.2%	87.9%	79.5%	85.7%	94.2%	88.2%
Number of cases	68	34	66	73	105	69	415
Percentage of adolescents/ young men who know the benefits of birth spacing (at least one):							
10-14 years	21.3%	32.1%	30.6%	25.4%	17.6%	53.3%	29.0%
Number of cases	61	28	62	59	85	60	355
15-19 years	78.9%	67.6%	66.2%	66.2%	46.4%	70.4%	64.1%
Number of cases	71	34	71	77	110	71	434
20-24 years	82.4%	82.4%	81.8%	74.0%	77.1%	87.0%	80.2%
Number of cases	68	34	66	73	105	69	415
Percent who have ever heard of contraception:	74.5%	70.8%	59.3%	65.6%	57.7%	62.5%	64.0%
Number of cases	200	96	199	209	300	200	1204
Percentage of adolescent/ young men who know at least 3 FP methods:							
10-14 years	23.0%	17.9%	8.1%	8.5%	7.1%	1.7%	10.1%
Number of cases	61	28	62	59	85	60	355

15-19 years	56.3%	41.2%	28.2%	50.6%	30.9%	25.4%	38.0%
Number of cases	71	34	71	77	110	71	434
20-24 years	82.4%	52.9%	34.8%	61.6%	59.0%	55.1%	58.3%
Number of cases	68	34	66	73	105	69	415
Awareness of contraceptive methods:							
Male condom	72.5%	63.5%	45.2%	61.7%	48.3%	60.0%	57.3%
Number of cases	200	96	199	209	300	200	1204
Oral contraception pill	53.5%	38.5%	28.1%	47.4%	46.3%	24.0%	40.4%
Number of cases	200	96	199	209	300	200	1204
Injectables	52.5%	41.7%	32.7%	42.6%	33.7%	27.5%	37.8%
Number of cases	200	96	199	209	300	200	1204
Implants	24.5%	25.0%	16.1%	22.5%	22.7%	30.5%	23.3%
Number of cases	200	96	199	209	300	200	1204
Female condom	48.5%	15.6%	9.0%	18.7%	15.3%	11.5%	19.8%
Number of cases	200	96	199	209	300	200	1204
Intrauterine device (IUD)	15.0%	10.4%	3.0%	8.6%	8.7%	12.5%	9.6%
Number of cases	200	96	199	209	300	200	1204
Emergency contraception (EC)	18.0%	9.4%	4.5%	10.5%	6.0%	4.0%	8.5%
Number of cases	200	96	199	209	300	200	1204
Percent of adolescent/young men who agree or are not sure that…							
Number of cases	200	96	199	209	300	200	1204
The use of a contraceptive injection can make a woman permanently infertile.	71.5%	83.3%	78.9%	65.1%	86.7%	86.5%	78.8%
The use of a contraceptive implant can make a woman permanently infertile.	70.5%	84.4%	84.4%	69.9%	86.3%	86.0%	80.3%
The use of an IUD can make a woman permanently infertile.	72.0%	91.7%	87.9%	75.1%	86.0%	87.5%	82.8%
The use of a daily pill can make a woman permanently infertile.	73.0%	83.3%	82.4%	65.1%	86.3%	86.0%	79.5%
People who use contraception can have many health problems later in life.	79.0%	93.8%	87.9%	77.5%	87.7%	90.0%	85.4%
Contraceptives can damage the uterus.	80.0%	93.8%	88.9%	78.9%	89.7%	82.5%	85.2%
Contraceptives reduce sexual desire	77.0%	80.2%	83.4%	86.1%	88.3%	81.5%	83.5%
Contraceptives can cause cancer	65.5%	91.7%	84.9%	79.4%	89.3%	84.5%	82.3%
Contraceptives can give you babies with deformities.	71.5%	90.6%	86.9%	77.5%	89.0%	81.5%	82.6%
Contraceptives are dangerous for young women who have not yet had a pregnancy.	88.0%	93.8%	89.9%	87.6%	94.7%	88.5%	90.4%
Percentage of adolescents/young people (who have ever had sex)	72.5%	76.1%	71.8%	57.7%	58.5%	89.9%	71.4%

who have a desire to use contraception in the future							
Number of cases	51	46	71	78	53	79	378

Table 24: Knowledge of Reproductive Health and Family Planning Among Female Youth, 10-24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescent/ young women who know the menstrual cycle and fertility periods							
10–14 years	0.0%	0.0%	3.1%	3.3%	0.0%	1.7%	1.4%
Number of cases	59	32	64	61	87	60	363
15–19 years	15.1%	8.1%	7.1%	7.9%	6.9%	9.9%	9.1%
Number of cases	73	37	70	63	102	71	416
20–24 years	23.5%	17.1%	14.9%	16.4%	7.2%	11.6%	14.1%
Number of cases	68	35	67	67	111	69	417
Percentage of adolescents/ young women who are aware of possible consequences of unprotected sex (at least one):							
10–14 years	33.9%	40.6%	48.4%	16.4%	11.5%	35.0%	28.9%
Number of cases	59	32	64	61	87	60	363
15–19 years	79.5%	73.0%	68.6%	66.7%	63.7%	87.3%	72.6%
Number of cases	73	37	70	63	102	71	416
20–24 years	89.7%	94.3%	83.6%	79.1%	83.8%	84.1%	84.9%
Number of cases	68	35	67	67	111	69	417
Percentage of adolescents/ young women who know the benefits of birth spacing (at least one):							
10–14 years	32.2%	31.3%	35.9%	41.0%	13.8%	53.3%	33.3%
Number of cases	59	32	64	61	87	60	363
15–19 years	82.2%	59.5%	60.0%	68.3%	65.7%	80.3%	70.0%
Number of cases	73	37	70	63	102	71	416
20–24 years	94.1%	97.1%	80.6%	89.6%	87.4%	91.3%	89.2%
Number of cases	68	35	67	67	111	69	417
Percent who have ever heard of contraception	79.5%	65.4%	55.7%	78.5%	66.0%	74.0%	69.8%
Number of cases	200	104	201	191	300	200	1196
Percentage of adolescent/ young women who know at least 3 FP methods:							
10–14 years	23.7%	12.5%	9.4%	27.9%	4.6%	6.7%	13.5%
Number of cases	59	32	64	61	87	60	363

15–19 years	75.3%	48.6%	35.7%	69.8%	52.9%	52.1%	56.0%
Number of cases	73	37	70	63	102	71	416
20–24 years	92.6%	65.7%	59.7%	83.6%	73.0%	60.9%	73.1%
Number of cases	68	35	67	67	111	69	417
Awareness of contraceptive methods:							
Injectables	66.0%	51.0%	48.8%	65.4%	52.7%	43.0%	54.5%
Number of cases	200	104	201	191	300	200	1196
Oral contraception pill	68.0%	48.1%	37.3%	66.0%	57.7%	36.5%	52.9%
Number of cases	200	104	201	191	300	200	1196
Male condom	67.0%	37.5%	25.4%	57.1%	39.0%	66.0%	48.7%
Number of cases	200	104	201	191	300	200	1196
Implants	56.5%	40.4%	28.9%	54.5%	47.0%	45.5%	45.9%
Number of cases	200	104	201	191	300	200	1196
Intrauterine device (IUD)	26.0%	13.5%	15.4%	18.3%	16.0%	23.5%	19.0%
Number of cases	200	104	201	191	300	200	1196
Female condom	42.5%	11.5%	10.0%	22.0%	14.0%	16.5%	19.6%
Number of cases	200	104	201	191	300	200	1196
Emergency contraception (EC)	21.0%	7.7%	5.5%	8.9%	3.3%	5.5%	8.3%
Number of cases	200	104	201	191	300	200	1196
Percent who agree or are not sure that…							
Number of cases	200	104	201	191	300	200	1196
The use of a contraceptive injection can make a woman permanently infertile.	61.5%	76.0%	74.1%	57.6%	76.7%	75.5%	70.4%
The use of a contraceptive implant can make a woman permanently infertile.	64.0%	80.8%	75.1%	65.4%	78.7%	76.5%	73.3%
The use of an IUD can make a woman permanently infertile.	63.5%	93.3%	83.6%	74.3%	78.7%	76.0%	77.1%
The use of a daily pill can make a woman permanently infertile.	59.0%	78.8%	75.1%	55.0%	74.7%	76.5%	69.6%
People who use contraception can have many health problems later in life.	75.0%	89.4%	86.1%	79.1%	78.0%	77.0%	79.8%
Contraceptives can damage the uterus.	71.5%	95.2%	92.0%	76.4%	82.0%	67.5%	79.8%
Contraceptives reduce sexual desire	74.0%	88.5%	86.6%	90.6%	84.0%	68.0%	81.5%
Contraceptives can cause cancer.	63.0%	89.4%	86.6%	73.8%	77.7%	66.5%	75.3%
Contraceptives can give you babies with deformities.	59.0%	85.6%	84.1%	73.8%	74.0%	64.0%	72.5%
Contraceptives are dangerous for young women who have not yet had a pregnancy.	85.5%	88.5%	91.0%	92.7%	95.3%	80.5%	89.5%
Percentage of adolescents/young women (who have ever had sex) who have a desire to use contraception in the future	38.5%	44.4%	33.3%	32.4%	51.5%	44.4%	40.3%
Number of cases	65	45	87	71	66	90	424

In the qualitative assessment, the extent of young people's awareness of RH issues—from the perspective of young people—was addressed through the semi-structured interviews conducted with

young women who had selected a modern FP method. In Kaolack, Kédougou, Saint-Louis, and Sédhiou, the young women who took part in the semi-structured interviews seemed to generally understand how their chosen FP method worked in terms of duration and pregnancy prevention and could name advantages and side effects. The women in Matam had a more inconsistent understanding of the potential side effects of their chosen FP methods, including the belief expressed by one young woman that her FP method protected completely against pregnancy had no side effects whatsoever. In Kolda, while some of the young women were highly knowledgeable about their chosen method (one young woman even specified on which day of her cycle the injectable should be administered and that it could cause irregular bleeding between periods), others were unable to recall what they knew about their FP method. One young woman seemed not to understand the difference between hormonal birth control and EC, telling the interviewer, "*I take the pill after having sex*."

Across the six regions, some of the young women noted they had noticed weight gain with certain contraceptives, particularly the pill. While a few viewed this as an advantage (one young woman in Sédhiou even said she would recommend FP to women who wanted to gain weight), others did not and, in Kaolack, some young women said their peers were unwilling to adopt a FP method for fear of gaining weight. In this region, the women also expressed concerns that FP could prevent them from ever getting pregnant again. In fact, the belief that FP could lead to sterility was raised across many regions. A father in Matam asserted, "*I see that it is risky to the extent that they can no longer get pregnant after using family planning. It can cause serious illnesses*." A mother in Saint-Louis similarly declared, "*Family planning causes infertility in our children and leads them to other illicit activities that end in prostitution [...]. Contraceptive products help to avoid pregnancy but destroy your entire body*." A community leader who worked on health issues in Kaolack explained the endurance of these misconceptions about FP necessitated more awareness-raising, saying what was required was: "*Always advocate, raise awareness among people who do not understand FP. There are a lot of rumors about different FP methods that say one method makes you big [refers to weight gain], another method prevents all future births, etc.*"

1.2 Awareness of Services Available for Adolescents and Youth

A major objective of this study is to determine the coverage of youth-friendly RH services, defined here as the percentage of the young persons aged 10–24 who are aware of AYRH services and who access them. To maximize use/access and consequent benefits from YFHS, young people must be aware of the services offered, perceive the services to be beneficial in terms of meeting their health needs, have physical and financial access to the services, and be satisfied with the quality of services provided. This information also provides insight into communication gaps which may be addressed by SDP efforts to sensitize youth about services, part of Standard 1. In this section, we determine, at the community level and among SDP clients, young people's awareness and acceptance of, access to, and utilization of YFHS.

For this assessment, awareness of YFHS was measured through a community survey of young persons aged 10–24 years and supplemented by exit interviews with young persons in that same age range who had received RH services from the SDPs selected for this study on the day of interview. The community survey respondents were asked what they had heard and understood about YFHS and how they had obtained the information. Utilization was determined by a positive response to the question « Have you used these services [AYRH] in the past 12 months? » This question was asked only of those who

reported to have ever heard about AYRH services and where one might obtain them. Tables 25 and 26 look at these indicators from the youth perspective or output level, among both clients and youth living in the SDP catchment communities.

Table 25 includes perspectives from 180 youth clients who have just received services in all of the six regions included in the study. As indicated above, knowledge of YFHS was assessed among randomly selected youth who received services at the surveyed SDPs on the day of interview. The study team made no assumptions that all young persons who received services from a YFHS-implementing SDP know about AYRH and that they were aware the SDP was implementing the YFHS package. The interviewed clients were asked to state whether they knew of YFHS and the type of services provided within the YFHS package. When asked if they were aware about AYRH services in the SDP where they had just received services, only half (53.3%) of clients interviewed were even aware they were attending an SDP that offered specific health services tailored to adolescents and youth. This percentage ranged from 23.3% in Sédhiou to 73.3% in Saint-Louis, highlighting a serious gap in awareness generation[e]. This result suggests one or all of three things: (i) The clients do not understand the features of the YFHS package; (ii) the SDP has not generated adequate awareness of its AYRH services among clients and community members; or (iii) clients could not see any differences between the SDP where they had just received services and other SDPs regarding the way services are provided to youth. Whatever the reason, SDPs need to create more awareness of their services and offer them in ways that make them attractive to youth.

Clients who were aware of AYRH services in the SDP were asked which services were offered to adolescents and youth. Table 25 shows that nearly two thirds (63.5%) of clients mentioned their SDP offered contraception services and about half (57.3%) mentioned that the SDP offered ANC/delivery care to youth. Fewer clients mentioned RH counseling (38.5%) or gynecological consultations (24%). Less than 20% of clients mentioned HIV/AIDS counseling and testing, support for GBV, post-abortion care (PAC), or mental health services.

Clients were asked about their key sources of information about AYRH issues. Sources of information are varied with school, parents, and peer educators the top three sources of information for youth clients. Very few clients mentioned the media, IEC materials or clubs/youth programs as sources of information about AYRH. Clients were also asked about how information was shared with them during their visit on the day of interview. Less than one-quarter (22.8%) of clients reported their provider used IEC materials such as flip charts, brochures, or samples of contraceptive methods during their counseling session with the provider, and even fewer were given an IEC material to take home with them (5.6%). However, a large majority of clients (86.7%) reported they received just the right or a lot of information during their visit on the day of interview; this finding was consistently reported across the six regions.

[e] It should be emphasized that all SDPs provide services to youth, whether or not they are implementing AYRH. Unless adequately implemented, clients may not notice any differences between SDPs that offer AYRH and those that do not.

Table 25: Experience with Adolescent and Youth Reproductive Health Services Among Youth Clients, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescents/ young people who are aware of the existence of AYRH services in the SDPs	50.0%	46.7%	66.7%	60.0%	73.3%	23.3%	53.3%
Number of cases	30	30	30	30	30	30	180
Among youth who are aware that AYRH services are offered in the SDP, services mentioned as offered:							
Family planning	60.0%	14.3%	60.0%	83.3%	72.7%	100.0%	63.5%
Care during pregnancy and childbirth	46.7%	0.0%	75.0%	88.9%	68.2%	28.6%	57.3%
SRH education and/ or counseling	6.7%	100.0%	55.0%	11.1%	36.4%	14.3%	38.5%
Gynaecological care	26.7%	7.1%	20.0%	33.3%	22.7%	42.9%	24.0%
Postnatal care	20.0%	0.0%	0.0%	66.7%	18.2%	28.6%	21.9%
Advice/ Screening for HIV/AIDS	0.0%	21.4%	30.0%	11.1%	22.7%	14.3%	17.7%
Treatment of and advice about STIs	0.0%	14.3%	0.0%	5.6%	50.0%	0.0%	14.6%
Gender based violence	0.0%	28.6%	25.0%	0.0%	0.0%	0.0%	9.4%
Postabortion care	0.0%	0.0%	0.0%	22.2%	9.1%	28.6%	8.3%
Mental health and psychosocial Help	6.7%	7.1%	5.0%	0.0%	0.0%	0.0%	3.1%
Other	0.0%	14.3%	5.0%	36.5%	0.0%	0.0%	11.5%
Number of cases	15	14	20	18	22	7	96
Sources of info regarding AYRH:							
School	0.0%	100.0%	20.0%	11.1%	22.7%	0.0%	26.9%
Parents	26.7%	0.0%	15.0%	38.9%	36.4%	75.0%	26.9%
Friends/peer educators	0.0%	0.0%	55.0%	5.6%	31.8%	0.0%	20.4%
Health structure	13.3%	7.1%	5.0%	50.0%	13.6%	0.0%	17.2%
Community Member	46.7%	0.0%	10.0%	5.6%	14.6%	25.0%	15.1%
NGO/MOH coordinator	0.0%	35.7%	0.0%	0.0%	18.2%	0.0%	8.7%
Through the media	0.0%	7.1%	5.0%	5.6%	4.5%	0.0%	4.3%
Spouse/Partner	6.7%	0.0%	0.0%	5.6%	0.0%	0.0%	2.2%
Leaflets/Posters	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	2.2%
Young girls' club	0.0%	0.0%	5.0%	0.0%	0.0%	0.0%	1.1%
Number of cases	15	14	20	18	22	4	93
Percent of adolescent/youth clients who report that their provider used flip charts, posters, brochures, or contraceptive samples during counseling	23.3%	6.7%	16.7%	6.7%	30.0%	53.3%	22.8%
Number of cases	30	30	30	30	30	30	180
Percent of adolescent/youth clients who report that they were given IEC materials on FP or other services during their visit	20.0%	0.0%	0.0%	3.3%	10.0%	0.0%	5.6%

Number of cases	30	30	30	30	30	30	180
Percent of adolescent/youth clients who reported that the amount of information they received during the visit was just right or plenty	90.0%	93.3%	80.0%	86.7%	80.0%	90.0%	86.7%
Number of cases	30	30	30	30	30	30	180

Table 26 presents similar information for community youth, showing the percentage of community youth survey respondents who have ever heard of AYRH, who know of a service delivery point offering AYRH, and who have ever accessed AYRH services. Knowledge of YFHS was generally low (17.3%), with important differences among regions: awareness was highest in Kédougou (33.0%) and lowest in Matam (7%). Furthermore, in each region, awareness increases with age, though not by sex (15.9% among males and 18.7% among females). Awareness ranged from a low of 0.0% among 10–14-year olds in Matam to 49.3% in Kédougou. An indicator on awareness of both the existence of AYRH services and awareness of a SDP or organization where they may be obtained was also calculated. Approximately 13.2% were aware of both the existence of services and a place to obtain them. These results were similar to awareness of services (alone), implying that youth who are aware of services are also likely to know a provider or SDP where they can obtain them.

Respondents living in YFHS SDP catchment areas were asked about channels of information about where to receive AYRH services. Those youth who had ever heard of AYRH services and knew where to obtain them were most likely to mention friends, parents, or neighbors as their main source of information about AYRH services and their location. Youth also mentioned that schools (36.6%), community health workers (e.g., ASC/relais/Bajenu Gox; 24 %), and health providers (17.7%) were also important sources of information. Radio and television were not critical sources of information about where to obtain services, although nearly half of youth in Sédhiou (28.3% radio and 20% television) mentioned they obtained information through these channels. In addition, schools were the most frequently mentioned source of information for youth in Sédhiou about where to obtain AYRH services. Community health workers (ASC/relais) were important sources of information in Kolda (34.1%) and Sédhiou (36.7%).

Youth who had ever heard of services were also asked what specific SDP or organization provided these services. Results varied by region, reflecting the overall landscape of available providers; a complete list is also shown in Table 26. Youth across the regions (with the exception of Saint-Louis) were often likely to mention that a HC near their community provided AYRH services (37.2%). In Kaolack, mobile outreach services and CDEPS[f] (Centre Départemental d'Éducation Populaire et Sportive) were also likely to be mentioned (23.1 % and 15.4%, respectively). In Kedougou, postes de santé (22.0 %) and mobile outreach services (18 %) were mentioned. Youth in Saint-Louis were most likely to mention ASBEF (62.5%), followed by Centres MSI (18.8%). In Kolda and Sédhiou, youth were also likely to mention les CCAs (Centres ADOs; 29.3% and 41.7%, respectively).

[f] Centre Départemental d'Éducation Populaire et Sportive, or the Regional Center of Popular Education and Sports is in charge of support for high-level sport, training in the professions of facilitation and sports supervision, as well as hosting youth and popular education associations. It also manages a network of youth centers similar to the CCAs which provide limited RH information and services for adolescents and youth.

Table 26 also presents an indicator on the percentage of youth who knew of at least one AYRH service provided at these SDPs. Among adolescents and youth who were aware of AYRH, 70.4% could name at least one AYRH service. These youth were asked specifically which services they know about. Most youth mentioned conseils/dépistage pour le VIH/SIDA (79.5%), followed by FP (58.7%) and RH education and counseling (53.6%). Youth were least likely to mention GBV services (6.1%), gynecological consultations (5.8%), and PAC (5.5%). These results varied by region. Youth from Saint-Louis were most likely to mention FP/RH counseling (73% for each); only one-third (32.1%) of youth in Kaolack and 42.9% of youth in Matam mentioned FP as an AYRH service.

Lastly, Table 26 shows the percent of adolescents and youth who can name at least one method of contraception which can be found in YFHS, as well as the FP methods named by youth. Over one half (52.2 %) of all youth who had ever heard of YFHS could name at least one contraceptive method offered at AYRH services. This percentage ranged from 35.4% in Saint-Louis to 65.0 % in Kolda. Among these youth, most mentioned they were aware that male condoms were available at AYRH services (75.7%). Youth also mentioned injectables (40.4%), oral contraceptive pills (37.6%), and implants (33.5%). Knowledge of male condoms was highest in Kaolack (93.9%) and Matam (90.0%) and knowledge of injectables was highest in Kolda (56.7%) and Saint-Louis (65.2%).

Table 26: Experience with Community Outreach Services Among Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
1.5. Percentage of adolescents/ young people who are aware of the existence of AYRH services, by age and sex:							
Total	21.3%	33.0%	25.8%	7.0%	10.8%	17.3%	17.3%
Number of cases	400	200	400	400	600	400	2400
10–14 years	10.0%	8.3%	10.3%	0.0%	1.7%	.8%	4.7%
Number of cases	120	60	126	120	172	120	718
15–19 years	21.5%	38.0%	24.8%	7.9%	12.3%	19.7%	18.6%
Number of cases	144	71	141	140	212	142	850
20–24 years	30.9%	49.3%	41.4%	12.1%	16.7%	29.0%	26.9%
Number of cases	136	69	133	140	216	138	832
Males	22.0%	36.5%	26.1%	4.3%	8.0%	14.0%	15.9%
Number of cases	200	96	199	209	300	200	1204
Females	20.5%	29.8%	25.4%	9.9%	13.7%	20.5%	18.7%
Number of cases	200	104	201	191	300	200	1196
21) Percentage of adolescents/ young people who are aware of the existence of AYRH services, and where these services are provided:							
Total	13.0%	25.0%	20.5%	6.3%	8.0%	15.0%	13.2%
Number of cases	400	200	400	400	600	400	2400

10–14 years	4.2%	5.0%	7.1%	0.0%	1.2%	.8%	2.8%
Number of cases	120	60	126	120	172	120	718
15–19 years	13.9%	25.4%	17.0%	7.1%	9.0%	17.6%	13.6%
Number of cases	144	71	141	140	212	142	850
20–24 years	19.9%	42.0%	36.8%	10.7%	12.5%	24.6%	21.8%
Number of cases	136	69	133	140	216	138	832
Males	13.5%	27.1%	22.1%	3.8%	5.0%	11.5%	11.9%
Number of cases	200	96	199	209	300	200	1204
Females	12.5%	23.1%	18.9%	8.9%	11.0%	18.5%	14.5%
Number of cases	200	104	201	191	300	200	1196
Sources of information regarding where to obtain AYRH services:							
Friends/ Parents/Neighbours	32.7%	36.0%	57.3%	44.0%	66.7%	38.3%	46.7%
Schools	32.7%	36.0%	32.9%	36.0%	31.3%	50.0%	36.6%
ASC/Relais/Bajenu Gox	15.4%	20.0%	34.1%	8.0%	12.5%	36.7%	24.0%
Health service providers	11.5%	22.0%	28.0%	12.0%	8.3%	15.0%	17.7%
Peer educators	3.8%	6.0%	9.8%	4.0%	4.2%	13.3%	7.6%
Radio	15.4%	2.0%	13.4%	0.0%	0.0%	28.3%	11.7%
Television	3.8%	0.0%	4.9%	16.0%	0.0%	20.0%	6.9%
Newspapers/magazines/posters	1.9%	2.0%	2.4%	0.0%	0.0%	1.7%	1.6%
Internet	0.0%	0.0%	0.0%	4.0%	0.0%	0.0%	.3%
Number of cases	52	50	82	25	48	60	317
21) Percentage of adolescents/ young people who are aware of the existence of AYRH services, and where these services are provided (multiple responses):							
Health Centre	63.5%	20.0%	26.8%	72.0%	18.8%	43.3%	37.2%
ADO Centre (CCA)	1.9%	16.0%	29.3%	0.0%	2.1%	41.7%	18.6%
ASBEF satellite clinic	0.0%	0.0%	13.4%	8.0%	62.5%	8.3%	15.1%
Outreach activities/ Mobile teams	23.1%	18.0%	8.5%	8.0%	2.1%	20.0%	13.6%
Health Post	1.9%	22.0%	19.5%	20.0%	0.0%	15.0%	13.2%
Health Hut	0.0%	14.0%	19.5%	0.0%	0.0%	5.0%	8.2%
MSI Centres	0.0%	0.0%	7.3%	0.0%	18.8%	10.0%	6.6%
CDEPS (Departmental Center of Public and Sports Education)	15.4%	8.0%	1.2%	0.0%	0.0%	0.0%	4.1%
Youth space	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	1.9%
Health structure	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
French alliance	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
NGO	1.9%	0.0%	3.7%	0.0%	0.0%	0.0%	1.3%
School	1.9%	10.0%	0.0%	0.0%	0.0%	0.0%	1.9%
ASC	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Dedicated youth space	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Red Cross	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Church (a nun)	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.3%
PMI	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.3%
Hospital	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
ECDE Family Life Education	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.3%

Number of cases	52	50	82	25	48	60	317
Among adolescents/youth who are aware of AYRH, percent who can name at least one AYRH service	65.9%	75.8%	73.8%	75.0%	56.9%	76.8%	70.4%
Number of cases	85	66	103	28	65	69	416
Services mentioned as offered in YFHS SDPs by adolescents/youth:							
Advice/screening for HIV/AIDS	96.4%	80.0%	72.4%	71.4%	59.5%	88.7%	79.5%
Family planning	32.1%	70.0%	71.1%	42.9%	73.0%	54.7%	58.7%
RH education and/or counseling	87.5%	24.0%	38.2%	76.2%	73.0%	45.3%	53.6%
Treatment of and advice on STIs	23.2%	12.0%	18.4%	23.8%	29.7%	32.1%	22.5%
Care during pregnancy and childbirth	0.0%	10.0%	17.1%	0.0%	21.6%	3.8%	9.6%
Mental health and psychosocial help	3.6%	10.0%	7.9%	4.8%	13.5%	0.0%	6.5%
Gender-based violence	5.4%	2.0%	7.9%	0.0%	18.9%	1.9%	6.1%
Gynecological care	1.8%	6.0%	9.2%	4.8%	8.1%	3.8%	5.8%
Postabortion care	0.0%	10.0%	10.5%	0.0%	2.7%	3.8%	5.5%
Number of cases	56	50	76	21	37	53	293
Among adolescents/youth who are aware of AYRH, percent who can name at least one method of contraception that can be obtained at youth-friendly health services	37.6%	60.6%	65.0%	35.7%	35.4%	65.2%	52.2%
Number of cases	85	66	103	28	65	69	416
Methods of contraception available at AYRH services (among those who can name at least one method):							
Male condom	93.9%	85.0%	73.1%	90.0%	56.5%	64.4%	75.7%
Injections	15.2%	37.5%	56.7%	20.0%	65.2%	28.9%	40.4%
Oral contraceptive pill	24.2%	35.0%	50.7%	30.0%	69.6%	15.6%	37.6%
Implants	15.2%	37.5%	31.3%	10.0%	60.9%	37.8%	33.5%
Female condoms	36.4%	5.0%	13.4%	0.0%	26.1%	4.4%	14.2%
IUD (intra-uterine device)	6.1%	0.0%	9.0%	0.0%	21.7%	0.0%	6.0%
Emergency contraception	3.0%	2.5%	6.0%	0.0%	4.3%	0.0%	3.2%
Cycle beads	0.0%	0.0%	3.0%	0.0%	4.3%	0.0%	1.4%
Number of cases	33	40	67	10	23	45	218

The qualitative assessment yielded a wide range of knowledge and perspectives regarding the RH services specifically geared towards adolescents and youth available in communities in the six regions. Across Kaolack, Matam, Saint-Louis, and Sédhiou, most parents who took part in the FGDs seemed to have limited awareness of AYRH services available in their regions. Parents in these regions who were asked where adolescents and youth should go to get assistance for their RH needs most often mentioned health care centers (health facilities, health posts, and hospitals—sometimes mobile health clinics and dispensaries) and/or health care providers like gynecologists and midwives. A mother in

Kaolack noted, "*At the gynecologist's office, or at ASBEF/Kaolack, there is a lady who gives talks there, even the youngest ones go there*." Some parents claimed to know of no AYRH services in their region; a father in Sédhiou, for instance, commented, "*I have heard of the existence of these services, but [only] in Dakar and Thiès. But here in the Sédhiou region, these structures adapted to young adolescents, to my knowledge, they do not exist at the moment*." Others, particularly fathers, seemed to see the issue as outside of their purview, responding that adolescents or youth should talk about RH issues with their mothers or with medical professionals. A father in Matam noted, "*Doctors are the ones who can diagnose and give prescriptions in order to provide the necessary care. We are men and we are not supposed to know about the sexual and reproductive health of our teenagers*." Those in these four regions who could not identify where services were offered oftentimes mentioned the Bajenu gox in their communities who could refer youth to the right places.

In Kédougou and Kolda, parents tended to bring up the CCA when they were asked about AYRH services, though there were parents in both regions who said they did not know of any such services or else pointed to health structures like hospitals. When asked where adolescents and youth could go to take care of RH problems, one father responded: "*There are the health facilities – they can go to the health posts, health centers and the teen counseling center [CCA]*." In Kédougou, the CCA appeared to have such a strong association with AYRH services that one father said, "*I only know the CCA*." Another father noted, "*The services I know, there is the CCA, KEO [Kédougou Coaching Guidance]. At the CCA, there is a laboratory technician for screenings, a midwife for pregnancy, menstrual cycle counseling, and technical advice*."

Community leaders who took part in the qualitative assessment, similar to parents, were fairly limited in their awareness of the AYRH services available in their communities. Many community leaders in Matam, Saint-Louis, and Sédhiou said adolescents or youth in need of assistance for FP/RH needs should visit a health structure (hospitals were often mentioned), health care provider, or a resource person, like a Bajenu gox, who could refer them to a health care provider when needed. When asked where young people should go to take care of their RH needs, a religious leader (Imam) in Saint-Louis answered, "*I do not really have any knowledge of that*," while another community leader responded no place existed for AYRH services. A community leader in Matam remarked, "*We have Bajènu Gox and NGOs here who are doing a good job of giving children food*," which seemed to indicate a lack of understanding concerning what AYRH entailed. One exception in Matam was a community leader who worked with a youth association, who illustrated his awareness of services by saying, "*We have an ADO [adolescent] space at district level. It is located inside the health district [offices] and is specifically dedicated to young people. There, they can meet and discuss reproductive health and generally sexuality and the life of a couple*."

In Kaolack, Kolda, and Kédougou, most of the community leaders named the CCA as the central resource for adolescents and youth to seek RH services. As one community leader in Kaolack noted, "*I have not heard much about these services except at the Teen Counseling Center.*" Another community leader in the region, however, claimed that, while the CCA used to play a central role in educating and provided resources to adolescents and youth, it had declined in recent years, apparently due to lack of funding:

We have to bring back the CCA, it's more adapted to the needs of young people, it's more confidential. In addition, a young person can come without people asking questions because some come for the sport [activities], others come for the theatre, or for culture. [...] Sensitization, awareness raising, condom distribution, voluntary AIDS testing, the CCA was doing all this. I do not understand why they stopped all that.

The community leaders in Kaolack, Kolda, and Kédougou also named SDPs and community health workers as offering SRH services to young people. As a community leader in Kolda noted, "*They can go to health centers and CCAs where they can find everything they need*."

Across the six regions, SRH program managers tended to have more awareness of the RH services available to adolescents and youth than community leaders or parents; as might be expected, this was particularly true of individuals whose organizations worked on youth and/or health issues. An SRH program manager in Kédougou, for instance, demonstrated a high level of awareness, listing a range of options at the district level: " *Health posts, the General Youth Inspectorate, the Departmental Center for Public and Sports Education [CDEPS], the Teen Counseling Center [CCA], and some organisations similar to the School Medical Inspectorate [IME]*." In Matam, SRH program managers consistently mentioned the CCA and "teen spaces" (youth corners) within health facilities, and one manager noted, "*In Matam, there is a chain of care that includes the CCA, the health district including the RH coordinator, also the bajenu gox association, the SCOFI project [girls' schooling project], AEMO [Educative Action in Open Community]. All this constitutes this chain*." At the same time, there were some managers with more limited awareness. An SRH program manager in Kédougou spoke of the CCA as a resource for counseling, but when asked about other services available, answered, "*At the health district level? ... No, I do not know*." A program manager in Kaolack responded, "*I only know the CCA, the medical region and the district we are used to working with*."

As might be expected given their roles, peer educators and SRH program managers who took part in the qualitative assessment across the six regions had a better grasp of the RH services available to adolescents and youth in their communities than other groups of participants. When asked about the AYRH services available in their communities, peer educators demonstrated particularly good knowledge of where adolescents and youth could turn for counseling or information, like the CCA, NGOs, and more informal resources like Bajenu gox and groups that worked in schools. A peer educator in Kédougou noted, "*For this [AYRH services], there is the CCA to provide information to young people. There are associations that fight against these scourges, the Family Life Education clubs that talk with young people and educate them at the same time. There are also health facilities like Kédougou health district*." Peer educators in Kaolack pointed in particular to the CCA and ASBEF as important resources and peer educators in Matam were able to name which day of the week the midwife came to the CCA for free consultations with adolescents and youth. The CCA was also mentioned frequently by peer educators in Sédhiou, where one observed of young people: "*They can go to the teen centre, the lab technician is there to guide them and advise them on early pregnancy and sexually transmitted diseases*." A peer educator in Saint-Louis noted approvingly that RH services were available to adolescents and youth from a variety of providers:

I think that in the health posts, in the dispensaries, there is a family planning service at all levels, there are services dedicated to reproductive health and they are free, I think. Apart from that, there are certain NGOs working in the same field as Marie Stopes who are active in this field, for example, UN Women.

In contrast, a peer educator in Sédhiou complained about the limited availability of spaces specifically designed for adolescents and youth, complaining there was just one "teen facilty" in the district: "*Here the YFS exist only in the districts so for me it's really disturbing to have adults and young people together. It's not adequate in our area*."

SRH program managers were highly knowledgeable about the range of AYRH services available in their communities which also meant they were acutely aware of what they believed to be gaps in the services available and room for improvement. In Sédhiou, for instance, the SRH program managers interviewed offered different assessments of the adequacy of the AYRH services available. One remarked, "*With regards to youth-friendly services in our district, I think that all the services are suitable. These include general consultations, prenatal consultations, postnatal consultations and family planning*." The other SRH program manager, on the other hand, commented on the deficiencies she had identified: "*Our main problem in Sedhiou district is that we do not have a specific teen/youth space at the district level. [...] As you have seen, our district is not adapted to the YFS. This is the big problem in meeting young people's AYRH needs*." The SRH program manager in Kaolack noted there were significant differences between health facilities depending on their resources in responding to a question of which types of AYRH services existed in her district:

At the district level, [AYRH services are] in the health centers, arranged and equipped so that we can offer quality services. The service is adapted [to adolescent/youth needs], the midwife can travel, there is a focal point, and peer educators who provide sensitization and guidance if the need is expressed. But in the SDPs where AYRH does not exist, we really have constraints, difficulties to be able to offer [youth-]adapted services.

This SRH program manager also noted CCAs were limited in the services they were able to provide to adolescent and youth: "*Unfortunately in the CCAs, we do not have adequate staff that can take care of the needs of young people. So if we direct them there, it will be for a psychosocial support, but not clinical [services]*."

1.3 Perception of Extent to which Service Providers seek to Ensure that all Adolescents and Youth have Access to Information About Services Available

Participants in the qualitative assessment in Kaolack held mixed views about whether health providers took part in education and awareness-raising activities concerning AYRH. Some perceived providers as largely absent from AYRH education efforts. An SRH program manager said awareness-raising was primarily a task for outreach workers rather than providers: "*The information travels through CHWs, home visits, talks, social mobilizations, and caravans. It allows young people to get to know the services, and if they come we will identify their needs and refer them for services or elsewhere*." A father noted of service providers, "*They are open to it, but we are not aware of sensitization on the part of the service providers.*" A community leader complained that the only campaigns he had seen health outreach workers undertake

were for vaccinations. In contrast, many parents felt service providers were engaged in awareness-raising. One father remarked, concerning education about AYRH, "*I think that service providers try to help us in this sense. They organize vaccination campaigns and even educate women on how to prevent early pregnancy*." A peer educator noted, "*There are health workers and youth from the Youth Action Movement affiliated with ASBEF who travel to neighbourhoods and schools to offer young people free screening days.*"

While most participants in Kédougou seemed to agree the efforts of service providers to raise awareness were working, some peer educators complained more needed to be done by providers to reach AYRH with information. One peer educator noted young people were largely unaware that services specifically for adolescents/youth existed, and another called for improved interactions between health service providers and their adolescent/young clients:

> *The people who are in these SDPs start to say that young people do not inform themselves and are not committed when this is not the case! It's the commitment of the staff that is missing. Although the SDPs are numerous, their presence is not felt. They (the service providers) do not answer all the questions of these teenagers.*

It was clear a large part of providers' approach for reaching adolescents/youth with information in Kédougou involved collaborating with local partners, often by sending a midwife or provider to an activity organized by a local partner to educate youth on RH issues. A SRH program manager in Kédougou noted, "*We work with social services, groups, many women's associations and the private sector. Strategies are in place and they are perfectly in line with our ongoing programs*." A community leader in the region likewise noted the collaboration between providers and school-based groups to educate adolescents and youth on RH issues: "*It is the health service providers together with the Family Life Education Clubs at the school level with the School Medical Inspectorate [IME] who organize these activities*." Parents in Kédougou disagreed about whether and to what extent service providers in their communities were raising their awareness about AYRH issues. One father declared, "*The community has never united to help children use SRH. We never mobilized for it.*" In contrast, when asked about where he had heard of AYRH services, he responded, "*I heard them talk about it for the first time in a talk organized in our neighborhood by community health workers.*"

Participants of all types described extensive outreach on the part of service providers in Kolda to reach adolescents/youth with information about services and counseling, noting they worked closely with Bajenu gox and community organizations to implement a wide range of activities. A peer educator in Kolda remarked, "*From time to time, at ASBEF or the CCA, people mobilize staff who will conduct on-site sensitization on issues related to sex*." A Bajenu gox noted:

> *Take the case of the health district, which sometimes invites us to talks to better address the concerns of adolescents/young people. Service providers discuss the care that is offered and sensitization among leaders and other actors. From time to time, young girls have psychological problems because of the sexual violence they have suffered in the past. Service providers, at their level, support leaders and stakeholders to direct these types of people to health facilities and CCAs.*

Parents in Kolda largely described active outreach on the part of service providers to members of the communities; as one father said, "*There are programs, talks, and in all cases, they do several things to make young people and parents aware of how to protect themselves. Health facilities do this, especially the teen counseling centre and the health centre*."

Outreach from the health structures and service providers in Matam was described as highly inconsistent and seemed to depend on outside funding sources and the actions of individual SRH program manager. This was perhaps most apparent in the interviews with SRH program managers: one of the managers interviewed could not identify specific strategies used by service providers to reach youth with information or services. Another manager described undertaking a wide range of outreach activities, including implementing RH education activities in schools and following up with youth individually to orient them towards services, training teachers to refer youth to the "espaces ado," and using community radio to reach youth with information. Mentions from other participants of outreach activities from service providers in Matam were sparse.

In Saint-Louis, many participants in the qualitative assessment said not enough was being done by health service providers to educate communities about AYRH issues. An SRH program manager, in response to a question about what was already being done, said, "*There are no specific channels for giving adolescents information. In any case, it is a challenge for us to really identify teenage CHWs and helpers who will be directly in touch with them to give them information enabling them to come and use our services*." A mother who took part in a FGD commented, "*There is no midwife who comes here to talk with young people about this*," while a father remarked concerning education and outreach by providers to adolescents and youth, "*There are structures that accompany pregnant women reliably but in terms of raising young girls' awareness, I have not heard of that*." When participants in Saint-Louis did say they had been exposed to AYRH information, they mostly attributed this to campaigns by Bajenu gox or civil society organizations.

As in many of the regions, perceptions concerning the extent of outreach by service providers to communities in Sédhiou were mixed. A few peer educators said they worked well and consistently with providers to better reach adolescents and youth, particularly within the context of the CCA; as one noted, "*If for example the activity is dedicated to early pregnancy, you go to the post [in a certain village] to ask that the midwife come here [to the CCA] because there are young people who are ashamed to go to health facilities for fear of meeting their mother*." Some community leaders also felt there was good collaboration between communities and health care providers. The leader of a CSO in Sédhiou, whose work was deeply intertwined with that of health service providers, noted the relationship was mutually dependent, saying of the providers, including doctors and technicians: "*They are readily available because what we actually are is helpers, the communication they had to carry out, a part of it is done by the community because they know they cannot go without us and we without them*." Bajenu gox and SRH program managers were described as more active in communities to promote awareness of and responses to AYRH issues. One mother in a FGD noted Bajenu gox were particularly focused on educating families about early marriage and pregnancies: "*Badiénes gox organize talks with parents to discuss and give advice to children.*" SRH program managers noted they engaged in a wide range of activities to make sure adolescents and youth were sufficiently informed about RH issues. One remarked, "*At school level there are talks, sensitizations about STIs, and early pregnancies just to get closer to these teenagers/young people. With these relationships that we weave with them, we encourage them to go to the district [health center]*." Other members of the

community did not feel there was much outreach or coordination with communities on the part of providers with respect to promoting awareness of RH issues or better RH outcomes for adolescents and youth. When asked whether health care providers ever worked with his community on AYRH issues, a religious leader (Imam) said, "*The service providers do it, but the initiative often comes from the NGOs. They are the ones who organize the activity and they call the health service providers to carry it out, in return they get perdiems*."

1.4 Efforts made by Servicve Delivery Points to Ensure Adolescents and Youth have Access to Appropriate Information at Facility Level

This last section examines the efforts of SDPs to ensure adolescents and youth have access to appropriate information in order to improve youth understanding of RH issues. Table 27 shows the number of SDPs that reported to be implementing Standard 1 elements by type and location of the SDP. This information pertains to the SDPs' efforts to ensure adolescents have access to appropriate information. During SDP audit interviews with in-charges, respondents were asked various questions about how they communicated with youth to inform them about available services. While SDP efforts to reach youth in their communities is important because youth are very likely not to be aware of YFHS services without these activities, indicators on these efforts are presented as part of Standard 4, later in this report.

According to these results, only about half (12 out of 23) of SDPs in the assessment had a sign indicating health specific services for adolescents and youth. While the standard is to include hours and service location on the signboard as well, no SDPs had posted their hours of operation or locations on any of the signboards.

It is also good practice for SDPs to develop and print copies of brochures, posters, and other IEC materials developed specifically for youth to take and read in the SDP or to take home. Only 15 out of 23 SDPs had at least two types of IEC materials available in the waiting rooms of the assessed SDPs.

According to these results, all SDPs had at least one provider who had received training on offering counseling and health services to youth. However, staff do not work every day of the year, so it is important to have more than one staff trained and available to offer counseling and services. In this assessment, 16 out of the 23 assessed SDPs had at least two trained providers ready to offer services to adolescents and youth.

Table 27: Indicators Related to Standard 1 (Every adolescent or young person, whatever their situation, has access to information and advice adapted to his health condition, his development and his rights)

Indicator	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (PPS)	**n=5**	**n=2**	**n=4**	**n=3**	**n=5**	**n=4**	**n=23**
Number of SDPs with a sign which indicates services specific to adolescents/ young people (services only, NO SDPs posted HOURS)	2	1	2	1	3	2	12
Number of SDPs with up-to-date IEC materials specifically developed for adolescents/ young people available in the waiting room (**at least 2 IEC materials observed)**	4	0	2	2	3	4	15
Number of SDPs with service providers (**at least one)** trained to provide SRH and counseling services to adolescents/ young people	5	2	4	3	5	4	23
Number of SDPs with service providers (**at least two)** trained to provide SRH and counseling services to adolescents/ young people	4	1	3	2	2	4	16

Standard 2: Every service delivery point is organized to offer every adolescent and young person quality reproductive health services adapted to his/her needs

The extent to which the health services assessed across the six regions met the second standard under Senegal's 2014–2018 strategy for AYRH was explored through analysis of the types of youth-friendly service available, the extent to which these services are able to meet key service provision standards, the extent to which they are accessible by youth, and the extent to which they are able to meet the needs of a wide variety of adolescents and youth, including those vulnerable youth who are typically excluded.

2.1 Utilization of Reproductive Health Services

Part of the goal of this assessment was to determine to what extent adolescents and youth utilized RH services available to them and for what reasons. Before examining efforts made by facilities to offer high-quality services, it is important to have information on youth's use of services. Table 28 presents the percent of youth who have both ever heard of AYRH services and used these services in the past twelve months. This information is presented in total and by age group, sex, and sexual activity (whether they reported ever having sex or not). Few youth have used AYRH services in the past 12 months; only 11.5% of youth (or 48 youth) who have ever heard of AYRH services have actually used them in the past year[g]. This number ranges from a low of 1.5% in Saint-Louis to 18.4% in Kolda. While recent use of AYRH among youth aged 10–14 years was reported by only **one** youth in Kolda, use in the past 12 months among youth 15 years and older was about 12%. There were similarly few differences between male and female youth (males were slightly more likely to have received AYRH services in the past 12 months (13.5% for males vs. 9.8% for females) and those who reported ever having sex (15.5%) vs. never having sex (7.9%). Overall, use of AYRH in SDPs was relatively low across the six regions.

[g] In looking at the total population sampled (n=2400, which includes those who have never had sex), this represents about 2% of the ***total*** youth population in these six regions having used services over the past 12 months (data not shown).

Table 28: Ever use of Adolescent and Youth Reproductive Health Services Among Youth, 10-24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescents/ young people (who have ever heard of AYRH services) who in the past 12 months, used YFS services in SDPs by age group and sex							
Total	14.1%	10.6%	18.4%	7.1%	1.5%	10.1%	11.5%
Number of cases	85	66	103	28	65	69	416
10–14 years	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	2.9%
Number of cases	12	5	13	0	3	1	34
15–19 years	25.8%	7.4%	17.1%	9.1%	3.8%	3.6%	12.0%
Number of cases	31	27	35	11	26	28	158
20–24 years	9.5%	14.7%	21.8%	5.9%	0.0%	15.0%	12.5%
Number of cases	42	34	55	17	36	40	224
Males	13.6%	17.1%	19.2%	11.1%	0.0%	10.7%	13.5%
Number of cases	44	35	52	9	24	28	192
Females	14.6%	3.2%	17.6%	5.3%	2.4%	9.8%	9.8%
Number of cases	41	31	51	19	41	41	224
Never had sex	14.3%	0.0%	9.3%	13.3%	2.2%	4.0%	7.9%
Number of cases	63	25	43	15	45	25	216
Ever had sex	13.6%	17.1%	25.0%	0.0%	0.0%	13.6%	15.5%
Number of cases	22	41	60	13	20	44	200

Results from the qualitative findings highlighted the main reasons for seeking RH services, which varied from region to region and from respondent to respondent. In response to the question of what services adolescents and youth most often sought in Kaolack, one SRH program manager responded, *"It is to manage their needs, such as STIs, sensitization, condoms that some take in secret and on top of that there is the availability of contraceptive methods*." The other manager said young women typically came to health facilities for prenatal visits or FP. She noted young men typically came to seek information:

> *At the level of structures, it is information they come to look for, or condoms. They also come if they suspect they have an STI. There they also want to be informed about these diseases; you know, with the advent of AIDS, they come to ask for condoms to prevent these sexually transmitted infections.*

An SRH program manager in Kaolack also noted differences in the types of services most often sought depending on the circumstances of the adolescent or youth: "*A young boy, who wants to buy condoms for example, prefers to go to the pharmacy instead of going to the health center. Unmarried girls also secretly consult midwives about family planning methods during late hours*."

In Kédougou, an SRH program manager asserted youth in Kédougou were more likely to go to the CCA for services than to the HCs, even for services beyond counseling like the testing and treatment of STIs and FP: "*Adolescents/young people also come for counseling and STI and HIV/AIDS testing, STI treatment, and counseling. Usually, they [the service providers] see young people at the youth counseling center [CCA]. Attendance at the health center is for disease consultation*." Asked what services adolescents and youth most often sought at the health facilities, the SRH program manager responded these were usually related to pregnancies: "*We have young mothers, pregnant young girls who come for prenatal consultations on a par with other adult women. We have young girls who have suffered miscarriages*."

When asked which AYRH services were used the most by adolescents and youth in Kolda, participants most frequently mentioned obtaining FP and treating STIs/HIV, though the manager added a few issues also common to her list:

> *I think family planning and counseling are their main reasons for attendance. Screening, they do it, but rarely. They also come for advice on STIs/HIV/AIDS. [...] I find that the prevention of unwanted pregnancies, management of gender-based violence, pregnancy and post-abortion care are among the reasons for attendance."*

The issues identified by one SRH program manager aligned with those of the other managers interviewed in Kolda, who noted: "*Reasons for adolescent/young people's attendance include rape, sexually transmitted infections, unwanted and early pregnancy, and contraception. Those who have entered into an early marriage also visit us for advice.*"

Participants in Matam frequently asserted adolescents and youth did not often use RH services, even when they were sick; this was also true of parents bringing their adolescent children to health facilities. A mother noted, "*It is the parent in question who brings his son or daughter to receive the services if the need arises. Here, frankly we do not see that.*" Similarly, a father declared it simply was not done, "*We inhabitants of [name of an agrarian zone], we do not do it. We do not take our children to the hospital to check anything*." Among those adolescents and youth who did seek RH services, one SRH program manager said they most often came in for STIs, to receive FP, and for prenatal consultations. The other manager in Matam said information was one of the key reasons adolescents and youth walked in the door; this was echoed by a Bajenu gox, who noted of youth going to health facilities in Matam, "*They go there to find out about their sexual and reproductive health*."

When asked about the primary reasons adolescents and youth sought RH services in Saint-Louis, the SRH program manager responded, "*They come for treatment of painful periods, for a free consultation, for early pregnancy care*." Another manager interviewed said she often saw adolescent/youth for STIs and for pains and problems related to menstruation. Also notable in this region, as in Matam, was that a number of participants described a strong aversion to seeking medical attention. A mother noted, "*Here, there is only the dispensary. And it's adults like us who go there. Even girls who sometimes have problems with painful periods do not go there*." One community leader similarly observed of adolescents/youth, "*They only go to the hospital in an emergency*," while another community leader claimed it was common for both adults and young people to avoid seeking medical treatment.

In Sédhiou, one SRH program manager said the main reason adolescents and youth sought RH services were for abdominal pains associated with menstruation and FP. Another SRH manager interviewed in this region offered a broader list of reasons: "*In general they come for counseling, for family planning information and sometimes also for advice on STIs, and for prenatal and postnatal visits*."

2.2 Quality of Advice/Guidance Adolescents/Youth Report Receiving at Youth-Friendly Service Delivery Points

Adolescents and youth were asked about the quality of the information and guidance received at YFHS SDPs. Respondents across the six regions tended to focus on the ways in which providers treated their clients and the environment in which services were provided. Some of the participants in the qualitative assessment in Kédougou, Kolda, and Sédhiou had the sense the care and advice given to adolescents and youth was of high quality. A community leader said of health providers in Kolda: "*Good if it's our health staff, frankly they do their job very well. I do not know what happens in the districts but here, if you have a health problem we take care of you, we discuss it with you*." A mother in Kedouhou, when asked if it was easy for young people to access services, responded, "*It's easy because there are people there just for them and they will find clear answers to their questions*." In Sédhiou, when asked whether the SDPs respond to the needs of adolescents and youth, a peer educator said they do "*because of the presence of midwives, doctors, and health staff who have a good grasp of young people's AYRH needs. They are available and welcoming*"

On the other hand, many participants complained of how providers treated their clients, though they were sometimes speaking about clients in general terms rather than specifically focusing on adolescents and youth. A bajenu box in Kaolack noted: " *Sometimes you see pregnant women who came a long way waiting a long time to be seen. From time to time they are even sent away by the service providers who tell them "We are tired, come back tomorrow.* " A peer educator in Kédougou likewise complained providers seemed too busy to talk to their clients: "*These SDPs, it is true that they are there but sometimes we do not feel their presence. Sometimes there are very committed adolescents/young people who want information. They ask for answers to their questions but eventually they are told no, we do not have time*." A Bajenu gox in Kolda made a similar complaint in Saint-Louis, observing, "*There are improvements to be made so that a young person finds an attentive listener there. But given the shortage of staff, structures, and equipment that exist there, do they have time to listen to a person*."

2.3 Organization of Youth-Friendly Services at Service Delivery Point Level

This next section examines the efforts of SDPs to ensure they are organized to offer high-quality AYRH. During SDP audit interviews with in-charges, respondents were asked various questions about the organization of services, availability of trained providers, physical attributes and basic commodities of the SDP, stocking and management of FP commodities, and other questions regarding readiness to provide services. Table 29 shows the number of SDPs that reported to be implementing Standard 2 elements by region at the time of the survey, and Table 30 includes feedback from adolescent and youth clients during exit interviews on several of these same indicators.

Table 29 shows the number of SDPs that reported to be implementing Standard 2 elements by location of SDP (region). According to these results, only 14 out of 23 SDPs had basic infrastructure including running water, electricity, toilet facilities, and a sharps container. In addition, only 14 SDPs reported having the sterilization equipment and supplies needed for providing a number of health services, including contraceptive services. Most SDPs (19) reported having a functional referral system with other SDPs offering AYRH and other social services. A total of 14 SDPs reported this system was developed in collaboration with relevant community members.

SDPs implementing AYRH services should always have relevant norms and protocols available on site as a reference; only 10 out of 23 SDPs had any such document available on-site. The next three indicators shown in Table 29 measure some of the fundamental components of youth-friendly services. Nearly all SDPs (22) reported the PPS hours of opening and closing are convenient for adolescent and youth clients. However, only seven (7) SDPs included an equipped space for adolescents and youth, and nine (9) SDPs have an observable counseling room which is clean and welcoming and which respects the standards of privacy and confidentiality in caring for adolescents and youth. It should be noted none of the SDPs in Kaolack nor Matam met this standard.

Several of the indicators listed in Table 29 present data on key AYRH health services. Few SDPs were integrated with other maternal and newborn health services, such as ANC, delivery, postpartum care, and neonatal care. While 12 SDPs (including CCAs, one IME, and HCss/ASBEF facilities) offered ANC at least two days per week, only four out of 23 YFHS SDPs (all four public HCs) were co-located with all three maternal services (ANC, delivery, postpartum care). This means pregnant adolescents and youth can find both YFHS services and comprehensive maternity services (including delivery services) only at HCs among all of the assessed SDPs in this study. However, nearly all (21) SDPs reported offering counseling for RH services; 19 SDPs reported offering prevention, diagnosis, and treatment services for STIs, and 18 SDPs reported offering contraceptive counseling and service provision for adolescents and youth.

The next set of indicators pertains to readiness of SDPs to offer high quality contraceptive services to youth. Table 29 shows that only 6 out of 23 SDPs (about one-quarter) reported offering a complete range of contraceptive methods, including EC and LARCs. None (0) of the SDPs in Kedougou, Kolda, or Matam reported having a full range of methods as described above. Furthermore, less than half (10 PPS) reported having at least one trained provider who could provide all methods, including injectables and implant/IUD insertions and removals. Nine (9) out of 23 SDPs had experienced a stockout of contraceptive methods over the past three months of any method usually offered, which may serve to discourage adolescents and youth to initiate or continue using FP.

Table 29: Indicators Related to Standard 2 (Each service delivery point is organized to provide every adolescent and young person with quality services tailored to their needs)

Indicator	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (PPS)	n=5	n=2	n=4	n=3	n=5	n=4	n=23
Number of SDPs with basic amenities (water, electricity, toilets, impenetrable disposal container for sharp objects)	5	1	2	1	3	2	14
Number of SDPs with adequate sterilization equipment and material	4	0	4	0	4	2	14
Number of SDPs with a functional referral system to other institutions offering SRH services and other social services	4	2	4	2	4	3	19
Number of SDPs whose referral system was developed in collaboration with the community	4	0	4	1	2	3	14
Number of SDPs with an AYRH care policy, standards, and protocols document	2	0	3	1	1	3	10
Number of SDPs that ensure opening hours are suitable for adolescent/ young clients	5	2	4	3	4	4	22
Number of SDPs with an equipped adolescent/ youth space	2	0	1	1	2	1	7
Number of SDPs with facilities including a welcoming and clean counseling room respecting privacy and confidentiality standards for the care of adolescents/ young people	0	1	2	0	3	3	9
Number of SDPs providing care during pregnancy (CPN), childbirth and the postpartum period (CPoN) for adolescent/ young mothers and their new-borns	1	0	0	1	1	1	4
Number of SDPs offering counseling on sexual and reproductive health issues for adolescents/ young people	4	2	4	3	4	4	21

Number of SDPs diagnosing, treating, and offering STI prevention counseling for adolescents/ young people	5	1	3	3	5	2	19
Number of SDPs offering counseling and contraceptive methods for adolescents/ young people (any methods)	4	1	4	3	4	2	18
Number of SDPs offering the full range of contraceptive methods, including emergency contraception and long-acting reversible contraceptive methods (LARC) to adolescents/ young people	2	0	0	0	2	2	6
Number of SDPs with at least one trained service provider who can provide all methods (injectables, insertion and removal of IUDs, implants, etc.)	3	0	0	1	4	2	10
Number of SDPs that have experienced a stock-shortage of FP products in the last three months (any method usually offered)	2	1	4	1	1	0	9

Table 30 below shows data from exit interviews with 180 adolescents and youth at the assessed facilities. While sample sizes are few by region, overall youth were satisfied with different aspects of services. Between 83.3% and 100.0% of youth from the six regions agreed the SDP environment was friendly and welcoming, the SDP was clean, and the costs of the services they received was affordable (with the exception of clients interviewed in Kaolack on the second and third indicators). A majority of clients (though certainly not all) agreed facilities had convenient hours and the waiting time was reasonable. Few clients (8.3% overall) agreed the SDP where they were interviewed took appointments for youth clients, a strategy to reduce waiting times and ensure the provider is available at the time a client presents for services at the facility. Lastly, all (100%) of the 47 family planning clients agreed the facility had the equipment, supplies, and commodities needed to provide them with FP services on the day of interview.

Table 30: Perceptions of Adolescents'/ Young People's Access to Youth-Friendly Services (Exit Interviews)

Quality component	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of adolescents/ young people who report that the SDP environment is welcoming	93.3%	100.0%	100.0%	86.7%	83.3%	100.0%	93.9%
Number of cases	30	30	30	30	30	30	180
Percentage of adolescents/youth who reported that the SDP was clean	0.0%	100.0%	100.0%	93.3%	93.3%	100.0%	81.1%
Number of cases	30	30	30	30	30	30	180
Percentage of adolescents/ young people who consider the costs of AYRH services in user friendly places to be affordable	73.3%	100.0%	100.0%	60.0%	90.0%	93.3%	86.0%
Number of cases	30	30	30	30	30	30	180
Percentage of young people who report that the SDP has convenient hours/days of service	70.0%	93.3%	96.7%	83.3%	63.3%	76.7%	80.6%
Number of cases	30	30	30	30	30	30	180
Percentage of young people who report that the waiting time is reasonable	56.7%	93.3%	76.7%	70.0%	60.0%	66.7%	70.6%
Number of cases	30	30	30	30	30	30	180
Percentage of adolescents/ young people who consider the location of AYRH youth-friendly areas in the SDPs to be accessible	40.0%	76.7%	63.3%	53.3%	76.7%	56.7%	61.1%
Number of cases	30	30	30	30	30	30	180
Percentage of young people who report that the SDPs have an established process for appointments	30.0%	6.7%	0.0%	0.0%	13.3%	0.0%	8.3%
Number of cases	30	30	30	30	30	30	180
Percentage of adolescents/ young people who are FP clients and have used the youth-friendly services and report that the SDP has adequate equipment, drugs, supplies and technology to provide **FP services**	100.0%	—	100.0%	100.0%	100.0%	100.0%	100.0%
Number of cases (FP clients)	10	0	5	2	11	19	47

2.4 Extent to which Services were Organized to Ensure:

2.4.1 Privacy

Across the six regions, participants in the qualitative assessment noted the lack of privacy in SDPs was among the most—if not *the* most—of the serious barriers for adolescents and youth seeking RH services within an SDP. As an SRH program manager in Saint-Louis said in response to a question about the factors that limited the use of RH services by adolescents and youth: "*The main factor may be at the post level, bringing together adults and young people.*" A peer educator in Kaolack similarly asserted: "*The main problem for young people is going to the hospital with SRH needs and finding adults who can recognize us, this is a reason for young people not going to health structures*."

In each of the regions, participants noted that being recognized by someone they knew and having conclusions drawn about why they were visiting the HC was a significant fear for adolescents and youth and could discourage them from seeking health services. In the words of a community leader in Kolda: "*Young people are often ashamed of going to the hospital to avoid meeting someone they know there*." This observation was echoed across many regions. As an SRH program manager in Sédhiou noted, "*Often there are adolescents/oung people who are forced to come when large crowds are observed in the morning, and they can find their parents here. As you know, here people's minds are fueled by gossip*." A manager in Kaolack observed, "*Access can be slowed down, sometimes a teenager can meet someone they know, and so they leave and wait for another day, that's for sure*." Others said that, rather returning another day, adolescents and youth simply kept away; as a manager in Kédougou said:

> *We are not in Dakar or other big cities, because the Kédougou region is not so vast they can easily bump into someone who knows their parents. And the following day, these people can tell the parents of adolescents/young people about their children's visit which can raise doubts. The young people [who live with their parents] flee the health center because of … the lack of patient confidentiality and the discretion.*

A recurring issue brought up by participants in most of the regions was that waiting rooms were particularly problematic as they forced young people to wait for services alongside adult clients who might recognize them and spread rumors about them. An SRH program manager in Sédhiou observed:

> *The way in which our premises are structured poses a problem because we should not put a girl in the same place as her elders or her mum but there is only one waiting room. As a result, anyone who comes for a consultation is directed to the waiting room where the girls are uncomfortable and that is what prevents them from coming.*

A SRH manager in Saint-Louis observed, "*It's the same queue for everyone, so the teenager may feel uncomfortable ... There is confidentiality but in the waiting room, we cannot guarantee this confidentiality*." A Bajenu gox in Saint-Louis noted the risk of bystanders jumping to conclusions about why adolescents and youth were seeking health services was especially high if the adolescents/youth were spotted in a waiting room assigned to a particular subspecialty, which further discouraged young people from seeking services in the SDPs: "*If you see a girl who has sexual problems coming in and who finds a woman who is*

heavily pregnant, and she sits beside her, with the eyes of society, people will wonder what she is doing in this place, specifically whether she is there for maternity care." Her remarks were echoed by a manager in Kolda, who said:

> *Among the reasons of non-attendance, let's take the example of the FP room. Adolescent/ young girls can come for FP needs. Once in the room they can find their mothers, aunts and other relatives. As a result, this mixing between these different people creates barriers that force young people to stop using the SDP. In a way, it can be said that it is stigma that makes teenagers hesitate to go to the district health center.*

Some providers told interviewers of creative solutions that had been attempted to try to address the issue of privacy for adolescents and youth in SDPs. A SRH program manager in Sédhiou noted that, since there was no youth corner ("éspace ado") in her district, the center had come up with another solution to try to preserve privacy:

> *We are obliged to carry out general consultations. So we bring everyone together so that no one can know what services patients are asking for. So these are general consultations: planning, general consultations, and postnatal consultations. Unfortunately, if we had a specific young adolescent center, we could talk to young people, give them advice; help them with sexual and reproductive health.*

A manager in Kaolack noted young people would come into the HC through the back door to avoid being seen: "*You have seen that there is a door inside the hospital and another at the back, that's where the kids come in. There is what is called self-stigmatization: a teenager can tell themselves that they feel that they are being watched even if it is not the case, and we did everything to respect the standards*." In Kaolack, a manager noted one of the SDPs used a combination of phone calls and back doors to ensure a young client could receive services without sacrificing privacy: "*We have phones and when a teenager comes, I call the midwife to tell her to come, that there is someone at the office. She comes to deliver the service and the girl exits on the other side*."

Beyond being recognized by other clients, participants in the qualitative assessment across most of the regions also noted the fact that service providers and other staff working in SDPs were from the same community could also discourage adolescents and youth from seeking services for fear staff would recognize them and tell their families. A SRH program manager in Kolda observed, "*Some adolescents/ young people do not attend the health district because of the presence of some members of their community who work there as matrons. They are afraid that they will disclose information to their parents, to the community*." Likewise, a manager in Sédhiou noted, "*The staff is not so easy. Community staff who work in the facility are often from the community. And sometimes young teens are afraid to meet someone from the community that they know well and that works in the SDP*." A father in Saint-Louis stated the potential for providers to personally know their clients was particularly high in rural settings: "*It must be emphasized that here it is different from the city; we are in a rural area. If a doctor receives a young teenager from here, they will surely know whose child he/she is. They will also know if the child is married or not.*"

2.4.2 Confidentiality

Closely tied to the issue of whether service providers would recognize adolescent clients seeking health services was concern over the confidentiality of the interactions between adolescent clients and providers.

SRH program managers who took part in the qualitative assessment emphasized, in several regions, they followed proper procedures to safeguard clients' confidentiality. For instance, a manager in Matam remarked, "*There are desks and windows, and the doors are closed, we take patient after patient. So, as far as confidentiality is concerned, I think it is there, now it's the fear of judgement that they are fleeing from, that's why they do not come to the SDP*." In Kédougou, a manager insisted confidentiality was not among the factors that dissuaded adolescents and youth from seeking services, asserting:

> *The non-attendance at the health facility is not related to discrimination and even less to negative attitudes of service providers because once in the consultation room, their secrets will be kept confidential. But, it is before reaching the consultation room that is to say that it is in the health center grounds or in the waiting room that they will be exposed to people they know.*

A program manager in Sédhiou said confidentiality of clients was consistently respected:

> *I really do not see any problems with confidentiality because the consultations are carried out according to the rules. Really, because we respect the confidentiality rules and respect the privacy of the person. Once the room is entered, the door is locked, and all that the teenager will say will stay in the room. Confidentiality is very much respected from the beginning; just the premises need to be improved so that teenagers can access them.*

Her confidence in the preservation of confidentiality was echoed by another SRH program manager in the region, who noted, "*All service providers are trained in this way. Consultation by sorting is forbidden here. Everyone buys the same ticket and ranks the same. [...] We will not know who came for this or that service. We do not have a confidentiality problem*."

The fear that providers would disclose information about whether adolescents visited an SDP—or, even more gravely, what was discussed during the consultation—could discourage youth from seeking services from SDPs. In contrast to the assurances of the SRH program managers quoted above, some of the participants in Sédhiou felt the confidentiality of clients was not respected. One peer educator in Sédhiou claimed nurses tended to gossip: "*There are also nurses who must be indexed, so that as soon as they see you they will tell the entire neighborhood that I saw such a person in the hospital she is pregnant, it is for this reason that people are reluctant to go to the hospital.*" Among the young women who took part in the semi-structured interviews, some said they had confidence the service provider they met with would keep this to themselves while others did not; one young woman in Matam, when asked whether she thought her provider would respect confidentiality, answered, "*No, she is too chatty*." Some participants in the qualitative assessment even shared personal stories of the confidentiality of their visits

not being respected, like a peer educator in Matam, who recounted:

> *One day a midwife told my mother, "You think your daughters are innocent, while they've been different for a long time," but as a peer educator I'm still in contact with midwives and my mother was worried and she thought I was like that, and she came to scold me. Therefore this midwife did not have the right to say that…she did not respect confidentiality.*

2.4.3 Parental Consent (where required)

In the qualitative assessment, information about whether providers sought parental consent before counselling or treating adolescents or youth came primarily from the SRH program managers interviewed. Across the six regions, the SRH program managers were fairly consistent when asked about this issue: for the most part, they did not. A manager in Matam replied, "*No, we do not demand it, when we receive a young person we ask them for the reason for their visit and consult them without parental consent. Unless the person wants to involve a parent, but we do not demand it*." A manager in Sédhiou similarly responded, "*No, service providers do not require parental consent...because when we receive a teenager and she expresses a need, we take care of the need without asking questions. We do not ask for the opinion of the mother or the parents*."

The SRH program managers across the six regions provided clear reasons providers like them would not seek consent, emphasizing they were primarily motivated to address the health issues of the adolescents and youth who came to them. A manager in Kédougou, when asked if providers required consent from parents, answered emphatically:

> *No, no, no, we do not need parental consent because we do not do anything that is not part of the standards and protocols [...] We are here to offer quality services rather than to judge. Sometimes we have teenagers who are accompanied by their parents, to show you that if she is not married she is consulted in front of her parents. The entire advice package offered is offered in front of her parents.*

A SRH program manager in Kaolack said providers did not seek consent because it would not only result in refusal from the parents but might also break adolescents' trust in providers: "*No, we do not require the parental consent, when the teenager comes they do it secretly, so if we ask the parents' opinion we will never see them again, you risk being called a liar*." Another manager in the region noted parental consent was not sought unless the service provider was testing for HIV:

> *Apart from screening, parental consent is not required, it may be in the judgments, but it is not written in the protocol that we must receive on reproductive health services for teens/young people. But the problem that sometimes arises is with respect to HIV testing, the parent has to agree, we need to have consent if the child is a minor.*

In Saint-Louis, two of the SRH program managers interviewed said they did not ask about or seek parental consent before seeing their adolescent clients. However, the third SRH program manager interviewed presented the caveat that, for very young adolescents, it could be important to try to

involve parents: "*If the girl or boy is under 15 years old, we can try to discuss it with his/her parents for a follow-up, especially because a young person alone cannot bear all the expenses*."

The SRH program managers also differed somewhat in their responses in Kolda. One said they did not seek parental consent before consulting with adoelscents and youth but "*Once the teenager comes to the structure for any need, we will consult her without the consent of her parents.*" The other contended service providers had to weigh the importance of seeking parental consent from parents against the potential health risks to clients if they did not provide them with services:

> *Sincerely, we do not do it. If you want to have parental permission to meet the needs of young people, you will never have it. For example, a teenage girl comes to see us because she has had unprotected sex and has doubts about getting pregnant. She comes to us for our services to be monitored and receive a FP method. When the girl arrives, you will do everything to screen for a possible pregnancy. Now, if you tell her that she is not pregnant and that her parents need to give approval for a FP method, you will not see her again. She will have unprotected sex again and may become pregnant. From this moment, it can be said that the service provider is the cause of this pregnancy.*

2.4.4 Operating Hours

As mentioned in the beginning of this section on findings, most SDPs operated on government, standard clinical hours, five days a week, generally between 8:00 and 18:00. Two SDPs reported they offer services 24 hours a day, throughout the year.

In the qualitative assessment, there was general agreement across the six regions the hours during which SDPs typically operated were not suitable to adolescents and youth. The two predominant reasons respondents named were summarized by a SRH program manager in Sédhiou:

> *In my opinion, the operating hours are not suitable for teenagers especially students, because we cannot go into the waiting room and take the students and leave the mothers, it will create controversy. That's why we let everyone wait their turn. I recognize that it is not easy for a student to lose a whole day of classes because of a health need. I think we need to make improvements at this level.*

Across the six regions, SRH program managers (who were the primary group of respondents asked about this issue) said students struggled to access health facilities during their opening hours because these overlapped with school and often involved very long wait times. A manager in Kédougou noted: "*Few young people come to the health centre for FP because they will have to queue. In addition, they are not free during opening hours because they have classes. These are the constraints that prevent them from coming here. They feel more comfortable at the CCA than at the health centre.*"

A manager in Saint-Louis also noted adolescents and youth seemed to prefer to access services during times that did not align with SDP hours of operation: "*There are hours when the services are not ongoing, so all of this can promote inaccessibility. Adolescents often want to identify least busy hours while these are the*

hours when services are closed." In Kolda, one SRH program manager argued the hours of operation should be expanded, noting operating hours and long wait times were among the barriers to RH services that adolescents and youth faced:

> *Opening hours should be adjusted in line with adolescents/ young people because of their large numbers at the health centre. The young people, because of their school hours, have problems with waiting at the health centre level. These long queues push them to desert the center, which was why the opening times that will allow them to visit should be identified. As far as possible, it is necessary to build spaces dedicated to the supply of YFS at the level of the health facilities that are attended only by the young people themselves.*

The other SRH program manager interviewed in the region said operating hours had already been adjusted at some SDPs to better accommodate adolescents and youth: "*Regarding unsuitable schedules, there are SDPs where teenagers/young people are seen on Fridays, Wednesday evenings and Saturday mornings. As women attend health facilities in the mornings, they utilise afternoons around 5 pm to receive and treat young people."*

Another reason many SRH program managers said operating hours were not suitable for adolescents and youth seeking RH services were because they were the same for adults and young people; as was mentioned on the section on privacy, many adolescents and youth were fearful of being spotted at SDPs by others who might draw conclusions about why they were there and tell their families or spread rumors about them. A SRH program manager in Saint-Louis observed: "*Young teens are a rather special target group, they do not like to frequent the structure at the same time as adults*," later adding:

> *There is no teenage space in our structure, if I take the health center for example. The premises are so cramped that we do not have enough space to be able to create a teen room to accommodate teenagers, that's a problem. So all we can do is try to rearrange hours to take care of them.*

This sentiment was echoed by various participants in the qualitative assessment in Kaolack, who argued adolescents and youth preferred to stay home over going to SDPs during the hours others from their communities could also be found there; a SRH program manager interviewed in the region noted, "*There are consultation hours, visiting hours that would have to be reviewed to allow these young people to use health services*."

An SRH program manager in Matam described the strategy providers had devised to see adolescents and youth outside of normal operating hours to avoid having them wait in SDPs alongside others who might recognize them:

> *Being young and unmarried, if they stay there they do not feel comfortable, I ask them myself what time and day they would be comfortable, and I inform the midwife, she comes without problem. We do consultations at night, we do consultations in the evening and on Sundays depending on the availability of the teenager in relation to early pregnancy.*

Another manager in the region similarly noted, "*I also refer cases of early pregnancy, as in our locality people talk too much, midwives take care of these cases at night or in the evenings*."

2.4.5 Avaliability of Medical Equipment and Products

While this issue was not explored in great depth in the qualitative assessment, participants, particularly SRH program managers, did provide insights into the extent to which commodities were available. Across the six regions, managers often referenced a project called "Yeksina" (or "Yegsi na"), implemented by the Pharmacie Regionale d'Approvisionnement (PRA). This program has been developed to ensure the availability of medical equipment and products, including FP products, across SDPs by coordinating with districts.

Stock-outs were perceived as frequent in Kaolack and Matam, though SRH program managers tended to try to downplay this problem and emphasize that serious progress had been made to address these issues with the help of "Yeksina." A manager in Matam, for instance, vacillated between declaring products were readily available and saying stock-outs were a recurring problem:

> *Yes, drugs are available, even FP products are available [...] There are instances of drug shortages, but then the problem is solved especially now with the "yegsi na, djeguisi na" (I arrived, I'm close) project, it's a new partnership with the Ministry of Health to bring the drugs to the SDP, and after stocks are replenished we pay the fees. Currently, we are facing a lot of drug shortages, maybe because of the fact that the partnership is new, and the system is not yet mastered.*

In Kaolack, some participants described frequent stock-outs at SDPs and one father complained that "*even paracetamol [Tylenol] is rare in pharmacies*." A SRH program manager in the region noted steps were being taken to address this thanks to the new "Yeksina" program: "*It depends, there can be a shortage [within] the supply chain which can [result in] stock shortages of the essential products [at the SDP level]. But…if the product is available [in the SDP] we do not have the problem of service provision.*" Another SRH program manager said health providers sometimes turned to other FP products if there were stock-outs, referring to two different brands of implants: "*In any case for the year 2017, there were no cases of FP stock shortages, perhaps with the implant because there was a withdrawal of the classic Implanon, and if the classic Implanon is not available, we can always insert Jadelle; they are all implants*."

Stock-outs were perceived as less severe in the other four regions, and in these regions, too, SRH program managers emphasized new strategies had been developed to manage supplies. In Saint-Louis, managers said there were virtually no stock-outs thanks to "Yeksina"; one manager remarked, "*There was a time when there were stock shortages. But in the last 4 years or even 5 years, especially [with] the advent of product accessibility, there are no more shortages, especially of FP products*." The one exception in this region appeared to be the availability of STI testing products; an SRH program manager in Saint-Louis noted, "*We do not have the means to do the actual screening. We can perhaps use the syndromic approach for example, if we receive a teenager/young person for a consultation and if we see that there is discharge, we take care of them using the syndromic approach and also give advice*." In Sédhiou, a manager stated it was very rare for a provider to have to send clients to pharmacies due to stock-outs at SDPs. She told the

interviewer, "*The products are readily accessible, it's been years since we had a stock shortage of FP products*," later adding, "*Here in Sédhiou district, the products are accessible today. The family planning products are essential and fundamental, so they are available at the level of Sédhiou health structures.*" In Kolda, as well, a manager characterized stock-outs as infrequent: "*They [products] are available in the district and at the health facility level and there is no shortage. All drugs and FP products come from the regional pharmacy supply [...] They are all available and since I have been here, I have not seen cases of shortages. Even if there was one, I have not felt it.*" *Another SRH program manager interviewed in the region declared, "Since I started working at the health centre level, I have not experienced a shortage of FP products*". A manager interviewed in Kédougou also perceived stock-outs in her region as a thing of the past, telling the interviewer, "*FP products are available in sufficient quantities. We did not have stock shortages during the whole of 2017.*" Referring to the new "Yeksina" system, she added, " *It works like the drug circuit. We receive drugs from the Regional Pharmacy Mobile Supply, and health posts will put in their orders [...] With regards to drug shortages, there were none in the year 2017 and ditto for 2016.*"

2.4.6 Use of Proper Procedures

The issue of whether proper procedures as far as RH service provision to adolescents and youth were followed were not extensively addressed in the qualitative assessment, since this aspect is better assessed through direct observation rather than self-reported behaviors. The issue of whether providers typically sought consent was previously discussed. Beyond this issue, SRH program managers were asked whether there was a minimum age at which young people were accepted at the SDPs for RH services. While some named a minimum age, many also said they did not concern themselves too much with the age of their clients because they felt it was important to provide services to adolescents who came in, regardless of their age.

In Kaolack, one SRH program manager said young people between the ages of 10 and 24 sought services. Another manager responded, "*We see patients from the age of 14, especially for maternal and newborn health (MNH), for psycho-social monitoring, because the young person has reached puberty, she gets her period and must be monitored, but puberty can occur at 10 years old, even earlier, and we will have to take care of this child.*" According to the manager in Kédougou, there was no minmum age for accessing services; she added the only requirement for adolescents and youth to access services was: "…*that the adolescent is sick; that the adolescent requires a RH service*."

In Kolda, too, the managers said they focused on the needs rather than the age of their adolescent clients. One noted, "*We take all ages because, sometimes we happen to see pregnant 13-year-olds – a reason why we take all ages. The people we receive here are aged in the range between 10-24 years.*" The other manager interviewed remarked, "Here*, we do not focus on age to treat adolescents/ young people. When a patient comes to the district for any health need, regardless of their age, we will advise them.*"

When asked what the minimum age was for adolescents and youth to access RH services was, a manager in Matam responded, "It *is from the age of fourteen, we are not going to say of maturity [laughs] but from fourteen we receive them.*"

In Saint-Louis, one manager said providers dealt with adolescents aged 10 to 24, while another remarked, "*There is no age really; In view of the social context, we even see young girls who come for a gynecological consultation, such as infection of the genital tract.*"

One manager in Sédhiou said the minimum age to access RH services was 14, while another noted, "*The minimum age is 15 years old. But we have girls pregnant at 12 so we can say that the minimum age is 12 years.*"

One other way in which the qualitative assessment sought to investigate whether providers employed proper procedures was to ask young women who took part in the semi-structured interviews whether the providers had explained all the FP methods available to them before they made their selection. Most of the young women who answered this question across the six regions said the providers had talked to them about many varieties of FP methods available and they had made their choice. In a few instances, however, the women said the provider only talked to them about two or three methods from which they could choose; as one young woman in Kolda noted, "*She gave me information on two methods: pills and injectables and showed me samples of these methods.*"

2.4.7 Proper Record-Keeping Practices

Across the six regions, SRH program managers described reporting the data collected at the lowest levels of RH service provision up to the centralized level, often with the help of DHIS2, a health management data platform. As a manager in Kédougou explained:

> *The data are entered in the "Global Area Report" registers. After the consultations, as I told you, the midwife provides the activity data in the health center report and I am responsible for the collection of the district reports. After collection, the reports will be sent from the health district to the health region, and finally to the central level. We also have the DHIS2 platform for capturing and reporting health data to the central level. It has become easier now. Just enter and send via the internet connection.*

A manager in Saint-Louis noted it was useful to use DHIS2 because "*It's a data warehouse that all service providers use to track information by age groups. It is used by all of Senegal. It is filled every month with different age groups. So you can have reports at all levels: district, regional and national.*"

2.4.8 Use of Service Data

Across the six regions, SRH program managers said they actively made use of the data they collected to make decisions, noting data could be analyzed for trends, shared with other partners, or discussed in meetings.

Both managers interviewed in Kaolack offered concrete examples of how service provision statistics at the regional level was used. One said a gap in service provision noted in the data had sparked greater efforts for awareness-raising activities: "*We use the data to see what needs to be done, and at some point, we felt the need to focus on talks and radio broadcasts. The program was asked to focus on it to reduce the rate*

of teenage pregnancies; we are seeing results now. The other manager gave a similar example of how a disappointing finding in service provision statistics had motivated the region to devote more energy to outreach:

> *These are data that will be transformed into information and said transformation means action to solve problems. So we will use these data in AYRH because we realized that we do not have good results in service use by teens/young people, I think we are at about 20%. They [service delivery staff] had been told to reinforce communication so that these teenagers use the services. In order to use this information for the greatest benefit, it is necessary to have appropriate support and collection tools to report this information. So this allows us to make corrections in order to improve performance.*

In Kédougou, a manager noted service data were reviewed regularly to identify trends and address them: "We *share this data at coordination meetings, and whenever there is a problem in a particular area, we make the decisions together. Every month we share RH data including AYRH data; if there are problems, we make the decisions together*." Similarly, a manager in Kolda observed, *"The reports developed allow us to measure the level of SDP use by the population, to see how the care is delivered, and the essential reasons for patient visits. Once this analysis is made, we will plan the activities to be carried out in the future*." In Saint-Louis, too, a manager described regular meetings to review the data:

> *Once this data is entered on the DHIS2 platform here at the district level, an analysis is done to see the gaps and obstacles, and try to find solutions. Each month, district level coordination meetings are organized, and this is an opportunity to identify all the problems and to solve them. These monthly coordination meetings are also held with community stakeholders at the [health] post level. If they identify problems, they discuss them with the stakeholders to find solutions.*

Finally, the SRH program managers in Matam and Sédhiou also noted they regularly reviewed and made decisions based on the data collected. In Matam, a manager noted, " *For decision-making, it is about seeing the performance in relation to certain indicators, to see if we are performing or not. Based on that, people will ask questions to see what is not working. Now with data analysis, there are coordination meetings that will allow us to see what is good and what is lagging behind*." A manager in Sédhiou noted regular reviews were also done in her region:

> *When we have the data, we do the analysis and after the analysis, we identify the difficulties encountered in relation to the AYRH and we try to provide solutions. For example, if we see that this month we had 10 girls who came for prenatal consultation and among these 10 there are 8 who are in the teenager age group, it can alert us to the fact that there is a resurgence of early pregnancies, so this is a problem that needs to be solved. All that to say that data allows us to develop strategies for the future.*

2.5 Accessibility of Adolescent and Youth Reproductive Health Services

In addition to assessing the RH services available to adolescents and youth in the six regions against the Senegal MOH standards, the assessment also looked at two additional factors related to Standard 2: adolescents' and youths' ability to physically access and pay for the services.

2.6 Perceptions Concerning the Geographical Accessibility of Adolescent and Youth Reproductive Health Services

Aside from hours and wait times, which were already discussed in Section 2, the distances between adolescents' and youths' homes and RH services were often cited as a key barrier to access. Across the six regions, participants in the qualitative assessment said the long distances individuals had to travel to reach services meant adolescents and youth—as well as adults—required a great deal of time in addition to financial means to pay for transportation to travel to an SDP. The quality of roads were described as making travel even more difficult.

Participants in the qualitative assessment across the six regions often mentioned many communities were remote, often isolated, and located far from more central areas where AYRH services might be available. A community leader in Matam remarked, "*The challenge here is the coverage, it is that we unfortunately are in isolated areas that are very far away, this is the first challenge [...] They [young women] are far from the health structures, far from the wells, there are even villages where there is no network.*" *Regarding geographic accessibility, I would say that all the young people in the department do not have easy access to the SDPs dedicated to them.*" In response to a question about the need to raise awareness about reproductive health, early pregnancies, early marriages, and abortions, a community leader in the region called for more CCAs to be established so adolescents and youth in more remote areas could reach RH services, telling the interviewer:

> *I confirm that the lack of availability and geographical inaccessibility of YFS is a problem in relation to teenagers/young people... The costs of services are adapted to the population because they are not very high. So, just a problem of access, availability or number of centers that can accommodate populations for any information or guidance. [Expanding the number of] activities carried out on the ground would greatly help to educate the populations better.*

A SRH program manager in Kédougou noted that, even when new adolescent- and youth-friendly services were created, there were still many adolescents and youth unable to access them:

> *We have set up this adolescent/ youth space in a health post in [a village] which is a few kilometres from the health centre. Not all young people have access to this site [...] it is accessibility that poses problems and is beyond our control. In this context we can mention the geographical accessibility, the lack of transport means due to impassable roads.*

The challenge of distance was often brought up as a crucial and dangerous barrier to accessing services in cases of emergency, such as when women and girls were in labor. A mother in Kaolack commented there were no SDPs where she lives, so seeking treatment required traveling to another locale; she

noted, "*The road is bad and every time women give birth on the way*." Another mother in the region commented, "*I am the matron, most of the time when I am bringing a woman in labor, she gives birth on the way. It happens too often; it is a real problem that we live with in everyday life. We are forbidden to give birth at home, but the roads are impassable, so there is a problem*." A father in Sédhiou observed, "*With caesareans, we are very far from a hospital for modern [maternity care], so by travelling to these places, she can die on the way*." The same concerns were raised in Saint-Louis, where a mother noted the distance between some people's homes and health services delayed treatment:

> *Here, if we have a sick person we look for a way to transport them. And even to find it is a problem. And in the meantime, anything can happen. For example, a woman who is about to give birth and begins to bleed, if there is no rapid means of transportation, she may have complications. It's the same for a young girl who is married and is about to give birth. So these are the difficulties we have."*

2.6.1 Perceptions Concerning the Costs of Adolescent and Youth Reproductive Health Services

As some of the above quotes illustrate, financial means were another significant barrier to many adolescents and youth accessing RH services. The prohibitive effect of costs on accessing RH services was highly dependent on the relative levels of poverty in different parts of some of the regions. Most participants who took part in the qualitative assessment in Matam, Kédougou, and Sédhiou identified costs as one of the principal barriers to accessing AYRH services. Participants also noted the same was true for poorer parts of the region of Kolda. A SRH program manager in Kédougou observed:

> *Of course, if you take a place like Kedougou that is considered one of the poorest areas after Kolda and Sédhiou, you cannot have a very high AYRH cost and expect the teenagers/young people to attend appointments and regularly go to see the social worker or the gynecologist or the midwife...*

In Saint-Louis and Kaolack, many participants said they felt the costs for AYRH services were reasonable; nevertheless, financial constraints came up frequently as an important factor in access to AYRH services. When asked whether there were any difficulties accessing AYRH services, a father in Kaolack responded, "*Health centers and posts exist in the area, but the problem lies in people's lack of resources to support themselves [and pay for services]*." It was clear that, regardless of the relative affluence of a particular district or region, in destitute communities and households, virtually any cost at all could block adolescents and youth from accessing RH services. The financial pressures were even more intense for adolescents and youth themselves, as they often did not have their own source of income. An SRH program manager in Saint-Louis remarked, "*We know that an adolescent/young person is economically vulnerable. If, for example, his parents cannot afford it, if he has a health problem, he must be seen and get medication. The cost is sometimes a problem for adolescents/young people*." A manager in Matam explained that adolescents and youth who wanted to keep any AYRH visits secret from their parents had a very difficult time affording AYRH services: "*They are teenagers who have no income, no income-generating activities. They can get money from their parents, but if they hide from their parents what they do*

[i.e., use RH services without parental knowledge], they may have a problem with money [if their parents find out and do not approve, they won't receive money in the future]."

Across the six regions, SRH program managers mostly agreed the prices for various RH services and FP products, which they said were the same across government-run SDPs, were affordable. A manager in Saint-Louis noted, "*The cost is not too high. It's affordable because the price of the consultation ticket is 500f [CFA] and includes IB drugs [generic medications]*." A manager in Sédhiou noted, " *The cost is affordable, because the highest price is 500f, and this is for long-acting reversible contraceptive methods, namely Jadelle and Implanon. The rest is 200f and the pills are 100f.*" In some of the communities in which the qualitative assessment took place, participants agreed the prices at SDPs were reasonable. A community leader in Saint-Louis observed, "*In terms of price, I see that health is priceless even if expensive, and that if we see a solution, I do not have a problem with the price*." Several participants in Kolda also asserted costs were not very high.

In other regions, however, many participants in the qualitative assessment noted services at SDPs and prescriptions, in particular, discouraged parents from taking adolescents and youth to get medical attention, including for RH issues. A father in Matam explained that parents had to prioritize how to spend the little money they had and AYRH issues were at the bottom of the list:

> *Parents have no means, a person who does not have enough to eat does not care about health, does not go to health district SDPs. When parents are worried about daily expenses and always make the most of it [do their best], chances are they will not worry about the health of teenagers/young people, and even less their sexual needs.*

A father in Kédougou said he limited the health services his children accessed to those the centers provided at very low or no cost: "*Of the medical assistance to children, I can say that we do not even take them to the hospital. We limit ourselves to just advice, guidance and awareness-raising; as for medical assistance, there is no means*." A mother in Matam lamented, " *Mothers do not have the means to meet the health needs of adolescents. We do not have enough money and teenagers do not have the money to pay for medical expenses. And if the prescription is expensive, we try to go to the doctor to find a cheaper way to buy it.*" A community leader in Sédhiou also noted prescriptions could be particularly prohibitive in cost: "*The cost of services, especially high medication prices, is also at the root of these problems. Many young people do not go to health facilities because of high medication costs*."

SRH program managers and other participants suggested a number of ways providers tried to mitigate the costs of seeking RH services for adolescents and youth or steer them towards alternative resources. Several noted adolescents were sometimes not required to pay. A manager in Sédhiou noted, "*The consultation tickets are fixed at a very affordable price or even insignificant [...]. I'm not saying that the ticket is free, but it's not as compulsory for teenagers. If they come without money, we take them.* A manager in Kaolack remarked," *If a teenager comes for STI care and if we know he cannot afford it, we take care of him medically and socially. There is free healthcare for people between the ages of 10 and 24, but medication has to be paid for, which is what supports the health committee*."

Some participants noted the efforts of USAID and international NGOs implementing projects had also resulted in lower costs for AYRH services in certain districts. A number of respondents also noted alternative sources of AYRH services that were less expensive or free of cost. A SRH program manager in Sédhiou suggested the "adolescent space" was an imperfect solution because it was still costly: "*There the ticket can be free, but the prescription will pose a problem, so if one does not have the means to pay, the SDP cannot take care of them. We do not have a social security fund, so in terms of taking care of the prescription, they have to take care of this*." Alternatively, a manager in Kaolack noted that some free services were available through schools: "*Maybe there are constraints, but students have the opportunity to use the health services attached to schools [IMEs], so in this case, affordability is not a problem*." The CCA was also raised as a viable alternative in several regions. A community leader in Kolda noted, "*Here at the CCA services are free, there is no payment. We have a consultant – a midwife who is there and the consultations are free. We also have a lab technician and that's free too. When it comes to the district, there you have to pay. We all know that.*" A mother in Kédougou also said one way to get around the costs of AYRH services was to go to the CCA: "*If you have any health problem and want to see a doctor you have to buy a ticket to queue to see him. So, if you cannot afford the ticket, it's better to go to the CCA*."

2.7 Perceived Extent to which Adolescent and Youth Reproductive Health Services are able to Serve Different Groups of Adolescents and Youth

The final dimension of Standard 2 the qualitative assessment examined was how well adolescents and youth of all kinds were reached by AYRH services. When asked about this issue, participants in the qualitative assessment across all six regions identified adolescents and youth outside of the formal education system as among the least reached by AYRH services. Participants in Kédougou, Matam, and Sédhiou also noted that adolescents and youth who lived in rural and remote areas also had less access to AYRH services. Other categories of adolescents and youth who were said to be harder to reach with AYRH services were those who were unmarried (said to be largely due to shame about asking about RH issues) and those who used drugs.

A strongly recurrent theme was that adolescents and youth not in school were less likely to access AYRH services and were also harder to reach with awareness-raising activities about AYRH issues. A SRH program manager in Saint-Louis said of education campaigns, "*They intervene in the school environment; they are well trained, unlike young people in the community who are not in school. Youth out of school are the most vulnerable group and they need more mentoring, guidance, and support. Only the peer educators will be able to do this work*." An SRH program manager in Sédhiou noted, "*Under UNHCR (UN High Commissioner for Refugees), we are developing AYRH programs at the Ado Center [CCA]. The CCA contains the Ado Centre and the high school and the CEM (middle school) are next to it, that's what they do. But not in the Daara [traditional Quoranic schools] where there are youth that are outside the service delivery scope [of the CCA] but who are in need of services*." A peer educator in Sédhiou also noted it was very difficult to engage uneducated youth in outreach activities: "*It is very difficult to work with adolescents/ young people who have not been to school; so sometimes you have to use local languages to really make them understand. I admit that it is very difficult to work with this group of teenagers*." A community leader in Kolda observed that, because uneducated adolescents and youth were hard to reach with typical outreach activities, home visits were a good strategy to reach out to them:

Regarding the home visit approach, you find people at home and it's good because nowadays it can be that the person you find at home does not have access to the internet or has not attended school, so [home visits are] a way to reach this person.

In the regions of Kédougou, Matam, and Sédhiou, the notion that adolescents and youth who lived in rural and remote areas were difficult to reach with AYRH services came across strongly in the qualitative data; often, these issues intertwined as many adolescents and youth who were uneducated were described as living in rural and remote areas and vice versa. A SRH program manager in Kédougou noted rural youth tended be underserved in terms of AYRH services: "*I will say that access to FP products is easy for [urban] adolescents/young people. But it will be a bit more difficult for young girls living in rural areas. I do not think a young girl, 14–15 years old, will be able to access it easily*." A community leader in Matam observed that adolescents and youth living in rural areas tended to be marginalized: "*We are in a rural area; young people do not have internet and do not have the communication tools. Also, there are disabled people, young people who have never been to school, and young people who live in remote places and do not even know what sexual and reproductive health of adolescents young people means*." This was echoed by a program manager in Sédhiou, who observed, "*The young people who are in the most remote places, they really have an infrastructure problem, they sometimes have [mobile phone] reception problems, sometimes there are children who are marginalized, they are put aside, and these people must be accepted*." Speaking of AYRH awareness-raising activities, another program manager in Sédhiou declared, "*Activities should be decentralized so that everything [does not have to] be done in Sedhiou. There are many stakeholders and targets. You have to go to the border areas between Gambia and Senegal*."

Standard 3: All providers have the knowledge, competencies, and positive attitudes to offer services adapted to the needs of adolescents and youth

The extent to which the health services assessed across the six regions met the third standard under the Senegal National Strategic Plan for AYSRH (2014–2018) was also explored. This next section presents an analysis of the extent to which service providers who took part in the assessment demonstrated their understanding of AYRH, their education and training on AYRH, and their demonstration of the knowledge, competencies, and positive attitudes required to offer services adapted to the needs of adolescents and youth. The extent to which youth clients were satisfied with their interactions with the provider is also discussed and presented.

3.1 Extent to which Service Providers Received Training on Youth-Friendly Services

Meeting Standard 3 includes efforts to ensure providers have an appropriate level of knowledge, competencies, and positive attitudes required to provide high-quality services. SDP-based providers need training to enhance their technical skills, acquire a deep understanding of AYRH issues, and gain exposure to up-to-date information about how services should be provided in a friendly manner. In addition, training affords service providers opportunities to learn from one another in order to improve their knowledge, competencies, and-importantly-their attitudes towards providing youth AYRH services. In this assessment, it is assumed formal training confers the required knowledge and competencies required to provide important AYRH services to youth. Therefore, SDP audits collected information on

overall numbers of trained provider and support staff. In addition, service providers at the assessed SDPs were interviewed and asked to state whether they had been trained in YFHS, and if so, the areas in which they were trained. Youth clients were also interviewed at SDPs during exit interviews to determine their feedback on provider counseling skills and attitudes.

Table 31 shows the number of qualified providers trained in RH services and counseling and the number of support staff oriented in AYRH services for adolescents and youth as reported by YFHS SDPs. This table also presents the percentage of providers who received either pre-service or in-service training in a variety of key AYRH services. This analysis shows SDPs in Kaolack have a sufficient number of trained providers (30 providers in five SDPs) and have also implemented support staff orientations (11 support staff have been oriented in SDPs based in Kaolack). In the remaining regions, only Matam has an average of two providers per SDP (8 providers trained across the three SDPs); other regions have fewer than two per SDP. In Kedougou, only one of the two SDPs reported they have one trained provider.

Table 31 also includes data from provider interviews on their training experiences. It should be noted only 34 out of the 50 providers interviewed were either nurses or nurse-midwives (no staff interviewed were doctors) and some interviewed staff were trained lab assistants providing HIV testing and counseling. These results show that only 36 out of 50 interviewed providers reported ever having either pre-service or in-service training on high-quality AYRH counseling, the most basic AYRH service provided by all types of YF SDPs (including both contraceptive and HIV/STI prevention counseling). Although not all of the AYRH approaches offer ANC, delivery, and postpartum care, providers were asked about their training experience in this important service area. Only seven out of 50 providers interviewed reported training in this area of service delivery. Surprisingly, only 16 out of 50 providers who offer AYRH reported receiving any formal training on offering a complete range of contraceptive methods, including EC.

Nearly half (24) of providers reported receiving training on counseling and management of contraceptive side effects, but 36 providers reported receiving training on STI prevention, diagnosis, and treatment, with 32 providers trained in providing confidential HIV testing and counseling. Nearly the same number (31) of providers have received training on support and management of GBV services.

Table 31: Indicators related to Standard 3 (All service providers have the knowledge, competencies and positive attitudes to provide services adapted to the needs of adolescents and young people)

Indicator	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (SDPs)	**n=5**	**n=2**	**n=4**	**n=3**	**n=5**	**n=4**	**n=23**
3.1. Number of qualified health personnel (doctors, nurses, and midwives) trained to provide SRH services and counseling to adolescents/ young people in SDPs	30 providers	1 provider	4 providers	8 providers	7 providers	7 providers	57 providers

3.2. Number of support staff (security officer, ticket vendor, janitor, etc.) in SDPs oriented in AYRH	11 support staff	0	0	0	0	0	11 support staff
Number of cases (providers)	**n=10**	**n=3**	**n=7**	**n=10**	**n=10**	**n=10**	**n=50**
3.3. Number of service providers interviewed with basic or continuous training to provide AYRH counseling (quality counseling)	7	2	6	6	6	9	72.0% (36)
3.4. Number of service providers interviewed with basic training to provide pregnancy care (CPN), care during childbirth, and postpartum (CPoN) care for young mothers	1	1	0	0	3	2	14.0% (7)
3.5. Number of service providers interviewed with basic or continuous training to offer a full range of contraceptive methods, including emergency contraception	4	1	1	3	5	2	32.0% (16)
3.6. Number of service providers interviewed with basic or continuous training to manage contraceptive side effects and address adolescents'/ young people's concerns about these side effects	6	1	5	2	4	6	48.0% (24)
3.7. Number of service providers interviewed with basic or continuous training to diagnose and treat STIs, monitor and offer prevention methods	7	3	6	7	6	7	72.0% (36)
3.8. Number of service providers interviewed with basic or continuous training to conduct HIV testing, provide appropriate counseling to adolescents/ young people, and	2	3	5	7	7	8	64.0% (32)

ensure proper management of confidentiality							
3.9. Number of service providers interviewed with basic or continuous training to provide the necessary support and adequate care for gender-based violence	5	2	6	6	4	8	62.0% (31)

Across the six regions, SRH program managers who took part in the qualitative assessment were about evenly split on the question of whether they had received training specifically on RH issues related to and service provision for adolescents/youth. In Kaolack, Kolda, Matam, and Sédhiou, one out of the two managers interviewed said they had received training on RH for adolescents and youth. The SRH manager in Kaolack spoke of a continuing training "*to manage services for teens/young people*," whereas the manager said this had been part of basic training. A manager in Matam spoke of a curriculum that had been focused on "*helping a teenager to understand themselves, to make a decision, and also to identify his sexual health problems*." A manager in Sédhiou remarked of the training she had undergone: "*I received training on the RH curriculum, many issues were raised about early sexuality, sexuality and adolescent/ youth reproduction in general*." Only in Saint-Louis did all three of the SRH program managers interviewed say they had received some sort of training, whether basic or continuing, on RH issues and service provision for adolescents and youth.

Those SRH program managers who said they had not received any formal training specifically related to RH issues and service provision for adolescents and youth (one out of the two interviewed in Kaolack, Kolda, Matam, and Sédhiou along with the lone program manager interviewed in Kédougou) tended to emphasize that any basic training they had received touching on the subject did not do so in a comprehensive way. An SRH program manager in Kaolack asserted, "*I have not received any specific training on the sexual and reproductive health of adolescents/young people. But in basic training, we have been strengthened to be able to take the holistic approach to reproductive health in all age groups*." A manager in Matam said that, while others had received training, "*I have not been trained on AYRH*," adding "*However, during integrated training we are given a small brochure on the sexual and reproductive health of young adolescents*." A manager interviewed in Kédougou said field experience had served as her only training for the specific issue of AYRH:

> *I will say no because all the knowledge I had to get, I got through my field experiences and my own research. I did not receive any specific AYRH training. It was part of the service package during our basic training. As for continuous education, I will say no. Apart from my own research, I did not receive specific AYRH training.*

3.2 Extent to which Service Providers Demonstrated Having the Skills and Competency to Provide Contraceptive Services to Adolescents and Youth

Results from interviews with providers regarding their reported skills and competencies in providing contraceptive services are presented in Table 32. The previous section indicated only 16 out of 50 providers have been trained on the full range of FP methods; however, 40 out of the 50 providers reported receiving training and offering at least one contraceptive method (which includes male condoms, usually offered in both HIV/AIDS testing and counseling and FP services) as part of their work in providing AYRH services to adolescents and youth (data not shown). Data in Table 32 includes these 40 providers, first showing the types of contraceptive methods offered by these providers. These data show that nearly all (92.5%, or 37) of the providers who have been trained to offer at least one method offer male condoms as part of their services offered to adolescents and youth. About three quarters of providers who offer contraceptive services to youth have been trained and offer pills and injectables (72.5 % of providers for each) as part of their work, and about two-thirds of these same providers offer implants (67.5%) or IUDs (62.5 %). About half of these providers have received training and offer EC (57.5%), female condoms (50.0%), lactational amenorrhea method (LAM; 50.0%), and CycleBeads (47.5%). One provider (2.5%) reported receiving training and providing a new method: the contraceptive ring.

Contraceptive service provision and choice of method can be heavily influenced by providers who may not be trained to offer all "clinical" methods, such as injectables or LARCs, who may: 1) not have the needed equipment or consumables to offer all methods; 2) choose to offer methods which require the least amount of time to provide but which are short-term or highly reversible by clients themselves (though not necessarily the easiest to use); or 3) choose to offer methods which are non-hormonal methods such as condoms or CycleBeads (hormonal methods may be understood by poorly trained providers to negatively affect the future fertility of adolescents). Providers who have been trained and provide at least one type of method were asked about which methods are usually offered to youth. Most providers reported they offer injectables (67.5%), oral pills (65.0%), or male condoms (55.0%) most frequently to adolescents and youth. Providers were least likely to report offering CycleBeads or MAMA (7.5% each).

Providers who have been trained and provide at least one contraceptive method were also asked about why the method they mentioned was most frequently given to adolescent and youth clients. The three most common reasons were "facile à utilizer" (51.2%), "disponible à tout moment" (40.0%), and "accessible financièrement" (22.5%). It should be noted that none of these reasons include adolescent and youth future reproductive intentions and two of the top three methods provided to clients, daily oral pills and male condoms, while highly controlled by users, are actually the most difficult to use as they involve daily use or use at each sexual contact. Ideally, in well-implemented youth-friendly services, availability and cost should not be factors in offering or selecting a contraceptive method since all methods should ideally be available and at low or no cost to clients in a youth-friendly setting.

As noted previously, one of the main limitations of this assessment is the inability to observe and objectively assess providers' skills in offering a variety of AYRH services, including FP. Therefore, this study relies on provider responses to questions on counseling and service provision procedures to

assess provider capabilities. Providers were asked to recite all of the steps they took during an FP counseling and service delivery consultation; responses are included in Table 32. It should be noted that a number of these providers provide male condoms in a general AYRH or HIV/AIDS testing service provision setting and may not follow the same FP counseling procedures as dedicated FP providers should. Results from this analysis show nearly all (90.0%) providers mentioned the first step, "reception/greeting the client", in receiving a youth client. Half (50.0%) or more of the providers mentioned all remaining steps, starting with "identify the goals/ objectives of the client's visit" (60.0%) and ending with "explain side effects" (67.5%) and "give an appointment or referral (if necessary, 67.5%)". Providers were least likely to "discuss client's FP preferences" (50.0%), which is a key step in FP counseling, but may not be possible/relevant in settings where availability of equipment, consumables, (affordable) commodities, or a trained provider is lacking.

Finally, a key component of ensuring provider competencies and capabilities is the support in terms of a quality assurance system coordinated and provided by health districts to ensure ongoing training for health providers, supervision to improve provider performance, and that quality assurance activities are regularly conducted. Table 32 also shows data from the 40 health providers who are trained to offer at least one contraceptive method regarding quality assurance and support from their health district. Over half (55.0%) of these providers reported their SDP did not have a system of quality assurance, including supervision. This was particularly true in Matam (9 providers out of 10) and Saint-Louis (7 providers out of 9 providers who are trained to offer FP methods mentioned they had no such quality assurance system). Among the remaining (18) providers, 13 reported their quality assurance system included "supportive supervision", nine (9) reported their system included "staff capacity building", and eight (8) mentioned "routine monitoring". In addition, these same providers were asked about the support received from the health district in quality assurance. Exactly 13 providers mentioned "capacity building" and 10 providers each mentioned "regular supervision" and "coordination meetings". Other support mentioned included "ensure the availability of essential medicines/ FP products" (7 providers)," make the YFS services available" (4 providers), and "ensure the that equipment is functional" (3 providers).

Table 32: Number and Percentage of Service Providers who Provide Family Planning Services and their Reported Skills and Competency to Provide Contraceptive Services to Adolescents and Youth

Indicator	REGION (Unweighted)						Total	
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou		
Number of providers who offer FP services	n=8	n=2	n=7	n=10	n=9	n=4	n=40	
Methods provided in which the service provider was trained (multiple answers are possible)								
Male condom	7	2	7	8	9	4	92.5%	(37)
Oral contraceptive pills	8	1	4	3	9	4	72.5%	(29)
Injectables	8	1	4	3	9	4	72.5%	(29)
Implants	7	1	4	3	8	4	67.5%	(27)
IUD	7	1	2	3	8	4	62.5%	(25)
Emergency contraception	6	2	3	4	5	3	57.5%	(23)

Female condom	4	1	1	3	9	2	50.0%	(20)
Exclusive breastfeeding (LAM)	7	1	1	3	6	2	50.0%	(20)
Cycle Beads	7	1	1	3	7	0	47.5%	(19)
Vaginal Ring	0	0	0	0	1	0	2.5%	(1)
Methods provider offers most often to youth:								
Injectables	6	1	4	4	8	4	67.5%	(27)
Oral contraceptive pills	3	1	4	6	8	4	65.0%	(26)
Male condom	0	2	7	7	3	3	55.0%	(22)
Implants	6	1	4	0	4	4	47.5%	(19)
Emergency contraception	1	1	3	1	4	0	25.0%	(10)
IUD	0	0	1	0	4	1	15.0%	(6)
Female condom	0	1	1	0	2	0	10.0%	(4)
Cycle Beads	0	0	1	0	2	0	7.5%	(3)
Exclusive breastfeeding (LAM)	0	0	1	0	2	0	7.5%	(3)
Reasons why these methods are most often provided by the provider:								
Easy to use	4	2	3	6	3	3	51.2%	(21)
Available anytime	2	2	4	5	1	2	40.0%	(16)
Financially accessible	0	1	2	3	2	1	22.5%	(9)
More effective	0	0	0	0	0	3	7.5%	(3)
Discreet	1	0	0	1	1	0	7.5%	(3)
Personal convenience	0	0	0	0	3	0	7.5%	(3)
Protection against STI/AIDS	0	1	1	1	0	0	7.5%	(3)
No side effects	0	0	0	2	0	0	5.0%	(2)
Most suitable for them	0	0	0	0	1	0	2.5%	(1)
Procedures followed by the provider when talking about FP with youth (multiple responses possible):								
Greeting/welcome the client	8	2	5	10	7	4	90.0%	(36)
Identify the goals/ objectives of client visit	6	2	6	4	5	1	60.0%	(24)
Perform a clinical examination	6	1	4	6	3	3	57.5%	(23)
Provide information about different FP methods	7	1	3	7	6	4	70.0%	(28)
Discuss the client's FP preferences	5	0	1	9	2	3	50.0%	(20)
Help the client to choose a method	8	2	1	7	4	4	65.0%	(26)
Explain to the client how to use the chosen method	8	2	1	8	5	3	67.5%	(27)
Explain the side effects	8	1	3	7	5	3	67.5%	(27)
Give an appointment or referral (if necessary)	7	2	3	9	4	2	67.5%	(27)
Type of quality assurance system (FP):								

Support supervision	6	0	3	1	2	1	32.5%	(13)
Staff capacity building	5	0	0	0	2	2	22.5%	(9)
Routine monitoring	3	2	2	0	0	1	20.0%	(8)
No QA system for FP exists	2	0	2	9	7	2	55.0%	(22)
Support received from the Health District to improve the quality of FP services in the SDP:								
Carry out capacity building	4	1	4	1	1	2	32.5%	(13)
Regular supervision	3	0	3	1	2	1	25.0%	(10)
Coordination meetings	6	1	0	1	1	1	25.0%	(10)
Ensure the availability of essential medicines/ FP products	4	1	1	1	0	0	17.5%	(7)
Make YFS services available	4	0	0	0	0	0	10.0%	(4)
Ensure the supplies/equipment are functional	2	1	0	0	0	0	7.5%	(3)
No support received	2	0	2	9	7	2	55.0%	(22)

In the qualitative assessment, the SRH program managers—the only participants whose work directly involved health service provision—were asked to explain their understanding of AYRH and services friendly to adolescents and youth in addition to being asked extensively about their communities' work in AYRH service provision.

By and large, the SRH managers across the six regions who took part in the qualitative assessment demonstrated a good understanding of what was entailed in ensuring RH services would meet the needs of adolescents and youth, even if they noted the SDPs they worked with fell short in some regards. Many spoke of the need to safeguard young people's privacy, especially given the fear associated with being seen by acquaintances at SDPs, and of encouraging the use of FP not only to space pregnancies among married adolescents and youth but also to avoid unplanned pregnancies and encourage girls—both married and unmarried—to stay in school. As was illustrated in Section 1 on the use of RH services by adolescents and youth, SRH program managers also had a good understanding of the main services for which adolescents and youth most often visited SDPs. A few managers also brought up other factors they deemed essential to reaching adolescents and youth with RH services, like having operating hours amenable to young people's schedules and ensuring young people trusted their providers to keep the information discussed confidential. One SRH manager in Matam further noted that having good rapport and building trust with young people was essential:

> *Services adapted for young adolescents, first of all we can mention access. There is accessibility, young people must be able to access services without stigma and without problems. [...] Because also, when the young person comes, we ask them questions, this …can result in young people not accessing services. It is necessary to foster a relationship based on trust and openness.*

3.3 Extent to which Service Providers had a clear Understanding of Youth-Friendly Services and Positive Attitudes about Providing Reproductive Health Services to Adolescents and Youth

As noted by WHO's *Global standards for quality healthcare services for adolescents* (2015), health care providers should be competent not only in managing adolescents in specific clinical situations, but also in demonstrating awareness of one's own attitudes, values, and prejudices that may interfere with the ability to provide confidential, non-discriminatory, nonjudgemental, and respectful care to adolescents. Table 33 presents data on provider attitudes in meeting adolescent and youth AYRH needs, ensuring confidentiality, and parental consent. Among providers who have been trained and offer at least one contraceptive method, all providers gave at least one answer to this question (data not shown) and nearly all (90.0%) mentioned their interactions with youth during counseling should "build confidence". Over half also mentioned ensuring "confidentiality" (70.0%) and "availability" (55.0%). A few providers (4) mentioned that, when interacting with adolescents and youth, it is important to "listen carefully" to their needs and wishes.

These same providers were also asked how they guarantee privacy for their clients so no one can hear them or see them during consultations. Nearly all providers (with the exception of two in Sédhiou region) reported a high level of protection of clients' privacy: "offices are locked during consultations" (95.0%). Providers were also asked if there were ever any situations in which they might refuse to respond to a youth's AYRH need. Only one provider (Matam) mentioned this situation might arise "if the requested service is not suitable" [presumably, to the youth's circumstances or physical health, such as a request for FP by a pregnant adolescent. It might also reflect a provider barrier, eg, a 15-year-old unmarried client who requests an IUD]. Providers who agreed a provider cannot refuse to offer AYRH services to adolescents and youth mentioned this is because "health is a right" (67.5%), "it is an obligation" (40.0%), and "to meet standards" (32.5%).

Lastly, providers who are trained and offer contraceptive methods were asked if they require the consent of parents or the spouse of a youth before providing FP services. It should be noted that the Senegal Ministry of Health FP norms/protocols clearly state no parental or spousal consent is required in order to offer FP to any client, including an adolescent or youth. None of the providers reported requiring parental or spousal consent, which means that, at a minimum, they are aware consent is neither required nor permitted in FP service provision. Reasons providers gave for adhering to this standard include: "For confidentiality reasons" (60.0%), "Respecting human rights" (60.0%), "Avoiding stigmatization" (17.5%), and "So that he/ she is more comfortable" (10.0%).

Table 33: Service Providers' Understanding of Youth-Friendly Services and Attitudes About Providing Reproductive Health Services to Adolescents and Youth

Indicator	REGION (Unweighted)						Total	
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou		
Number of providers who offer FP services	n=8	n=2	n=7	n=10	n=9	n=4	n=40	
A service provider's attitude during a FP consultation with a teenager/ young person should include:								
Building confidence	7	2	7	8	8	4	90.0%	(36)
Confidentiality	7	2	5	9	2	3	70.0%	(28)
Availability	4	1	5	5	6	1	55.0%	(22)
Ensuring security	7	1	2	7	1	1	47.5%	(19)
Empathy	4	1	0	4	4	3	40.0%	(16)
Privacy	5	2	0	6	2	1	40.0%	(16)
Neutrality	3	1	2	5	2	2	37.5%	(15)
Listening attentively	0	1	1	1	1	0	10.0%	(4)
Ways in which a health service provider guarantees privacy so that no one can hear or see them during the consultations:								
Offices are locked during consultations	8	2	7	10	9	2	95.0%	(38)
Interviews are on individual basis	8	2	1	6	4	1	55.0%	(22)
Offices are secure	7	2	1	3	4	3	50.0%	(20)
Offices are isolated	7	0	1	1	3	4	40.0%	(16)
Percentage of service providers reporting that a service provider can refuse to meet an AYRH need of an adolescent/ young person	0	0	0	1	0	0	2.5%	(1)
Scenario in which it would be acceptable for a service provider to deny an RH need of an adolescent/ young person:								
If the requested service is not suitable	0	0	0	1	0	0	2.5%	(1)
Reason why it would be unacceptable for a service provider to refuse to respond to an adolescent's/ young person's RH need:								
Health is a right	8	2	2	7	6	2	67.5%	(27)
It is an obligation	3	1	4	3	4	1	40.0%	(16)
To meet standards	1	1	1	4	2	4	32.5%	(13)
Percentage of service providers who do not require the consent from the parents or spouse of an adolescent or young person to provide FP services	8	2	7	10	9	4	100.0%	(40)
Reasons why a service provider would not require the consent of the spouse or parents to provide FP services to adolescents/ young people:								

For confidentiality reasons	2	2	6	5	5	4	60.0%	(24)
Principles of respect for human rights	7	1	2	7	5	2	60.0%	(24)
To avoid stigma	3	0	1	2	1	0	17.5%	(7)
To make him/ her more comfortable	0	2	0	2	0	0	10.0%	(4)

While the survey data most likely reflected provider knowledge/intentions rather than their actual behaviors, the qualitative data gave additional information on provider attitudes and practices regarding working with youth. Many of the SRH program managers who were interviewed—themselves also providers—had positive things to say about the providers in their districts or regions. A manager in Kaolack noted, "*It is the staff who are attentive, who are welcoming, who take into account all the aspects, all the needs of adolescents/young people, service availability, we also say that a referral is care.*" A manager in Kolda observed, "*For the attitude of service providers, I can say that we have excellent relationships with adolescents/ young people.*" In response to a question about whether adolescents' and youths' reluctance to seek RH services was tied to providers' discrimination, a manager in Kédougou asserted, *"Inadequate attendance at the health facility is not related to discrimination, and even less so to the poor attitude of service providers because once in the consultation room, their secrets will be kept confidential*."

In other cases, SRH program managers were more mixed in their assessments. While two of the managers in Saint-Louis said providers' attitudes were not a problem, a third manager interviewed from this region acknowledged that competencies around working with adolescents and youth were not universal among providers: "*Each individual behaves in a way that is specific to them, so we cannot change the behavior of the latter overnight, and in each group, there are always black sheep. There are some who do the job properly. On the other hand, others who are a bit reluctant.*" In Kaolack, a manager observed, "*If we really respect the standards and client's rights, there should not be any discrimination, but it is always a problem, there are service providers who respect this, all who do good things as they say, others who do the opposite*." A manager in Sédhiou initially asserted protecting confidentiality of adolescents and youth was not a problem because providers were properly trained; asked whether providers' attitudes were a problem, she replied it was not a problem in her district because "*All health service providers are trained in sexual and reproductive health*." Yet later in the interview, she seemed to change her opinion; asked about the quality of AYRH services, she responded, "*This is a problem because the staff there, including midwives, are not yet trained in AYRH. So for the staff, yes, it is a problem, because service providers should not judge values*."

3.4 Extent to which Youth Clients were Satisfied with their Interactions with the Provider

Table 34 includes feedback from adolescent and youth clients during exit interviews on related indicators, which reflects the output of SDP efforts to train, mentor and supervise providers offering AYRH services in a youth-friendly way. Clients rated nearly all of the indicators related to provider interactions, information received, treatment, privacy, and assurance of confidentiality over 90%. Nearly all (99.4%) of clients felt they were treated "well" or "very well" by the provider during the visit. Several indicators on information, encouragement of client questions, and visual privacy were identified as gaps by clients in a few SDPs. For example, only 76.7% of the 30 interviewed clients in Kaolack agreed they received desired information from the health provider, and 46.7% of these clients reported being encouraged to ask questions during the counseling session. Across most of the regions, less than half of clients felt they were encouraged by the provider to ask other questions. In addition, only 60.0% of clients in Sédhiou felt they were provided with adequate visual privacy during their interactions with

the provider[h]. Despite these gaps, clients reported a high level of satisfaction with their interaction with the provider during AYRH services.

Table 34: Perceptions of the Quality of Adolescent and Youth Reproductive Health Services by Adolescents/Youth (exit interviews)

Quality component	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (exit interviews)	**30**	**30**	**30**	**30**	**30**	**30**	**180**
Felt that he/she received the information he/she wanted	76.7%	100.0%	83.3%	96.7%	86.7%	86.7%	88.3%
Was encouraged by the provider to ask any other questions	46.7%	73.3%	40.0%	53.3%	60.0%	36.7%	51.7%
Was treated "well" or "very well" by the provider during the visit	96.7%	100.0%	100.0%	100.0%	100.0%	93.3%	98.3%
Was treated "well" or "very well" by other providers during the visit	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	99.4%
Was treated "well" or "very well" by the registration staff during the visit	93.3%	100.0%	100.0%	100.0%	93.3%	100.0%	97.7%
Felt that that the provider's explanations during the visit were easy to understand	93.3%	96.7%	96.7%	100.0%	100.0%	96.7%	97.2%
The provider did not do or say anything that made him/her uncomfortable	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Said that no one could hear the conversation he/she had with the provider	90.0%	96.7%	100.0%	93.3%	93.3%	96.7%	95.0%
Met with the provider in a separate room	96.7%	100.0%	100.0%	100.0%	100.0%	93.3%	98.3%
Felt meeting with the provider was private (no other clients could see respondent)	93.3%	100.0%	100.0%	90.0%	86.7%	60.0%	88.3%
Believed that the information he/she shared with the provider will be kept confidential	80.0%	96.7%	100.0%	90.0%	96.7%	83.3%	91.1%
Will return for another visit to this SDP	96.7%	100.0%	100.0%	96.7%	100.0%	100.0%	98.9%
Reports being "satisfied" or "very satisfied" with their visit	90.0%	100.0%	100.0%	100.0%	93.3%	90.0%	95.6%

[h] It may be important to highlight that the majorit of client exit interviews in Sédhiou obtained services through a mobile outreach team. These answers perhaps suggest that visual privacy is more likely a concern for that particular type of service delivery approach.

In the qualitative component, youths' perceptions of whether providers showed respect and interacted with adolescent and youth in a manner that demonstrated professionalism— refraining from passing judgement, safeguarding their privacy and confidentiality, etc.—were very mixed across the six regions. Though there were some exceptions, most of the young women who took part in semi-structured interviews about their experiences obtaining modern contraceptive said their experiences interacting with providers to obtain this method were positive, often mentioning providers were "correct" with them, meaning appropriate and respectful. Some said the provider had been easy to talk to and many said they were largely satisfied with the experience; one young woman in Matam noted of the service provider she had interacted with: "*She was correct and nice. There was no problem*." A community leader and Bajenu gox in Kolda also describe providers as professional and open in their interactions: "*It's very easy to access them [SRH services], everyone can get there without a problem, they (service providers) are very open minded*."

Concerns about providers' professionalism towards adolescents and youth were also voiced by various non-provider participants in the qualitative assessment, who most often complained of service providers being moody and temperamental, tired, judgmental, and not respecting clients' privacy and confidentiality. One of the young women who took part in a semi-structured interview in Matam said of the provider she met with during her visit to get a modern contraceptive method, "*She did not welcome me very well. Each time she said that she was tired, that we had to wait. And it was uncomfortable because her tone and face showed concern. She spoke aloud, "Did you come here for family planning? Where is her file? And everyone heard that.*" A mother in Matam also claimed that providers could be quite moody in their interactions with members of the community, "*It depends on the doctors' moods and this varies. Sometimes they can welcome you with open arms and other times they may not give you any importance*." A mother in Sédhiou similarly complained that providers seemed to be temperamental and judgmental in their treatment of clients: *"It happens that you get pregnant and cannot go to the hospital, which is very dangerous and can even cause illness. So when you go to the hospital the midwife will not look at you and say that you did not keep your appointments*." The perception that clients were judged by providers likewise came across in comments made by a mother who took part in a FGD in Kaolack, who noted providers' judgmental behavior could cause some young people to avoid health facilities altogether:

> *The midwives and matrons were born here and have grown up there, so they think of all the children as theirs, and they lecture nonstop. They ignore professionalism to criticize the behavior of the young people. Even when a mother comes for a contraceptive, she is asked why, and they are worse with the children, therefore no single girl will dare to come here to ask for a contraceptive product.*

Standard 4: Members of the community, including adolescents and youth, facilitate the implementation and utilization of health services by adolescents and youth

As described previously, Standard 4 is concerned with a SDP's efforts to provide an "enabling environment" at the community level to provide support for youth to use health services. Ideally, a YFHS SDP implements outreach programs "to ensure that parents, guardians, and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents." (WHO 2015). This section

will examine the extent to which SDPs coordinate with external organizations, members of the community, and perform outreach activities to create a positive and supportive environment for adolescents and youth to use services.

4.1 Coordination with the Community and Outreach Activities Efforts

In Table 35, the first set of indicators is measured *at the SDP level* and the last three indicators are data obtained from interviews with community health workers (ASC/relais) who serve in the catchment areas of interest, but may not be attached to the assessed SDPs included in this study. Data collected from the SDPs include the number of active ASC/relais attached to the SDP, number of youth reached, and number of community-level outreach activities implemented. Table 35 examines some of these variables at the output level among youth interviewed at community level in order to determine if youth, parents, or other community members are reached with sensitization activities on AYRH in their communities.

SDPs have a responsibility to either directly provide information to youth at community level or to engage community health workers or partner with local organizations to increase awareness of the services they provide to youth. Indicators were calculated related to SDP efforts to provide or support community outreach activities and are shown in Table 35. These data reveal that only two SDPs included at least one staffmember who is trained to carry out community-based outreach activities for youth, one in Kolda and one in Kaolack. Despite the fact that 16 SDPs have a plan to perform outreach activities at the community level, fewer than half (11 out of 23) of the assessed SDPs reported to have regularly organized community outreaches regarding AYRH information and services (included FP).

Further, 18 out of 23 SDPs (78.3%) keep an updated list of organizations supporting adolescent and youth AYRH service utilization, which can serve as a reference list for service referrals for other types of services (eg, social support, mental health, FGM). However, only five SDPs report they are working with ASC/relais at community level to reinforce and promote AYRH service utilization among adolescents and youth. These SDPs include one (1) youth center (CCA), one (1) IME, and three (3) separate space/youth corners based in Kaolack (1), Kolda (1), Saint-Louis (2), and Sédhiou (1). Regarding the number of ASC/relais, this information is even more scarce. Among these five SDPs, only two were able to provide lists of ASC/relais trained and attached to the SDP. These two PPS reported only working with 32 ASC/relais agents who have been trained and who are supervised to provide AYRH at community level.

SDPs were more likely to report working with trained peer educators at community level (as opposed to ASC/relais) to provide information and promote AYRH services among adolescents and youth. Across the six regions, 11 out of 23 assessed SDPs reported working with 403 peer educators, more than half of which perform outreach in Kaolack (217 peer educators). While this number is greater than the numbers of attached ASC/relais, peer educators generally have lower levels of training, support, and supervision than their more skilled ASC/relais counterparts.

As mentioned previously under Standard 1, more than half (16, or 69.6%) of SDPs reported they have a community outreach activity plan, though only 10 SDPs report implementing outreach programs by

providers or ASC/relais at community level (parents, community members, local leaders) on the value of providing RH services to adolescents and youth over the past three months. Overall, less than half of the SDPs assessed are training and supervising outreach workers or conducting outreach activities on supporting youth to use AYRH services.

The last set of indicators in Table 35 is measured using interviews with ASC/relais who work in the catchment areas of the assessed SDPs, but **who are not necessarily attached to them**. Out of the 150 interviewed, 122 (81.3%) report they have an implementation plan to conduct awareness activities to inform adolescents and youth about AYRH services provided at their respective SDPs. Exactly 91 of these 122 ASC/relais reported conducting outreach activities with youth in their communities in the 12 months preceding the interview and recording the number of youth reached (data not shown). After reviewing their records, these 91 ASC/relais estimated they had reached about 30,283 youth across the six regions. This ranged from a minimum of 537 youth reached by 12 ASC/relais (over a period of 12 months) to a maximum of 10,305 adolescents and youth reached (15 ASC/relais) in Saint-Louis. These records were not validated by their supervisors at the SDP level, but activity levels among ASC/relais seem to vary greatly across the six regions. Finally, the total number of promotional activities at community level for all audiences was also recorded during these interviews. Among the 150 ASC/relais interviewed, 119 reported conducting 8,734 promotional activities at community level on AYRH in the past 12 months. Activities implemented ranged from 319 conducted by 23 ASC/relais in Matam in the past 12 months to 4,248 outreach activities conducted by 25 ASC/relais in Kaolack.

Table 35: SDPs which Support Adolescent and Youth Reproductive Health Community Outreach for Adolescent/Youth, by Region

Indicator	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (SDPs)	**n=5**	**n=2**	**n=4**	**n=3**	**n=5**	**n=4**	**n=23**
Number of SDPs which have an outreach activity plan at the community level	5	2	2	1	2	4	16
Number of SDPs which regularly organize community outreaches about YFHS (including FP)	2	1	3	2	2	1	11
Number of SDPs that have updated the list of partner organizations to increase community support for adolesents/ young people to use the services	4	2	3	3	2	4	18 (78.3%)
Number of SDPs that have planned outreach programs with CHWs/Bajenu gox to inform young people, parents, community organisations, schools, etc. about the value of providing health services to adolescents/ young people in the last 3 months	2	1	2	0	4	1	10
Number of SDPs working with CHWs to promote health and strengthen service use (in general)	1	0	1	0	2	1	5
Number of SDPs with **at least one** CHW/BG/matron trained to conduct outreach activities for adolescent/ young people in the community	1	0	1	0	0	0	2
Number of community level staff in SDPs (CHWs, relais, etc.) trained in AYRH	30	0	2	0	0	0	32 ASC
Number of SDPs that provide supportive supervisions to adolescent/ young peer educators	4	0	2	2	2	1	11
Number AYRH trained peer educators in SDPs	217	20	20	61	66	19	403 pairs éducateurs
(Indicators below are from the CHWs/relais dataset)							

Number of cases (CHWs/relais)	n=25	n=13	n=25	n=25	n=37	n=25	n=150
Number (percent) of CHWs/relais who report that they plan awareness programs to inform adolescents/ youth about the provision of AYRH services	19 (76.0%)	13 (100.0%)	24 (96.0%)	12 (48.0%)	30 (81.1%)	24 (96.0%)	122 (81.3%)
Number of adolescents/ young people educated on SRH/ FP in the SDPs over the last 12 months by the CHWs/ relais	3,984 (15)	593 (10)	9,713 (15)	537 (12)	10,305 (15)	5,151 (24)	30,283 (91 ASC/relais)
Number of AYRH promotional activities carried out in the community in the last 12 months by CHWs/ relais	4,248 (25)	687 (12)	1,339 (23)	319 (23)	1,428 (12)	713 (24)	8,734 (119 ASC/relais)

Table 36 presents data from community-based youth interviews in order to review the level of output on indicators related to Standard 4. According to these results, 10.3% of all community youth who have ever heard of AYRH services have received AYRH information or referrals from a peer educator. This percentage varies by region, ranging from 3.1% of youth in Saint-Louis to 16.5% of youth in Kolda who have been reached by a peer educator on AYRH. A small proportion of youth (3.6%) who have ever heard of AYRH services have actually received a referral from any community health worker (ASC/relais). This proportion was similar across regions with the exception of Sédhiou region where 11.6% of youth reported receiving a referral for AYRH services from an ASC, relais, or other community health worker. Across the six regions, nearly one-third of adolescents and youth who have ever heard of AYRH services reported participating in health promotion and sensitization activities which focused on increasing utilization of AYRH services with a low of 17.4% of youth in Sédhiou to a high of 42.9% in Matam. Finally, approximately 14.4% of youth agreed that organizations and individuals in their communities supported the provision of AYRH services and their use by adolescent and youth. These percentages were lowest in Saint-Louis and Sédhiou regions (7.7% and 7.2%, respectively) and higher in Matam, Kédougou, and Kaolack regions (21.4%, 19.7%, and 18.8% respectively). Overall, if examining these percentages at the global level (n=2400), only about 6% youth are reached through promotional activities at the community level conducted by any organization or SDP (data not shown).

Table 36: Experience with Community-Level Adolescent and Youth Reproductive Health Outreach Services Among Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of youth who have ever heard of AYRH services and received AYRH services from a peer educator	4.7%	7.6%	16.5%	14.3%	3.1%	15.9%	10.3%
Number of cases	85	66	103	28	65	69	416
Percentage of youth who have ever heard of AYRH services and who have received a referral for services from any community health worker (ASC/Relais/Bajenu Gox)	1.2%	3.0%	2.9%	3.6%	0.0%	11.6%	3.6%
Number of cases	85	66	103	28	65	69	416
Percentage of young people (who have ever heard of AYRH services) who are exposed to health promotion and awareness raising activities that aim to increase the use of AYRH services	29.4%	34.8%	36.9%	42.9%	40.0%	17.4%	32.7%
Number of cases	85	66	103	28	65	69	416
Percentage of young people (who have ever heard of AYRH services) who report that community stakeholders and organizations support their provision and use	18.8%	19.7%	14.6%	21.4%	7.7%	7.2%	14.4%
Number of cases	85	66	103	28	65	69	416

4.2 Extent to which Members of the Community were Perceived as Facilitating the Implementation and Utilization of Health Services by Adolescents and Youth

To qualitatively understand the extent to which the fourth standard of Senegal's 2014–2018 strategy for AYRH was met, the assessment explored the roles that non-providers, including peer educators, Bajenu gox, parents, community leaders, and those involved in civil society organizations, played in facilitating service provision, especially by raising awareness about RH issues that were particularly pressing for adolescents and youth.

While many participants in the qualitative assessment across the six regions said more needed to be done to raise awareness about AYRH issues and increase access to AYRH services, most of the participants were able to name at least one kind of non-provider in their region who was involved in raising awareness about and/or facilitating linkages to RH service provision for adolescents and youth. Indeed, across all six regions, it seemed there were a variety of actors outside of service providers—particularly Bajenu gox, civil society organizations, and peer educators, but also community leaders, religious leaders, and school clubs—who were actively involved in an extensive range of activities, often in coordination with one another and/or YFHS SDPs, to try to address various AYRH issues. As one community leader in Kaolack summarized when asked about what AYRH-related programming was

available:

> *There are NGOs working on this. There are also imams working on this plan thanks to the NGOs that train them in communication techniques so that they can raise awareness. Also, some women do it voluntarily. There are also "Bajènu gox" who raise awareness on these issues because children often go to confide in them.*

4.2.1 Perceptions Concerning the role of Bajenu Gox

Bajenu gox were often among the first (and sometime the only) non-provider resource named by participants in the qualitative assessment when they were asked if the community benefitted from any AYRH-related outreach activities or service provision by actors other than those directly tied to the SDPs. Bajenu gox across the six regions consistently described their work as engaging with communities to answer their RH-related questions and refer them to appropriate services. As one Bajenu gox in Kédougou explained: "*My roles and responsibilities in adolescent/ youth sexual and reproductive health are to communicate and be available to guide them. It is my responsibility to counsel them, to educate them about the benefits and harms related to sexual health especially in my community.*" A Bajenu gox in Saint-Louis noted that engaging with communities took many forms:

> *We often organize talks to talk with people. We carry out home visits to educate others who do not attend talks, individual interviews, mass activities such as social mobilization with the presence of leaders to get the message across. We plead with opinion leaders, male heads of households, and religious influencers, to help us share information to change behavior.*

Among participants who took part in the qualitative assessment, Bajenu gox were described as dedicated volunteers who provided a valuable service to their communities. A father in Matam explained Bajenu gox educated members of his community: "*They are the ones we see on the ground talking to children about adolescent and youth sexual and reproductive health issues*." A SRH program manager in Kédougou praised the Bajenu gox for their dedication: "*Our partners, for example the Bajenu Gox, work with us 24 hours a day, they give guidance, they support, they give talks, and they do everything. They are always with us.*" She also noted they were able to reach individuals in remote locations who were difficult to reach otherwise: "*There are also Bajenu Gox from other areas that are trained to go to remote areas, villages or neighbourhoods to raise awareness, give talks, carry out home visits and individual interviews with community stakeholders*." In response to a question about the reasons a parents would not refer their children to SDPs for RH services, a mother in Sédhiou noted they called on the Bajenu gox to fill this need: "*But us adults, when we have problems we call a meeting and we invite the Bajenu Gox. They advise us and when I return I call my children and advise them on this subject. But to direct them to these services, I have never done that.*" As this final quote indicates, Bajenu gox were often the first to hear about RH issues facing adolescents and youth in their communities; their role was to educate community members and encourage them to seek out the services that adolescents and youth required.

Despite the many ways in which the Bajenu gox were described as important to outreach and education around AYRH, they seemed to be an imperfect solution to the wide range of RH problems adolescents and youth faced. Across all six regions, participants in the qualitative assessment—including many Bajenu

gox themselves—noted they received little if any training related to AYRH, which meant some of the advice they gave and services they provided fell short of the standards that might be expected of a true health service provider. For instance, both Bajenu gox interviewed in Kolda expressed the belief that parental consent was required to treat young people at health facilities, which not only contradicted the views held by the SRH program managers interviewed in this region (as well as the opinions expressed by the majority of parents and community leaders who took part in FGDs and IDIs in the region) but could also mean that the Bajenu gox could discourage young people who might otherwise have sought out services from doing so. A Bajenu gox in Kédougou remarked, "*As a Bajenu Gox, I should be aware of some services like the health center, the CCA, but I have not been informed about this.*" A Bajenu gox in Matam brought up the fact that Bajenu gox were not paid, which was demoralizing. This meant they had a difficult time completing all the work they needed to do with little training and no payment, adding: "*We are asking for financial motivation and qualified training that will allow us to work without difficulty*."

4.2.2 Perceptions Concerning the role of Civil Society Organizations and Non-Governmental Organizations

Across the six regions, participants in the qualitative assessment named a large number of local CSOs as well as several international NGOs and projects engaged in the AYRH space, many in coordination with other organizations, district, or national authorities and/or the health system. Those most often mentioned by participants were Enda (including Enda Santé), MSI, TOSTAN, the Red Cross, and the Neema project.

Representatives from a wide variety of CSOs, including CSOs focused on youth and/or health, took part in the qualitative assessment and described undertaking a range of activities to address AYRH issues, from mobilizing young people to raising parents' awareness, administering HIV/SI testing, and building the capacities of health providers and other actors to provide AYRH services or tackle stigma around specific AYRH issues. As one SRH program manager said of the work the organization did in Kédougou around AYRH: "*We carry out joint activities there: screening, talks, awareness raising, condom distribution*." A manager in Matam said the organization's work consisted of "*raising awareness about excision, raising awareness about keeping girls in school, raising awareness about HIV and also raising awareness about literacy. [...]. We also give talks in primary and secondary schools*." These are but a few examples of the wide variety of work the representatives of the CSOs who took part in the qualitative assessment said they undertook, often in coordination with health providers, other CSOs, and other community actors. An SRH program manager in Kaolack, for example, noted the organization worked with Bajenu gox: "*With the* Bajenu gox *or relais [CHWs] who are members of an association, we work with them on awareness-raising. In Kaolack, there are many relais associations*."

Participants in the qualitative assessment also pointed to efforts by other organizations to address AYRH issues. A mother in Kolda rattled off a list of actors who were involved in raising awareness about and facilitating access to services for AYRH issues: "*Sometimes it's the CCA, there's also Enda Youth Action, Enda Health ... Sometimes we play skits to illustrate what we say so that people learn from them, Tostan also they do their best. Really there are a lot of NGOs involved in youth issues*." A community leader in Sédhiou noted a number of different organizations worked on AYRH issues in his community, including school clubs and an international initative: "*These include Family Life Education Clubs, student clubs in*

schools. There is also OSIWA (Open Society Initiative for West Africa) that works in the context of raising awareness among young adolescents and parents of adolescents for behavior change." A SRH program manager also mentioned school clubs when asked about collaboration around AYRH efforts: "*There is the Neema Council, which brings together NGOs and works within the AYRH framework. Most recently, 14 relais have been trained. There are the Family Life Education Clubs and youth associations we are used to working with*." A father in Kaolack said his community received financial and other support from NGOs including Enda Jeunesse Action and a religious charity: "*We also build partnerships with goodwill organisations, NGOs, resource persons. We even accompany girls with early pregnancies to buy prescriptions with a medical emergency support ticket through our partners like Enda Youth Action and CARITAS*." Enda was also mentioned by a mother in Sédhiou who expressed great enthusiasm for their activities: "*Now sensitization is done at all levels especially with the implementation of Enda, young people are involved, they educate their peers. They enter all local neighbourhoods, daaras, schools everywhere. Mashallah! [bravo, congratulations]*." A SRH program manager in Saint-Louis noted MSI played an important role in larger-scale activities such as supporting free services in the health structures and building youth-friendly spaces: "*With the youth space set up with the Marie Stopes International project, they visit the schools and discuss the themes with students. They talk to teenagers/ young people, and also to parents because they have some responsibility*."

4.2.3 Perceptions Concerning the role of Peer Educators

Many of the peer educators who took part in the qualitative assessment across the six regions seemed to take great pride in their work and extensively described their efforts to reach adolescents and youth, as well as their parents and their wider communities, with information and advice. Peer educators' roles consisted of home visits, distribution of male and female condoms, individual counseling, group discussions and activities to raise awareness, and referrals. As one peer educator in Matam explained, "*we carry out home visits, talks and social mobilizations* "; others noted they worked with laboratory technicians to deliver mobile STI testing, reached out to school principals and teachers to plan activities for school students, or organized concerts and events to educate people about AYRH issues. A peer educator in Sédhiou summed up the role in this way: "*Our role is to participate in all youth activities, sexual and reproductive health, and all our areas of intervention*." Peer educators displayed creativity and resourcefulness in their work, using local musicians and radio as well as putting together theater sketches to reach youth. A peer educator in Kaolack explained, "*Theatrical plays are also one of the best ways because there are people who can only be educated with a play*." A peer educator in Matam noted, "*We contacted rappers to write a song about HIV/AIDS, we did a radio show at [a local venue] to raise awareness.*" Film screenings were also mentioned as a tool peer educators used in several regions. Peer educators described using cell phones, WhatsApp, Facebook, face-to-face meetings, and *Clic Info Ado* to interact with and educate adolescents and youth; the latter was explained by one peer educator in Sédhiou: "*We have a database on the computer and when a young person wants information, he enters the question and the computer gives him the answer directly.*"

Collaboration with other organizations and with health providers was a major focus of many of the peer educators' work across all six regions. A peer educator in Kédougou noted peer educators engaged a great deal with schools through clubs: "*We have the Family Life Education club in schools, as it is there that we see the most of each other to communicate on early marriage and pregnancy, STIs/ AIDS*." Another peer

educator in the same FGD added, "*We can also add the AEMO [Educational Action in Open Environment], the Child Guidance Center, the CAOSP [Academic Center for School and Professional Guidance] which is also there to guide young people*." A peer educator in Kaolack remarked that peer educators collaborated with health providers to carry out their activities, "*We have good collaboration with the stakeholders; the activities are under the guidance of the district or the medical region*." In Sédhiou, a peer educator noted that other peer educators collaborated with civil society organziations, the CDEPS (Departmental Center of Public Education and Sports), and providers:

> *As health service providers, we can say that we have an open collaboration because when we talk about the CCA, there has to be a link with the health posts, health centers, and the district, as there are certain activities that require their approval and supervision.. It is interdependence; we may need them, as they too may need us to carry out activities.*

Asked about the role young people played in promoting AYRH, a peer educator in Kaolack said approvingly: "*They play a really great role, they are organizing talks, raising awareness, talking to each other, taking care of their concerns*."

4.2.4 Perceptions Concerning the role of Community Radio

While not discussed in-depth, it was clear from the qualitative data that community radio played an important role in raising awareness of AYRH issues. Many parents across the six regions said they had first heard of RH services adapted to the needs of adolescents and youth through the radio and were able to learn more about these issues by tuning in. A mother who took part in a FGD in Sédhiou observed that a community radio station in her area: "*carries out awareness raising in the community about early sexuality and early marriage.*" Some of the SRH program managers noted they and other service providers sometimes spoke about AYRH issues on the radio. Peer educators, too, highlighted radio as an important resource. A peer educator in Kédougou noted peer educators used it in the region to educate the community: "*Sometimes we advertise on the radio. We also have radio debates on AIDS to raise awareness, especially among rural people, so that information can reach everyone*." A peer educator in Kaolack noted, "*There is also a community radio station with a show dedicated to adolescents. Adolescents/young people are on the air to discuss these issues*."

<u>Standard 5:</u> The health services management system appropriately considers the sexual and reproductive health needs of adolescents and young people

To understand the extent to which the fifth standard of Senegal's 2014–2018 strategy for AYRH was met, the assessment explored what kind of supervision and oversight existed at the SDP level, as well as recording and use of service statistics. This section presents findings on management and data practices at SDP level, as well as uptake of relevant AYRH services in the assessed SDPs.

Data on the management practices, including record keeping, and use of data is presented at the SDP level in Table 37. According to these results, all facilties (23) have registers or some other system for collected data on key AYRH services provided. However, slightly more than half (13) of these SDPs mentioned they reported data regularly (quarterly or monthly) to health districts on the use of specific

AYRH services by adolescents/ youth, and 12 SDPs reported using service data for action planning and implementation of quality improvement initiatives.

More than half (15) of the 23 assessed SDPs reported they had a functional supervision and quality assurance system to improve provider capacties for offering AYRH services. However, only seven (7) SDPs in Kaolack, Matam, and Sédhiou receive or conduct supportive supervision activities on a regular basis (at least monthly). A total of 11 SDPs reported their supervision activities include a data quality review of the registers and SDP-based HMIS to ensure AYRH data and indicators are verified.

Peer educators and community health workers need regular contact and support with refresher training, tools, and supportive supervision to ensure their efforts and information shared is of good quality. In the previous section (Standard 4), 11 facilties reported they have a program of training and supporting peer educators which provide outreach services in the community. However, Table 37 shows only 7 of these SDPs have a system and tools for monitoring and supervising the peer educators on a monthly basis.

SDP managers were asked about whether or not they had a mechanism for youth to provide feedback on their satisfaction with YFHS. Slightly more than half (13) reported to have a way of obtaining feedback from their adolescent and youth clients and 10 of these reported they regularly analyze and utilize data from these sessions to improve services for young people. Additional information from the community and client youth surveys on youth feedback on services will be presented later in this section.

Table 37: Key Indicators Related to Standard 5 (The health services management system appropriately considers the sexual and reproductive health aspects of adolescents and young people)

Indicator	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (SDPs)	**n=5**	**n=2**	**n=4**	**n=3**	**n=5**	**n=4**	**n=23**
Number of SDPs with registers or other systems in place to collect data on service utilisation	5	2	4	3	5	4	23 (100%)
Number of SDPs reporting regularly (quarterly or monthly) to health districts with data on the utilisation of **specific services by adolescents/ young people**	2	1	2	2	3	3	13
Number of SDPs using service data for action planning and implementation of quality improvement initiatives	2	1	2	2	3	2	12

Number of SDPs with a functional supervision system to improve service provider performance	5	0	2	2	4	2	15
Number of SDPs which receive or conduct supervision visits **at least monthly**	3	0	0	2	0	2	7
Number of SDPs in which each supervision includes a data quality review to ensure AYRH data and indicators are verified	2	0	2	1	4	2	11
Number of SDPs which have a system and tools for monitoring and supervising peer educators on a monthly basis	3	0	0	2	1	1	7
Number of SDPs which have a mechanism for youth to provide feedback on their satisfaction with YFHS	4	0	4	2	3	0	13
Number of SDPs which analyse and utilize data from these feedback sessions to improve services for young people	4	—	3	2	1	—	10

SRH program managers who were asked about supervision of health providers noted there was a formal supervision structure, though many respondents did not provide a great deal of information about the nature of the supervision that took place. A manager in Matam noted simply, "*There is a monitoring and evaluation system, and, in this case, we involve our community stakeholders, relais, community health workers and bajenu gox, who will allow us to monitor the services.*" Several participants noted supervision took place at several levels; as a manager in Saint-Louis explained: "*The district supervises the health posts every three months and the district is supervised by the [medical] region every six months. Health posts also supervise health huts on a monthly or bi-monthly basis*."

At the regional level, a SRH manager in Kolda explained, there was "*The Ministry of Health and Social Action who deploy agents who come to carry out supervision.*" A manager in Saint-Louis said there was a meeting held every three months to review the previous period's data and activities and the ICP (*Infirmiers Chef de Poste*) would visit communities once per month.

At the district level, according to the Kolda SRH program manager quoted above, "*We conduct supervision visits to health posts, especially on reproductive health*." The manager in Kaolack noted district-level visits of health posts took place every two or three months. The nature of these meetings was described by another SRH program manager interviewed in Kaolack, who explained, "*In coordination*

meetings we discuss all the problems in the district. Each program manager describes his program, shares his problems, and we study them together."

A bit more detail was provided about how supervision tended to operate at the health post level. One manager in Kaolack explained:

> *Monitoring at the health post level is done through meetings with stakeholders every month, the ICP with the midwife near the post organizes a coordination meeting. We can also take stock of activities every month and every stakeholder will be able to report on all the activities that have been carried out during the month. And at the post level, now the ICP will come to the district level for a monthly coordination meeting and all the posts will be convened at this meeting. This will be a meeting for all district service providers. With the management team, they will share and make the monthly assessment.*

Some participants in the qualitative assessment said supervision was not robust, particularly when speaking specifically about AYRH service provision. In response to a question about whether a supervision system existed, a SRH program manager in Sédhiou responded: "*No, we do not have an AYRH monitoring and evaluation system in our district.*" A manager in Saint-Louis asserted a new AYRH project was having a hard time getting off the ground because approval was needed: "*The major constraint is lack of commitment and leadership. If the initiatives do not come from the boss, the activities to be carried out can drag. However, if there were ownership of the program by the District Chief Medical Officer, it would make things easier*."

Uptake of Youth-Friendly Health Services and Access Barriers, Challenges, and Proposed Solutions

In this assessment, YFHS providers interviewed as part of the SDP audit were asked to provide data on the total number of youth (both new and revisiting clients) served in the 12 months preceding the survey[i]. The data were used to analyze the overall volume of youth served in the assessed SDPs by type of service received and by region. It also includes the number of youth who received FP counseling and/or methods disaggregated by sex and five-year age group, by type of SDP, and by region. Uptake of services was measured by the number of youth SDP-based service providers recorded as having received services in registers or other available reports; thus only SDPs that had an available register or other data/report for the period of April 2017 to March 2018 were included in the analysis. The data presented in Table 38 show a total of 16,671 male and female youth aged 10–24 years were served in the 23 SDPs over the 12 months prior to the assessment through a combination of counseling, testing, treatment, and FP commodity provision services for HIV, STIs, contraception, PAC, gynecological care, and general RH counseling. By service, SDPs were most likely to provide HIV-related services to youth, with a total of 8385 youth served with voluntary counseling and testing for HIV, HIV testing and treatment, or general HIV counseling services. Contraception and FP counseling and services were also provided to youth; a total of 5326 youth received either FP counseling alone or FP counseling and

[i] It should be noted that not all of the figures were verified by the interviewers. Some service providers did not have registers or show their registers or reporting forms to the interviewers.

method provision (including both new and returning clients). In addition, a total of 2576 female youth were seen for gynecological consultations (reason not specified). Among the 12 SDPs who reported they provide support services for GBV, none reported seeing any clients over the prior 12 months before the assessment. It was unclear from the data if these services are not provided or if clients receiving these services are not recorded.

This data is also shown by type of service delivery model. It should be noted that the number of clients depends on the total number of SDPs in the region which offer FP services and record data as well as the total number of providers at SDP level offering services, among other factors. However, it appears that separate youth corners co-located in HCs which provide comprehensive RH services recorded the greatest total number of FP clients over the preceding 12 months (4366 clients among a total of seven SDPs offering FP and recording data). The five youth centers (CCAs) offering either FP counseling alone or FP services recorded serving 781 clients over the previous 12 months, and the two mobile outreach teams recorded a total of 179 clients over the previous 12 months. Neither the stand-alone YFS site nor the non-health settings SDPs (IMEs) recorded offering any FP counseling or services to adolescents or youth over the 12 months prior to data collection.

Table 38 also shows additional information about the sex and age group 5326 youth who received FP counseling and service provision[i]. Across the six regions, 18 PPS offered either FP counseling alone or FP counseling and contraceptive methods. However, only 17 PPS had an observable register where data were recorded, either as FP counseling alone or counseling and method provision (this included 16 SDPs which provide both counseling and FP methods and one SDP which recorded data on contraceptive counseling alone). Data from these 17 PPS reveal nearly non-existant service provision among the 10–14-year age group; 0 males and only 6 females aged 10–14 years received counseling or contraceptive methods in the one year preceding the assessment. In addition, few males aged 15–19 or 20–24 years received services (49 and 73 males, respectively). As expected, most clients were females aged 20–24 years (1836 in the previous 12 months).

Table 38: Number of Youth Reported by Service Providers to have Accessed Youth-Friendly Health Services in the one year Preceding the Survey (March 2017–February 2018)

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Number of cases (SDPs)	n=5	n=2	n=4	n=3	n=5	n=4	n=23
Total number of youth receiving RH services in past 12 months, by type of service:							
Gynecological consultations (females only)	459	0	341	36	1740	0	2576
Number of SDPs offering the service with available register/data	4	1 (1*)	3	3	3 (1*)	1	15 (2*)

[i] Data from four SDPs in Kolda do not have data disaggregated by age and sex for FP counseling/method provision.

Menstrual hygiene/counseling (females only)	33	0	88	41	77	—	239
Number of SDPs offering the service with available register/data	2 (2*)	2	4	3	4(1*)	0	15 (3*)
Post-abortion care (females only)	55	—	—	40	23	2	120
Number of SDPs offering the service with available register/data	3	0	0	1	2	1	7
SRH counseling (females only)	20	0	0	13	0	0	33
Number of SDPs offering the service with available register/data	1 (3*)	2	2	3	1 (3*)	3	12 (6*)
FP counseling	6	0	0	0	189	2	197
Number of SDPs offering the service with available register/data	4	1	3	2 (1*)	2 (1*)	1 (1*)	10 (3*)
FP services	610	129	2795	170	1369	56	5129
Number of SDPs offering the service with available register/data	4	1	4	2 (1*)	3 (1*)	2	16 (2*)
HIV advice	84	0	254	95	632	122	1187
Number of SDPs offering the service with available register/data	4 (1*)	2	3	3	4 (1*)	4	20 (2*)
Testing and treatment VIH	344	0	0	41	410	0	795
Number of SDPs offering the service with available register/data	5	1	2	3	5	1	17
HIV voluntary counselling and testing	3165	940	2177	45	8	68	6403
Number of SDPs offering the service with available register/data	2 (1*)	1	3	3	2	1	12 (1*)
Gender-based violence	0	0	0	0	0	0	0
Number of SDPs offering the service with available register/data	1	2	3	2	3	1	12
Total youth served for above RH services in past 12 months	**4770**	**1069**	**5655**	**481**	**4446**	**250**	**16671**
Number of SDPs offering FP counseling and/or services to youth in the past 12 months with an available register/data	4	1	4	2	4	2	17
Total number of youth receiving FP counseling/services, by type of YFS model:							
Stand-alone YFHS SDP, n=1							0
Number of SDPs (with observable FP registers)							1
Youth centers (CCAs), n=7							781

Number of SDPs (with observable FP registers)							5
Non-health settings (IMEs), n=6							0
Number of SDPs (with observable FP registers)							1
Separate space within the SDP, n=7							4366
Number of SDPs (with observable FP registers)							7
Mobile outreach services, n=2 (events)							179
Number of SDPs (with observable FP registers)							2
Total number of 10–14 male youth receiving conseil/PF services	0	0	—	0	0	0	0
Total number of 15–19 male youth receiving conseil/PF services	2	47	—	0	0	0	49
Total number of 20–24 male youth receiving conseil/PF services	46	25	—	0	2	0	73
Total number of 10–14 female youth receiving conseil/PF services	3	0	—	0	3	0	6
Total number of 15–19 female youth receiving conseil/PF services	156	33	—	53	307	18	567
Total number of 20–24 female youth receiving conseil/PF services	409	24	—	117	1246	40	1836
Total number of youth receiving conseil/PF services	616	129	2795	170	1558	58	5326

Challenges and proposed solutions in reaching an AYRH SDP as well as accessing AYRH services within an SDP were discussed and recorded as part of interviews with both clients immediately exiting the SDP as well as with youth in communities who were aware of AYRH services. The barriers to use AYRH services have already been touched upon in earlier chapters of this report. Besides the unsupportive attitudes of parents and community leaders, it has been shown that knowledge of AYRH is low across the country, not only among youth but also among their parents. As stated earlier, youth can only access AYRH if they are well-informed of their availability and benefits, and parents can only encourage their sons and daughters to access AYRH services if they are also aware of these services and their benefits. This report shows that only about 17% of the community youth survey respondents aged 10–24 had heard about AYRH and most parents did not know about AYRH. Community leaders also reported that lack of knowledge on AYRH makes it difficult for youth to access these services. It has also been shown that, among both parents and youth, there are misconceptions about RH services. For example, there is the perception the use of injectables will destroy the womb or cause cancer; some people also believe that FP methods are for adults and youth who are married. Such misconceptions make it difficult for youth to access FP methods. In the subsequent paragraphs, we present a summary of other access challenges and proposed solutions mentioned by different respondents.

Tables 39 and 40 show this feedback as reported by both exit clients and community youth. In comparing feedback from these two groups of youth, it should be noted that clients exiting the services

have just accessed an SDP and have very recent (same-day) experience obtaining services. Alternatively, community youth who have ever heard of AYRH may have *never* actually accessed and used services and may base their understanding and information on what they have heard from others rather than what they have actually experienced themselves. However, having these two perspectives gives us complementary feedback on both how youth broadly perceive the challenges of accessing services at the community level, as well as on the recent experiences a smaller group of experienced youth may have had with services, than if feedback was obtained from only one of these groups of youth.

Both tables show that, while adolescent and youth clients were more than twice as likely (16.7 %) as community youth (7.7%) to have experienced challenges in accessing services, this percentage is still relatively low. Regarding accessing an AYRH SDP, both client and community youth mentioned "distance from the AYRH SDP/isolation" as the most critical challenge in accessing services (66.7% of clients and 81.3% of community youth, among those who responded challenges existed), understandable given the small number of SDPs offering services in these six regions and the rural vastness and lack of road and transport infrastructure in the regions themselves. Others mentioned lack of awareness or understanding of services, poor road infrastructure, and lack/cost of transportation. Suggestions for improving access to AYRH included adding AYRH to all health facilities, increase the number of mobile outreach services, constructing new AYRH outlets, doing activities to sensitize and promote services, and providing or facilitating transport to services for youth.

A similar number (10.6% of clients and 12.5% of community youth) responded they are aware of challenges accessing services within an SDP as well. Non-availability of services or FP commodities was mentioned by several clients and community youth, lack of information about available services at SDP level, operating hours/days of services, and treatment ("stigmatization") of youth by providers were also critical challenges for both clients and community youth. Youth mentioned that solving these challenges might be addressed by simply correcting the deficits: providing services or FP commodities youth would like to obtain, providing better information on available services, having more appropriate operating hours for services, and sensitizing and training staff to interact with youth more positively.

Table 39: Feedback on Improving Adolescent and Youth Reproductive Health Services Among Clients, 10-24 years old (exit interviews)

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Percentage of youth clients who have experienced challenges in accessing SDPs where AYRH services are offered	16.7%	3.3%	0.0%	40.0%	36.7%	3.3%	16.7%
Number of cases	30	30	30	30	30	30	180
Challenges with accessing an SDP:							
Distance from the AYRH SDP/ isolation	100.0%	100.0%	—	91.7%	27.3%	0.0%	66.7%
Ignorance/ lack of information	0.0%	0.0%	—	0.0%	45.5%	100.0%	20.0%
Non-passable roads	0.0%	0.0%	—	16.7%	0.0%	0.0%	6.7%
Waiting time	0.0%	0.0%	—	0.0%	9.1%	0.0%	3.3%
Absence of service providers	0.0%	0.0%	—	8.3%	0.0%	0.0%	3.3%
Hight Cost	0.0%	0.0%	—	8.3%	0.0%	0.0%	3.3%

Number of cases	5	1	0	12	11	1	30
Suggestions for overcoming these challenges:							
Make SDPs accessible	80.0%	100.0%	—	75.0%	36.4%	0.0%	45.0%
Make AYRH available in all SDPs	0.0%	0.0%	—	16.7%	90.9%	0.0%	30.0%
Increase the number of mobile teams/ outreach activities	80.0%	0.0%	—	25.0%	0.0%	0.0%	17.5%
Sensitization/ explain existence of AYRH	0.0%	0.0%	—	0.0%	18.1%	100.0%	7.5%
Number of cases	5	1	0	12	11	1	30
Percentage of youth who agree that there are challenges in accessing services offered at the level of the SDP	20.0%	0.0%	3.3%	13.3%	23.3%	3.3%	10.6%
Number of cases	30	30	30	30	30	30	180
Challenges with accessing services within an SDP:							
Lack of AYRH services/availability	16.7%	—	0.0%	75.0%	57.1%	100.0%	47.4%
Inconvenient operating hours	33.3%	—	100.0%	50.0%	14.3%	0.0%	31.6%
Stigmatization by staff	16.7%	—	0.0%	25.0%	42.9%	0.0%	26.3%
High cost of care	16.7%	—	0.0%	25.0%	28.6%	0.0%	21.1%
Long waiting time	50.0%	—	0.0%	0.0%	0.0%	0.0%	15.8%
Poor reception/welcome	0.0%	—	0.0%	0.0%	28.6%	0.0%	10.5%
Lack of discretion/ confidentiality	0.0%	—	0.0%	0.0%	28.6%	0.0%	10.5%
Lack of privacy	0.0%	—	0.0%	0.0%	14.3%	0.0%	5.3%
Number of cases	6	0	1	4	7	1	19
Suggestions for overcoming these challenges:							
Make AYRH services available	33.3%	—	0.0%	75.0%	71.4%	100.0%	57.9%
Free/ low cost care	50.0%	—	0.0%	25.0%	28.6%	0.0%	31.6%
Convenient operating hours	33.3%	—	100.0%	25.0%	14.3%	0.0%	26.3%
Make the places private	16.7%	—	0.0%	0.0%	57.1%	0.0%	26.3%
Ensure (good) reception	16.7%	—	0.0%	25.0%	28.6%	0.0%	21.1%
Reduce waiting times	50.0%	—	0.0%	0.0%	0.0%	0.0%	15.8%
Strengthen the staff	16.7%	—	0.0%	25.0%	0.0%	0.0%	10.5%
Ensure confidentiality	0.0%	—	0.0%	0.0%	28.6%	0.0%	10.5%
Educate the staff	0.0%	—	0.0%	0.0%	14.3%	0.0%	5.3%
Number of cases	6	0	1	4	7	1	19

Table 40: Feedback on Improving Adolescent and Youth Reproductive Health Services Among Youth, 10–24 years old

Variable	REGION (Unweighted)						Total
	Kaolack	Kédougou	Kolda	Matam	Saint-Louis	Sédhiou	
Among youth who have ever heard of AYRH services, percentage of youth who experience challenges in accessing SDPs where services are offered	11.8%	6.1%	8.7%	14.3%	6.2%	1.4%	7.7%
Number of cases	85	66	103	28	65	69	416
Challenges with accessing an SDP:							
Distance from AYRH SDPs/ Isolation	60.0%	100.0%	88.9%	75.0%	100.0%	100.0%	81.3%
Low frequency of outreach activities	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%
Mobility related to a physical disability	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%
Other	20.0%	0.0%	11.1%	25.0%	0.0%	0.0%	12.5%
Number of cases	10	4	9	4	4	1	32
Suggestions for overcoming these challenges:							
Make SDPs accessible	50.0%	25.0%	55.6%	25.0%	75.0%	100.0%	50.0%
Make YFS available in all SDPs	50.0%	75.0%	55.6%	25.0%	25.0%	0.0%	46.9%
Increase the number of mobile teams/outreach activities	10.0%	25.0%	44.4%	25.0%	25.0%	100.0%	28.1%
Means of transport/ ambulance	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	3.1%
Build a clinic	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	3.1%
Facilitate the transport of those with disabilities	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%
Number of cases	10	4	9	4	4	1	32
Percentage of youth who are aware of challenges in services offered at the level of the SDP	32.9%	9.1%	7.8%	14.3%	9.2%	0.0%	12.5%
Number of cases	85	66	103	28	65	69	416
Challenges with accessing services within an SDP:							
Lack of information	35.7%	83.3%	62.5%	50.0%	16.7%	—	44.2%
Lack of FP product availability	50.0%	0.0%	25.0%	0.0%	0.0%	—	30.8%
Stigmatization by staff	17.9%	33.3%	25.0%	25.0%	83.3%	—	28.8%
Lack of privacy	0.0%	66.7%	62.5%	0.0%	16.7%	—	19.2%
Poor reception	3.6%	33.3%	25.0%	0.0%	50.0%	—	15.4%
Lack of discretion/ confidentiality	0.0%	0.0%	12.5%	25.0%	16.7%	—	5.8%
Inconvenient operating hours	0.0%	0.0%	37.5%	0.0%	33.3%	—	9.6%
Lack of AYRH service availability	0.0%	16.7%	12.5%	25.0%	16.7%	—	7.7%
Long waiting times	3.6%	0.0%	0.0%	25.0%	16.7%	—	5.7%
Number of cases	28	6	8	4	6	0	52
Suggestions for overcoming these challenges:							
Make AYRH services available	57.1%	16.7%	28.6%	0.0%	16.7%	—	39.2%

Educate the staff	17.9%	66.7%	28.6%	25.0%	83.3%	—	33.3%
Information/ sensibilization/ Inform about the existence of AYRH	39.3%	0.0%	0.0%	0.0%	0.0%	—	21.5%
Ensure (good) reception	3.6%	33.3%	28.6%	25.0%	50.0%	—	17.6%
Convenient operating hours	0.0%	50.0%	42.9%	0.0%	16.7%	—	13.7%
Make the places private	0.0%	0.0%	42.9%	25.0%	16.7%	—	9.8%
Make FP products available	3.6%	16.7%	42.9%	0.0%	0.0%	—	9.8%
Free/ low cost care	3.6%	0.0%	28.6%	0.0%	16.7%	—	7.8%
Ensure confidentiality	0.0%	0.0%	14.3%	25.0%	16.7%	—	5.9%
Provider training for service improvement	3.6%	0.0%	0.0%	0.0%	0.0%	—	2.0%
More service delivery	0.0%	0.0%	0.0%	25.0%	16.7%	—	3.9%
Have up to date information	0.0%	0.0%	0.0%	25.0%	0.0%	—	2.0%
Raise awareness among parents of young people	3.6%	0.0%	0.0%	0.0%	0.0%	—	2.0%
Respect clients	0.0%	16.7%	0.0%	0.0%	0.0%	—	2.0%
Number of cases	28	6	7	4	6	0	51

Recommendations

- The data collected from young people, both through the community-based survey and exit interviews in SDPs, revealed little knowledge or awareness about the availability of YFHS or the range of services offered. Even some young people who had just utilized those services were not aware they were at a YFHS site. As a result, every effort should be made to *develop appropriate strategies to* ***create awareness about YFHS****, particularly in catchment areas surrounding YFHS SDPs, including the package of services offered, benefits of services, and intended beneficiaries.* Strategies could include:
    - Use existing peer educators, ASC/relais, NGOs, and the media (radio) to engage in health promotion to raise awareness of RH issues, especially regarding the menstrual cycle, STIs and different contraceptive options, including reducing myths and misconceptions of adolescent users and their parents.
    - Expand access to information about YFHS for adolescents, young people and their parents, including through home visits by ASC/relais, WhatsApp messaging platforms amongst youth, Click Info Ado, skits, and discussions.
- Both quantitative and qualitative data gathered for this report showed that conversations about sexuality and RH were not only not normative, but also considered taboo. Little family communication about FP/RH was taking place between parents and youth. Strikingly, even young people seemed to avoid talking about RH among themselves. Open communication is an important vehicle for learning about RH and for sharing family values about sexuality. Given this, it is important to work with key stakeholder to **examine social norms** related to early marriage, adolescent pregnancy, contraception and utilization of YFS, and to *promote a* ***change in social norms regarding communication about reproductive health and rights*** *by creating opportunities to stimulate RH communication among in families, youth peer groups, schools, mosques, and community settings.* Educating parents about FP/RH and family life education in schools and mosques are effective strategies to promote family communication and increase knowledge. Local television

programs, such as *That's Life,* which highlight RH issues through contemporary drama, can also be useful.

- Data from some of the regions in this study[k] suggest that open communication between young people and their parents about RH YFHS is a facilitating factor for adolescents and youth to access services. However, as mentioned above, the study also revealed that family communication about RH is generally very limited. In addition to the cultural taboo of speaking about RH/FP, this study also suggests that parent's lack of knowledge about RH and YHFS is also an obstacle for open communication. It is there important to *implement* ***specific strategies with parents of adolescents and youth*** *to help them better understand AYSRH, to gain an awareness of YFS and where these services are offered and to improve their capacities to discuss AYSRH issues with their children*.

- It is now an established fact that girls' education has a positive impact on a broad range of RH outcomes and, with every additional year of education, these RH benefits accrue. *A multi-sectoral strategy for* ***keeping girls in school*** *is critical to enhancing the general wellbeing of the youth population and the generations to come.* Not only can school attendance advance girls' economic security and agency, but it can help reduce early marriages and too-early pregnancies, which jeopardize the health and futures of young women in Senegal.
- Ensuring YFHS respond to the needs of married adolescents. The qualitative findings presented early in the report indicate early marriage is perceived as a major concern in all six regions and this is confirmed by Senegal's official demographic data as well as some of quantitative the findings in this report. YFHS should be designed to **meet the specific needs of married adolescent girls—including very young adolescents—and young married women**, which are quite different than unmarried adolescents and young women. This includes programming for first-time young mothers to promote healthy timing and spacing of pregnancies.
- Expanding access to RH counselling services and condoms for very young adolescent (VYA) boys, especially in Kolda and Matam where approximately 10% of boys in this age group reported already being sexually active (yet none of the SDPs offered any FP counselling or services to this age group). *The school-affiliated IMEs could be useful SDPs for such services, since they have direct links with boys of this age. Targeted community outreach activities for VYA should also be explored.*
- Offering young people access to the **full range of contraceptive options** is fundamental to the realization of the sexual and reproductive rights of youth and a cornerstone of voluntary informed choice counseling. This study identified a number of factors that serve to limit the contraceptive options of young people. Below are recommendations to address some of these limiting factors in both SDP and community settings:
    - Increasing the ability and willingness of providers to counsel on a wider range of methods can be achieved by periodic training and sensitization to address misconceptions about married and unmarried adolescents' use of diverse birth control methods.
    - Provide training to peer educators and bajenu gox to counter misconceptions, improve their counseling and referral skills and, generally, be more responsive to the needs of adolescents and youth.

[k] Especially Kaolack and Saint-Louis

- Continue to support efforts to strengthen the availability of contraceptives and other YFHS products.
- Bring services closer to where youth live and strengthen referral systems to youth-friendly SDPs for methods that cannot be offered at community level[l].
- Introduce specific efforts to offer comprehensive AYRH counselling to adolescent boys and young men at health centers and health posts, especially in settings where notable numbers of them procure condoms from SDPs.

- AYRH services models should be tailored to the local or regional context. There really is no one "correct" model of AYRH services which is relevant regardless of context. The selected model(s) should reflect the specific target population, desired behavioral and health outcomes, range of services to be offered, and needs and objectives for scalability and sustainability. The results from this study suggest that the following considerations should be prioritized in order to **tailor AYRH services modles to the regional context:**
  - Involve frontline community health workers with a good knowledge of the specific regional context, such as Bajenu Gox and peer educators, to design region specific service delivery strategies and models for each region.
  - Expand access to YFS through increasing the number of SDPs offering quality YFS, especially in rural areas.
  - Expand outreach and mobile services to address the challenge of distance in remote rural areas.
  - Actively engage adolescents and youthin the design, implementation and monitoring of programming and outreach efforts, including the distribution of condoms and other contraceptives permitted by Senegalese policies.
- The study revealed inconsistency in the relationship between SDPs and community agents to advance RH. In some regions, the relationship has been more regularized, while in others, community agents seemed to act largely independently. *SDPs should* ***leverage opportunities to extend YFHS and education to communities*** *by making consistent use of ASC/relais, peer educators, community leaders, and NGOs.* These relationships should not be left to chance but must be planned, implemented, monitored, and adjusted according to changing community and youth needs. Such efforts should also be done with full participation of youth associations, student groups and other platforms that can bring youth voices to the design and implementation of community-based AYRH interventions. Given that most AYRH outreach is being conducted at community level by providers not affiliated with designated YFS SDPs, it is important for district level coordinators to ensure consistency of messages, high quality training (and refresher training), and regular supervision of outreach staff. This is especially important in SDP catchment areas and communities where there is a shortage of health professionals to provide outreach.
- In both the survey conducted and exit interviews with youth, privacy and confidentiality emerged as priority concerns for young people. In response, *steps should be taken, considering the available resources, to* ***organize services that guarnatee privacy for youth*** *throughout their visit to the YFHS SDP—from waiting queues to the services themselves. Such efforts should be designed in consultation with adolescents and youth themselves to ensure they address concerns as perceived by youth and incorporate solutions informed by youth perspectives*. Ensure awareness-raising campaigns about services emphasize

[l] According to Senegal's national policies, not all FP methods are authorized to be offered at community level.

their confidentiality and privacy. Where services cannot be reorganized to provide adolescents and youth with more private access to services, consider other creative approaches, like having operating hours during which services are only available to adolescents and youth, offering a separate waiting area or entrance/exit, facilitating privacy and access through phone calls, and/or ensuring no names or details of health appointments are disclosed in waiting rooms or where others might overhear.

- Making young people aware of their rights to quality health service is an essential component of quality of care. Once young people have an awareness of their rights, they are more likely to become informed users: more likely to express their needs, have raised expectations both about the range of services offered and their quality, and more willing to voice their concerns about services. The recommendation to ***raise awareness among young people about their right to quality health services*** *should be coupled with efforts to involve young people in mechanisms to monitor and improve SDP and community-based health services.* This can include promoting their participation in SDP committees that involve the community and aim to address concerns about quality, access, utilization, and equity.
- This study revealed there was a high degree of inconsistency in the training providers received regarding YFHS. Some providers had received no training specific to the needs of adolescents and young people, others had received limited training covering only certain aspects of YFHS. Still others were not sure whether they had received YFHS training. Considering this diversity of exposure, it is important to ***bring consistency to the training that YFHS providers receive*** *and ensure it is comprehensive in nature, covering all of the essential services outlined in the National Strategic Plan for Adolescent and Youth Sexual and Reproductive Health. Part of the training should also include values clarification exercises to promote unbiased and respectful care.*
- Interviews with providers revealed that, by and large, no systematic approach to quality assurance specific to YFHS was being taken in the SDPs in which they worked. Effective systems of quality assurance provide mechanisms for providers to assess the status of their services, as measured against nationally recognized standards of quality. They also enable and empower staff to develop plans to address shortfalls in service. Finally, providers and in-charges have a mechanism to monitor progress. The most effective quality assurance approaches encourage a cultural shift in the SDP, where all staff see it as their personal responsibility to promote quality services. Given the importance of this managerial tool, efforts should be made to ***consistently implement a standardized system for quality assurance in FP and YFHS*** *to increase the quality and responsiveness of clinical and community-based services to the needs of adolescents and youth. As part of this, support both health care providers and ASC/relais with regular and predictable supportive supervision specifically focused on adolescents and young people.*

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Annex 1. Service Delivery Point Data Collection in the 12 Districts

Regions	Districts	Targeted SDPs	Surveyed SDPs	Observations
KAOLACK	Kaolack	CCA	√	The only midwife offering services is absent during the survey (traveling)
		ASBEF Clinic	√	
		YFS4: ASBEF Mobile Services	**No**	The information provided by ASBEF indicates that there were no activities during 2017/2018 due to financial resource constraints
		YFS5: ASBEF Community Services	**No**	
		IME	√	
	Nioro	MSI (Mobile Team)	√	This mobile team delivers their services at the Ndorong health post in Kaolack District
		Health Centre	√	
KÉDOUGOU	Kédougou	CCA	√	We recall that the Kedougou region has only one district of the same name.
		IME	√	
KOLDA	Kolda	CCA	√	
		ASBEF Clinic	√	
		YFS4: ASBEF Mobile Services	**No**	The information provided by ASBEF indicates that there were no activities during 2017/2018 due to financial resource constraints
		YFS5: ASBEF Community Services	**No**	
		IME	√	
	Vélingara	CCA	√	
MATAM	Matam	CCA	√	
		IME	√	
	Kanel	Health Centre	√	
SAINT- LOUIS	Saint-Louis	CCA	√	
		ASBEF Clinic	√	
		YFS5: ASBEF Community Services	**No**	The information provided by ASBEF indicates that there were no activities during 2017/2018 due to financial resource constraints
		IME	√	
		MSI Sanar (PS)	√	
	Dagana	Health Centre	√	
	Richard-Toll1	YFS4: ASBEF Mobile Services	**No**	The information provided by ASBEF indicates that there were no activities during

		YFS5: ASBEF Community Services	**No**	2017/2018 due to financial resource constraints
SEDHIOU	Sédhiou	CCA	√	
		IME	√	Teachers who have received capacity building (informal) provide SRH services
	Bounkiling	Health Centre	√	
		MSI Mobile team	√	MSI carries out service delivery in health posts
TOTAL	**12**	**30 (targeted)**	**23 (achieved)**	

[1] In Richard-Toll District, it was planned to visit Mobile Community Outreach Services (ASBEF/ Mobile Services): 1 at the community level and 1 with the mobile team. For the reasons mentioned, ASBEF could not carry out any of the planned activities in 2017-2018.

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