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ANALYSIS OF ADOLESCENT REPRODUCTIVE HEALTH POLICIES IN SENEGAL

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Abstract

In 2005, the Senegalese Ministry of Health and Social Action adopted an adolescent health strategy, as well as a reproductive health law giving adolescent health a status within it. The adolescent health strategy focuses on access to appropriate services, responsible behavior and the promotion of the rights of adolescents and young people in the context of reproductive health. In 2018, the institutional framework was strengthened by a new policy based on a vision combining prevention, assistance, counseling and support for adolescents.

However, despite this proactive approach, there has been little improvement in adolescent reproductive health indicators over the past 30 years. Several contextual factors are affecting adolescent reproductive health indicators, mainly (i) social norms that are not sufficiently favorable to the consideration of adolescents' rights, and (ii) poorly targeted interventions for specific groups (people with disabilities, early workers, migrants/displaced, HIV-positive adolescents, etc.).

Key words: Reproductive health, adolescents, health policies, contraception, early marriage, Senegal.

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Introduction

With a relatively young population, Senegal is home to 22.5% of adolescents aged 10-19 and 9% of young adults aged 20-24[4] in the general population (ANSD, 2013). This demographic situation has led to a significant increase in social needs, particularly in reproductive health. Similarly, the demographic dependency rate[5], which is 83.7%, reflects both the demographic opportunities that have opened up in Senegal[6] over the past few decades as well as the challenges to be met in order to capture the demographic dividend. Fertility is still high, although it is falling, with an average of 4.7 children per woman in 2014, while to a lesser extent, the mortality rate is falling (ANSD, 2014).

In this context, the sexual and reproductive health of young people is becoming a central health and development issue in Senegal. The maternal mortality rate remains high among adolescents: 629 deaths per 100,000 live births compared to 434 deaths per 100,000 live births in the adult population (ANSD, 2013). About a quarter of adolescent girls are married before the age of 20 and a third of all adolescents aged 15-19 are already sexually active (ANSD and Macro International, 2013). In addition, almost 70% of unmarried sexually active young women have an unmet need for contraception (MacQuarrie, 2014).

Despite these rather alarming indicators, knowledge production in this area remains scant in Senegal. However, it must be noted that the field of study of adolescence is relatively recent. It dates back about forty years, though there has been an acceleration in the production of knowledge since the 1990s (Rodriguez-Tomé et al., 1997).

This paper focuses on contextual factors such as the socio-political and institutional environment in the analysis of the adolescent reproductive health situation. It is these interactions between reproductive health policies and key indicators that this contribution aims to systematize.

[4] The WHO defines young people as those aged 10 to 24, including adolescents aged 10 to 19 and young adults aged 20 to 24.
[5] This rate is defined as the share of young people under 15 and adults over 64 in the working age population (15-64).
[6] Located in the extreme west of the African continent in the Sudano-Sahelian zone, Senegal covers an area of 196,722 km² with a population of 15.7 million in 2018. The population is unevenly distributed and is concentrated in the west and center of the country, while the east and north are sparsely populated.

To that end, the analysis focuses on the evolution of policies implemented in the area of adolescent reproductive health in Senegal by putting them in perspective with some key indicators of the sector: (i) the marital status and fertility of adolescents (adolescent mothers at age 15, adolescent mothers at age 17, adolescents pregnant with a first child at age 15) and (ii) the proportion of adolescents and women in union using contraceptive methods (any traditional or modern contraceptive method).

The first part summarizes the methodology of the literature review, while the second part outlines the theoretical framework and the context of high household vulnerability in Senegal over the past decade. The third part reports on the results of the research, focusing on three decisive periods in adolescent reproductive health policies from the colonial period to the present day, in addition to defining indicators as markers of achievements and gaps in the field concerned. Finally, a conclusion summarizes this evolution while discussing possible explanations for the indicators' slow progress.

1.Methodology: a literature review combining quantitative and qualitative data

The methodology is detailed in a report produced by the authors APHRC (2020). It can be noted that the data was collected by exploiting secondary data from various scientific and administrative publications and grey literature, as well as through semi-structured interviews with the main stakeholders. An interdisciplinary approach was favored through a dual quantitative and qualitative approach. A team of researchers in social sciences and quantitative methods were mobilized from July to October 2019 to carry out joint analyses and systemize the results.

Within the research team, the qualitative team carried out a review of the official and scientific resources available in Senegal on adolescent reproductive health, the history of policies in the field and carried out a map of the actors. In the same time, the quantitative team was responsible for identifying and describing the available data, supporting the analysis of databases and monitoring quantitative documentary sources.

The analysis consisted of studying different types of documents (e.g. scientific articles, study reports, policy documents, training materials). This analysis was carried out using bibliographic resource portals and online documentation web sites of which the main ones are Cairn info, Pubmed, Perseus, and Google Scholar, African Index, Memoire Online.

The websites of relevant UN agencies, NGOs and international development partners were also used. Additional material was found through meetings with national partners, consulting research centers and sourcing relevant policy documents from institutional websites. The documents research was based on some keyword like "adolescent girls", "reproductive health", "sexual rights".

Due to a lack of scientific documentation on adolescent reproductive health at the national level, in the interest of comprehensivenes, the sources of information as much as possible have been diversified. Thus, all documents found online, such as reports from intervention programs, press articles, blogs and forums were integrated into the literature review. This exercise allowed for the collection of additional documentary resources, but also for the identification of the main obstacles to adolescent reproductive health and lessons learned from their experience.

The third part of the study process consisted in the analysis of available databases. The databases and/or reports produced by the major actors in the reproductive health field were analyzed to determine the status of the key indicators (metadata) they collect. The structures targeted were the National Statistical Agency (ANSD) for the census and specific surveys; ANSD and Macro International for the Demographic and Health Survey.

The last methodological step consisted of a cross-analysis of the various past and present policies and key adolescent reproductive health indicators in order to highlight the main gaps and the way forward to improve the quality of adolescent reproductive health.

2.Research context: theoretical orientations on adolescence in a precarious environment

The analysis of the research literature shows the predominance of psychosocial models, which are based on a logical approach through health protection. These models have often been criticized because their approach focuses on individuals, who are considered capable of deciding and choosing their behavior on a rational basis (Bajos et al., 1997; Eaton et al., 2003; Thiam, 2004). This perspective isolates the behavior of individuals from the social environment in which they operate. Adolescents constitute a heterogeneous group with a plurality of trajectories that are largely dependent on the contexts and specificities of countries. Adolescents can change from a population at risk to a group of actors capable of acting, committing themselves and making life choices.

The multi-domain psychosocial framework of adolescent risk was developed by Jessor (1991) in light of the above. It combines both social cognitive theory and the ecological approach by identifying five key domains that explain adolescent risk and protective factors: the ambient social environment (e.g. socio-economic status), the perceived social environment (cultural norms, religion, local values), personality (self-esteem, self-efficacy, ambitions), behavior, and genetic-biological factors (innate intelligence, alcoholism in the family). All these areas are considered to have an influence on adolescent lifestyles (Guiella, 2012). Furthermore, it is recognized that the experience of this period is highly dependent on the contexts in which adolescents live (Lesclingand and al., 2017).

Over the past ten years, several studies and publications have provided a comprehensive overview of vulnerabilities among adolescents in West and Central Africa and particularly in Senegal. The research has shown the multidimensional nature of these vulnerabilities, which intertwine and mutually influence the lives of adolescents (Cissé and al., 2017).
Among these vulnerabilities, adolescent health is the major critical factor, given trends in early marriage, early sexuality, unwanted pregnancies, abortions and their economic and social consequences, as well as risks and protective behaviors towards HIV.

Results from the 2005-2014 multi-country Demographic and Health Surveys (DHS) show that contraceptive use remains a challenge. According to Sedgh, Ashford and Hussain (2016), 23% of women are simply opposed to it, 26% of women fear the side effects and 20% say they do not need it because of breastfeeding. It should also be noted that infrequent sex and being single are also reasons given for not using contraception. These results reveal a need for information to ensure that women are able to choose the method that suits them best. This is especially true as the age of first sexual intercourse is declining throughout the West African sub-region.

The results of a 2015 UNICEF study show that while the age of marriage is declining, the practice persists and is accompanied by high rates of early pregnancy and childbearing.

In addition to health issues, adolescents continue to work long hours or in hazardous workplaces and conditions that expose them to physical or psychological abuse, causing them to drop out of school. They also experience mobility/forced migration in the event of displacement or conflict or by personal choice. The search for sustainable livelihoods, lack of employment and/or underemployment, lack of decent working conditions, and uncertain economic prospects

in the countries of origin are the main motives. There is a range of adolescent profiles, including out-of-school adolescents, married adolescents, adolescent mothers, young people with disabilities, very young domestic workers, refugees, internally displaced persons, migrants, and young people living with HIV. In the face of these multiple vulnerabilities, it is clear that the care of adolescents is an urgent issue. However, several barriers are at work and limit progress towards social change for better protection of this category.

3. Research findings: Three key periods and slow evolution of adolescent reproductive health indicators

The analysis of reproductive health policies distinguishes three periods: (1) from independence to 1994; (2) from 1994 to 2004; and (3) from 2005 to the present day, when the issue of adolescent reproductive health was institutionalized in Senegal.

- **From independence to 1994: school health was prominent**

During the colonial period, school health was introduced in Senegal in 1942 by a decree regulating it (No. 3521 of 7 October 1942)[1] and establishing the general school medical inspection service. The policy in this field was mainly preventive, notably with vaccination campaigns in schools, the hygiene of the school environment, the control of students' aptitude for physical and sports tests, and finally the health control of food in boarding schools, particularly in secondary schools. The target population covers children and adolescents aged between 6 and 20 who are in school. With periodic medical monitoring and systematic vaccination in educational establishments, school health had its glory days until the end of the 1970s.

The onset of the Structural Adjustment Plans (SAPs) in the early 1980s led to a narrowing of state action to the detriment of social policies. The consequence of this new situation was a reverse boost to the associative movement, which became involved in the management of free spaces and emerging needs. The health of young people and adolescents is part of these areas, which are little covered by public policies and which the voluntary sector has highlighted in experiments in school and out-of-school environments.

● Schools taking over the health of adolescents/young people

From 1986 onwards, the school takes charge of the issue of student health with the creation of the "Division du Contrôle Médical Scolaire" (DCMS) (decree n° 86-877 of July 19, 1986). However, it was not until the involvement of UNFPA that adolescent reproductive health was seriously addressed. This impetus was reinforced by the production of data on the subject through the Senegalese Fertility Survey (SFS) in 1978 and the Demographic and Health Survey (DHS) in 1986.

New concepts were introduced in institutional documents such as the "Declaration of Population Policy of Senegal" (DPP) in 1988. It refers to sexually transmitted infections, sexual relations outside of marriage, early pregnancies, etc. The International Conference on Population and Development (ICPD) in 1994 had the effect of boosting interventions in favor of adolescent reproductive health through two types of intervention. First, elementary schools were targeted with the Family Life Education (FLE) program in 1992. Then, in 1994, the "Groupe pour l'Étude et l'Enseignement de la Population" (GEEP) launched a series of EVF clubs run by students and teachers in middle and high schools. At the same time, other initiatives were launched in the communities: the "Youth Promotion Project" and the "Xàll Yoonn" ("showing the path") project implemented by the Senegalese scout movement.

Table 1 shows that in 1992-1993 (the year of the second Senegalese Demographic and Health Survey), nearly four out of ten 19 year old (38%) were already "mothers" and 43.5% had already begun their fertile life (were "mothers" or "pregnant with a first child"). Among 15 years old, these rates are quite low, at 3.5% and 4.8% respectively. According to the same source, the change occurs quite abruptly between the ages of 17 and 18. For example, the proportion of mothers is 17.4% among 17 years old and doubles (34.2%) among 18 years old. Similarly, the proportion of adolescents who have begun their fertile life, which is 21.1% among 17 years old, rises to 39.8% among 18 years old.

Table 1: Marital status and fertility of adolescents in 1992-1993

	% of adolescent mothers	% of adolescent girls pregnant with first child	% of adolescent girls who have already started their fertile life
15 years old	**3.5**	**1.3**	**4.8**
16 years old	**11.8**	**2.5**	**14.3**
17 years old	**17.4**	**3.7**	**21.1**
18 years old	**34.2**	**5.6**	**39.8**
19 years old	**38.0**	**5.6**	**43.5**

Source: ANSD (1994)

In 1992/1993, the proportion of 15-19 year-olds in a union using any method of contraception was only 4.6% (Table 2). This rate is three times lower than that of their older counterparts aged 20-24 (14.8%), who were fairly close to the rate of women at the end of their fertile period (15.2%). Adolescents also used traditional methods relatively more (3.6%, or 80% of all 15–19-year-old using a contraceptive method) than their elders (for example, among women aged 20-24, the rate of use of traditional methods is 8.1%, or 55% of all 20-24 year old using a contraceptive method).

Table 2: Proportion of women in a union using contraceptive methods in 1992/1993 (%)

	Any method**	Any modern method*	Any traditional method*
15-19 years	4.5	0.9	3.6
20-24 years	14.8	6.7	8.1
45-49 years	15.2	7.0	8.2
All age groups	20.4	10.6	9.8

Source: * ANSD (1994); ** Our calculations from ANSD (1994)

- **From 1994-2005: The first steps in the process of institutionalizing reproductive health in Senegal**

  - **The Cairo Conference definitively establishes reproductive health**

It was not until the Cairo Conference that home economics penetrated schools and internalized reproductive health in the teaching of elementary, middle and secondary cycles by encouraging teachers of another discipline, Life and Earth Sciences, to devote more openly time slots to teaching the prevention of STIs, HIV/AIDS, and the prevention of major endemics (malaria, tuberculosis, leprosy, etc.). From then on, the school curricula, relayed by the activities of associations in family life education clubs within schools and outside school, set the pace for health education for adolescents.

The International Conference on Population and Development (ICPD) in Cairo in 1994 marked a decisive turning point in the promotion of the health of young people and adolescents, which was henceforth considered a priority area in the reproductive health policy of the Ministry of Health.

In 1994, the will to take charge of the diversity of adolescent reproductive health needs was clearly displayed by the National Program for Health and Social Development (PNDSS). The

strategy document refers to access to health care but also to protection against risky behavior, early marriage, unwanted pregnancy, vaccination and early marriage.

A new continental strategy developed by the WHO

In 1998, the WHO defined a new strategy for 2007 with a holistic approach that takes into account the strengthening of knowledge about the body, including the functioning of the genitals, the responsibility of adolescents in the use of the contraception and prevention of risky sexual behavior. This echoed at the national (senegalese) level concerns with the creation in the within the Ministry of Health of a specific unit for adolescent health in the department of reproductive health. At the operational level, it translated into funding for NGOs under the Integrated Health Development Program (PDIS) initiated in the 2000s.

The aim of the strategy was to stimulate demand for adolescent reproductive health services. Several international institutions including UNFPA, WHO, Population Council, UNICEF and the World Bank offer a variety of interventions. This momentum reinforced state action but also that of many NGOs and associations.

The Senegalese Association for Family Well-being invested in family planning and youth clinics while the Group for the Study and Education of the Population will gradually set up family life education clubs in schools in several regions of the country.

The strategy aims to promote community approach especially in peri-urban areas which concentrate disadvantaged populations will not be left out with the Community Association for Development) and the experience of listening and counseling centers for adolescents initiated by the Project Youth Promotion.

- **The UNESCO conference in 2000, Education for All: an institutional turning point for adolescents and young people**

Following the 2000 conference called “Education For All”, UNESCO revived the issue of school health, nutrition and HIV / AIDS. To do so, the FRESH program as a rigid part of the Development Plan for Education and Training has benefited from joint funding from several international institutions. Hence the emergence of the School Health and Nutrition Program will be carried out with students aged 6 to 12 over 10 years. However, reproductive health

struggles to fully understand the content of learning. It is no better than under the name of the notions of preventive health and study of the human body, including the genitals and the menstrual cycle at the middle cycle level.

From 2001 onwards, with the support of UNFPA, the GEEP's extracurricular EVF ("Education à la vie familiale"[7]) program was followed by the integration of EVF into the scouting program, the adolescent counselling centers by the Ministry of Youth, and the integration of adolescent reproductive health into the school curriculum. In 2003, EVF in middle and secondary education and EVF in a dozen "daara" in six regions echoed the concept of "education for all". The alert launched is strong, and a mobilization of the diversity of actors is taking place to counter the multiple vulnerabilities of adolescents.

Thus, Senegal has achieved the convergence of three main public policies on the health of young people and adolescents: the PDEF, which proposes to make health an input for education, the PDIS, which makes the health of young people and adolescents a priority for their development, and the National Youth Policy, which aims to have healthy and educated young people as a driving force for economic and social development.

In 1997, 35.8% of 19-year-old girls out of ten were "mothers", as shown in Table 3, compared to 38% four years earlier, as seen above. Among 15-year-olds, the proportion of "mothers" was 2.9%, compared to 3.5% in 1992/1993, reflecting a very modest decline in the phenomenon. As in 1992/1993, the changeover occurred at age 17 in 1997, but with less intensity. The proportion of adolescent "mothers" rose from 16.1% among 17 year old to 27.8% among 18 year old.

Table 3 : Marital status and fertility of adolescent girls in union in 1997

	% of "adolescent mothers"	**% of adolescent pregnant with their first child**	**% of adolescents who have already started their fertile life**
15 years old	2.9	1.8	4.7
16 years old	7.9	1.5	9.4
17 years old	16.1	6.8	22.9

[7] Family Life Education.

18 years old	27.8	5.9	33.7
19 years old	35.8	3.8	39.7

Source: ANSD (1997)

Compared to the situation in 1992/1993, contraceptive use did not improve significantly in 1997. The proportion of unionized 15–19-year-olds using any method of contraception was 5.5% in 1997 (Table 4), compared to 4.6% in 1992/1993, as we noted in the previous section. However, we note that in 1997 the gap between the 15-19 year-olds and their 20-24 year-old counterparts narrowed to the extent that the contraceptive use rate for the latter was only 9.1%. We also note that the use of modern contraceptive methods among 15-19 year-olds in union has increased modestly, from 0.9% in 1992/1993 to only 1.5%. In other words, the vast majority of adolescents using a contraceptive method (73%) use traditional methods.

Table 4: Proportion of women in union using contraceptive methods in 1997 (%)

	Any method**	**Any modern method***	**Any traditional method***
15-19 years old	**5.5**	**1.5**	**4.0**
20-24 years old	**9.1**	**3.7**	**5.4**
45-49 years old	**9.5**	**5.7**	**3.8**

Source: * ANSD(1997); ** Our calculations from ANSD (1994)

- **2005 to present: A robust, multi-sectoral policy framework**

  - **Institutionalization of the adolescent health strategy by the Ministry of Health**

In 2005, the Ministry of Health adopted the adolescent health strategy, supported by UNFPA and WHO. In the same year, the law on reproductive health was adopted in July (No. 15/2005 of 19 July 2005) and gave adolescent health a status within the Ministry of Health. This law

made it possible to move from a logic of assistance to young people to the creation of an environment favorable to the health of young people and adolescents.

The law is followed by the National Strategy on Adolescent and Youth Health, which focuses on improving adolescents' access to services adapted to their needs, the adoption of responsible behavior and finally the creation of a regulatory environment geared towards adolescent and youth health in the context of reproductive health.

- **Open spaces for adolescents in health centers**

The opening of spaces dedicated to adolescents in health structures from 2014 influenced the content of training content for health professionals. Indeed, this new situation which meets the needs of the former health personnel on non-biomedical aspects in order to promote the use of services by adolescents. Specific skills must be strengthened among caregivers to remove socio-cultural barriers that limit access to reproductive health care for adolescents.
Within this framework, the Ministry of Health lunched spaces for adolescents in several health structures, not without difficulties of adaptation to different contexts. The associations and NGOs which could have helped to contextualize this dynamic of setting up spaces dedicated to adolescents are limited due to the lack of funding for their own activities.

- **A multiplicity of actors and an interactive framework for consultation**

The emergence of a multitude actors is made possible by an institutional environment more open to adolescent reproductive health issues. The effects are likely to boost the demand for reproductive health services for young people and adolescents. Interventions are carried out by international organizations such as UNFPA or even NGOs with significant volumes of funding such as the African Network for Health Education (RAES), Save the Children, Marie Stopes, World Vision and AMREF.
The institutional level is not left out as the Ministry of Health is developing a reproductive health strategy characterized by a holistic and intensive approach to the health of young people and adolescents. About twenty youth spaces have been opened in the structures with a desire to expand across the country.

- **The new policy on reproductive health and adolescent rights: a holistic and intersectoral framework**

The following conceptual framework (figure 1) shows the broad scope of the vision and the focus on prevention, care, counseling, and support for adolescent girls. The policy encompasses a variety of state actors (ministries in charge of youth, health, education and gender), technical and financial partners, NGOs and associations. It is therefore a policy that is open to stakeholders who are involved in defining and monitoring-evaluating it through the consultation framework led by the adolescent reproductive health division.

Figure 1: Conceptual framework

Source: The authors

The new policy vision for adolescent reproductive health, reflected in this conceptual framework, is comprehensive in articulating monitoring, adolescent care (pregnancy and delivery and postpartum care), access to health care, sex education, and protection against various risks (abuse, sexual exploitation, cybercrime). Relational and psychological aspects up to self-esteem, parent-adolescent communication, IEC/BCC and counseling to address other vulnerabilities such as HIV, genital mutilation, malnutrition, drugs, smoking, accidents or trauma, use of psychoactive substances.

This vision puts into perspective adolescents who are protected, counseled, and have access to medical care, while making responsible choices. It positions adolescents as individuals that communicate with their environment and are proactive in their self-awareness and rights in the face of all forms of stereotypes and stigma in favor of freedom and dignity.

The challenge of this policy is to be effective. The standards and protocols as well as the strategy developed by the Adolescent Reproductive Health Division point the way. The partnership with non-governmental actors should go beyond consultation so that the co-produced policy finds public resources for its joint implementation: The partnership with non-governmental actors should go beyond consultation so that the co-produced policy finds public resources for its joint implementation: the State, associative actors, local authorities and development partners.

Between 2010 and 2019, there has been a decline in indicators related to adolescent fertility, but it is relatively modest (Table 5). Among 19-year-old, the proportion of "mothers" fell from 28.3% to 26.4% (a decline of 1.9%). Among 15-year-old, the variation was from 2.4% to 0.8% (-1.6%). The proportion of adolescents who are pregnant with their first child has, against all expectations, increased slightly between 2010 and 2019 among adolescents in union aged 15 (+0.7%) and especially among those aged 16 (+1.6%). On the other hand, their elders are experiencing fewer first pregnancies: -1.4% among 17-year-old and -2.4% among 19 year old.

Table 5: Marital status and fertility of adolescent girls in union in 2010/2011 and 2019

	Mothers (had a live birth)		Pregnant with your first child		Have already started their reproductive life	
Age	**2010-2011**	**2019**	**2010-2011**	**2019**	**2010-2011**	**2019**
15	2.4	0.8	1.3	0.6	3.7	1.4
16	7.3	3.7	3.8	2.2	11.2	5.8
17	11.6	7.7	4.2	5.6	15.8	13.2
18	26.2	13.4	2.9	4.4	29.1	17.9
19	28.3	26.4	3.7	6.4	32.1	32.8

Source: ANSD (2012 & 2020)

Table 6 shows the persistence of rigidity in contraceptive method use by adolescents during the period 2010 to 2019, and this rigidity is even more pronounced than among their elders. Among adolescents in a union aged 15-19, the proportion using any contraceptive method has improved by only 2.3% over the past ten years, and by 2.6% for modern methods. In contrast, among young women aged 20-24 in union, these two rates have each increased by 11.8%, i.e. an increase of about five times that of adolescents.

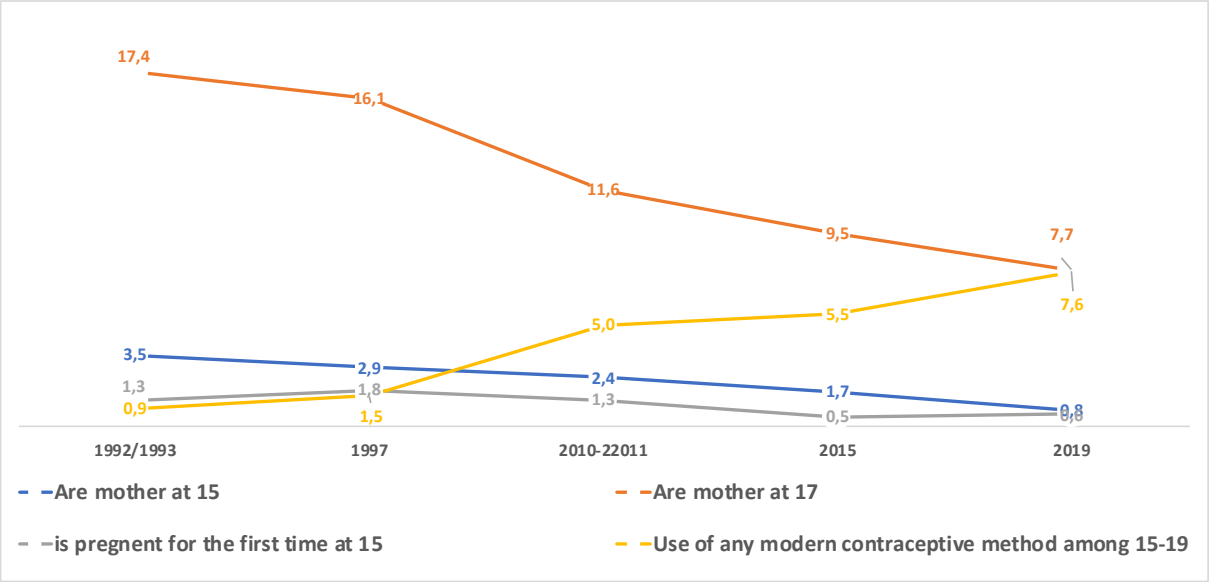
Table 6: Proportion of women in a union using contraceptive methods between 2010 and 2019 (%)

	Any method		Any modern method		Any traditional method	
	2010-2011	**2019**	**2010-2011**	**2019**	**2010-2011**	**2019**
15-19 years old	5.8	8.1	5.0	7.6	0.8	0.4
20-24 years old	9.1	20.9	8.4	20.2	0.7	0.7
45-49 years old	11.0	25.1	9.9	23.0	1.1	2.0

Source: ANSD (2012 & 2020)

Figure 2 summarizes the evolution of four major reproductive health indicators (proportion of mothers among 15-year-old and among 17year old in a union, proportion of 15 year old in a union and pregnant with a first child, and the rate of use of any modern contraceptive method) over the period 1992/1993 to 2019. It emerges that the trend is always in the direction sought by the policies, regardless of the indicator, but the levels of variation are fairly modest everywhere. For example, over 17 years, the proportion of adolescent girls in union and who are mothers has only been reduced by 2.7% in absolute terms. If we consider the low level of this indicator from the outset (which makes it relatively more difficult to reduce it), the level of variation in the rate of mothers among teenagers in a union aged 17 (a fall of only 9.7% in almost two decades), confirms the difficulty of reducing fertility. This is confirmed by the change in the use of a modern contraceptive method among 15–19-year-olds, which has only increased by 6.7 percentage points.

Figure 2: Trends in four major reproductive health indicators from 1992 to 2019 (%)



Source: ANSD (1994, 1997, 2016 & 2020)

Conclusion: The resistance of social norms to interventions that have difficulty scaling up in a context of a lack of scientific evidence on adolescence.

The evolution of adolescent reproductive health is illustrative of the adaptation of intervention strategies to international consensus in the field.

As early as 1942, school health was on the public agenda, but it only concerned adolescents in school, while the large number of young people were not taken into account by the policies. Other categories were not included in the target of public actions, such as married adolescents, those who worked prematurely, and certain groups with specific characteristics (attending daaras[8], family helpers in markets, etc.). This period, which lasted until 1994, was also marked by the effects of structural adjustment plans, which, from 1980 onwards, led to a reduction in social policies, thus propelling the emergence of the associative movement. The state was thus taken over by the associations in the new needs of adolescents and the spaces left unattended.

The National Education Forum organized in 1981 reintroduced the "Division du Contrôle Médical Scolaire (DCMS)" in 1986, placing school health at the forefront. The intervention of

[8] Koranic schools

UNFPA made this gap the framework for integrating reproductive health into the school medical system, during which time specific scientific data on adolescents was produced.
Senegal's 1988 Population Policy Declaration (DPP) strengthened these various initiatives, which were aimed at targeting adolescents. The International Conference on Population and Development (ICPD) in Cairo opened a new era in which reproductive health became an important pillar in national health policy.

From 1994 to 2005, a number of interventions were observed, thus contributing to the effectiveness of the Cairo Declaration. Firstly, international institutions such as UNESCO, WHO and UNFPA, which are concerned with population issues and facilitate the actions of the association movement. Numerous experiments have been developed targeting adolescents both in and out of school. The Senegalese Ministry of Health set up the adolescent health division and the PDIS, which focuses on youth health.

From 2005 to the present day, associative intervention has been running out of steam due to a lack of funding, while the institutional framework has been strengthened, in particular with the law on adolescent health and the national strategy for adolescent reproductive health. This strategy provides a holistic framework, with particular emphasis on the rights of adolescents in their diversity. The consultation framework between the Ministry and the various stakeholders, including civil society, has fostered consensus on the favorable orientations of the strategy and the law.

Nevertheless, not only are the rights not generally effective, but the indicators are more worrying. This contribution therefore compares the evolution of reproductive health policy with the indicators as revealed by the available statistical data. The explanation for this discrepancy can be found in at least three directions.

The first concerns social norms, which are still insufficiently favorable to the consideration of adolescents' rights. In the Senegalese cultural environment, the demands of the family dominate individual choices and the social groups to which they belong govern the lives of their members. There is a strong patriarchal tradition and a hierarchy between the sexes and generations. The growing gap is not without consequences for the well-being of adolescents. Studies on the social norms favorable to change and on individual and collective cultural barriers remain useful in

order to better understand the limits to the expression of changes for a greater effectiveness of adolescents' reproductive health rights.

As social norms are complex but not fixed, they can evolve according to the power relations that structure the game of social actors. Similarly, rights are also inherent to societies and remain dependent on the margins left by social norms. Therefore, the promotion of a dialogue between the generations for mutual understanding is essential. This could take the form of a more open learning model, allowing adolescents to make responsible choices while preserving their aptitudes and skills.

A second area of concern is that interventions are not broadly responsive to the needs of adolescents. A study of the mapping of reproductive health interventions in Senegal carried out by LARTES-IFAN in 2019 reveals significant gaps, especially in landlocked regions and recent administrative regions such as Kaffrine and Diourbel (in the center), Matam (in the north) and Kédougou (in the east). From a thematic mapping point of view, there is a concentration on IEC/BCC actions which consist in stimulating the demand for reproductive health services as well as on the essential aspects of reproductive health and adolescent development. The gaps are around rights-related interventions, including the right to dignity, expression, confidentiality, communication between parents and adolescents, adolescent sexuality, and sexual abuse and other violence.

The reproductive health needs of some profiles of adolescents are difficult to meet. One way to achieve this is to strengthen the use of technology in intervention strategies to reach adolescents with limited access to information and services, such as those in rural areas and those not attending school.

A final issue is the lack of scientific evidence to facilitate the targeting of different adolescent profiles in interventions. For example, there is little research evidence on specific groups such as young adolescents in the 10-14 age group, HIV-positive adolescents, those with physical or mental disabilities, etc. These adolescents are likely to be the most vulnerable to HIV infection. These adolescents are likely to experience many forms of vulnerability, risk exposure, discrimination, exclusion and stigmatization. It has become a priority to fill the knowledge gaps on adolescents in order to better address reproductive health needs. Similarly, studies are needed to describe the behaviors of today's adolescents, to determine whether these behaviors are indeed new, to measure possible changes in practices and to understand the multifaceted determinants.

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