

Reproductive Health Education Strategies of the CCA for out-of-school youth in Mbour, Tamabounda, and Kolda, Senegal

Oulèye Niang Fall, l'Université Cheikh Anta Diop, l'Institut de Population et le Développement en Santé de la Reproduction (IPDSR)

Amy P. Sommer, The New School, Graduate Program in International Affairs (GPIA)

1 September 2009

ABSTRACT

In 2000, the Senegalese Ministry of Youth, through its Youth Promotion Project (PPJ), created the Adolescent Counseling Centers (CCA). This network of 13 CCAs has as its primary objective to raise awareness among young people in the area of reproductive health to lower the incidences of STIs, early pregnancies, and HIV/AIDS. Out-of-school youth, by virtue of their vulnerability to reproductive health challenges, constitute the principal target population of the CCAs. This study presents an analysis of the CCA's strategies designed to raise awareness and change behaviors of out-of-school youth in Mbour, Tambacounda, and Kolda, and offers a logistical framework for the development of a programme designed to better reach this population.

Table of Contents

LIST OF ABBREVIATIONS.....	4
INTRODUCTION.....	5
IDENTIFICATION AND FORMULATION OF THE RESEARCH QUESTION	5
LITERATURE REVIEW	5
OBJECTIVES	7
HYPOTHESIS.....	8
METHODOLOGY.....	8
RESULTS	9
DISCUSSION AND RECOMMENDATIONS	11
APPENDICES.....	13
BIBLIOGRAPHY.....	20

LIST OF ABBREVIATIONS

ADEMAS	l'Agence pour le développement du marketing social (Agency for the development of social marketing)
WB	World Bank
CCA	Centres conseil pour les adolescents (Youth Counseling Centers)
CCC	Communication pour un changement de comportement (Communication for Behavior Change)
CDEPS	Centre départemental d'éducation populaire et sportive (Departmental Center for Popular and Sports Education)
GEEP	Groupe Pour l'Etude et l'Enseignement de la Population (Group for the Study and Instruction of Population)
VACT	Voluntary and Anonymous Counseling and Testing
ICPD	International Conference for Population Development
IMF	International Monetary Fund
IEC	Information, Education, and Communication
STI	Sexually transmitted infection
MDG	Millennium Development Goals
WHO	World Health Organization
NGO	Nongovernmental organization
FP	Family planning
PPJ	Projet promotion des jeunes (Youth Promotion Project)
PMTT	Prevention of mother-to-child transmission
VATS	Voluntary and anonymous testing services
RH	Reproductive health
UNFPA	United Nations Population Fund

INTRODUCTION

The 1994 International Conference on Population and Development (ICPD) in Cairo adopted a radically different way of thinking, shifting the existing focus of sustainable development towards a response to the needs and preferences of women and men as individuals in the area of reproductive health (RH). The ICPD established a wider definition of RH, encompassing family planning (FP), maternity without risk, protection against sexually transmitted infections (STIs) and promotion of sexual health.

Today, the incidence of STIs, HIV/AIDS, and the frequency of early pregnancy constitutes a palpable health problem among adolescents, particularly among out of school youth. These facts underscore the importance of reproductive health education. It is within this framework that the Ministry of Youth of Senegal, by means of its Project for the Promotion of Youth (PPJ), seeks to provide adequate RH education and services for adolescents and youth. The goal is to promote RH for out of school youth through a network of adolescent youth counseling centers (CCAs). The CCA have as their primary objective to raise awareness among adolescents and young people with the aim of lowering the incidence of early pregnancy, and the transmission of HIV and other STIs. The intervention strategies used in these programs are crucial with regard to programme efficacy. Given this, what is the influence of these strategies on the level of RH education for out of school youth? This study, carried out in the cities of Mbour, Tamabacounda, and Kolda from June 6th to July 31st, seeks to analyze the RH education strategies of the CCAs. It will identify problems with the underlying strategy and propose recommendations to improve the strategies at hand to better reach the target population.

IDENTIFICATION AND FORMULATION OF THE RESEARCH QUESTION

Senegal is ranked 156 of 177 countries in the Human Development Index (HDI) (UNDP, 2008). Senegal's population is 13.7 million, with a population growth rate of 2.7%. Ninety-four percent (94%) of the population is Muslim, 4% is Christian, and 1% is of other religions (CIA, 2009). It is estimated that only 40% of the population has access to health care services, and 75% of health care personnel are located in the cities of Dakar and Thiès (USAID, 2006). Life expectancy is estimated at 62.8 years, and the infant mortality rate is 60 per 1,000 live births. The mean age at first marriage is 18.3 years, and fertility is 5.3 children per woman. Modern contraception is practiced among 10.3% of the population (UNFPA, 2006).

Young people under the age of 20 represent 58% of the population of Senegal (UNICEF, 2007). This implies that the RH of youth is of supreme importance for the general development of the country. In fact, RH of youth figures prominently among the Millennium Development Goals (MDGs). Only a RH education that responds to the needs of this population will be able to diminish the breadth and gravity of problems caused by STIs, HIV/AIDS and early pregnancy.

Out of school girls are more likely to have sexual relations, contract STIs, and become prematurely pregnant than their in-school peers. Premature births, spontaneous abortions, and stillborns are more frequent among adolescent mothers. Furthermore, these mothers are four times more likely to die due to problems during pregnancy than their in-school peers (FHI, 2004). Rural youth are more inclined to be out of school due to a lack of access to education (FHI 2004). Since out of school youth do not formally receive RH information, they oftentimes do not have the knowledge necessary to make good decisions with regard to their reproductive health. Therefore, programmes that have as their objective effecting good RH behavior among youth must consider the particular needs of this population.

Sub-Saharan Africa is particularly challenged with regard to achieving a reduction in maternal and infant mortality rates (Gribble and Haffey, 2008). However, there is a difference between the level of knowledge and behaviors with regard to RH and sexuality among in-school youth and out-of-school youth. Young people who stay in school benefit from guidance and resources that allow them to easily obtain information and services with regard to their sexuality.

In 2000, the Senegalese Ministry of Youth, through its Youth Promotion Project (PPJ), created the Adolescent Counseling Centers (CCA). The network of 13 CCAs has as its primary objective to raise awareness among young people in the area of reproductive health to lower the incidences of STIs, early pregnancies, and HIV/AIDS. The CCA program is comprised of two main facets: (1) awareness-raising, and (2) the provision of psycho-medical-social services. In theory, these two facets should lead to the achievement of the program objectives. However, despite 13 years of activities carried out by the CCA out-of-school youth's behavior with regard to RH remains at-risk. What is the specific strategy of the CCAs to reach this target population? What are the elements which pose problems for this strategy? Does the strategy take into account the recommendations present in the literature concerning RH education for out of school young people? If not, how can the program incorporate these recommendations and lessons learned? A logistical framework that takes into account these issues and offers solutions would be extremely useful for the CCA and its partners.

LITERATURE REVIEW

Early pregnancy and education for girls

Early marriage and early pregnancy constitute a setback for the universal education of girls. Premature birth, spontaneous abortions and stillborns are more common among adolescent mothers. Globally, pregnancy is the number one cause of dropouts among girls. Furthermore, these mothers are four times more likely to die due pregnancy-related causes than their in-school peers (FHI, 2004).

Social investments in girls have the effect of increasing the age of girls at the time of marriage and at the time of their first childbirth. These factors have positive multiplier effects on population growth. Investments in delayed marriage and delayed childbirth promote larger intervals between generations, lower family size, and increase negotiation power of women with regard to the health and education of their children. Delaying the first birth also advances economic growth, since the productive population grows steadily while the dependency burden declines. All these effects have strong implications for the decline of maternal and infant mortality rates, and for a rise in human capital (UNFPA, 2007).

Some traditional attitudes surrounding education are present in Senegal. The regions of Tambacounda and Kolda are characterized by a high incidence of early marriage (UNFPA, 2006). A weak appreciation for the education of girls is prevalent. Forty-four percent (44%) of girls between the ages of 15 and 24 are illiterate, in comparison with 59% of boys their age (UNICEF, 2007). The mean percentage of married children (aggregated for urban and rural areas) between 1998 and 2007 was 39% (UNICEF, 2007). Eighty-one percent (81%) of boys are enrolled in school, as compared to 79% of girls (UNFPA, 2009e).

Moreover, early pregnancy bears a strong correlation to maternal mortality and obstetric complications. The rate of maternal mortality in Senegal is 690 women for every 100,000 live births. The three main factors contributing to a decline in maternal mortality are: (1) access to contraception to avoid unintended pregnancy, (2) the presence of qualified personnel during childbirth (such as a midwife), and (3) access to emergency obstetric care (UNFPA, 2009e). Since access to emergency obstetric care is limited in rural areas, the maternal mortality rate is higher in these regions. In some rural regions, 1 out of 19 women dies during childbirth (Kodio, 2002).

Contraception and condom use

Abstinence is still more frequently promoted than contraception in the RH education for young people in Senegal. The fertility rate of young people is 52 births per 1,000 women between the ages of 15 and 19 (UNFPA, 2009). Nevertheless, condom and contraception use are sometimes stigmatized outside marriage. Despite these negative perceptions of their use, the reality is that young people have sex, and, given this reality, only condoms and contraception can prevent STIs, unexpected pregnancies, and HIV infection (Advocates for Youth, 2005).

Condom use rises sharply among young people who have access to affordable and accessible distribution systems. Such systems may include: distribution in public places, pharmacies, kiosks, youth centers, schools, the workplace, vending machines, and sports and recreation sites (Advocates for Youth, 2005). Social marketing and distribution efforts that use peer education may also be successful in reducing the stigma of condom use among young people (Van Rossem and Meekers, 2006).

HIV/AIDS and other STIs

In Senegal, the HIV/AIDS rate is 0.8% (National Census, 2002). Prevalence of HIV among young people (between 15 and 24) is 0.3% among young men, and 0.8% among young women. In the departments of Thiès, Tambacounda and Kolda, prevalence is 0.2%, 0.4%, and 2.0%, respectively (National Census, 2002). Kolda is particularly concerning with regard to HIV prevalence among youth; the prevalence of HIV positive youth between 15 and 24 in Kolda is 2%; for young girls it is 2.3%, and 1.2% for young boys (UNFPA, 2006). Mbour, which is located in the department of Thiès, benefits from a relatively large tourist industry, which, despite positive economic effects, can figure negatively on the sexuality of vulnerable populations exposed to sex work or transactional sex, activities which have an impact on the prevalence of HIV and other STIs.

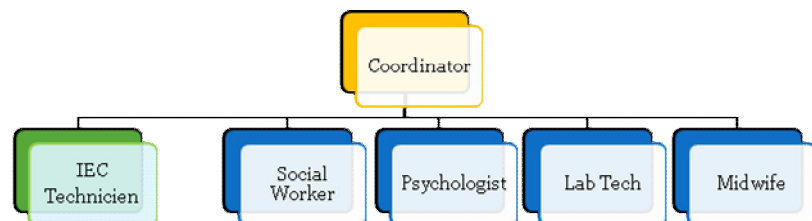
STIs occupy the second leading cause of health problems for young women of reproductive health age, after mortality linked to pregnancy and childbirth (UNFPA, 2009). Young people are less informed on the modes of transmission and means of prevention of STIs. In 2008, only 82% of boys and 78% of girls could cite at least one means of prevention of HIV (UNFPA, 2007). It is estimated that 23.7% of boys have a comprehensive knowledge of HIV/AIDS that allows them to avoid infection, whereas only 19.3% of girls have such knowledge (EDS, 2005). Even if they have good knowledge, good decision making is sometimes negatively influenced by a lack of financial means or a lack of power, especially among girls (UNFPA, 2009).

The problem of the CCA

In 1992, the Ministry of Youth established the Projet de Promotion des Jeunes, or Youth Promotion Project (PPJ). In 1996 the network of Centres de Conseils des Adolescents, or Youth Counseling Centers (CCA) was established, creating 13 centers in 8 regions of the country. The CCA program is divided into two main tracks : (1) awareness-raising, and (2), the provision of psycho-medical-social services. The CCAs use a method of information, education and communication (IEC) to raise awareness and induce behavior change with regard to RH according to two strategies: (1) on-site activities, and (2) advanced activities, offered off site. The former is often accomplished through one-on-one communication, while the later is largely done through communication en masse.

CCA personnel is composed of a coordinator who watches over activities, develops partnerships, ensures financing, produces reports, and supervises other personnel (see Figure 1). An IEC technician manages awareness-raising activities. For the psycho-medical-social facet, there is a technical team which includes a midwife, a lab technician for voluntary and anonymous HIV testing, a psychologist or counselor, and a social worker.

Figure 1: Organizational Chart of the CCA



The importance of RH education programs for out-of-school youth

The realization of programs with effective strategies to obtain an acceptable level of knowledge, attitudes, and behaviors in RH is critical to lower the incidence of early pregnancy, STIs, and HIV/AIDS among out of school youth (FHI, 2004). Young people who do not receive a formal education in RH constitute the primary target population for the CCA. Given their knowledge levels, they oftentimes have riskier sexual behavior. Therefore, programs with the objective of inducing good behavior in RH should consider the particular needs of this population. Previous studies on RH programs for out of school youth have offered the following recommendations:

1. Identify the target population as either mainstream or socially marginalized :

2. Involve community leaders in programs to establish credibility, support, and durability;
3. Consider accessibility, confidentiality, and affordability for targeted youth;
4. Involve young people in the design and implementation of programs;
5. Use collective education as well as one-on-one communication.

(FHI, 2004; WHO, 2004; Population Council, 1999; Wade, 2005)

Missing strategies, lessons learned, and problems identified

Despite the presence of CCA programs, high levels of early pregnancy, STIs, and HIV/AIDS are still prominent among out of school youth in Senegal. In 2005, the UNFPA estimated that not a single CCA had an integrated strategy to target out of school youth. In its 6th Cooperative Program with the Government of Senegal, UNFPA set the goal that 100% of the CCAs in intervention zones have such a strategy by 2011 (UNFPA, 2006).

One of the goals of the CCA is to innovate in the area of awareness-raising (UNFPA, 2005). In 2005, some proposals of “new” activities were developed to transcend the traditional tactics (such as chats, film screenings, etc.). These included:

- Activities at strategically selected intersections, such as movie theaters, hospitals, markets, etc.;
- Awareness raising during family events, marriages, and anniversaries;
- Radio talk shows;
- Press conferences at the CCA;
- Walks, rallies, and info competitions;
- Non-stop days of information distribution in a school building, including expositions, film projections, chats, interviews, and conferences;
- Awareness raising through theater troupes;
- Reproductive health fairs (expositions with diverse activities);
- The creation of a web site;
- Educational comic strips and stories.

(UNFPA, 2005)

In reality, the above activities are simply a reformulation of traditional awareness raising activities. Additionally, some of these activities would not reach the target population (particularly events organized at schools). Others are problematic for out of school youth who are often illiterate (comic strips, stories, and web sites). Organizing events at cultural gatherings could raise more opposition than awareness. Furthermore, success in changing behavior is not so much a question of *activities*, but *strategies*. What, then, is the next frontier for the evolution of CCA's strategy to touch out of school youth?

The multisectorial effort in St. Louis and Louga, Senegal

In 2008, Population Council published an evaluation of a multisectorial program between the health department, schools, the community at large, and the media with the aim of raising awareness on RH among adolescents between 10 and 19 years of age in St. Louis and Louga. The program employed a curriculum to train peer educators to lead communication activities en masse and one-on-one. The study found a less desirable level of behavior among girls, the younger children, and out of school youth; they also found poor knowledge among parents. The model was found to be more successful when it was supported with financing from the health department as compared to when it was supported at the municipal level in coordination with the CCA (Population Council, 2008).

The Final Report of the PPJ for the 5th Programme of Cooperation between UNFPA and the Government of Senegal

The 5th Programme carried out more awareness-raising activities than planned. The PPJ noted that ownership of activities by youth and contributions of religious and administrative authorities were a positive feature of the programme. However, the principal constraint was a decline in financial means. The final report of the PPJ for the 5th Programme of Cooperation between UNFPA and the Government of Senegal found the principal difficulty to be a deficit of human resources (see Appendix A, Table 1). In light of these recognitions, the PPJ issued the following recommendations for the 6th Programme: (1) the development of a grant writing tool, (2) the renewal of audiovisual material for centers in need, and (3) the provision of logistic means (PPJ, 2007).

The results of these studies show a relationship between the level of reproductive health education of out of school youth and RH intervention strategies of different programs. However, there has not been a study specifically conducted to evaluate CCA RH education strategies targeted at out-of-school youth. Thus, it has not yet been determined if RH education strategies for out of school youth are succeeding in reaching this target population. It is within this framework that the present study seeks to improve intervention strategies of the CCA.

OBJECTIVES

The general objective of this study is to analyze RH education strategies of the CCA to reach out of school youth in the cities of Mbour, Tambacounda and Kolda with the final aim of making innovative recommendations to raise awareness and induce behavior change among out of school youth in the area of RH. Specific objectives include:

- Identifying the CCA's strategy to reach out of school youth;
- Analyzing problems linked to the execution of this strategy;
- Identifying knowledge, attitudes, and behaviors in RH for the population target of the three sites;
- Proposing a logistical framework for a new programme designed to raise awareness and induce behavior change in the target population;
- Making specific recommendations for innovative strategies in the administrative, political and economic context of the CCA.

Figure 2: Knowledge and Behaviors Expected of the Target Population

HYPOTHESIS

RH education strategies of the CCA have not resulted in a favorable level of RH education among out of school youth. Hence the following anticipated tendencies with regard to knowledge and behaviors in the target population (see Figure 2):

ξ **Group 1, partial shortfall:** youth who have good knowledge but lack good behavior due to poor life skills and decision-making skills.

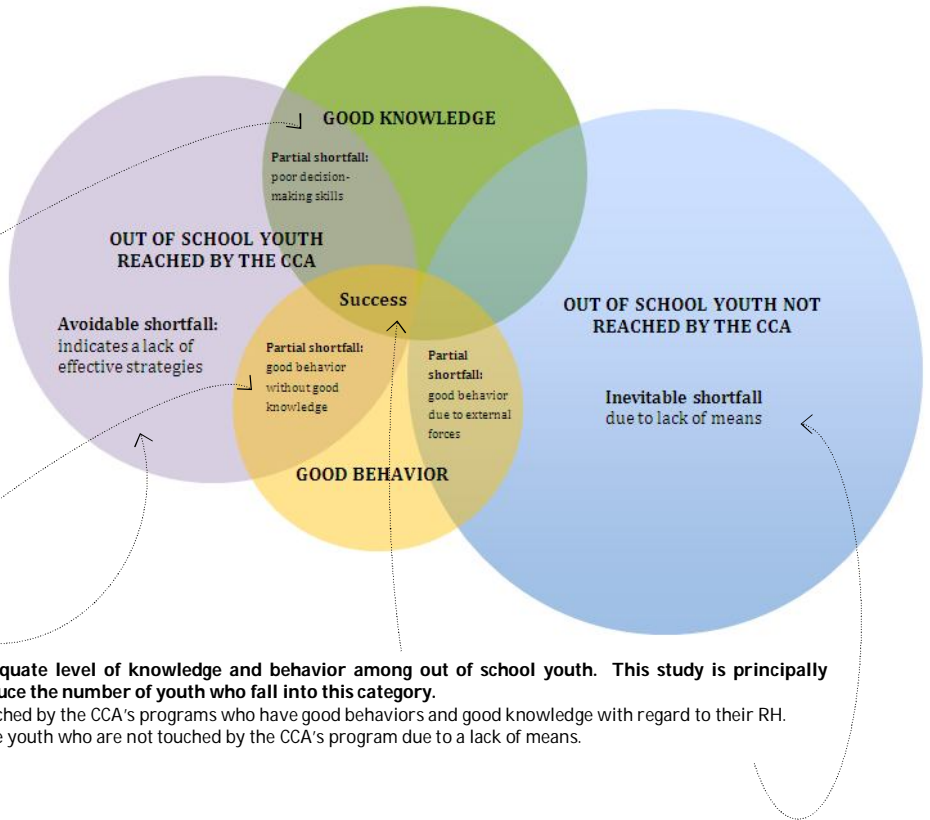
ξ **Group 2, partial shortfall:** youth who have good behavior but lack critical RH knowledge; these youth may have desirable behaviors in accordance with traditional, cultural, or religious norms; however, they do not understand the reasoning behind these behaviors, which puts them at risk for undesired behavior as a consequence of the tendency of people their age to question authority.

ξ **Group 3, avoidable shortfall:** This indicates a lack of effective strategies

which allow the program to effect an adequate level of knowledge and behavior among out of school youth. This study is principally concerned with proposing strategies to reduce the number of youth who fall into this category.

ξ **Success:** there are very few youth who are reached by the CCA's programs who have good behaviors and good knowledge with regard to their RH.

ξ **Inevitable shortfall:** there will always be some youth who are not touched by the CCA's program due to a lack of means.



METHODOLOGY

Type of Study

In order to evaluate the strategies used by the CCA to reach the target population, we have chosen to realize a quasi-experimental study in three sites in the interior of the country: Mbour, Tambacounda, and Kolda. These three sites are characterized by a relatively high incidence of STIs, HIV/AIDS, and early pregnancy among youth.

A review of the literature with regard to RH of out of school youth, including studies conducted by multilateral organizations, international NGOs centered on youth RH, UN agencies, and the WHO, among others, has provided a foundation for this study. We also observed activities and services offered by the CCAs at the three sites, conducted interviews with CCA personnel, consulted available statistics on the CCAs in question, as well as RH indicators available from the national census of 2002.

Sample and data collection

To obtain an understanding of knowledge, behaviors, and attitudes among out of school youth, we conducted semi-structured interviews and focus groups (of 5 to 6 people) with out of school youth (those who dropped out or never attended school) between the ages of 15 and 24. We performed a pretest of our tools (interview questions and focus group themes) on the ground in Mbour from June 15 to June 17. Some changes were made to the interview questions in accordance with this pretest.

In order to find our sample, we sought participants following two methods:

1. Using the snowball method, we established contacts with actors linked to the CCA (for example, youth association leaders). These individuals introduced us to youth reached by the CCA's programs. Those youth in turn introduced us to their peers, which allowed us to expand the sample.
2. Using a reasoned sample search, in order to engage youth not reached by the CCA, we sought out youth in various neighborhoods. We visited sites such as beauty salons, wood and metal workshops, youth associations, vocational training institutes, markets, the beach, the stadium, and the streets in various neighborhoods.

We sought to maintain equilibrium between girls and boys in the sample. In searching for participants, we did not seek to define a specific number of youth for a control group and an experimental group. It is during data analysis that the emergence of these two groups occurs: out of school youth *reached* by the CCA (experimental group), and out of school youth *not reached* by the CCA (control group). In comparing these two groups, we are able to recognize correlations and tendencies with regard to knowledge, attitudes and behaviors between the two groups, therefore achieving an analysis of the efficacy of the CCA's strategies to reach this population.

Ethical considerations

We adhered to a procedure of informed consent to guarantee confidentiality and anonymity among participants in the study. We also took measures to be conscious of the potential disturbance related to talking about the taboo topic of sexuality, and the psychological effects such a discussion may have for survey participants. We prepared a waiver of participation for youth in the case that an individual demonstrated troubling characteristics with regard to his or her psychological state or maturity. However, we did not encounter such a case over the course of the study.

RESULTS

Sample description

The sample was composed of 80 participants from the cities of Mbour, (N = 22 individuals) Tambacounda, (N = 28) and Kolda, (N= 30). The experimental group was composed of 34 participants, representing out of school youth who were reached by the CCA's activities and services. The control group was comprised of 46 participants and was constituted by out of school youth who were not reached by the CCA (see Table 3 in Appendix B).

Socio-demographique profile

The median age range was between 15 and 18 years of age. The mean age was 19.25 years (see Table 4). Muslims were the majority religion (97.9%), followed by Catholics (2.10%) (see Table 5).

The majority of survey participants did not reach high school; only 35.42% entered high school, whereas 64.58% reached primary school (see Table 4). In general, girls achieved a lower level of education than boys, but the total of boys who did not go to school at all was higher than that of girls (see Table 7).

The majority of survey participants were single (81.3%), followed by married individuals (12.5%) and divorcés (6.3%) (see Table 8). Fourteen point six per cent (14.6%) of participants had children, the majority of whom were divorcés (33.3%) (see Table 9).

Knowledge

With regard to RH knowledge, the experimental group demonstrated stronger knowledge in terms of transmission of HIV/AIDS, STIs, and early pregnancy. Concerning knowledge of HIV transmission, 95.8% of the experimental group could cite that HIV is transmitted by unprotected sex, contrary to the control group, where only 70.8% of those surveyed were familiar with this mode of transmission (see Table 10). The same tendency was observed with regard to transmission of STIs; only 25% of the experimental group had *no* knowledge whatsoever of STIs, contrary to the control group, where 41.7% of those surveyed had no knowledge whatsoever of STIs (see Table 11).

The experimental group more frequently cited condom use as a means to prevent early pregnancy (50% of those surveyed), whereas the control group cited abstinence more frequently as a means to prevent early pregnancy (58.3%) (see Table 12). With regard to contraception, only 12.5% of the experimental group had no knowledge whatsoever of contraception, in comparison with the control group, where 16.7% had no knowledge of the subject (see Table 13). Likewise, the experimental group demonstrated a stronger level of knowledge with regard to condoms; 58.3% of the experimental group cited condom use as a means to prevent STIs, whereas only 41.7% of the control group cited this practice. Furthermore, only 8.3% of the experimental group had no knowledge whatsoever of condoms, as compared to the control group, where 12.5% had no knowledge whatsoever on the subject (see Table 14).

Behaviors

Among those surveyed, 70.8% had had sexual intercourse; 86.4% of boys and 57.7% of girls had sex.

The experimental group more frequently admitted to taking sexual risks from time to time than the control group; 14.3% of the experimental group said that they take risks with regard to their RH, as compared to 0% of the control group. With respect to participation in transactional sex, (that is, having sexual relations to obtain money or goods) 7.1% of the experimental group said their peers partake in transactional sex, whereas none of the control group indicated this tendency. Furthermore, the experimental group cited abstinence less frequently as a means to protect themselves from sexual risks: only 14.3% of the experimental group cited abstinence as a means of protection, in comparison with 25% in the control group. We noted a distinct difference with regard to the quantity of participants who had children among the two groups: there was a mean of 1.8 children per person in the experimental group, as compared to a mean of 0.5 children in the control group. This tendency is supported by an indication of the experimental group, where 14.3% said their peers had early pregnancies, in comparison with 8.3% of the control group who cited this trend.

If the experimental group indicated they take greater risks with regard to their reproductive health, they also admitted more frequently to taking protective measures during sexual activity. The experimental group indicated more often than the control group that they use contraception; 14.3% of the experimental group use contraception, as compared to none of those in the control group. Among the experimental group, 64.3% said their peers protect themselves using condoms during sex, whereas only 41.7% of the control group indicated their peers take this measure. Fidelity was also more commonly cited in the experimental group; 14.3% of this group cited fidelity as a means of protection, as compared to 8.3% of the control group.

Attitudes towards reproductive health

With respect to STIs and HIV/AIDS, 28.13% of those surveyed indicated condom use as a means of protection. Only 15.63% indicated abstinence as a means of protection. HIV testing was noted by 12.5%. Three point thirteen percent (3.13%) noted the importance of HIV testing as a means of prevention of HIV transmission from mother to child (MTCT).

A minority of youth (34.28%) said they were in support of condom use. Twenty five percent (25%) were against family planning and 21.88% were in favor of it (53.12% non response).

The majority of youth indicated that early pregnancy (EP) is the fault of the youth's parents (28.3%); 15.63% indicated it is the fault of the girl. Fifteen point sixty-three per cent (15.63%) said that EP is a risk for maternal health. Nine point thirty-eight per cent (9.38%) said that EP is a consequence of a lack of financial means. The same quantity (9.38%) noted early marriage as a factor in EP. Eighteen point seventy-five per cent (18.75%) cited condom use as a means to prevent early pregnancy; only 3.13% indicated family planning as a means of prevention.

Attitudes towards the CCA

Among the three sites, the CCA was most well-known in Mbour (72.73% of participants were familiar with the CCA's services and programs), followed by Kolda (30%) and then Tambacounda (18.8%). Concerning attitudes towards CCA and its programs, the majority of youth had a favorable opinion of the CCA. We noted that 58.3% had a very positive impression of the CCA's mission. Likewise, no survey participant indicated a negative impression of the CCA's mission (see Table 15). Fifty-six point twenty-five per cent (56.25%) said they would trust CCA personnel to administer a service in time of need. Among youth who had a favorable opinion of the CCA, a considerable number expressed an appreciation for HIV testing services (12.5%) and condom distribution (9.38%). Some youth (6.25%) also noted the positive domino effect of CCA's services and activities in the community at large.

Among youth who received a service from the CCA, 30% attended a midwife consultation; the same quantity (30%) received educational material; 20% received counseling, and 10% received HIV testing. There were 10% who said they benefited from condom distribution.

Among the experimental group, 48.2% said their participation in activities and services of the CCA increased their knowledge in the area of RH. The majority of those indicated they learned about STIs (16.7%). The same quantity indicated their knowledge improved with regard to HIV/AIDS (16.7%). Family planning was noted as an area of increased knowledge by 12.5%. A considerable number, 14.3% of participants, said they learned nothing from activities or services rendered.

The experimental group also noted a change in behavior as a consequence of their involvement in activities and services. Abstinence was noted as a behavior change by 12.5% of the experimental group. Condom use (6.25%), the abandonment of the practice of having multiple sexual partners (6.25%) and increased HIV testing (3.13%) were other changes noted. There were 6.25% who did not change their behavior as a consequence of their involvement with activities or services of the CCA.

The experimental group indicated an appreciation for theater sketches (27.7%), activities concerning HIV/AIDS (16.67%) and chats (11.11%). They did not like the CCA facility to be rented out for private parties where alcohol was present (3.13%). No other CCA activity was negatively viewed. Among those surveyed, 50% said that the CCA should expand its activities in outlying neighborhoods and emphasize efforts to reach out to the target population. Thirty per cent (30%) indicated a preference for an on-site HIV testing center.

Observations on the organization and efficacy of the CCA: strengths, weaknesses, and opportunities

We noticed various differences in the administration of the programmes at the three sites. Likewise, we noted some global problems at the three sites. There are also various opportunities to improve the program and to develop a strategy designed to target out of school youth.

In Mbour, we noticed a strong involvement on behalf of the coordinator. However, there is a serious lack of personnel at this site; there is no full-time midwife (they benefit from a midwife three afternoons a week, though she has not been formally trained). The center has no counselor/psychologist, no lab technician, and no social worker (they benefit from summer interns from a university in Belgium which provides social work undergraduates 4 months out of the year). There is a supervision problem due to the fact that the coordinator is juggling multiple roles as a result of the personnel deficit. IEC strategies are neglected in favor of HIV testing; this is linked to the fact that most of the financing for this center comes from the World Bank, the IMF, and KFW (a German development NGO) to promote testing activities at the health department. The only financial support provided by the state is the salary of the coordinator; all other expenses are paid out of pocket by the coordinator (including vehicle maintenance, gasoline, office supplies, etc.). Therefore, there is a strong dependence on the HIV testing partner to support the center as a whole (they provide office equipment and educational materials for support the HIV testing awareness program). There is no on-site HIV testing center in Mbour and youth are referred to the Department of Health for testing.

We also noted a lack of personnel in Kolda. The IEC technician is provided through a state-subsidized social work program. There is no social worker, no lab technician, and no counselor/psychologist. The center has no on-site testing facility, and the building is notably under construction, with only two of the five rooms completed and furnished. We noticed a serious problem with regard to the center's success in reaching the target population of out of school youth. Specifically, only 35.87% of youth who appeared in the register from January to July 2009 were out of school youth. This implies that the remainder (64.13%) of youth reached by the center during that period was comprised of students, teachers, peer educators, or other individuals (such occupations indicated by those registrants who were not out of school youth). This implies a serious problem with regard to the CCA's success in targeting out of school youth at this site.

The CCA in Tambacounda had relatively few problems. This site has a fully-staffed body of personnel, though the IEC technician had little experience. The organization of IEC activities were, however, more expansive than Mbour and Kolda. The center offers an on-site HIV testing facility. Its financing was relatively diversified, and they benefit from several revenue-generating activities, such as the rental of chairs and space, and a private internet café. The center was well-equipped with stimulating educational material throughout the building, and there was an organized system in place for client reception.

We noticed several global problems at the three sites. None of the CCAs had a full-time midwife. At the most, there was a midwife who visited the center 3 afternoons a week, and in the worst case, the midwife was inexperienced and lacked training. The absence of a full-time midwife resulted in a long line of young girls waiting to receive consultations, with some turned away at the end of the day. All the sites suffer from a lack of financial and material means. None of the coordinators, or the IEC technicians, could cite their specific strategy to reach out of school youth, even if they did confirm that this was their principal target population. However, they did indicate the importance of "advanced activities," or those activities carried out off site, in the neighborhoods and workplaces of the target population. However, we noticed a very low quantity of such activities (over the course of our eight weeks in the field, we did not have a single opportunity to observe one of these activities). Finally, there were very few active peer educators. Mbour has approximately 10,

Tambacounda has approximately 20, and Kolda has approximately 5. Furthermore, there was no standard curriculum in place for the training of peer educators.

DISCUSSION AND RECOMMENDATIONS

We noticed a clear tendency of the experimental group to have a higher knowledge level with regard to STIs, HIV/AIDS, condom use, contraception, and prevention of early pregnancy. However, this group also indicated they took more risks with regard to their reproductive health as compared to the control group. Furthermore, the experimental group indicated an improvement in their knowledge and behavior change as a result of their involvement in CCA services and activities.

These trends indicate that the awareness raising activities and the psycho-social-medical services provided by the CCA have a positive effect on the target population; that is, the program appears to induce an increase in reproductive health knowledge, and a desired behavior change with regard to protection from STIs, HIV/AIDS, and early pregnancy.

However, we noted among youth and CCA personnel the prevailing opinion that advanced activities are crucial to reaching young people. At the moment, a severe lack of financial means is impeding the three sites from executing a sufficient quantity of advanced activities. Furthermore, both the youth surveyed and the CCA personnel interviewed emphasized the predominance of parent guidance with regard to RH education. Nevertheless, there is no program in place, nor any strategy developed to involve parents of out of school youth in terms of protection from STIs, HIV/AIDS and early pregnancy. The regions of Tambacounda and Kolda in particular have high incidences of early marriage and early pregnancy in relation to national trends. Even if awareness raising programs have the desired effect on young people, if parents do not reinforce this good knowledge and behavior, and if they continue to support the tradition of early marriage, which perpetuates the educational disenfranchisement of young girls, we will not see the desired changes in RH among out of school youth.

The youth surveyed expressed an appreciation for theater sketches, events relating to HIV/AIDS, and a preference for chats. We do not need to reinvent the wheel; we do not notice any particular problems with the efficacy of the activities themselves, given the noticeable difference in knowledge and behaviors between the experimental and control groups. We can, thus, explain the weakness in reaching the target population by a lack of accessible activities; that is, there is a failure to realize a sufficient number of activities in the neighborhoods where out of school youth live, work, and play.

Given these realities, we propose a strategy that does not differ dramatically in *form* of reaching out of school youth, but differs in the *quantity* and *places* where these activities are carried out. That is, we emphasize the importance of going *towards the people* to carry out activities and programs. It is through the amplification of activities and programs in the neighborhoods of these youth, and not merely in the city center, that we will see a change in the efficacy of the programme.

Furthermore, there must be a strong and continuous dialogue with parents of out of school youth, particularly young parents. It is for this reason that we recommend the development of a network of parent peer educators. This network would have as its objective the promotion of the same knowledge and appreciations emphasized in programs for youth, but with the idea of encouraging acceptance of condom use, contraception, and discouraging early sexuality—both in and out of marriage—among parents.

If a lack of means is the culprit for a lack of advanced activities, what is the solution? Financial partners will not involve themselves in the program if they have no evidence that the program is on the right track. However, it is difficult to get on the right track without means. It is for this reason that revenue-generating activities are so important. We noted that the CCA in Tambacounda was the strongest of the three sites; they were also the only center with an on-site testing facility; they were the only center with a complete staff (except for the midwife, who was part time); they were also the only center with revenue-generating activities in place. If potential partners see that the CCA is making an effort to be self-sufficient, this will stimulate confidence in the efficacy of the center, and potential partners will be more inclined to invest. Therefore, revenue-generating activities represent the first step to economic stability.

The second step to economic stability is financial diversification. No CCA should rely on a single financial partner, including the State, for its economic means. If the one and only funding partner withdraws, the program fails, which will create a downward spiral with regard to program efficacy. In December of 2006, the UNFPA began to withdraw its funding across the CCA network with regard to personnel. Nevertheless, they maintained financing for some activities. New partnerships have been developed since 2006. Notably, the World Bank and the IMF entered into a partnership alongside the KfW of Germany in 2008 for a program centered on HIV testing. Likewise, ADEMAs, an NGO centered on social marketing, has established a partnership to promote the use of both masculine and feminine condoms. At a decentralized level, some CCAs have established other partnerships with national and international NGOs (e.g. Family Health International, Catholic Children's Fund, among others). Some CCAs also have partnerships with foreign universities to provide short-term social worker and counseling interns. However, the diversification of financing and support is not a reality among all the CCAs. Diversification of support must be a priority in programme administration. The CCA needs to evaluate the success of its programmes to adequately demonstrate to current and potential funders that those programmes are worth funding.

Once financing increases, the CCAs must procure and train adequate personnel (both paid and unpaid) to carry out services and activities. Such efforts should keep in mind training for peer educators (youth and parent) as well. GEEP uses a curriculum to train peer educators in schools. The CCA should adapt such a curriculum to train its own peer educators. This curriculum should consider means of training illiterate PEs seeking to reach their illiterate peers. It should also account for the various languages spoken, as many out of school youth do not speak French or Wolof.

CONCLUSION

Reproductive health risks experienced by out of school youth can be mitigated by awareness raising programs with the objective of effecting behavior change, in harmony with health services appropriate for this sub-demographic. However, if these activities do not reach a plurality of youth in all neighborhoods, we will not see the desired effects on the general population.

We have developed a logistical framework (Log Frame) with specific objectives composing a strategy to reach out of school youth (see Appendix C). This involves three main objectives: (1) increasing advanced activities, (2) reinforcement of human resources, and (3) increase of financial and material means. It is through the realization of these three objectives that we will begin to see an improvement in the efficacy of the program, and the desired effect with regard to reproductive health of out of school youth. Since we have noticed relative success at the CCA in Tambacounda, we have incorporated several of their activities in the proposed strategy.

Above all, the promotion of advanced activities figures prominently; however, expanding these activities to reach a greater number of youth is not possible without the development of human, material, and financial resources. It is therefore with a certain harmony that all these objectives must be sought after, so as to reinforce one another. This type of balanced progress will furnish the desired results, and the instances of improved RH knowledge and diminished risky sexual behaviors among out of school youth will become a less elusive reality.

APPENDICES

Appendix A

Table 1 : Awareness raising activities realized by the CCA since 2002

CCA	Number of young people reached by awareness raising activities				
	2002	2003	2004	2005	2006
Tamba	8711	31353	10697	13794	12762
Louga	32731	53503	13602	17435	13491
Mbacké	11811	28360	25690	13593	7866
Bakel		2360	3957	2118	11045
Pikine - Guédiawaye	30000	28704	34984	20616	23452
Rufisque	18990	6040	24032	10950	18969
Kaolack	9900	20955	17346	19513	21321
Mbour	35630	36804	26440	10137	18969
Kolda		2370	1293	8713	11658
Vélingara		1408	3227	6843	11508
Ziguinchor	25256	7044	3503	4024	9704
Parcelles Assainies					5196
Kédougou		15116	3720	9734	11631
National level	42200	43327	23500	29700	18206
	215229	277344	191991	167170	195778
TOTAL	1 047 512				

Source : Projet Promotion des Jeunes (PPJ), 2007.

Table 2: Personnel deficits at the 13 CCA as of 2006 (at the end of the 5th Programme)

	Coordinator	IEC Technician	Midwife	Psychologist	Social Worker	Lab technician
Quantity	13	9	11	1	11	9
Deficit	0	4	2	12	2	4

Source: Projet Promotion des Jeunes, 2007

Appendix B: Results

Table 3: Study sample

City	Quantity of participants	Study group		Sex of participants	
		Experimental Group	Control Group	Boys	Girls
Mbour	22	10	12	11	11
Tambacounda	28	15	13	14	14
Kolda	20	7	13	10	10
Total	70	32	38	35	35

Table 4: Age range, median, and mean

City	Age range	Median	Average
Mbour	15 to 24	18	19.36
Tambacounda	16 to 24	17	19.89
Kolda	15 to 24	15	18.55
Globally	15 to 24	15 to 18	19.25

Tableau 5: Religion

Religion	No.	Freq.
Muslim	47	97.90%
Catholic	1	2.10%
Protestant	0	0.00%
Other	0	0.00%
TOTAL OBS.	48	100%

Table 6: Educational level

Primary	No.	Freq.
CI	1	2.10%
CP	0	0.00%
CE1	2	4.20%
CE2	4	8.30%
CM1	7	14.60%
CM2	17	35.40%
Total	31	64.58%
High School	No.	Freq.
6th	1	2.10%
5th	0	0.00%
4th	1	2.10%
3rd	3	6.30%
2nd	2	4.20%
1st	1	2.10%
final	1	2.10%
No education	7	14.60%
Koranic school	1	2.10%
Total	17	35.42%

Table 7: Educational level and sex

Educational level	Boys	Girls	TOTAL
CI	4.5%	0.0%	2.1%
CP	0.0%	0.0%	0.0%
CE1	4.5%	3.8%	4.2%
CE2	18.2%	0.0%	8.3%
CM1	9.1%	19.2%	14.6%
CM2	18.2%	50.0%	35.4%
6th	4.5%	0.0%	2.1%
5th	0.0%	0.0%	0.0%
4th	0.0%	3.8%	2.1%
3rd	0.0%	11.5%	6.3%
2nd	9.1%	0.0%	4.2%
1st	4.5%	0.0%	2.1%
final	4.5%	0.0%	2.1%
No education	18.2%	11.5%	14.6%
Koranic school	4.5%	0.0%	2.1%
TOTAL	100%	100%	100%

Table 8: Marriage status

Marriage status	No.	Freq.
Single	39	81.30%
Married	6	12.50%
Divorced	3	6.30%
Widowed	0	0.00%
TOTAL OBS.	48	100%

Appendix B (continued)

Table 9: Matrimonial status and children

<i>Children ?</i>	<i>Single</i>	<i>Married</i>	<i>Divorced</i>	<i>Widowed</i>	<i>TOTAL</i>
Yes	12.80%	16.70%	33.30%	0.00%	14.60%
No	87.20%	83.30%	66.70%	0.00%	85.40%
TOTAL	100%	100%	100%	0.00%	100%

Table 10: Knowledge of modes of HIV transmission (experimental v. control group)

<i>Knowledge (experimental group)</i>	<i>Percent</i>
Unprotected sex with a person living with HIV	95.80%
Unclean instruments (needles, razors, syringes, etc.)	79.20%
Transmission by blood	16.70%
False knowledge	12.50%
Mother-to-child transmission	12.50%
No knowledge	0.00%
TOTAL	100%

<i>Knowledge (control group)</i>	<i>Percent</i>
Unprotected sex with a person living with HIV	70.80%
Unclean instruments (needles, razors, syringes, etc.)	58.30%
False knowledge	20.80%
No knowledge	12.50%
Mother-to-child transmission	8.30%
Transmission by blood	0.00%
TOTAL	100%

Table 11 : Knowledge on causes of STI transmission

<i>Knowledge (experimental group)</i>	<i>Percent</i>
Unprotected sex	66.70%
Sex (in general)	33.30%
No knowledge	25.00%
Other (false knowledge)	12.50%
Multiple sexual partners	8.30%
TOTAL	100%

<i>Knowledge (control group)</i>	<i>Percent</i>
Unprotected sex	41.70%
No knowledge	41.70%
Sex (in general)	33.30%
Multiple sexual partners	16.70%
Other (false knowledge)	12.50%
TOTAL	100%

Table 12: How to prevent early pregnancy (experimental v. control group)

<i>Method (experimental group)</i>	<i>Percent</i>
Condom use	50.00%
Abstinence	45.80%
Contraception	29.20%
Awareness raising among parents on early/forced marriage	12.50%
No knowledge	8.30%
Basing sexual activity on the menstrual cycle	8.30%
The morning-after pill	8.30%
False knowledge	4.20%
TOTAL	100%

<i>Method (control group)</i>	<i>Pour cent</i>
Abstinence	58.30%
Condom use	41.70%
Contraception	16.70%
No knowledge	16.70%
Basing sexual activity on the menstrual cycle	4.20%
Awareness raising among parents on early/forced marriage	0.00%
The morning-after pill	0.00%
False knowledge	0.00%
TOTAL	100%

Appendix B (continued)

Table 13 : Knowledge on contraception

Knowledge (experimental group)	Percent
Birth control pills	54.20%
Injections	37.50%
Masculine condoms	25.00%
No knowledge	12.50%
Family planning (in general)	12.50%
Norplant	12.50%
Abstinence	8.30%
Abortion	8.30%
IUD	8.30%
False knowledge	4.20%
Traditional methods (talisman)	4.20%
Non response	4.20%
The morning-after pill	4.20%
Basing sexual activity on the menstrual cycle	0.00%
TOTAL	100%
Knowledge (control group)	Percent
Birth control pills	41.70%
Masculine condoms	25.00%
Injections	20.80%
No knowledge	16.70%
False knowledge	16.70%
Family planning (in general)	12.50%
Traditional methods (talisman)	8.30%
Norplant	4.20%
Abstinence	4.20%
Non response	4.20%
Basing sexual activity on the menstrual cycle	4.20%
Abortion	0.00%
IUD	0.00%
The morning-after pill	0.00%
TOTAL	100%

Table 14: Attitudes and beliefs about condoms

Knowledge (experimental group)	Percent
They prevent STIs	58.30%
They prevent early and unwanted pregnancies	50.00%
They prevent the transmission of HIV/AIDS	20.80%
They must be used during each sexual encounter	8.30%
No knowledge	8.30%
There are masculine and feminine condoms	8.30%
They are not 100% guaranteed	4.20%
There are correct and incorrect methods of use	4.20%
They are not necessary if you know your partner	4.20%
Some have spermicide	4.20%
You can have multiple sexual partners if you use condoms	0.00%
They are available at the pharmacy	0.00%
Non response	0.00%
TOTAL	100%
Knowledge (control group)	Percent
They prevent STIs	41.70%
They prevent early and unwanted pregnancies	41.70%
They prevent transmission of HIV/AIDS	25.00%
They must be used during each sexual encounter	16.70%
No knowledge	12.50%
They are not guaranteed 100%	8.30%
You can have multiple sexual partners if you use condoms	8.30%
There are masculine and feminine condoms	4.20%
There are correct and incorrect methods of use	4.20%
They are not necessary if you know your partner	4.20%
They are available at the pharmacy	4.20%
Some have spermicide	0.00%
Non response	8.30%
TOTAL	100%

Table 15: Opinion of the CCA mission

Opinion	No.	Freq.
Non response	12	25.00%
Very positive	28	58.30%
A little positive	3	6.30%
Neutral	5	10.40%
A little negative	0	0.00%
Very negative	0	0.00%
TOTAL OBS.	48	100.00%

Appendix C: Logistical Framework for a Strategy Targeted at Out of School Youth

GENERAL OBJECTIVE: REDUCE INCIDENCES OF HIV/AIDS, STIs, AND EARLY PREGNANCY AMONG OUT OF SCHOOL YOUTH			
SPECIFIC OBJECTIVES	OUTPUT	ACTIVITIES	INPUT
<p>The deadline for the objectives is May 2010.</p> <p>Objective 1: Increase of advanced activities and programs for out of school youth.</p>	<p>Output 1: Awareness-raising programme targeted at out of school youth in each neighborhood within 20 km of the city center.</p> <ol style="list-style-type: none"> 1. 1 chat/workshop on the transmission of HIV/AIDS, STIs, or early pregnancy 1 time per month in 3 different neighborhoods. 2. 1 theater sketch 1 time per month on early marriage, early pregnancy, condoms, contraception, fidelity, or abstinence in 3 different neighborhoods; 3. 1 concert 1 time per month relating to different subjects on RH for youth in 3 different neighborhoods ; 4. 1 social event or recreational activity where condoms are distributed with literature and media reducing the stigmatization of the purchase and use of condoms by young people. 	<ul style="list-style-type: none"> · Generation of a city map with targeted neighborhoods, including details on the number of youth who inhabit the region, the predominant languages spoken, and the area (km) of the neighborhood; · Development of a rotating schedule to ensure the involvement of each neighborhood within 20 km of the city center at least 1 time per month ; · Execution of a survey on the degree of youth's satisfaction with events after 40% of events. Ensure availability of a survey appropriate for illiterate youth; · Adaptation of events according to the feedback received from surveys; · Monitoring of condom distribution at the CCA and community kiosks ; · Collaboration with UNFPA experts to ensure activities are of a high quality; · Establishment of contacts with artists and performers who could participate regularly in the advanced activities ; · Translation of awareness-raising materials into Wolof, Pular, and other languages as appropriate; · Training of youth in theater, development and design of educational materials, translation, and interpretation. 	<ul style="list-style-type: none"> · Consultation of city maps and demographic statistics ; · Consultation of relevant literature on lessons learned with regard to RH education in sub-Saharan Africa ; · Design of a survey to evaluate youth's satisfaction with each chat, workshop, theater sketch, concert, etc.; · Regular consultation of condom distribution registers and generation of monthly reports to provide statistics on the age and sex of each recipient ; · Monthly meetings with UNFPA to evaluate the realization of advanced activities; · Generation or adaptation of a curriculum to train out of school youth on programme execution; · Procure a vehicle, driver, and necessary fuel to realize activities in neighborhoods as far as 20 km from the city center.

SPECIFIC OBJECTIVES	OUTPUT	ACTIVITIES	INPUT
Objective 2: Strengthening of human resources for awareness raising	<p>Output 2: Network of parent peer educators</p> <ol style="list-style-type: none"> 1. Establishment of contacts with young interested parents; 2. Training of parent peer educators; 3. Execution of a monthly schedule of events to raise awareness. Ensure a rotation to each neighborhood within 20 km of the city center; 4. Monthly evaluation of the programme and implementation of periodic improvements; 	<ul style="list-style-type: none"> · Establishment of a leader and team members for the network; · Promotion of the programme on the radio, at community events and other places where young parents may be found ; · Meetings to involve interested parents; · Development of a training curriculum ; · Realization of training events; · Design a map and schedule to carry out awareness raising activities; · Design an evaluation tool to implement monthly improvements to the programme; 	<ul style="list-style-type: none"> · Establishment of qualified contacts to lead the network; · Establishment of contacts to promote the programme; · Consultation of the literature on parent peer education networks in the area of RH for sub-Saharan Africa ; · Regular meetings with parent educators to provide ongoing training and feedback.
Objective 2: Strengthening of human resources for awareness raising	Output 3 : Reinforce the training of peer educators	<ul style="list-style-type: none"> · Establishment of a leader/team; · Development and implementation of a curriculum for out of school peer educators. Ensure the curriculum is appropriate for illiterate youth; · Design a training program for youth following the curriculum; the programme should incorporate continuing training for PEs; · Design of a program in harmony with the objective of increasing the quantity of advanced activities; · Design and monthly use of an evaluation tool for the programme. 	<ul style="list-style-type: none"> · Consultation of the literature on the creation of a network of peer educators for out of school youth in sub-Saharan Africa; · Adaptation of the curriculum <i>Grandir en Harmonie</i> (used by GEEP) for out of school youth ; · Regular meetings with PEs to evaluate the programme and realize improvements.

SPECIFIC OBJECTIVES	OUTPUT	ACTIVITIES	INPUT
<p>Objective 2: Strengthening of human resources for awareness raising</p>	<p>Output 4: Reinforce grant writing tools</p> <ol style="list-style-type: none"> 1. Seek grants at least 4 times per year with national and international partners to secure new financial and material support; 2. Follow-up on the status of grant applications and maintenance of good ties with existing and potential partners. 	<ul style="list-style-type: none"> · Establishment of a lead grant writer; · Training of the grant writer ; · Research new grant opportunities monthly on the internet, and through local, regional, and international contacts ; · Establish a database to track potential grants, submitted grants, pending grants, and accepted grants ; 	<ul style="list-style-type: none"> · Consultation of the literature on proper grant writing procedure; · Seek quality translators to assist with grants to be submitted in foreign languages.
<p>Objective 2: Strengthening of human resources for awareness raising</p>	<p>Output 5 : Diversification of partners</p> <ol style="list-style-type: none"> 1. Establishment of 1 new long-term financial partner per year. 	<ul style="list-style-type: none"> · Attend regional and international conferences to establish new contacts; · Invite potential partners to programs and events ; · Follow-up with existing and new partners, including through letters, reports, communiqués, and visual documentation on activities and progress; · Establish and maintain a database on formal and informal partners; 	<ul style="list-style-type: none"> · Accommodate attendance at conferences and events ; · Obtain a camera to document activities and events; · Establish a fund for trips to conferences.
<p>Objective 3: Increase material and financial means;</p>	<p>Output 6 : Self-sufficiency through the provision of paid services</p>	<ul style="list-style-type: none"> · Establish a private internet café ; · Rent materials for community events; · Establish a private store for the sale of drinks, food, cell phone credit, etc. 	<ul style="list-style-type: none"> · Procure personnel and an air-conditioned and secure building to house computers, a printer, and fax machine ; · Procure a building suitable to function as small store; · Search for organizations and associations which could benefit from renting CCA materials and space.

BIBLIOGRAPHY

- Advocates for Youth. 2005. "Youth's Reproductive Health: Key to Achieving the Millennium Development Goals at the Country Level." Retrieved from <http://www.advocatesforyouth.org/PUBLICATIONS/iag/millenniumgoalscountry.pdf>. Accessed 9-Mar 2009.
- CIA World Factbook. 2009. "Senegal." Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/sg.html>. Accessed 27-Apr 2009.
- Étude Démographique et de Santé (EDS). 2005. La République du Sénégal. Ministère de la Santé et de la Prévention Médicale. Centre de Recherche pour le Développement Humaine. Dakar, Senegal.
- Family Health International (FHI), YouthNet. A. Burns, August, Claudia Daileader Ruland, William Finger, Erin Murphy-Graham, Rosemary McCarney, and Jane Schueller. 2004. "Reaching Out-of-School Youth with Reproductive Health and HIV/AIDS Information and Services." Youth Issues Paper 4.
- Gribble, James et Joan Haffey. 2008. « La santé reproductive en Afrique subsaharienne. » Population Reference Bureau. Retrieved from : http://www.Prb.org/pdf08/reproductivehealth_subaharanafrica-FR.pdf. Accessed 21 July, 2009.
- Langer, Ana. "Cairo after 12 years : successes, setbacks, and challenges." 1-Nov, 2006. *The Lancet*. DOI:10.1016/S0140-6736(06)69486-5.
- Population Council/Frontiers. 1999. "Improving the Reproductive Health of Youth in Senegal." Retrieved from <http://www.comminit.com/en/node/116020/306>. Accessed 9-Mar 2009.
- Population Council/Frontiers. March 2008. Diop, Nafissatou J. et Anta Fall Diagne. « Enhancing Utilization of the Findings from the Youth Reproductive Health Project in Senegal. »
- Projet Promotion des Jeunes (PPJ), La Ministère de la Jeunesse, le Gouvernement du Sénégal. 2003. « Composante Consolidation des Acquis en SR dans les centres conseil pour adolescents - Rapport Final. »
- United Nations Development Program (UNDP), 2007/2008 Human Development Report: Senegal.
- UNICEF. 2007. Senegal statistics. Retrieved from http://www.unicef.org/infobycountry/senegal_statistics.html. Accessed 27-Apr 2009.
- UNAIDS/WHO. 2004 "Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections – Senegal." Retrieved from http://data.unaids.org/publications/Fact-Sheets01/senegal_en.pdf. Accessed 28-Apr 2009.
- UNAIDS. March 2004. "Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People. Addendum to the UNAIDS 'National AIDS Programmes: A Guide to Monitoring and Evaluation.'" Retrieved from http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf.
- UNFPA, 2005. "La santé de la reproduction des adolescents(tes) au Sénégal. Étude documentée de quelques expériences."
- UNFPA, 2006. Plan d'Action du Sixième Programme de Coopération entre Le Gouvernement du Sénégal et Le Fonds des Nations Unies pour la Population (UNFPA).
- UNFPA. 2007. "Framework for Action on Adolescents and Youth. Opening Doors with Young People: 4 Keys." Retrieved from http://www.unfpa.org/upload/lib_pub_file/715_filename_adolescent.pdf. Accessed 27-Apr 2009.
- UNFPA. 2009a. "Breaking the cycle of sexually transmitted infections." Retrieved from <http://www.unfpa.org/rh/stis.htm>. Accessed 27-Apr 2009.
- UNFPA. 2009c. "Ensuring that every pregnancy is wanted." Retrieved from <http://www.unfpa.org/rh/planning.htm>. Accessed 27-Apr 2009.
- UNFPA. 2009d. "Preventing HIV/AIDS. Focus on especially vulnerable groups." Retrieved from <http://www.unfpa.org/hiv/groups.htm>. Accessed 27-Apr 2009.
- UNFPA. 2009e. "Stepping up efforts to save mothers' lives." Retrieved from <http://www.unfpa.org/mothers/index.htm>. Accessed 27-Apr 2009.
- USAID. June 2006. "Cost-Effective Interventions to Reduce Maternal Mortality in Senegal: The Role of Postabortion Care and Family Planning. An Application of the Allocate Model." Retrieved from http://pdf.usaid.gov/pdf_docs/PNADH640.pdf. Accessed 28-Apr 2009.
- Van Rossem, Ronan and Dominique Meekers. 2000. "An evaluation of the effectiveness of targeted social marketing to promote adolescent and young adult reproductive health in Cameroon." *AIDS Education and Prevention*. 12(5), 383. Retrieved 14-March 2009.
- Wade, A.S., C. Enel, and E. Lagarde. July 2005. "Prevention of HIV and other STIs in rural Senegal: a study of prevention-related events collected by sentinel observers." *Journal des Aspects Sociaux du VIH/SIDA*. Vol 2(2), 251-257.
- The World Bank. 2007. "Senegal Data Profile." Retrieved from http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED. Accessed 27-Apr 2009.
- World Health Organization (WHO). December 2004. "Protecting young people from HIV and AIDS : the role of health services." Retrieved from <http://whqlibdoc.who.int/publications/2004/9241592478.pdf>.