ADOLESCENT AND YOUTH HEALTH SITUATIONAL ANALYSIS, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH, WITHIN ECOWAS

Final Report

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PREFACE

Established on 28 May, 1975 and being one of the five African Regional Economic Communities, the Economic Community of West African States (ECOWAS) is a demographical area which stretches over about 5,079, 400 km². It brings together fifteen (15) Member States, namely: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

In 2014, the population of ECOWAS was estimated at about three hundred and thirty-five million (335, 000,000) inhabitants and is growing at an average annual rate of 2.7%, one of the highest in the world. More than a third of this population is made up of the 10-24-year age bracket, which brings the number of young people living within ECOWAS to about one hundred million. With the strong population growth rate and given the more serious projections, the number of young people in West Africa will reach 200 million by 2050.

This impressive number of adolescents and young people can be a real opportunity for socio-economic development if consistent development policies and programmes are formulated by incorporating the specific problems and needs of this age bracket, including those relating to health. On the other hand, in place of getting a demographic dividend, one could rather witness a real disaster.

That is why the West African Health Organization (WAHO), which is the sole specialized institution of ECOWAS in the area of health, has, as part of its mission, and given the urgent attention required by adolescent and youth health which includes sexual and reproductive health (AYH/SRH), undertaken the development of this Guide for the countries to enable them to take inspiration from it to formulate or update their national AYH/SRH documents which are based on proven strategies through integrated and suitable effective health services. It should be stated that the WAHO 2016-2020 Strategic Plan adopted by the 48th Conference of Heads of State of ECOWAS held in December, 2015 is made up of13 priority programmes, including the one dealing with the improvement in the health of mothers, newborn babies, children, adolescents, young people and the aged.

The results of this situational analysis will provide a solid basis for the formulation of the Guide which can bridge a gap by providing the countries with a practical tool for the formulation or updating of the national AYH/SRH documents.

WAHO hopes that readers will find in this document points which will enable them to assess the AYH/SRH situation and the needs of ECOWAS countries for purposes of decision-making and appropriate action. It welcomes any contribution meant to improve upon the contents of the document.

Thank you.

Dr. Xavier CRESPIN
DG, WAHO

ACKNOWLEDGEMENTS

The formulation of this adolescent and youth health situational analysis report within ECOWAS was sponsored by the West African Health Organization (WAHO) as part of the development of an Orientation Guide for the countries.
The analysis of the situation of adolescents and young people in the ECOWAS region went through three phases, namely the preparatory phase, a document review backed by a field trip to 5 targeted countries and the validation of the situational analysis report.

This situational analysis was conducted with the collaboration of an external consultancy firm and the support of a management committee. Its production was made possible through the contribution of the technical and financial representatives and partners of the various key ministries of the ECOWAS countries. Thus, WAHO would like to express its acknowledgement through this medium to all these people and to particularly express gratitude for the kind attention of the Ministers of Health and the sound cooperation of the WAHO focal points and the reproductive health (RH) programme officers of the countries visited during the situational analysis.

WAHO is particularly grateful to USAID West Africa for its financial support and constant concern, MSH for its technical support through the LMG West Africa Project, and Katie CHAU, Principal Adviser (Youth Affairs) of Evidence to Action (E2A) for her wise counsel for the preparation of this Guide.

WAHO hopes that the countries, their partners and readers will find in this document points which will enable them to avail themselves of national integrated health service policies and strategies suitable for adolescents and young people within ECOWAS. It welcomes any contribution meant to improve upon the contents of the document

Dr. Xavier CRESPIN
DG, WAHO

SUMMARY

WAHO, in collaboration with all key partners involved in the Adolescent and Youth Sexual and Reproductive Health of the region, proposes to develop and to provide the countries with an orientation guide for the formulation of national strategies for the provision of integrated health services suitable for adolescents and young people in the ECOWAS member countries. It was because the aim was to develop a realistic orientation guide that this prior situational analysis was conducted.

The main objective of this work was to conduct an adolescent and youth health situational analysis within ECOWAS whose results will help to develop an orientation guide for the formulation of national strategies for the provision of integrated health services suitable for adolescents and young people.

The conduct of the situational analysis was made up of three stages: 1) Preparation of the mission, 2) Document review and 3) A more in-depth situational analysis in five ECOWAS countries, namely: Benin, Cape Verde, Nigeria, Senegal and Sierra Leone. These five countries were chosen on account of the level of their performance in the area of national AYRH strategies, the demographic influence, geographical position of the country and the three languages spoken in the ECOWAS countries.

Main Salient Points Mentioned by the Analysis:

The standard indicators of the health status of the adolescent and youth population within ECOWAS, namely mortality, morbidity and DALY, have assumed a worrying dimension

Most of the structural social health determinants, i.e. the circumstances under which adolescents and young people are born, grow, live, work and grow old within ECOWAS, as well as the systems put in place to confront diseases, are far from the optimum. However, these circumstances which reflect policy choices depend on the distribution of power, money and resources at all levels – national and local. They can be improved upon through real political will and enhanced social justice. In fact, the current scope of adolescent and youth demography can be a dividend for the countries. The determinants specifically studied in this report are as follows: demography economy, health system, education, employment, culture and health equity.

The proximal social determinants, i.e. the circumstances of everyday life which have a more direct influence on the attitudes and behavioural patterns of a person, currently constitute a serious threat to adolescent and youth health. However, these threats can be minimized and even transformed into opportunities for the promotion of and improvement in adolescent and youth health. Although the countries have found them to be fascinating and have been vastly deployed by NGOs in particular, the peer-educator approaches and adolescent and youth centres have shown their limitations. The proximal social determinants specifically studied in this report are: family and school environment.

The knowledge, behavioural patterns and mode of life of adolescents and young people in the countries of the ECOWAS region currently constitute a threat to adolescent and youth health. Indeed, the situational analysis revealed that most adolescents and young people of the countries in the ECOWAS region suffer from a crucial lack of good and sound information, and adopt harmful behavioural patterns and modes of life (unprotected sex, sedentary

lifestyle, harmful consumption of alcohol, tobacco and drugs, poor diet and, above all, addiction to information and communication technology (ICT). These behavioural patterns and modes of life pave the way for an epidemic of non-communicable diseases in the years to come.

Although they are still not too effective, the Ministries of Health and their strategic and operational partners have put in place a response which will be improved as the years go by. In fact, most countries have a real partnership for adolescent and youth health, with a broadly functional coordination mechanism in place. It is observed that there is national leadership at the highest level with pro-youth and pro-adolescent legal measures, advocacy and health resource mobilization efforts for adolescent and youth health. The countries have introduced policies, strategies and directives for youth and adolescent health with broadly suitable health interventions and provision. The availability of data, particularly gender and age disaggregated data, is still a real weakness within ECOWAS. The financing of adolescent and youth health still needs to be improved.

The main strengths mentioned by the strategic and/or operational partners in most of the countries are: the existence of a consultation or coordination framework, availability of many stakeholders, availability of strategic documents and the existence of youth centres.
The main weaknesses mentioned by the partners are similar in all of the countries visited: weak coordination of stakeholders, non-availability or inadequacy of trained providers, poor reception by providers, overlapping of the interventions of the various partners, non-integration of interventions, competition among stakeholders, lack of dissemination of strategic documents, lack of research, lack of advocacy with religious leaders, etc.

The problem of poor involvement and non-performance of the coordination mechanisms which exist in the countries is a major concern for the partners.

The strategy of the youth centres which are very popular in the various countries reveals more weaknesses than strengths, and, in the light of new evidence, both its design and implementation must be looked at again.

This analysis clearly shows that parents also need to be helped to facilitate assistance to their children.

Finally, adolescents and young people are demanding representation in decision-making bodies.

The major challenges to be addressed by ECOWAS countries through WAHO are as follows:

1. The positioning of adolescent health as a top priority with the allocation of substantial financial, human and material resources.
2. A reduction in adolescent and youth mortality, DALY and morbidity.
3. The identification of effective evidence-based interventions which take all the components of the adolescent and youth health sub-system into account.

4. Inter-sectoral coordination (involvement of the stakeholders of the other sectors to ensure an improvement in adolescent and youth health)
5. Intra-sectoral coordination within the Ministries of Health of the countries.
6. The reduction in threats relating to structural social determinants.
7. The reduction in threats relating to proximal social determinants.
8. The actual involvement of young people in the design, planning, implementation and evaluation of activities meant for them.
9. The adoption of protective behavioural patterns and healthy modes of life by adolescents and young people.
10. The fight against the addiction of adolescents and young people to ICT.
11. The development of truly friendly and integrated youth centres.
12. The development of appropriate and qualified AYH human resources, including AYSRH.
13. The definition of exact consensual indicators on adolescent and youth health.
14. The promotion of the culture of the evaluation of implemented strategies.
15. The availability of data on adolescents and young people (gender and age disaggregated data).
16. The harmonization of legal, policy, strategy, planning, monitoring and evaluation documents.

ACRONYMS AND ABBREVIATIONS

WB	World Bank
ECOWAS	Economic Community of West African States
DALY	Disability-Adjusted Life Year
DHS	Demographic and Health Survey
IMF	International Monetary Fund
HPV	Human Papillomavirus
HDI	Human Development Index
STIs	Sexually Transmitted Infections
KfW	Kreditanstalt für Wiederaufbau ("reconstruction credit institute ")
LMG	Leadership Management & Governance
FGM/E	Female Genital Mutilation/Excision
MICS	Multiple Indicators Cluster Survey
NCDs	Non-Communicable Diseases
MSH	Management Sciences for Health
NA	Not Available
NSD	Illiterates and Dropouts
OCCGE	Francophone Coordination and Cooperation Organization for the Fight Against Serious Endemics
MDGs	Millennium Development Goals
WHO	World Health Organization
NGO	Non-Governmental Organization
INGO	International NGO
NNGO	National NGO
UNAIDS	Joint United Nations Programme on HIV/AIDS
WAHO	West African Health Organization
CSOs	Civil Society Organizations
GDP	Gross Domestic Product
UNDP	United Nations Development Programme
PRB	Population Reference Bureau
SRHP	Strategic Reproductive Health Plan
AYH	Adolescent and Youth Health
AIDS	Acquired Immune Deficiency Syndrome
HIS	Health Information System
RH/FP	Reproductive Health/ Family Planning
AYRH	Adolescent and Youth Reproductive Health
SRH	Sexual and Reproductive Health
AYSRH	Adolescent and Youth Sexual and Reproductive Health
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization

INTRODUCTION

0.1 GENERAL OVERVIEW

Today, the number of young people in the 10-24-year age bracket is higher in the world than ever before in the history of humanity. In some regions, in addition to the fact that the number of young people has increased, their share of the entire population has also increased. Besides, there are countries where more than one inhabitant out of three is young. These demographic trends are important for several reasons. In certain countries, the growth rate of the population of young people exceeds that of the economy and is beyond the capacity of institutions tasked with providing this population with basic services. Will the schools, secondary schools and universities be able to meet the demand for education? Some 120 million young people attain the working age every year. Will there be enough jobs to meet their demand for jobs and decent incomes? Will there be enough and effective health services? Will young people, including adolescents, find information and services suitable for their various needs? Will the next generation be able to realize their human rights and full potential? [1]

The emergence of an unprecedented population of young people can have profound repercussions, be they positive or negative, on any country, depending on the ability of the authorities to meet their needs and to enable them to fully and truly participate in the civic and economic life. The authorities may consider the growing number of young people as a liability whose weight will further constrain already over-stretched resources or as a source of new opportunities. With the required policies and investments, and with the participation of young people in the development of their own potential, the generation of young people with the highest population in the history of humanity may provide these nations with the producers, creators, entrepreneurs, agents of change and leaders with the capacity to solve problems in the decades to come. [1].The current generation of young people aged between 10 and 24 years is slightly lower than 1.8 billion individuals out of a world population of 7.3 billion inhabitants. It was only 721 million in 1950, at a time when the world population was 2.5 billion inhabitants. The population of adolescents (young people aged between 10 and 19 years) is about 1.2 billion [1].

The United Nations Population Division of the Department of Economic and Social Affairs projects in its “average fertility” scenario (often considered as reflecting the most plausible demographic trend) that the number of young people aged between 10 and 24 years will reach 2 billion by the middle of this century. However, slight changes in the expected birth and death rates can easily alter this result.

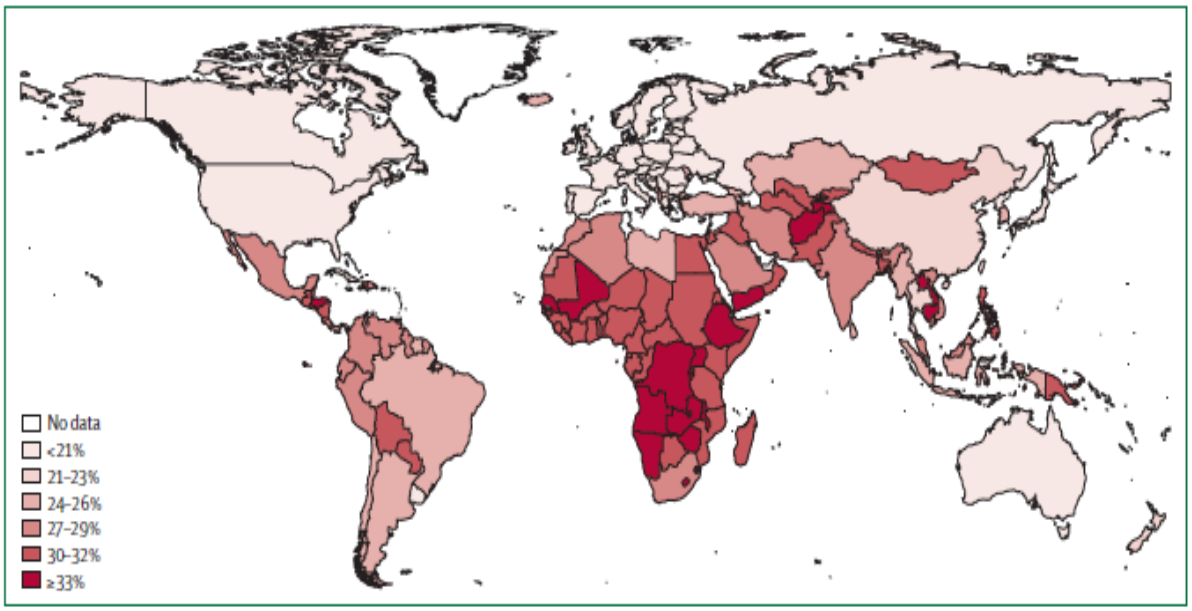
Furthermore, global estimates and projections hide vast differences in the age structures between countries and regions of the same country. The presence of ever-growing vast populations of young people already presents challenges to many under-developed low-income countries where the capacity and resources of the State are facing considerable constraints. In the absence of appropriate investments today in the youth, girls, boys, young adolescents and young adults to prepare them for the future, the difficulties faced by the response to the needs of an ever-growing population will only worsen gradually in many countries of the low-income categories.

The highest proportions of young people are today found in poor countries where the obstacles to their development and the realization of their full potential are most serious. The highest poverty prevalence rates, the lowest level of access to basic health care, education,

potable water and basic hygiene and sanitation as well as the most frequent conflicts and violence, and the harshest standard of living are found in these countries.

Not less than 89 % of the youth aged between 10 and 24 years, i.e. nearly nine out of ten, live in less developed countries. The percentage is even higher for the younger age brackets. The youth constitute a little less than a quarter of the world population. In the least developed countries (a category defined by the United Nations which includes 33 Sub-Saharan African countries, eight Asian countries, six Oceanian countries and Haiti in the Caribbeans), this age bracket accounts for 32 % of the population. In the developed countries, the proportion is 17 % [1].

Chart 1 from the 2012 Lancet [2] shows the distribution by country of adolescents and young people aged between 10-24 in the world.



Source: 2012 Lancet [2]
Chart 01: Distribution by Country of the Proportion of Young People aged between 10 and 24 Years

0.2 STRUCTURE OF THE REPORT

This situational analysis report tackles the problem of adolescents and young people from the health perspective. Many reports studied the health status of adolescents and young people in the world [4], Africa, Sub-Saharan Africa and the African Regions of WHO [3, 4, 5, 6]. This report carries out a more specific study of the health status of adolescents and young people in the 15 ECOWAS countries, which come under the purview of WAHO. It is structured into four parts. The first part presents the background, organization of the situational analysis and the conceptual framework of the analysis; the second part presents the results of the review of

the literature on adolescent and youth health; the third part presents the results of the analysis in five countries within ECOWAS, while the fourth part proposes a summary of the analysis.

PART ONE: BACKGROUND AND PRESENTATION OF ECOWAS AND WAHO, ORGANIZATION OF THE SITUATIONAL ANALYSIS AND CONCEPTUAL FRAMEWORK

1.1 BACKGROUND AND RATIONALE OF THE SITUATIONAL ANALYSIS

According to the data collected in the countries during an RH/FP situational analysis carried out in 2014 by the West African Health Organization (WAHO), the population of the Economic Community of West African States (ECOWAS) was estimated at more than 320 million inhabitants in 2012, with more than half (52.6%) living in Nigeria. It is witnessing strong growth because it is increasing by more than 2% a year in all the countries of the region, except Cape Verde.

According to 2014 world health statistics, the highest population growth rates were observed in Niger (3.7%), The Gambia (3.2%), Liberia (3.1%), Mali (3.1%) and Benin (3%).

Another remarkable characteristic of the population is its youthfulness. Indeed, the median age fluctuates between 15 years (Niger) and 23 years (Cape Verde); that is to say that more than half of the population is less than 23 years old.

These young people have specific health needs which must be taken into account by any development policy or programme in order to guarantee the conditions for realizing their full potential and development to ensure their crucial contribution to the sustainable development of their nation. Among others, actions for young people and adolescents should take the following into account[1]:

- The fight against early child marriage and early pregnancy (among female adolescents);
- The fight against female genital mutilation;
- The fight for the use of a contraceptive method by young people who are already sexually active;
- Actions to promote child education, particularly girls, their continued stay in school and transition to secondary school;
- Sexual and productive health education, including HIV/AIDS prevention and screening (comprehensive education);
- The fight against HIV/AIDS and the other STIs (including Human Papillomavirus (HPV), and
- The fight against all forms of violence against children as well as child employment.

From the health viewpoint, the high frequency of problems of which the youth and adolescents are victims is due to the fact that their specific health needs are not adequately taken into account. In order to meet these specific needs more effectively, numerous initiatives have been taken in the countries with the contribution of development partners both at the normative level (preparation of documents on policies, norms and standards or strategies) and the level of the provision of services. However, an integrated and appropriate response does not seem to have been recommended or found to effectively cater for all the

[1](These are urgent priority actions identified by the 2012 Report on the Status of Adolescents and Young People in Sub-Saharan Africa: Opportunities and Issues)

health needs of this age bracket of the population. To offer an effective response, the effective consideration of these diversified aspects by these countries requires them to develop and implement appropriate integrated interventions involving all key stakeholders.

It is against this background that WAHO is, in collaboration with all key partners in the area of Sexual and Reproductive Health of Adolescents and Young People in the region, proposing to develop and provide the countries with an orientation guide for the formulation of national strategies for the provision of integrated health services suitable for the adolescents and young people of the member countries of the ECOWAS region.

1.2 PRESENTATION OF ECOWAS AND WAHO

1.2.1 Presentation of ECOWAS

ECOWAS is a West African intergovernmental organization established on 28 May, 1975. It is the main body meant to coordinate the activities of the countries of West Africa. Its main goal is to promote integration and cooperation in order to establish a West African economic and monetary union. Today, ECOWAS is made up of the following 15 Member States: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo (See Table 1.1). According to the International Monetary Fund (IMF), in 2012, the overall Gross Domestic Product of the ECOWAS Member States was 564.86 billion US dollars, making it the world's 25th economic power [7, 8].

Table 1.1: List of the 15 ECOWAS MEMBER COUNTRIES

Language	Member Countries	Population aged between 10 and 24 years (in millions) 2014 [1]
French-Speaking Countries (8 in all)	1. Benin 2. Burkina Faso 3. Cote d'Ivoire 4. Guinea 5. Mali 6. Niger 7. Senegal 8. Togo	3.4 5.7 6.7 3.9 5.0 5.7 4.7 2.2
English-Speaking Countries (5 in all)	1. Ghana 2. Liberia 3. Nigeria 4. Sierra Leone 5. Gambia	8.3 1.4 55.5 2.2 0.6
Portuguese-Speaking Countries (2 in all)	1. Cape Verde 2. Guinea-Bissau	0.2 0.6
Total	15	105.9

1.2.2 Presentation of WAHO

WAHO was established on 9 July, 1987 when the Heads of State and Government of all the fifteen ECOWAS countries adopted the Protocol on the establishment of the Organization. This Protocol, which was subsequently ratified by each government of the sub-region, conferred on WAHO the status of a Specialized Institution of ECOWAS and described the mission of the Organization as follows:

> "The objective of the West African Health Organization is to offer the highest possible level of health care delivery to the populations of the sub-region based on the harmonization of policies of the Member States, pooling of resources and cooperation between Member States and third countries in order to collectively and strategically look for solutions to the health problems of the sub-region ".

The driving force behind the establishment of WAHO was the inappropriateness of programmes which were implemented by the two inter-governmental health organizations which existed in the sub-region – the Francophone Coordination and Cooperation Organization for the Fight Against Serious Endemics (OCCGE) and the Anglophone West African Health Community (WAHC). It was thought that, given the fact that disease has no borders, the organizations could better serve the populations of West Africa if their efforts were synchronized and their resources put together, thereby avoiding duplication, reducing costs and enhancing efficiency. Thus, the OCCGE and WAHC merged to form WAHO, an organization committed to transcending the linguistic frontiers of the sub-region in order to serve all the fifteen ECOWAS Member States.

In October, 1998, the Heads of State and Government of ECOWAS established the headquarters of WAHO in Bobo-Dioulasso, Burkina Faso and appointed a Director-General and Deputy Director-General to enable the organization to commence operations as the first-line health authority in the sub-region. Its activities commenced in March, 2000 in Bobo-Dioulasso to serve the 15 ECOWAS member countries as the main tool for regional integration in the area of health [Wikipedia 7, 8].

1.3 ORGANIZATION OF THE SITUATIONAL ANALYSIS

1.3.1 Objectives of the Situational Analysis

The main objective of this work is to analyse the health status of adolescents and young people within the Economic Community of West African States (ECOWAS), including sexual and reproductive health.

The results of the situational analysis will help develop an orientation guide for the formulation of national strategies for the provision of integrated health services suitable for adolescents and young people within the Economic Community of West African States (ECOWAS).

1.3.2 Method of Conduct of the Situational Analysis

The conduct of the situational analysis was made up of three stages: 1) Preparation of the mission, 2) Document review and 3) More in-depth situational analysis in five ECOWAS countries.

- **Stage 1: Preparation of the Mission**

The main activities carried out during this stage basically dealt with the following: 1) signing of the recruitment contract, 2) formulation of the plan for the conduct of the mission, including an understanding of the terms of reference by the consultant and its submission to WAHO for observations, and 3) validation of the plan for the conduct of the mission which will define the guidelines of the mission. Activities 2 and 3 enabled the consultant and management team to harmonize their points of view on the vision and strategic orientations to be considered, context, objectives, methodological approach, time-series chart and expected final products.

- **Stage 2: Document Review**

The method of conduct of this document review was made up of a search for recent and reliable information on adolescent and youth health in the world, Sub-Saharan Africa and the ECOWAS region. The document search will be conducted at the following sources:

- Document search at WAHO;
- Search at the following institutions: WHO, UNFPA, UNICEF, USAID, World Bank, Population Reference Bureau, International NGOs, National NGOs, etc.;
- Search for documents on ECOWAS countries;
- Google search;
- Survey reports: DHS and MICS survey;
- Publications on adolescents and young people;
- Consultation of specialized data bases;
- Consultation of reference works, and
- Health Information System (HIS)

After the documents were collected, they were sorted out, used and critically analysed.

- **Stage 3: More In-Depth Situational Analysis Through Field Trips in Five ECOWAS Countries**

  - **Selection of the Five Countries**

The criteria for the selection of these countries considered the level of performance in the area of national AYRH strategies, demographic weight, geographical location of the country and the three languages spoken within ECOWAS. The 5 selected countries appear in alphabetical order: Benin, Cape Verde, Nigeria, Senegal and Sierra Leone.

  - **Stakeholders and Structures To Be Met In The Countries**

Table 1.2 shows the four key categories of stakeholders and structures involved in the health of adolescents and young people met during the visits to the countries. The details of stakeholders met are presented in the third part of this report.

Table 1.2: Categories of Stakeholders or Structures Met During Visits To Countries

No	Targets
1	Public Structures
2	Strategic and/or Operational Partners (United Nations Agencies, Bilateral Institutions, National NGOs and International NGOs)
3	Parents of Adolescents and Young People
4	Adolescents and Young People of both Sexes

- **Techniques for Data Collection in the Countries**

The techniques for data collection were made up of semi-structured interviews with the various stakeholders. The tools used are summarized in Table 1.3.

Table 1.3: Data Collection Tools

Questionnaires/Interview Guide	Targets
Tool 1 : Country response questionnaire	Ministry of Health as a priority
Tool 2 : Guide for interviews with adolescent and youth stakeholders in the countries	AYH stakeholders
Tool 3 : Guide for group interviews with adolescent and youth associations	Adolescents and young people
Tool 4 : Guide for interviews with the association of parents of adolescents and young people	Parents of adolescents and young people
Tool 5 : Guide for interviews with managers of adolescent and youth health structures	Managers of the structures
Tool 6 : Main health indicators, including AYH indicators	Ministry of Health as a priority

1.4 CONCEPTUAL FRAMEWORK OF THE ADOLESCENT AND YOUTH HEALTH SITUATIONAL ANALYSIS

The analysis of the situation of adolescents and young people within ECOWAS is organized on the basis of a conceptual framework which we adapted from the one contained in one of the reports of the 2012 Lancet series on "Adolescent Health" [2012 Lancet 2].

The seven different components which work on the health of adolescents and young people and factored into this conceptual framework are as follows:

1 Adolescence and youth in the stages of life;
2 Society, school and adolescents and young people;
3 Biology/Physiology, puberty and social transitions;
4 Psyche and Psychology;
5 Knowledge, Behavioural Patterns and Mode of Life;
6 Morbidity, DALY (Disability-Adjusted Life Year) and Mortality, and
7 Country Response.

- **Importance of Health to Each Stage of Life**

Adolescence is a basic link between childhood and adulthood. Sawyer and Coll. [2, 14] use a conceptual framework to describe a perspective based on the course of life which emphasizes the dual advantage of investing in adolescents, namely the sustainability of investments made in the area of child health and the promotion of behavioural patterns and positive results relating to adult health. Adolescent health is not only important for the sustainability of investments in child health and the promotion of good health for adults, but also because adolescents are most vulnerable to SRH/maternal health problems.
The factors influencing health strengthen one another mutually as a result of their interaction. Thus, adolescents are influenced by the health factors at childhood; and this is in spite of the emergence of new risks and protection factors and their incidence on their future health. If they attain adulthood in good health by adopting firmly established healthy behavioural patterns, they will have a better chance of becoming healthy and productive adults. Similarly, risky or negative behavioural patterns adopted by young people can have life-long consequences. It is thus estimated that nearly 90% of adult smokers started smoking before the age of 20. In the longer term, the current health of adolescents has implications for the next generation insofar as the health of pregnant young girls has a direct impact on the development of their babies.

- **Social Determinants of Health: Society, Family, School, Media and Adolescents and Young People**

Society and its various institutions, the family and school in particular play a basic role in the prevention, promotion and handling of adolescent and youth health. According to the World Health Organization, the social determinants of health are the "circumstances in which individuals are born, grow, live, work and grow old." These circumstances "depend on the distribution of power, money and resources at the global, national and local levels" [11, 15].

The social determinants are at two main levels: structural and proximal.

Structural Determinants – the manner in which a society is organized vis-à-vis social, economic and political backgrounds – may create divisions leading to differences of status, power, privileges and access to resources and information. Examples include national wealth, income inequality, level of education, sexual or gender norms or ethnic origin as well as national laws, policies and regulations [11, 15].

Proximal determinants are everyday life circumstances which have a more direct influence on the attitudes and behavioural patterns of a person. Among the examples of proximal determinants are the quality and nature of relationships with family and peers, availability of food and housing, leisure opportunities and the school environment. Since proximal relationships are partly built by stratifications resulting from structural determinants and cultural, religious and community factors, they can lead to important variations in the exposure and vulnerability of young people to health risks [11, 15].

- **Biology/Physiology, Puberty and Social Transitions**

Adolescence is generally defined by chronological age (10 to 19 years), but health behavioural patterns have a much stronger association with the physical changes engendered by puberty. Current research is focusing on the manner in which hormonal changes and the other biological changes which occur during puberty influence the development of the brain, implications in decision-making and adolescent behaviour. For example, the part of the brain which controls the quest for reward and pleasure is developed earlier than the part which determines self-control, a situation which may explain increased risk-taking during adolescence. A better understanding of the impact of biological changes and their interaction with social and economic factors will ensure an improvement in youth policies and programmes.

Finally, as emphasized in Lancet [2], puberty also initiates the social transition of the adolescent who must begin to prepare himself to take up roles in society: end of school, employment, marriage, founding of a family and procreation.

- **Psyche and Psychology**

The social and biological factors influence the psyche and psychology of adolescents and young people, and may determine their behavioural patterns.

- **Knowledge, Behaviour and Mode of Life**

Knowledge, behavioural patterns and mode of life of adolescents and young people are the immediate determinants of their state of health. These behavioural patterns and mode of life most often result from interactions with social, biological, psychic and psychological determinants.

- **Mortality, Morbidity and DALY**

Mortality, morbidity and DALY (Disability Adjusted Life Years) result from the interaction between the various social, biological, psychic, psychological and behavioural determinants. Many risky behavioural patterns and diseases have their roots in adolescence and youth.

Adolescence is generally considered as the healthiest period in the life of a person. Nevertheless, young people account for a substantial part of the morbidity burden in the world.

- **Country Response**

The policies, strategies and interventions put in place by the countries are expected to take account of the various social, biological, psychic, psychological and behavioural determinants which are important for a reduction in mortality and the morbidity burden among adolescents and young people.

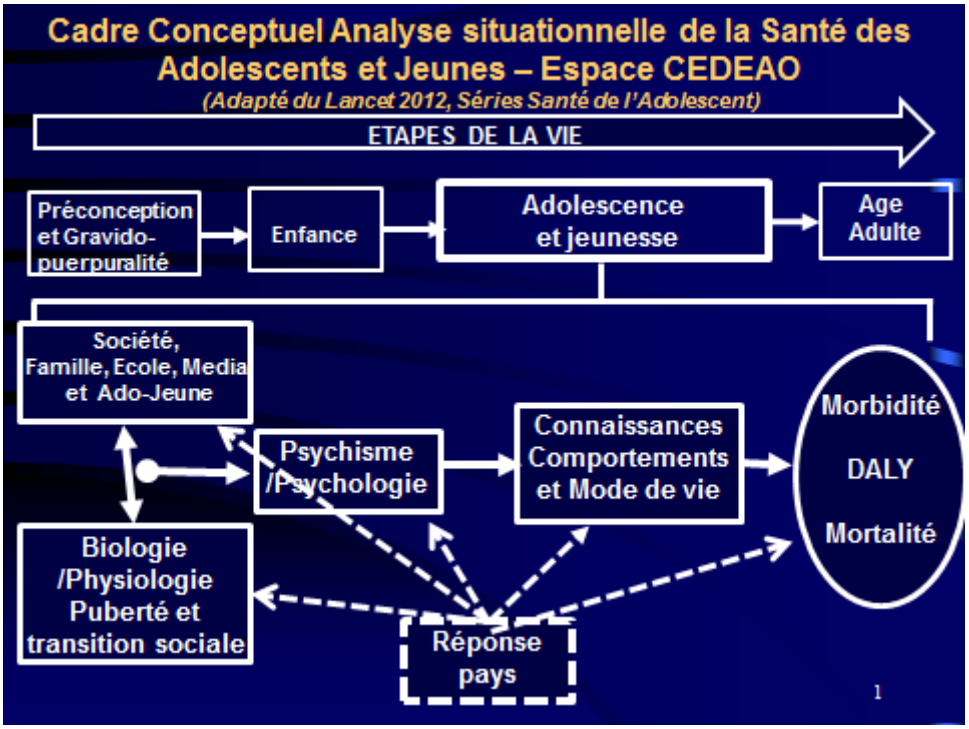


Chart 1.2: Conceptual Adolescent and Youth Health Framework – ECOWAS Region *(Adapted from 2012 Lancet, Adolescent Health Series [2])*

PART TWO: RESULTS OF THE REVIEW OF LITERATURE ON ADOLESCENT AND YOUTH HEALTH WITHIN ECOWAS

Promoting the health and development of adolescents and young people requires a good understanding of current circumstances. This part of the report analyses the health status of adolescents and young people within ECOWAS through a document review. In this regard, it relies on the most recent data from international surveys and, where necessary, complemented by national sources and research outcomes. The main sections of this chapter are:

- "adolescence", "young", and "youth" concepts;
- Social determinants of adolescent and youth health;
- Biological, psychic and psychological determinants and social transition: psychoanalytical perspective;
- Knowledge, behavioural patterns and mode of life of adolescents and young people, and
- Status of adolescent and youth health problems: Morbidity, DALY and mortality.

2.1 "ADOLESCENCE", "YOUNG" AND "YOUTH" CONCEPTS

This section presents the definitions of the adolescence, young and youth concepts as found in the literature and describes the complex nature of the task of defining these three concepts.

2.1.1 Definitions of Adolescence, Young and Youth

Table 2.1 summarizes the main definitions found in the literature on the "adolescence", "young" and "youth" concepts. (See Annex 1 for a more detailed version of the definitions of adolescent, young and youth). Like this table shows, although there seems to be a consensus to define the "adolescence" concept as young people aged between 10 and 19 years, the same cannot be said for the "jeune" and "jeunesse" concepts for which the terms young people and youth are used variably. In fact, the United Nations uses the terms "youth "and "young people" interchangeably [14]. WHO, UNICEF and UNPFA use them differently. Indeed, in its document entitled Adolescent Health in the African Region [17], WHO defines young people as people aged between 15 and 24 years and youth as people aged between 10 and 24 years.

Table 2.1 : Definitions of the Adolescent, Young and Youth Concepts

No	Definitions	Source
1.	Adolescents : 10-19 years Early adolescence : 10-14 years Late adolescence: 15-19 years Young people : 15-24 years Youth : 10-24 years	WHO [13]
2.	Youth : 15- years	UN Secretariat/UNESCO/ILO [14]
3.	Youth : 15-32 years	Agenda 21 [14]
4.	Adolescent : 10-19 years Young people : 15-24 years Youth : 10-24 years	WHO [13] UNICEF/WHO/UNFPA [14]
5.	Child up to 18 years	UNICEF/Convention on Human Rights of the Child [14]
6.	Youth: 15-35 years	The African Youth Charter [14]

2.1.2 Difficulties with the Definition of the "Adolescent", "Young" and "Youth" Concepts

As described in the Situation of Children in the World 2011 by UNICEF [19], it is difficult to give an exact definition of adolescence for several reasons.
First of all, it is widely acknowledged that each person goes through this period differently, depending on their physical, emotional and cognitive maturity as well as other factors. The beginning of puberty, which could appear as a clear demarcation line between childhood and adolescence, does not simplify matters.

In fact, puberty sets in at very different times for girls and boys, and for each person of the same sex. On the average, it begins 12 to 18 months earlier for girls than boys. The average age of the first menstruation is 12 years, while the first ejaculation generally occurs around 13 years. However, the first menses can appear right from age 8. Nevertheless, the facts show that puberty is beginning earlier than before: the puberty age of girls and boys has come forward by three years, as compared to the two previous centuries, mainly due to progress made in the area of health and the better quality of nutrition. In other words, girls, and indeed some boys, reach puberty and experience some of the main physiological and psychological changes associated with adolescence before the age determined by the United Nations (persons aged between 10 and 19 years). Similarly, it is not uncommon for boys to become pubescent at 14 or even 15 years, the age at which they have been sitting for two years in adolescent classes in their schools with girls and boys who are physically and sexually more developed than them.

The second factor which complicates any attempt at defining adolescence resides in the vast diversity of national laws which determine the minimum age threshold for participation in activities deemed to be reserved for adults, including the right to vote, marriage, military service, ownership of property and the consumption of alcohol. The age of "majority" is in

the same situation: it is the ideal age at which nations confer the status of adulthood on persons and require them to shoulder all responsibilities. Under the age of majority, a person is still considered to be a "minor". In many countries, the age of majority is fixed at 18 years, a situation which presents the importance of conformity with the ceiling of the child age bracket stipulated by Article 1 of the Convention on the Rights of the Child.

However, the age of majority is not the only factor which complicates the definition of adolescence in the various national jurisdictions because it often differs from the age at which persons are legally fit to carry out certain tasks associated with adulthood. This "age of consent" can vary depending on the activities, and there is no universal standard on the matter. In the United States, for example, where the age of majority is fixed at 18 years, adolescents have the right to drive at 16 in most States. On the other hand, young adults must generally wait until they attain 21 before they can buy alcohol. The legal marriage age can also vastly differ from the age of majority. Many countries distinguish the age at which it is legally possible to get married and the age (lower) at which marriage is allowed with the authorization of parents or that of a court. It should be noted that in some West African countries, the minimal marriage age is lower than the age of majority, particularly in the case of girls (for example: Burkina Faso, Mali, Niger and Senegal).

The following is the third difficulty raised by the definition of adolescence: whatever the legal threshold separating childhood and adolescence from adulthood, many adolescents and young children in the world are engaged in adult activities like work, marriage, domestic chores and participation in conflicts, all of which are roles which deprive them of their childhood and adolescence. In practice, the laws on the legal marriage age are widely infringed upon generally by men who desire to marry young girls who are still minors. Cultural norms are also responsible for the perpetuation of early marriages. It is not limited to the individual desires of some men, but rather caused by social and cultural norms.

In conclusion, the definition of the concepts of adolescence and youth is, therefore, a challenge. In this report, we shall adopt the concepts as defined by WHO, in view of the fact that "health" is our main working framework. The following are the definitions adopted in this report: Adolescent: Young people aged between 10 and 19 years; Young people: Young people aged between 15 and 24 years and Youth: Young people aged between 10 and 24 years.

2.2 ADOLESCENT AND YOUTH HEALTH STATUS WITHIN ECOWAS: MORTALITY, MORBIDITY AND DALY

2.2.1 Situation at the Global Level

In spite of the fact that it is generally considered as a healthy period of life, adolescence is indeed plagued by very high mortality and morbidity rates. However, most of these deaths and diseases could be avoided or treated. The lack of prevention or treatment of the most frequent causes of morbidity and mortality during adolescence does not only compromise the lives of many young people, but also imposes a burden on the future. Indeed, modes of life and behavioural patterns which have unfortunate life-long consequences often begin during adolescence.

2.2.1.1 Adolescent Mortality

According to the WHO Report on adolescent health published in 2014 [3], 1.3 million adolescents died in 2012 around the world. These deaths are mainly due to avoidable or treatable causes. Mortality is higher among boys than girls and among older adolescents (15-19 years) than among the younger ones (10-14 years). Although many causes of mortality are the same for girls and boys, the problem of violence is the most frequent for boys, while pregnancy is the main cause of death among girls.

A. Mortality Rate among Adolescents aged between 10 and 19 Years

Table 2.2 illustrated by Chart 2.1, taken from the 2014 WHO Report, shows the mortality rates for adolescents aged between 10 and 19 years in 2012 in the WHO Regions.
A study of this table shows that adolescent mortality continues to be high in the WHO Africa Region. In fact, it increased from 34% to 43% between 2000 and 2012 [3]. Just like the other WHO regions, the mortality rate in the African Region is higher among boys than girls.

Table 2.2: Mortality Rate among Adolescents aged between 10 and 19 Years in WHO Regions (for all causes) Year 2012 (for 100,000 Adolescents aged between 10 and 19 Years)

WHO Regions	Mortality Rate Overall	Mortality Rate Girls	Mortality Rate Boys
Africa	282.5	275.3	289.5
Eastern Mediterranean	118.3	100.9	135.0
South East Asia	102.3	100.7	103.9
The Americas	77.5	47.4	106.6
Europe	57.4	43.5	70.6
Western Pacific	43.6	36.3	50.2
High-Income Countries	31.0	19.9	41.4
World	110.7	102.2	118.7

Source : Report: Health for Adolescents in the World [3]

B. Causes of Death by Sex among Adolescents at the Global Level

Chart 2.1 presents the first 10 causes of death among adolescents aged between 10 and 19 years in the world in 2012. The following salient points emerge from this chart:

- road accidents were the first cause of adolescent mortality in 2012 and claimed about 330 lives a day;
- HIV-AIDS was the second cause of death among adolescents in the world, and
- the other main causes of mortality are suicide, lower respiratory infections and inter-personal violence.

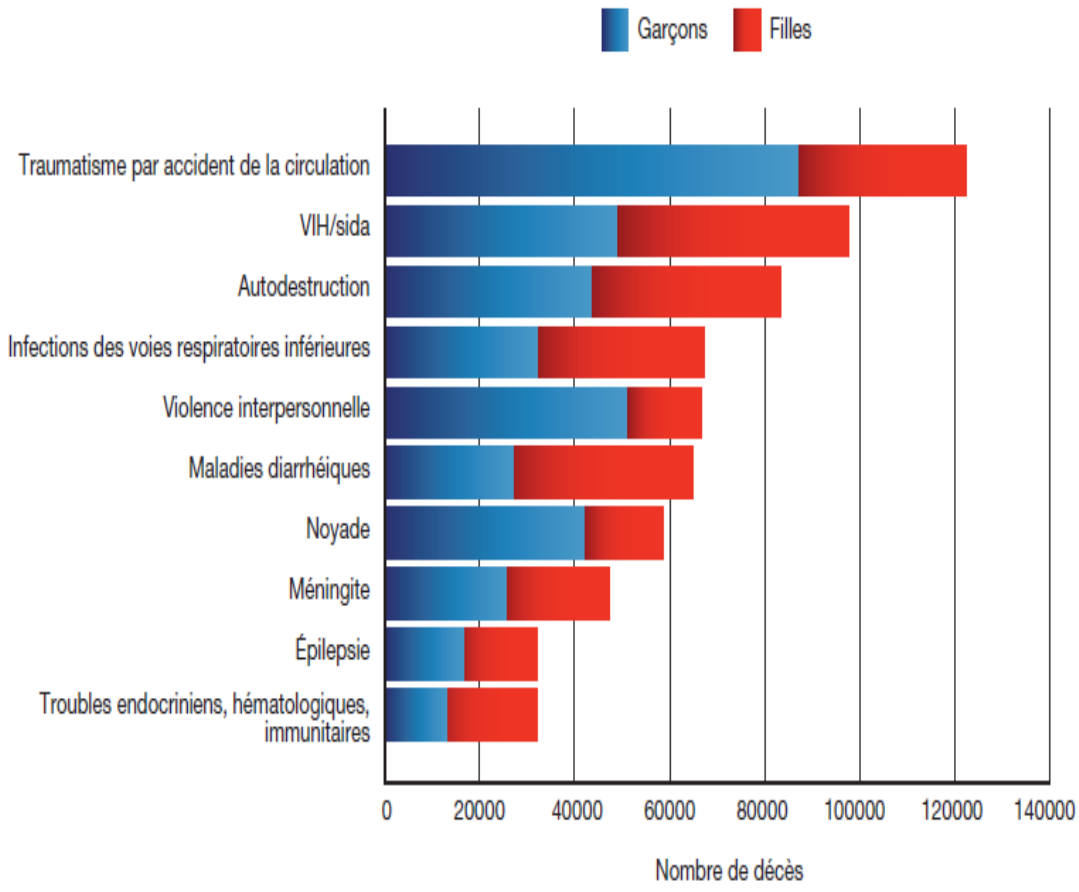


Chart 2.1: First 10 Causes of Death among Adolescents, by Sex

C. Common Points and Differences between the WHO Regions

Table 2.3 summarizes the characteristics of mortality among adolescents aged between 10 and 19 years in the WHO Regions. This information was taken from the 2014 WHO Report on Adolescents. With regard to the African WHO Region, note is taken of the predominance of HIV, road accidents and pregnancy complications as the main causes of adolescent mortality.

Table 2.3: Characteristics of Adolescent Mortality in the WHO Regions

Common Points and Regional Differences	Causes of Mortality	Characteristics
Common Points between Regions	Involuntary Traumas	Major cause of mortality and incapacity and adolescents. - Road accidents are among the first 5 causes of adolescent deaths in all the Regions, all ages and both sexes, except among female adolescents in Africa. - Drowning is also an important cause of adolescent deaths in all regions, except Africa.
	Pregnancy and delivery complications	Pregnancy and delivery complications are the second cause of mortality in the world among young girls aged between 15 to 19 years. The rate of 34 for 100,000 observed in the African Region is the highest among all the WHO Regions.
	Suicide	Main cause of mortality among adolescents aged between 15 and 19 years. - Suicide is among the first 5 causes of mortality in all the regions, except Africa.
	Infectious diseases (other than HIV-AIDS)	Lower respiratory infections are among the first 5 causes of death in all the regions, except in the high-income regions and the Western Pacific. Diarrheal diseases are particularly frequent among the 10-14-year age bracket. All respiratory infections and meningitis account for 21% of all adolescent deaths in the African Region.
Regional Differences and Variations	HIV	The African Region has by far the highest adolescent mortality rates, HIV accounts for 16% of deaths and 90% of deaths linked to HIV among adolescents in the world.
	Inter-personal violence	Violence is a major cause of death. At the global level, some 30% of young girls aged between 15 and 19 years are subjected to violence by their partners.
Distinctive Regional Characteristics		• 1 death out of 3 among male adolescents in the Region of the Americas is due to inter-personal violence. • 1 death out of 5 among adolescents in high-income countries is due to road accidents. • 1 death out of 6 among adolescents in the African Region is due to HIV.
Variations by Age and Sex		- Mortality is slightly high for the 15-19-year age brackets, compared to those of the 10-14-year brackets (127 and 94 for 100,000 respectively). This same trend was observed in the past and continues up to the 20-24-year brackets.

		- Compared to girls, the mortality rates are consistently high for boys; they are often substantially high, except for the 10-14-year brackets in the African Region. - The mortality rates which are often high among boys further reflect deaths due to road accidents and inter-personal violence.

2.2.1.2 DALY among Adolescents

A. DALY Rate among Adolescents aged between 10 and 19 Years

DALY (Disability Adjusted Life Years) is a measurement of the years of healthy life lost due to illness, incapacity or premature mortality. They estimate the differential between the current health status and the ideal health status for an entire population living up to an advanced age without suffering illness or infirmity. DALY is, therefore, a measurement of the years of life in perfect health which have been lost. DALY is calculated as the sum of years of potential life lost (Years of Life Lost –YLL) due to premature mortality and years of productive life lost due to incapacity (YLDs = Years Lived with Disability).

The method used is that of the Global Burden of Disease. DALY incorporates the notions of mortality and morbidity and constitutes a particularly useful basis to define public health priorities during adolescence. By combining data on morbidity and mortality, it indicates the total impact of adolescent health problems and health behavioural patterns during life and on public health in general [3].

According to the 2014 Report, between 2000 and 2012, at the global level, DALYs reduced from 165 to 152 for a population of 1,000 [3].

Table 2.4 shows the DALY rates in the WHO Regions in 2012. This table shows that the African Region recorded the highest DALY rates of the world in 2012. Lower rates were recorded in the Western Pacific Region and the Americas.

Table 2.4: DALY Rates in the WHO Regions in 2012

WHO Regions	DALY Rates for 1,000
Africa	300
Eastern Mediterranean	165
South East Asia	148
The Americas	125
Europe	111
Western Pacific	84
High-Income Countries	84
World	152

Source: Report: Health for Adolescents in the World [3]

B. Causes of DALY among Adolescents, by age and by sex

With the exception of HIV, the main causes of DALY among adolescents hardly witnessed any change between 2000 and 2012. Chart 2.2 presents the first 10 causes of DALY in the world in 2012. This chart shows that the first 5 causes of DALY among adolescents are: depression, road accidents, iron deficiency anaemia, HIV-AIDS and self-destruction. This structure of the causes of death (or sickness) varies in the various WHO regions, particularly in the AFRO Region.

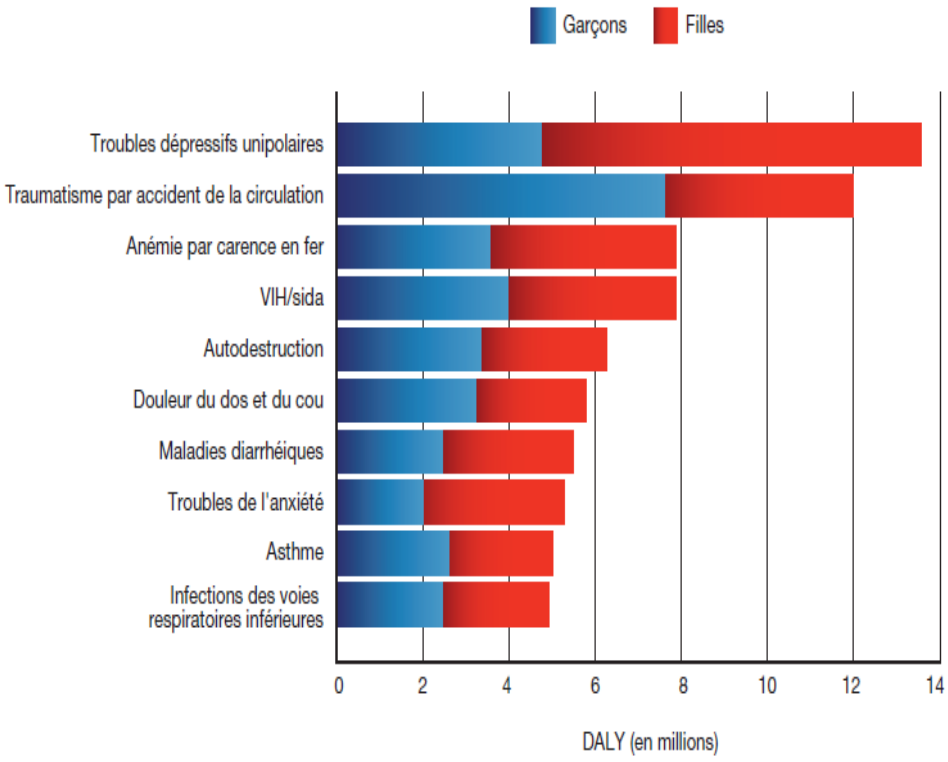


Chart 2.2: First 10 Causes of DALY among Adolescents, by sex

C. Common Points and Differences between WHO Regions

Table 2.5 summarizes the characteristics of DALYs among adolescents aged between 10 and 19 years in the WHO Regions. This information is taken from the 2014 WHO Report on adolescents. This table brings out the WHO Regions' similarities and differences by sex and age, on the one hand, and the similarities and differences between the regions and causes, on the other hand.

With regard to the WHO Africa Region, note is taken of the predominance of HIV, road accidents and pregnancy complications as the main causes of DALY.

Table 2.5: Characteristics of DALY in the WHO Regions

Common Points and Regional Differences	Causes of DALY	Characteristics
Similarities and differences: sex and age		- There are similarities and differences between boys and girls, on the one hand, and between the 10-14-year age brackets and the 15-19-year age brackets, on the other hand: This has policy, strategic and programming implications. For example, risky health behavioural patterns like the use of alcohol are predominant among boys, while pregnancy complications commence during the 15-19-year period. - At the global level, DALY is generally slightly higher among boys than girls.
Similarities and differences between regions and causes	HIV-AIDS	- Predominance of HIV in the African Region.
	Depression	- Depression is among the first 3 causes of DALY in all the regions, except the African Region.
	Road accidents	- Road accidents are the first cause of DALY among adolescents aged between 15-19 years in all the regions and, to some extent, for the 10-14-year age brackets. - The rates are substantially higher for boys than for girls in these two age brackets. - The highest rates were recorded in the African Region. - The use of alcohol by adolescents and young people is a predisposing factor.
	Violence and self-destruction	- Violence is the second cause of DALY in all of the regions among adolescents aged between 15 and 19 years, but is the first cause of DALY in the Americas Region.
	Alcohol and substances	- The use of alcohol is among the first 5 causes of DALY among boys aged between 15 and 19 years in the following 4 Regions: Americas, Western Pacific, Europe and high-income countries where it is the first cause.
	Pregnancy complications	- **Among girls aged between 15 and 19 years, pregnancy complications are the third cause of DALY in 2012, accounting for 5%.** - **In the African Region, they place second with an estimated DALY rate of 26 for 1,000.**

2.2.2 Situation within ECOWAS

The health status of adolescents and young people in the WHO Africa Region described in the previous section says a lot about the health status of adolescents and young people within ECOWAS. Unfortunately, since the World Report on Adolescents does not provide details on a country-by-country basis, we shall, in this section, content ourselves with some data found in the literature on the health status of adolescents and young people within ECOWAS.

2.2.2.1 Adolescent and Youth Mortality

Since they are an integral part of the WHO Africa Region, ECOWAS countries experience the same realities as the Region with regard to adolescent and youth mortality. The main causes of adolescent and youth mortality in the Region as seen in the previous section are as follows: HIV, road accidents and pregnancy complications.

A. Pregnancy and Delivery Complications

According to WHO [20], pregnancy among female adolescents remains one of the main factors of mother and child mortality and contributes to the vicious cycle of poor health and poverty. In fact, nearly 16 million young girls aged between 15 and 19 years and some 1 million young girls under 15 give birth every year – most of them in low-income or middle-income countries. This way, pregnancy and delivery complications are the second cause of death among young girls aged between 15 and 19 years in the world. Unsafe abortions top these complications. Indeed, every year, nearly 3 million young girls aged between 15 and 19 years have unsafe abortions which constitute a serious public health problem in Sub-Saharan Africa. Table 2.6 summarizes the information on unsafe abortions in Sub-Saharan Africa taken from the 2008 WHO Report on Unsafe Abortions among Women aged between 15 and 44 years (most recent found report). This report shows that Sub-Saharan Africa accounts for 25% of the number of unsafe abortions in the world and 61% of maternal deaths due to unsafe abortions. The abortion rate is more than double that of the world; the same can be said for the rate of lethality linked to unsafe abortions.

According to WHO, nearly 60 % of unsafe abortions in Africa concerns women below the age of 25 years and nearly 80 % of women below the age of 30 years [21,22].

Table 2.6: Incidence of Mortality due to Unsafe Abortions in Sub-Saharan Africa in 2008

	Incidence of Unsafe Abortions		Mortality Linked to Unsafe Abortions			
	Number of unsafe abortions	Rate of unsafe abortions (for 1,000 women aged between 15 and 44 years)	Number of maternal deaths due to unsafe abortions	Ratio of mortality due to unsafe abortions (for 100,000 live births)	% maternal deaths due to unsafe abortions	Rate of lethality linked to unsafe abortions (deaths for 100,000 abortions)
Sub-Saharan Africa	5 510 000	31	28 600	90	14	520
World	21 600 000	14	47 000	30	13	220
% Sub-Saharan	25,5		60,9			

Africa /World						

Source: [20]

B. Mortality due to HIV and Road Accidents

HIV and road accidents occupy a very important position and are part of the main causes of adolescent and youth mortality in the WHO Africa Region. Although we do not have direct data on adolescents and young people in the ECOWAS region, we shall use as a proxy the situation of the general population to at least show the background in which adolescents and young people live in each of its countries with regard to deaths linked to HIV and road accidents.

Table 2.7 presents the estimate of the number of deaths due to HIV/AIDS and the number of deaths through road accidents in the 15 countries of the ECOWAS region.

This table shows that with regard to HIV-AIDS, adolescents and young people in Cape Verde live in an environment where prevalence and death are low; on the other hand, those living in Cote d'Ivoire, Guinea-Bissau, Nigeria and Togo live in an environment where prevalence and death are high.

This table shows that with regard to road accidents, adolescents and young people in the ECOWAS region live in an environment where the rates of mortality linked to accidents are very high. The situation appears to be more worrying in Liberia, Togo, Burkina Faso and The Gambia.

Table 2.7: Estimate of the Number of Deaths due to AIDS and the Rate of Deaths due to Road Accidents for 100,000 inhabitants

Country	Adult HIV Prevalence (aged between 15 and 49)*(2012)	Estimate of Number of Deaths due to AIDS* (in 2012)	Estimate of Rate of Deaths from Road Accidents for 100,000 inhabitants**
1. Benin	1.1	3100	27.7
2. Burkina Faso	1.0	5500	30
3. Cape Verde	0.2	<100	26.1
4. Cote d'Ivoire	3.2	31000	24.2
5. Gambia	1.3	<1000	29.4
6. Ghana	1.4	12000	26.2
7. Guinea	1.7	5100	27.3
8. Guinea-Bissau	3.9	2300	27.5
9. Liberia	0.9	1700	33.7
10. Mali	0.9	4900	25.6
11. Niger	0.5	3400	26.4
12. Nigeria	3.1	240000	20.5
13. Senegal	0.5	1900	27.2
14. Sierra Leone	1.5	3300	27.3
15. Togo	2.9	7200	31.1

Source: * 2013 UNAIDS Report (23]

** Global Report on Road Accidents [24]

2.2.2.2 Adolescent and Youth Morbidity

Morbidity is important for the determination of the health priorities of adolescents and young people. Although there is scanty specific information on adolescent and youth morbidity within ECOWAS, we were able to obtain something. Data on morbidity permit a certain estimate of the high number of non-fatal disease conditions which develop during adolescence owing to the use of demographic and health survey reports (DHS) and multiple indicator surveys. In this section, we have presented information on four morbidity situations within ECOWAS: Sexually transmitted infections, HIV-AIDS, nutrition and anaemia.

A. Prevalence of Sexually Transmitted Infections

Population and health surveys and multiple indicator surveys conducted in the various countries of the ECOWAS region enabled an assessment of a "reported prevalence" of sexually transmitted infections (STIs). Respondents who have already had sex were requested to state whether, in the course of the 12 months preceding the survey, they had contracted an STI or symptoms associated with the presence of these infections (abnormal and foul-smelling discharges, genital sores/ulcers for girls and penile discharges, genital sores/ulcers for boys). The results for women and men who have already had sex are presented in Table 2.8.

- **Case of Girls**

The study of the data on girls presents the following salient points:

- The percentage of girls who have reported having contracted an STI varies from 0.8 % (Senegal) to 31% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 6 out of 13 countries.
- The percentage of girls who have reported having had abnormal and foul-smelling vaginal discharges varies from 4.5 % (Gambia) to 42.7% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 11 out of 13 ECOWAS countries.
- The percentage of girls who have reported having had genital sores or ulcers varies from 2.5 % (Benin) to 37.1% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 7 out of 13 ECOWAS countries.
- The percentage of girls who have reported having contracted an STI or had a sore or an ulcer varies from 6.6% (Niger) to 53.7% (Liberia).These percentages exceed 5% (hence a relatively substantial incidence) in 13 out of 13 ECOWAS countries.

It should be noted that the situation appears to be very worrying in Liberia.

- **Case of Boys**

The study of the data on boys presents the following salient points:

- The percentage of boys who have reported having contracted an STI varies from 0.2 % (Senegal) to 13.8% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 5 out of 13 ECOWAS countries.
  The percentage of boys who have reported having had penile discharges varies from 1.1 % (Burkina Faso) to 14.1% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 7 out of 13 ECOWAS countries.
- The percentage of boys who have reported having had sores or genital ulcer varies from 0.95 % (Senegal) to 8.4% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 4 out of 13 ECOWAS countries.

- The percentage of boys who have reported having contracted an STI, penile discharges, sores or ulcer varies from 1.7% (Burkina Faso) to 19.0% (Liberia). These percentages exceed 5% (hence a relatively substantial incidence) in 7 out of 13 ECOWAS countries.

Table 2.8 Declared Prevalence of Sexually Transmitted Infections (STIs) and Declared Symptoms of STIs among Women and Men aged between 15 and 24 Years

Country	Girls				Boys			
	One STI	Abnormal and Foul-Smelling Vaginal Discharges	Sore/ Genital Ulcer	STI/ Discharges/ Sore or Ulcer	One STI	Penile Discharges	Sore/ Genital Ulcer	STI/ Discharges/ Sore or Ulcer
1. Benin	3.3	7.4	2.5	9.9	7.5	6.7	4.3	12.6
2. Burkina Faso	3.4	9.6	3.2	11.0	1.0	1.1	1.0	1.7
3. Cape Verde								
4. Cote d'Ivoire	9.3	26.9	5.7	29.4	6.5	8.4	5.0	13.2
5. Gambia	1.8	4.5	4.7	7.8	1.0	1.6	2.4	4.2
6. Ghana	5.2	24.6	8.7	26.4	3.4	6.9	1.8	8.3
7. Guinea	6.8	399	11.7	41.8	7.1	9.8	5.3	14.2
8. Guinea-Bissau								
9. Liberia	30.9	42.7	37.1	53.7	13.8	14.1	8.4	19.0
10. Mali	13.2	21.4	11.2	27.7	3.9	7.8	2.7	9.9
11. Niger	1.6	5.4	3.1	6.6	1.2	2.8	0.4	2.8
12. Nigeria	3.2	6.1	3.7	8.0	1.8	2.8	1.5	4.2
13. Senegal	0.8	11.2	3.4	13.2	0.2	2.8	0.9	3.5
14. Sierra Leone	10.5	18.0	13.4	23.3	13.4	12.8	6.7	17.3
15. Togo	3.2	17.1	12.9	22.7	2.2	3.1	2.1	4.9

Source: Country DHS [25-39]

B. HIV Prevalence among Adolescents and Young People

Table 2.9 shows the prevalence of HIV in ECOWAS countries. As shown in this table, HIV prevalence ranges from <0.1% (Cape Verde) to 1.7% (Guinea-Bissau) among girls and <0.1% (Cape Verde, Liberia, and Niger) to 0.9% (Guinea-Bissau). In general, prevalence rates are higher for girls than for boys. This same trend of feminization of infection is also observed among the general population

Table 2.9: HIV Prevalence among Young People aged between 15 and 24 Years within the ECOWAS Region

Countries	**Girls**	**Boys**
	Percentage of youth aged between 15 and 24 years living with HIV, 2012 (UNAIDS Report 2013) [23]	**Percentage of youth aged between 15 and 24 years living with HIV, 2012 (UNAIDS Report 2013) [23]**
1. Benin	0.4	0.2
2. Burkina Faso	0.5	0.4
3. Cape Verde	< 0.1	< 0.1
4. Côte d'Ivoire	1.2	0.7
5. Gambia	0.5	0.2
6. Ghana	0.5	0.3
7. Guinea	0.8	0.4
8. Guinea-Bissau	1.7	0.9
9. Liberia	0.1	< 0.1
10. Mali	0.3	0.2
11. Niger	0.1	< 0.1
12. Nigeria	1.3	0.7
13. Senegal	0.3	0.1
14. Sierra Leone	1.0	0.3
15. Togo	0.9	0.5

Source: UNIADS Report 2013 [23]

C. Nutritional Status of Female Adolescents aged between 15 and 19 years

Nutritional status is one of the determinants of maternal mortality, smooth progress of pregnancies and their outcomes. It also affects the morbidity and mortality of young children. The nutritional status of women is dependent on the energy balance, their health status, the time that has elapsed since the last childbirth.

Table 2.10 shows the proportion of adolescent girls in the 15-19 age-brackets with chronic energy deficiency and the proportion of adolescent girls who are overweight or obese in the ECOWAS countries.

This table shows the proportion of adolescent girls aged between 15 and 19 years with chronic energy deficiency which ranges from 11.8% (Togo) to 34.5% (Senegal). In 10 of the 13 countries where data are available, the proportion of adolescent girls with chronic energy deficiency exceeds 15%. Furthermore, it can be noticed that the proportion of adolescent girls aged between 15 and 19 years who are moderately and severely thin ranges from 3.5% (Côte d'Ivoire and Togo) to 18.4% (Niger). In 8 of the 13 countries with available data, the proportion of adolescent girls who are moderately thin is over 5%.

Although still in a lesser proportion, there is also a tendency towards overweight among adolescent girls in ECOWAS countries. Table 2.10 shows that the proportion of overweight adolescent girls aged between 15 and 19 years varies from 11.8% (Togo) to 2.7% (Senegal). In 10 of the 13 countries where data are available, the proportion of adolescent girls with chronic energy deficiency is over 15%.

Table 2.10: Nutritional Status of Feamle Adolescents aged between 15 and 19 years, ECOWAS countries

	Body Mass Index <18.5 (Total (thin)	Body Mass Index <17 (moderately and severely thin)	Body Mass Index >=30.0 (Obese)
1. Benin	13.2	3.7	2.7
2. Burkina Faso	23.4	7.8	0.6
3. Cape Verde			
4. Côte d'Ivoire	16.4	3.5	1.4
5. Gambia	27.0	8.5	2.2
6. Ghana	16.2	4.3	1.6
7. Guinea	18.8	5.4	0.8
8. Guinea-Bissau			
9. Liberia	15.0	5.2	0.3
10. Mali	19.4	5.3	1. 3
11. Niger	30.5	18.4	1.1
12. Nigeria	23.1	9.3	1.1
13. Senegal	34.5	15.8	0.5
14. Sierra Leone	15.4	4.8	1.4
15. Togo	11.8	3.5	1.8

Source: Demographic and Health Surveys (DHS) of countries [25-39]

D. Prevalence of Anaemia among Women

Table 2.11 shows the prevalence of anaemia according to haemoglobin level among adolescent girls aged between 15 and 19 years. A review of this table shows that anaemia has a high prevalence among adolescent girls in the ECOWAS Region. Indeed, the proportion of adolescent girls aged between 15 and 19 years with anaemia varies from 34.2% (Cape Verde) to 63% (Ghana). In 11 of the 12 countries with available data, the proportion of adolescent girls with anaemia is over 40%.

Table 2.11: Anaemia depending on Hemoglobin Level: Percentage of Anaemic Female Adolescents aged between 15 and 19 years

Countries	Anaemia (NP <12.0 g/dl / P <11.0 g/dl)	Severe (NP < 7.0 g/dl / P < 7.0 g/dl)
1. Benin	41.6	0.2
2. Burkina Faso	47.9	1.5
3. Cape Verde	34.2	0.5
4. Côte d'Ivoire	53.9	0.3
5. Gambia	58.2	1.5
6. Ghana	63.0	1.8
7. Guinea	47.1	1.0
8. Guinea-Bissau		
9. Liberia		
10. Mali	50.8	1.8
11. Niger	46.0	0.9
12. Nigeria		
13. Senegal	55.5	2.3
14. Sierra Leone	49.5	0.6
15. Togo	54.7	1.3

Source: Demographic and Health Surveys (DHS) of countries [25-39]

2.3 ANALYSIS OF ADOLESCENT AND YOUTH HEALTH SOCIAL DETERMINANTS

According to *Le Petit Robert [40]* Dictionary, society is defined, among other things, as "a group of individuals among whom there are lasting and organized relationships, most often established in institutions and guaranteed by sanctions, human environment in relation to individuals , a set of forces of the environment acting on individuals (social constraints)".

The social context in which adolescents and youth live largely determines their health status. The social determinants of health are the circumstances in which individuals are born, grow, live, work and age as well as the systems put in place to deal with disease. These circumstances, which reflect political choices, depend on the distribution of power, money and resources at all levels, global, national and local. [16] Within countries there are very wide differences in health status that are closely linked to social condition. These health

inequalities, which could be avoided, stem from the circumstances in which individuals grow, live, work and age, and the healthcare systems available to them. In turn, the conditions under which people live and die depend on political, social and economic forces. Social and economic policies largely determine the chances of a child to develop fully and lead a totally fulfilled life.

Countries provide adolescents and the youth with systems and structures of opportunity as they grow. Since health and health behaviours develop from adolescence (and even childhood) to adulthood, the way in which these systems and structures of opportunity affect the health of adolescents and the youth is important for the health of the entire population of the country. Critical structural factors or determinants that affect the health of populations in general, and adolescents and the youth in particular, include political and economic systems, the country's wealth and especially its distribution within the country, the education system including access to education, healthcare delivery system including access to healthcare, job opportunities for the youth, poverty, migration and homelessness, and cultural factors such as gender inequality, gender and ethnicity, as well as factors such as wars or conflicts and climate change [11, 15].

In this section, we will examine the social context in which adolescents and the youth live in the ECOWAS Region. After presenting an anthropological perspective of adolescence and society, we will analyze 1) structural social determinants, 2) local social determinants related to family, school and adolescents or young people.

2.3.1 Adolescence and Society: Anthropological Perspective

As Emmanuelli observed in his book *"L'adolescence"* (Adolescence)[42], little has been said about adolescence for centuries, quite on the contrary, today it is increasingly being talked about. Since the end of the nineteenth century, adults have made adolescence the cause of concern, agitation, and violence. In 1904, Stanley Hall published the first book of psychology of the adolescent, which constitutes an important summary. Its conception of development is nevertheless marked by the ideas of the nineteenth century and is inspired by the theory of evolution. It places a high premium on the biological nature, while going over again the romantic concept of a tumultuous adolescence, plagued by stress and conflict, where enthusiasm, hotheadedness and also instability dominate: indeed, according to Stanley Hall it repeats the period of a tumult which, in the history of humanity, would have preceded the appearance of civilization. This point of view will for a long time mark American psychology. However, it is challenged by the advocates of cultural anthropology who, through the study of other societies, highlight the relativity of this description and the fundamental role played by culture [42].

Cultural anthropology is based on field surveys carried out in societies whose social organization and culture are different in order to discern, for example, the part of the constructions of the mind in relation to the reality of biological facts: This is how Margaret Mead studies education in the Samoa Islands, then in New Guinea, societies that were then protected from Western influences [42].

The study of the adolescence process of young girls in the Samoan Islands is presented from the introduction onwards as the use of the anthropological method to challenge recent

psychological theories which, in the face of manifestations of unease presented by American adolescents at the beginning of the 20th century, propose to explain them by the unavoidable characteristics of age [42].

Mead questions Hall's point of view which presents adolescence as "the era of life when idealism blossoms, rebellion against all authority takes shape, clashes and conflicts are inevitable", and does so by revealing the central role of social factors on what is happening in that period. In this book she describes, among Samoans, a society in which adolescence "is not necessarily a strained and tormented period," and in which physiological puberty is not inevitably generating conflicts [42].
She is concerned about proposing a reflection that throws light on the American educational methods, so she compares the two civilizations, and explains the conflicts and the unease presented by the American adolescents after 1918 by a social evolution which plunges them, at various levels, into the contradiction: “Tension, constraints are in our civilization itself; they are not the consequence of the physical transformations that children undergo ". The choices facing the American youth, and which place this generation in a position of breaking off relations with the previous generation, the contradictions exhibited by a society which no longer agrees, as in primitive societies, on a single lifestyle model, economic and social pressures and the rigidity of sexual morality, explain to him the psychological difficulties of American adolescents in the early twentieth century [42].

This work, coupled with the various and sometimes contradictory contributions of Malinowski, Roheim, Bateson and Maurice Godelier just recently, have indeed highlighted the role society plays in the way adolescents tackle this period, in the variable duration given to such period, and have shown the diversity of the means by which societies mark this essential transition between two periods of life: one asexual, according to traditional society, and the other marked by access to the world of sexual relationship [42].

The duration of the transitional phase - adolescence - varies according to culture, and "responds to a period of prolonged subordination created to satisfy the demands of the ruling class, adults", as is the case observed in many animal societies. In most of them, there is indeed the need to find facilities to manage the youth of the group from the crucial moment of puberty: their access to reproductive capacities leads to variable responses ranging from integration, maintaining hierarchical dependency, excluding the youth [42].

Such an observation does not contradict the idea proposed by psychoanalysis, according to which adolescence constitutes an important stage in the reactivation of conflicts, which engages the need for psychological elaboration in the young subject. But traditional societies have, in the majority of cases, set up rites symbolically marking the passage from childhood to adulthood: these initiation rites introduce adolescents into adult society, in a way that is controlled by the adults. In doing so, they maintain individual psychological work by serving as a framework for socialized expression to the conflicts inherent in this transitional period between the world of childhood and the adult world. Through the play of symbolization, they offer psychological adjustments to the anxiety of castration that the access to sexual maturity entails, and the problem of separation. The rare absence of these rites is, in some cases, compensated for through the social organization of adolescent groups, which also underlines the special status accorded to this age group because of its specificity explicitly or implicitly recognized by societies [42].

In industrialized societies, certain experiences such as the certificate of studies, religious rites and military service have for a time taken the place of initiation rites because of their symbolic significance. Their individual character and their heterogeneity do not, however, allow the registration into a symbolism that the social body bears, which gives an increased importance to the family and its network of interactions with the adolescent. The disappearance of rites results in a failure of the representation processes: it can be seen as a factor of destabilization of adolescents, left on their own to face conflicts and by using their own initiation rites such as wandering or using drugs. Mental illness itself may be valued as a ritual by some adolescents [42].

2.3.2 Analysis of the Structural Social Determinants of Adolescent and Youth Health in ECOWAS countries

It should be recalled that structural social determinants are defined as "the way in which a society is organized with regard to social, economic and political context". The different parameters include: 1) colonial heritage and the previous history of social movements, 2) demography, 3) economy, 4) health system, 5) education, 6) employment, 7) the physical environment, (8) culture, and (9)) health equity.

2.3.2.1 Colonial Legacy, Antecedents of Conflicts and Antecedents of Social Movements in ECOWAS Countries

The colonial past of African countries in general and that of the ECOWAS countries in particular has left marks that can influence the health of populations in general and that of adolescents and youth in particular. Indeed, in most African countries the health system, and education, to name but a few, depend greatly on the systems of the colonizing countries. The same applies to the previous history of conflicts. The detrimental effects of armed conflict on the lives of adolescents and youth are widely described [2, 14].

Among the major threats to childhood - violence, ill-treatment and exploitation - many are particularly exacerbated during adolescence. Adolescents are the first to be enlisted in conflict (child soldiers) or forced to work under hazardous conditions (child labourers) [19].

Social movements in schools and universities, such as strikes, expose adolescents and youth to risky situations (debauchery, prostitution, etc.). But these aspects are not well documented in literature [44, 45].

Table 12.2 shows that 8 of the 15 ECOWAS countries inherited the Francophone system, 5 from the Anglophone system and 2 from the Portuguese-speaking system. Similarly, one third of the ECOWAS countries have a previous history of conflicts (the last two decades).

Table 2.12: Colonial Legacy, and Antecedents of Social Conflicts in ECOWAS Countries

Countries	Anglophone	Francophone	Portuguese-speaking	Previous History of Conflicts in Sub-Saharan African Countries
1. Benin		YES		
2. Burkina Faso		YES		
3. Cape Verde			YES	
4. Côte d'Ivoire		YES		YES
5. Gambia	YES			
6. Ghana	YES			
7. Guinea		YES		YES
8. Guinea-Bissau			YES	YES
9. Liberia	YES			YES
10. Mali		YES		
11. Niger		YES		
12. Nigeria	YES			
13. Senegal		YES		
14. Sierra Leone	YES			
15. Togo		YES		YES
Total	5	8	2	5

2.3.2.2 Demography of Adolescents and Young People in ECOWAS Countries

The characteristics of the population are essential for understanding the nature and functioning of societies and communities; they are also insightful points for the study of a population. For example, age structure-the comparative size of specific age groups for a population as a whole-does not only show the absolute or relative size of each population group, but can also potentially reveal a lot of information on the history of the population, present and future political, economic and security challenges of the countries [46].

This section of the report explores the age and sex structure of adolescents and young people in the ECOWAS Region.

A. Demographic characteristics of the populations of the ECOWAS Region

Africa is the continent with the youngest population in the world. The youth make up the largest proportion of the population in sub-Saharan Africa, with more than one third of the population aged between 10 and 24 years. In addition, Sub-Saharan Africa is the only region in the world where the number of young people continues to grow substantially. By 2025, the number of young people (aged 10-24 years) in Sub-Saharan Africa is expected to increase to 436 million; the population is expected to increase further to 605 million by 2050. Although this scenario presents challenges, with the right investments, nations have an unprecedented

opportunity to capitalize on the potential of their young population in order to strengthen economic growth and national development [4].

Table 2.13 shows the main demographic variables of adolescents and young people in the 15 ECOWAS countries. As in Sub-Saharan Africa, the youth constitute the largest proportion of the population in the ECOWAS Region, with more than a third of the population aged between 10 and 24 years in all 15 countries in the region. Indeed, the percentage of the population aged between 10 and 24 years estimated in 2014 [1] varies from 31% to 33% in the ECOWAS Region. The highest percentage was recorded in Burkina Faso.

It has also been observed that the total fertility rate varies from 2.3 to 7.6. Cape Verde has the lowest index while Niger has the highest. In all the 15 countries, life expectancy at birth is higher among women, compared to men. The greatest disparity in life expectancy was observed in Cape Verde: 71 years for men as against 79 years for women.

Table 2.13: Demographic Characteristics of Adolescents and Young People in the 15 ECOWAS Countries

Countries	Total Population (in millions) 2014	Population aged between 10 and 24 years (in millions) 2014	Population aged between 10 and 24 years (in %) 2014	Total Fertility Rate, 2010-2015	Life Expectancy at Birth,	
					Men	Women
1. Benin	10.6	3.4	32	4.9	58	61
2. Burkina Faso	17.4	5.7	33	5.7	55	57
3. Cape Verde	0.5	0.2	32	2. 3	71	79
4. Côte d'Ivoire	20.8	6.7	32	4.9	50	51
5. Gambia	1.9	0.6	32	5.8	57	60
6. Ghana	26.4	8.3	31	3.9	60	62
7. Guinea	12	3.9	32	5.0	55	57
8. Guinea-Bissau	1.7	0.6	32	5.0	53	56
9. Liberia	4.4	1.4	32	4.8	59	61
10. Mali	15.8	5.0	32	6.9	55	55
11. Niger	18.5	5.7	31	7.6	58	58
12. Nigeria	178.5	55.5	31	6.0	52	53
13. Senegal	14.5	4.7	32	5.0	62	65
14. Sierra Leone	6.2	2.0	32	4.8	45	46

15. Togo	7.0	2.2	32	4.7	56	57
Total	336.2	105.9				

Source: Report: Status of the population 2014 [1]

- **Proportion of adolescents and young people in ECOWAS countries per age bracket of 5 years and implications**

In most Sub-Saharan African countries, the 10-14 age-bracket is the largest among the three five-year age groups that constitute the entire group of "young people". This trend is the same in countries in all the sub-regions of Sub-Saharan Africa. -West Africa, Central Africa, East Africa, and Southern Africa

Table 2.14 shows the proportions of adolescents and young people in the ECOWAS countries according to the three five-year age groups. These data were extracted from the Demographic and Health Survey reports of the 15 ECOWAS countries [25. to 39]. Like Sub-Saharan Africa, the 10-14 age-group is the largest in all 15 countries. The highest proportions were found in the following countries: Mali, Guinea, Niger and Cape Verde.

This demographic trend has implications for current and future development. Very young adolescents (10 to 14-year-olds) are still considered as dependants that need access to the education system, health and other social services, yet their needs are not taken into account in policies and programmes. On the one hand, this group is not taken into consideration under programmes targeting children, such as immunization campaigns and efforts to enroll children in school. On the other hand, peer-education programmes and youth centers tend to attract older young people and hardly aim to meet the specific needs of very young adolescents. Given the fact that the size of this age group is likely to continue to increase in Sub-Saharan Africa in the coming decades, it will continue to put pressure on secondary education and health systems to provide services to this population [4].

Table 2.14: Proportion of adolescents and young people in ECOWAS countries per age bracket of 5 years

Countries	10-14 years	15-19 years	20-24 years	Source
1. Benin	14.9	8.3	6.4	DHS 2011-2012
2. Burkina Faso	14.1	8.5	7.1	DHS 2010
3. Cape Verde*	15	13.5	8.8	DHS 2005
4. Côte d'Ivoire	13.1	9	8.5	DHS 2011-2012
5. Gambia	12.6	10.3	8.8	DHS 2013
6. Ghana	13.1	10.2	7.9	DHS 2008
7. Guinea	15.1	9.1	6.8	DHS 2012
8. Guinea-Bissau	12.2	11.8	9.3	MICS 2010
9. Liberia	13.1	9.8	7.6	DHS 2013
10. Mali	15.3	7.2	5.7	DHS 2012-2013
11. Niger	15	6.3	5	DHS 2012

12. Nigeria	12.3	8.8	7.2	DHS 2013
13. Senegal	12.8	9.8	8.7	DHS 2010-2011
14. Sierra Leone	12.6	9.8	6.8	DHS 2013
15. Togo	14	8.5	7.4	DHS 2013-2014

- Cape Verde does not have a recent DHS

Source: DHS of countries [25-39]

- **Proportion by sex of adolescents and young people aged 10-24 years in ECOWAS countries**

Analysis by sex or gender analysis is important, inter alia, for studies of marriage markets, formation of family, and equity in access to health, education, labour market and income.

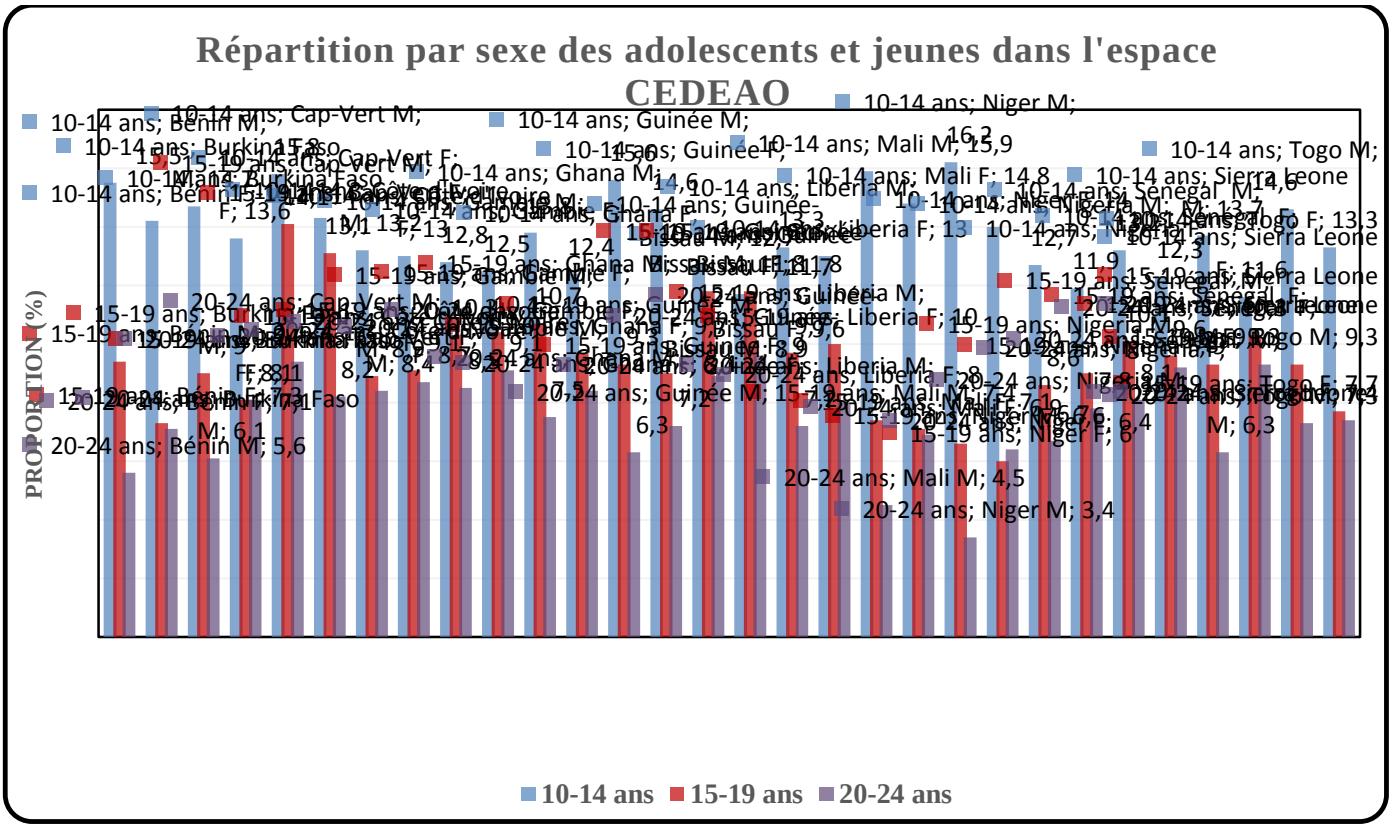
Table 2.15, illustrated in Figure 2.3, shows the proportions of adolescents and youth aged 10-24 in the ECOWAS countries by sex. The most salient fact in this table is the predominance of the proportions of adolescent girls in the age group of 20-24 years in 14 of the 15 countries of the ECOWAS Region. The only country that appears to be an exception is Cape Verde. This demographic trend has social and health implications. Indeed, young girls aged 20-24 are at the crossroads of their sexual and reproductive lives with all the possible consequences if they are not given a good support.

Table 2.15: Proportion by Sex of Adolescents and Young People aged between 10 and 24 years in ECOWAS countries

Countries	**Age Group**	**Male**	**Female**	**Source**
1. Benin	10-14 years 15-19 years 20-24 years	15.5 9.4 5.6	14.2 7.3 7.1	DHS 2011-2012
2. Burkina Faso	10-14 years 15-19 years 20-24 years	14.7 9.0 6.1	13.6 8.1 8.1	DHS 2010
3. Cape Verde	10-14 years 15-19 years 20-24 years	15.8 14.1 9.4	14.3 13.1 8.2	DHS 2005
4. Côte d'Ivoire	10-14 years 15-19 years 20-24	13.2 8.9 8.4	13.0 9.1 8.7	DHS 2011-2012

	years			
5. Gambia	10-14 years 15-19 years 20-24 years	12.8 10.3 8.5	12.5 10.4 9.1	DHS 2013
6. Ghana	10-14 years 15-19 years 20-24 years	13.8 10.7 7.5	12.4 9.7 8.4	DHS 2008
7. Guinea	10-14 years 15-19 years 20-24 years	15.6 9.3 6.3	14.6 9.0 7.2	DHS 2012
8. Guinea-Bissau	10-14 years 15-19 years 20-24 years	12.7 11.8 8.9	11.7 11.8 9.6	MICS 2010
9. Liberia	10-14 years 15-19 years 20-24 years	13.3 9.7 7.2	13.0 10.0 8.0	DHS 2013
10. Mali	10-14 years 15-19 years 20-24 years	15.9 7.4 4.5	14.8 7.1 6.9	DHS 2012-2013
11. Niger	10-14 years 15-19 years 20-24 years	16.2 6.6 3.4	14.0 6.0 6.4	DHS 2012
12. Nigeria	10-14 years 15-19 years 20-24 years	12.7 8.6 6.7	11.9 9.0 7.8	DHS 2013
13. Senegal	10-14	13.2	12.3	DHS 2010-

	years 15-19 years 20-24 years	10.1 8.1	9.6 9.2	2011
14. Sierra Leone	10-14 years 15-19 years 20-24 years	13.7 9.3 6.3	11.6 10.3 9.3	DHS 2013
15. Togo	10-14 years 15-19 years 20-24 years	14.6 9.3 7.3	13.3 7.7 7.4	DHS 2013-2014



Sources: DHS Country [25-39]

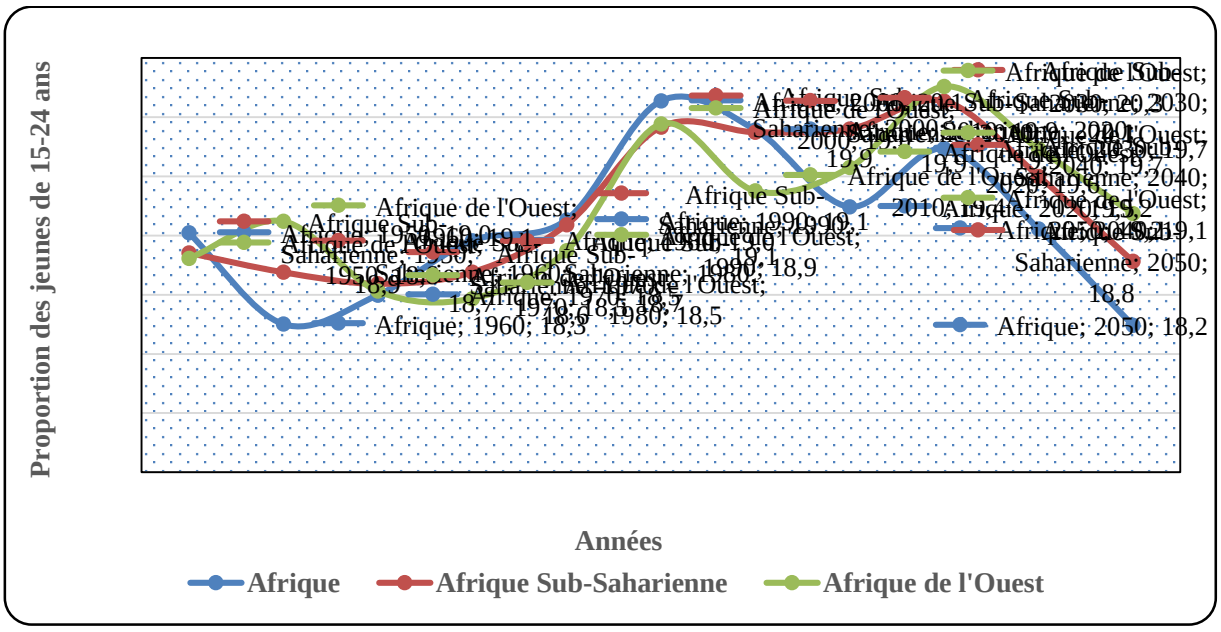
Chart 2.3: Proportion by sex of adolescents and young people aged between 10 and 24 years in ECOWAS countries

- **Trend of the total population and age group of adolescents and young people in the ECOWAS Region from 1950 to 2050**

    - **Trend of the proportion of young people aged between 15 and 24 years in Africa, Sub-Saharan Africa and West Africa from 1950 to 2050**

An analysis of the sound situation is not limited to a simple collection of facts describing the epidemiology, demography and health status of the population. It should encompass the full range of current health issues and potential future issues as well as their determinants. Thus, knowledge of the trend of the proportion of adolescents and young people aged between 10 and 24 years should help to anticipate current and future needs. Figure 2.4 and Table 2.16 show respectively the trend of the proportion of young people aged between 15 and 24 years in Africa and the trend of adolescents and young people aged between 10 and 24 years from 1950 to 2050.

The review of Figure 2.4 shows that the proportion of young people aged 15-24 years in Africa peaked in 2005 and is expected to begin a downward trend in the following decades and to accelerate after 2030. It is evident from Figure 2.4 that the decline is faster in North Africa, where it peaked in 2005 and began to decline in 2010. Sub-Saharan Africa, for its part, will only peak in 2025 and will begin to decline around 2035. However, on the whole, despite the general downward trend in the proportion of young people in Africa, their absolute numbers will be increasing. This trend is evident in Table 2.16 for the ECOWAS Region.



Source: African Youth [5]

Chart 2.4: Trend of the Proportion of African Populations aged between 15 and 24 years from 1950 to 2050

Table 2.16: Trend of the total population of adolescents and young aged between 10 and 24 years in the ECOWAS Region from 1950 to 2050

Countries	Trend of the total population and age group of adolescents in the ECOWAS Region from 1950 to 2050					
	Age group	Population of Adolescents (in thousands)				
		1950	1980	2015	2030	2050
Benin	**10-24 years**	583	1138	3529	4890	6419
Burkina Faso	**10-24 years**	1326	2156	5961	8960	12985
Cape Verde	**10-24 years**	60	107	161	155	135
Côte d'Ivoire	**10-24 years**	832	2340	7423	10138	14538
Gambia	**10-24 years**	82	184	642	1028	1545
Ghana	**10-24 years**	1559	3447	8423	11321	13469
Guinea	**10-24 years**	899	1359	4053	5800	7935
Guinea Bissau	**10-24 years**	151	249	582	792	999
Liberia	**10-24 years**	294	578	1435	2011	2709
Mali	**10-24 years**	1366	2166	5673	9272	14300
Niger	**10-24 years**	835	1771	6170	11893	24011
Nigeria	**10-24 years**	11506	22243	57225	85555	120852
Senegal	**10-24 years**	753	1685	4819	7441	10544
Sierra Leone	**10-24 years**	577	883	2101	2775	3188
Togo	**10-24 years**	413	836	2317	3319	4481
ECOWAS Region	**10-24 years**	21235	41143	110514	165349	238111

- Source: United Nations. Department of Economic and Social Affairs. Population Division. World Population Prospects, 2015 Review. New York 2015

In conclusion, from these salient facts we can derive the present and future demographic size of adolescents and young people in the ECOWAS Region. This large and growing demographic size has and will have present and future implications at the triple political, strategic and programmatic levels for the health of adolescents and young people and the health system of the ECOWAS countries.

2.3.2.2 Economic and Development Background of ECOWAS Countries

Social and economic policies largely determine the chances of an adolescent or young person to develop fully and lead a totally fulfilled life. The circumstances in which adolescents and young people are born, grow, live, work and age as well as the systems in place for them to deal with diseases, all these determine the status of their health. These circumstances, which reflect the political and economic choices made by the leadership in the country, depend on the distribution of power, money and resources at all levels of the country. Health inequalities undoubtedly reflect the degree of equity in distributing a country's wealth. "Human development is a process that leads to an expansion of the range of choices available to each

person. The most essential ones are: living long and healthy lives, acquiring knowledge and having access to the necessary resources to enjoy a decent standard of living. "[48].

Tables 2.17 and 2.18 present the economic, development parameters and multidimensional poverty indices of countries in the ECOWAS Region. From these tables we can derive the following highlights:

- According to the typology of the World Bank [43], 10 of the 15 ECOWAS countries are low-income countries and 5 of the 15 countries are lower bracket middle-income countries;
- The per capita Gross Domestic Product (GDP) which measures the standard of living and, roughly, the purchasing power of the inhabitants varies from US $ 6,311 to US $ 884;
- The Human Development Index (HDI), measuring the average level achieved in three essential dimensions of human development: health and longevity, access to education and decent standard of living is considered low in 13 of the 15 countries, and it is average in two countries (Cape Verde and Ghana).
- The percentage of the population whose income is below the poverty line (income poverty) ranges from 28.5% (Ghana) to 69.3% (Guinea-Bissau).
- The multidimensional poverty index defined as a percentage of the population living in multidimensional poverty, adjusted to the degree of deprivation varies from 24% to 60%;
- Percentage (%) of the population living in extreme poverty varies from 12% to 67%

In conclusion, it follows from these salient facts that adolescents and young people in the ECOWAS Region live in a precarious economic environment with implications for employment, access to health and education to name but a few .

Table 2.17: Economic and Development Parameters of ECOWAS countries

Countries	**Level of income of Sub-Saharan Africa [43]***	**GDP per Capita ****	**Human Development Index (HDI)****		
			Value	Rank (Out of 187 countries)	Classification
1. Benin	Low	1 687	0.476	165	Low
2. Burkina Faso	Low	1 528	0.388	181	Low
3. Cape Verde	Middle income lower bracket	6 311	0.636	121	Average
4. Côte d'Ivoire	Middle income lower bracket	2 747	0.452	171	Low
5. Gambia	Lower	1 565	0.441	172	Low
6. Ghana	Middle income lower bracket	3 638	0.573	138	Average
7. Guinea	Low	1 216	0.392	178	Low
8. Guinea-Bissau	Low	1 164	0.396	177	Low
9. Liberia	Low	782	0.412	175	Low
10. Mali	Low	1 607	0.407	176	Low
11. Niger	Low	884	0.337	187	Low
12. Nigeria	Middle income lower bracket	5 440	0.504	153	Low
13. Senegal	Middle income lower bracket	2 174	0.485	160	Low
14. Sierra Leone	Low	1 586	0.374	184	Low
15. Togo	Low	1 286	0.473	167	Low

*** GDP expressed in 2005 international dollars on the basis of purchasing power parity rates

Source: [43] * [48] **

Table 2.18: Income Poverty and Multidimensional Poverty ***

Countries	(Income Poverty)		Multidimensional Poverty Index		
	Population living with less than US $1.25 per day (PPA)	%Population with income below poverty line	Index	Incidence	% Population living in extreme poverty
1. Benin	47.33	36.2	0.412 i	5 897 i	45.7 i
2. Burkina Faso	44.6	46.7	0.535	12 875	63.8

3. Cape Verde			-	-	-
4. Côte d'Ivoire	23.75	42.7	0.310	11 772	32.4
5. Gambia	33.63	48.4	0.324	901	35.9
6. Ghana	28.59	28.5	0.139	7 559	12.1
7. Guinea	43.34	55.2	0.506	8 283	68.6
8. Guinea-Bissau	48.9	69.3	0.462	1 168	58.4
9. Liberia	83.76	63.8	0.485	2 883	52.8
10. Mali	50.43	43.6	0.558	10 545	66.8
11. Niger	43.62	59.5	0.605	15 408	73.5
12. Nigeria	67.98	46	0.240	71 014	25.5
13. Senegal	29.61	46.7	0.439	9 247	45.1
14. Sierra Leone	29.61	46.7	0.388	4 180	46.4
15. Togo	28.22	58.7	0.250	3 207	26.4

Source: [48]

2.3.2.3 Performance of the Health Care System in ECOWAS countries

In his introductory message to the World Health Report 2000 | 37], Dr. Gro Harlem Brundtland, former Director-General of WHO, defined the performance of a health system in the following words: *"The difference between an effective health system and a failing system is measured by the resulting deaths, incapacities, impoverishment, humiliation and despair."*

The main parameters of the health care system that will be examined in this part of the report are: indicators of health status, health system performance, human resources and health expenditure.

A. Indicators of the health status of the populations in the ECOWAS Region

The health status of the populations in the ECOWAS Region can be assessed through the three key indicators: the maternal mortality rate, the neonatal mortality rate and the mortality rate of children under five years old. Table 2.19 shows some health indicators in the ECOWAS countries. According to the UNFPA World Report 2014, the maternal mortality rate ranges from 53 to 1,100 per 100,000 live births, making this region the highest maternal mortality area in the world. Neonatal mortality rates range from 17 to 39 per thousand live births. The mortality rate of children under five years old varies from 14 to 156 per thousand live births. Cape Verde stands out in the region as the country with the best indicators of maternal, neonatal and infant-child health, while Sierra Leone has recorded the poorest performance.

Table 2.19: Indicator of the health status of the populations within the ECOWAS Region

Countries	**Maternal Maternity Mortality * [50]**		Neonatal Mortality Rate (‰)**	Mortality Rate of Children under 5 years (‰)**	Source/Year of DHS**
	Marternal Mortality Ratio	Progress toward the achievement of MDG 5A			
1. Benin	405	No progress	23	70	DHS 2011-2012
2. Burkina Faso	371	Insufficient Progress	28	129	DHS 2010
3. CapeVerde	42	Achieved	17	33	DHS 2005
4. Côte d'Ivoire	645	No progress	38	108	DHS 2011-2012
5. Gambia	706	No progress	22	54	DHS 2013
6. Ghana	319	Insufficient Progress	30	80	DHS 2008
7. Guinea	679	Insufficient Progress	33	123	DHS 2012
8. Guinea-Bissau	549	Insufficient Progress	45	116	MICS 2010
9. Liberia	725	Insufficient Progress	26	94	DHS 2013
10. Mali	587	Insufficient progress	34	95	DHS 2012-2013
11. Niger	553	Insufficient progress	24	127	DHS 2012
12. Nigeria	814	No progress	37	128	DHS 2013
13. Senegal	315	Insufficient progress	29	72	DHS 2010-2011
14. Sierra Leone	1360	Insufficient progress	39	156	DHS 2013
15. Togo	368	Insufficient progress	27	88	DHS 2013-2014
World	216				

Source: DHS of countries [25-39]

WHO [50]

B. Access and Quality of Health Care

Strong health systems are essential to enable people to be healthy throughout their lives and take action against all health threats. In countries where access to health care is not widespread, many factors may prevent women, including those aged 15-19 years, from

receiving medical advice and treatment when they need it. Quality of care is also a challenge for health systems.

Table 2.20 shows the information extracted from the DHSs of the countries in the ECOWAS Region on problems of access to health care for young girls aged 15-19 years. This table shows that the percentage of young people aged 15-19 years who reported at least one of the problems of access to health care varies from 28% to 78%. Financial barriers are the main problem mentioned followed by geographical accessibility and reluctance to go to health care facilities alone. The reality of financial barriers to access to health care in Africa was also highlighted in the 2014 WHO Africa Report [51].

Quality of health care is also a major concern in Sub-Saharan Africa. Table 2.20 shows the percentage of respondents answering "satisfied" to the question posed by the Gallup survey as part of a global survey: "Are you satisfied with the quality of health care available?"[48]. From this table, the percentage of people who expressed satisfaction with the quality of health care varies between 21% and 47%, with a global average of 57%. The lowest percentages were observed in Côte d'Ivoire, Guinea and Togo.

Table 2 .20: Access to and Quality of Health Care

Countries	Problems of access to health care encountered by young people aged 15-19 years*					Quality of health care**
	Have permission to seek treatment	Have money for treatment	Distance to health care facility	Do not want to go alone	At least one of the problems encountered in accessing health care	(% of satisfaction)
1. Benin	33.2	56.7	41.2	29.2	64	44
2. Burkina Faso	24.6	66.9	42.6	24.6	74.2	42
3. Cape Verde						-
4. Côte d'Ivoire	28.2	65.6	37.8	20.2	75.4	21
5. Gambia	6.1	28.9	28.1	11.9	43.9	-
6. Ghana	9.5	45.8	25.6	24.5	77.7	46
7. Guinea	-	-	-	-	-	21
8. Guinea-Bissau	-	-	-	-	-	-
9. Liberia	8.6	45.6	33.8	23.7	58	32
10. Mali	27.7	45.8	31.7	22	53.7	31
11. Niger	22	51.3	38.7	38.3	31.6	37
12. Nigeria	13.6	41.8	28.9	20.4	54.4	47
13. Senegal	17.2	45.6	30.9	21.3	58.1	42

Countries	Problems of access to health care encountered by young people aged 15-19 years*					Quality of health care**
	Have permission to seek treatment	Have money for treatment	Distance to health care facility	Do not want to go alone	At least one of the problems encountered in accessing health care	(% of satisfaction)
14. Sierra Leone	18	65.5	36.1	15.1	70.3	34
15. Togo	14	55.3	27.3	26.2	65.5	23
World						57

Source: * DHS of countries [25-39] ** [48]

C. Human Resources for Health

The staff working at the heart of the system is the driving force behind any progress in health. There is ample evidence that the number and value of staff has a positive impact on immunization coverage, the extension of primary health care, as well as infant-child and maternal survival. It has been shown that there is a correlation between the favourable outcome of cardiovascular diseases and physician competence as well as their density. Conversely, infant-child malnutrition has worsened as a result of staff cuts during the health sector reform. Health workers are in the best position to make innovative improvements in the quality of health care because they are in the best position to see where innovation is available. In a health system, staff act as watchdogs and navigators, and if they do well or badly, the resources - medicines, vaccines and miscellaneous supplies - are used efficiently or wasted. In this section, we examine the situation of human resources for health in the ECOWAS Region, with reference to the situation in the world.

As shown in Table 2.21, drawn from the WHO World Health Report 2006, the African Region has the lowest density of health personnel in the world. Table 2.22 presents the densities of physicians, psychiatrists, midwives and nurses. The density of doctors per 10,000 inhabitants ranges from 0.1 (Sierra Leone) to 4.1 (Nigeria). Cape Verde comes second in terms of density of doctors in the region after Nigeria. Twelve of the 15 countries in the ECOWAS Region have a lower than average physician density in the WHO African Region. The density of nurses and midwives per 10, 000 inhabitants ranges from 1.4 (Niger) to 16.1 (Nigeria). Fourteen of the 15 countries of the ECOWAS Region have a lower than average density of nurses and midwives in the WHO African Region. With regard to psychiatrists, they are almost non-existent in the ECOWAS Region.

This shortage is compounded by the motivation of human resources for existing health care and the issue of its optimal or equitable distribution.

Table 2.21: Total Number of Health Professionals depending on their Density in the WHO Regions

Région OMS	Ensemble du personnel de santé		Prestateurs de services sanitaires		Personnel administratif et d'appui	
	Nombre	Densité (pour 1000 habitants)	Nombre	Prestateurs de services sanitaires	Nombre	Pourcentage du total
Afrique	1 640 000	2,3	1 360 000	83	280 000	17
Méditerranée orientale	2 100 000	4,0	1 580 000	75	520 000	25
Asie du Sud-Est	7 040 000	4,3	4 730 000	67	2 300 000	33
Pacifique occidental	10 070 000	5,8	7 810 000	78	2 260 000	23
Europe	16 630 000	18,9	11 540 000	69	5 090 000	31
Amériques	21 740 000	24,8	12 460 000	57	9 280 000	43
Ensemble du monde	**59 220 000**	**9,3**	**39 470 000**	**67**	**19 750 000**	**33**

Source: WHO Report 2006 [52]

Table 2.22: Density of Health Personnel (per 10, 000 inhabitants)

Countries	Doctors	Nurses and Midwives	Psychiatrists
1. Benin	0.6	7.7	< 0.05
2. Burkina Faso	0.5	5.7	< 0.05
3. Cape Verde	3.0	4.5	0.1
4. Côte d'Ivoire	1.4	4.8	< 0.05
5. Gambia	1.1	8.7	< 0.05
6. Ghana	1.0	9.3	< 0.05
7. Guinea	-	-	< 0.05
8. Guinea-Bissau	0.7	5.9	-
9. Liberia	0.1	2.7	< 0.05
10. Mali	0.8	4.3	< 0.05
11. Niger	0.2	1.4	< 0.05
12. Nigeria	4.1	16.1	< 0.05
13. Senegal	0.6	4.2	< 0.05
14. Sierra Leone	0.2	1.7	< 0.05
15. Togo	0.5	2.7	< 0.05
African Region	2.6	12	< 0.05
World	14.1	29.2	0.3

WHO Afro Report 2014 [51]

D. Health Expenditure

In 2001, the Abuja Declaration proposed that 15% of public spending be allocated to the health sector. However, progress towards this goal has been slow and health spending is still considered as"consumption" rather than an "investment". Only five countries, Botswana, Madagascar, Rwanda, Togo and Zambia, have achieved the Abuja Declaration goal of spending more than 15% of total public spending on health care and they are spending more than US $ 44 per capita in health care.

Table 2.23 shows the level of four health expenditure indicators in ECOWAS countries

We notice that the share of Gross Domestic Product devoted to health spending ranges from 4% (Cape Verde) to 16.3% (Sierra Leone). Only two countries achieved the Abuja goal in 2012. The State's share of health expenditure ranges from 75.5% (Cape Verde) to 16.2% (Sierra Leone). In 10 of the 15 countries in the ECOWAS region, the State's share of health expenditure is less than 50%.

When the State's involvement in health care expenditure is low, the difference is offset by private expenditure, of which about 85% is spent by patients. This means that payment is made at the point of access to health services, [38] which is a major barrier to access to health care. In the ECOWAS region, private health expenditure as a percentage of total health expenditure ranges from 24.5% (Cape Verde) to 83.8% (Sierra Leone). In 10 of the 15 ECOWAS countries, the share of private expenditure in health expenditure is over 50%. Such a method of payment does not encourage the pooling of risks and this has a high probability of causing disastrous expenditure and this can lead to the impoverishment of households. A

study conducted in 15 African countries showed that in most African countries the system of financing health expenditure is too low to protect households from disastrous expenditure. Resorting to borrowing money or selling of personal effects in order to finance health care is a common practice [53].

External resources are becoming a very important source of funding for health in ECOWAS countries. Indeed, external financing accounts for more than 15% of health expenditure in 11 ECOWAS countries. The external resources are particularly important in the following countries: Gambia (62%), Liberia (54%) and Guinea Bissau (47%).

Table 2.23: Health Expenditure in ECOWAS countries (2012)

Countries	Total Health Expenditure as a percentage of Gross Domestic Product	Government Health Expenditure as a percentage of Total Health Expenditure	Private Health Expenditure as a percentage of Total Health Expenditure	External Funding as a percentage of Total Health Expenditure
1. Benin	4.5	52.1	47.9	35.3
2. Burkina Faso	6.4	49.5	50.5	25.7
3. Cape Verde	4.0	75.5	24.5	18.0
4. Côte d'Ivoire	6.8	24.5	75.5	11.1
5. Gambia	4.7	62.3	37.7	61.6
6. Ghana	5.3	55.9	44.1	13.2
7. Guinea	6.0	24.3	75.7	12.2
8. Guinea-Bissau	6.3	26.8	73.2	47.3
9. Liberia	15.6	29.7	70.3	54.0
10. Mali	6.8	43.8	56.2	25.4
11. Niger	6.8	33.2	66.8	21.8
12. Nigeria	5.7	34.0	66.0	5.1
13. Senegal	5.0	55.8	44.2	16.8
14. Sierra Leone	16.3	16.2	83.8	18.2
15. Togo	8.0	52.2	47.8	17.4
African Region	6.2	48.3	51.7	11.8
World	9.1	58.8	41.1	0.4

Source: WHO Afro Report 2014 [51]

In conclusion, the main parameters of the health system, after being examined, show that adolescents and young people from the ECOWAS region live:

- in an environment of high maternal, neonatal and infant-child mortality;
- in an environment where access to and quality of health care is a major concern
- in the context of a shortage of health workers
- in an environment where the health system is underfunded, with a substantial financial contribution from the already poor populations

2.3.2.4 State of Education in ECOWAS Countries

As highlighted in the Lancet [11, 15] education is one of the major structural determinants affecting the health of adolescents and youth. Education, especially beyond the primary level, is also associated with benefits throughout one's life path, such as lower HIV prevalence, injuries and births among adolescent girls or improving adult health and increasing the survival of future children. Countries with higher secondary school completion rates are making greater economic and political gains, with increased productivity, sustainable development and social stability [11, 15].

Table 2.24 shows some parameters related to education in the ECOWAS countries. There has been an appreciable increase in the net enrollment ratio in primary education (1999-2013) in many ECOWAS countries. Indeed, this rate ranges from 42% (Liberia) to 100% (Benin) among boys. This rate ranges from 56% (Côte d'Ivoire) to 96% (Cape Verde) among girls. In 14 of the 15 countries, this rate is over 50%. This is undoubtedly a reflection of the efforts of countries to achieve the Millennium Development Goal 2, i.e. achieving universal primary education. Indeed, among all the regions, sub-Saharan Africa has achieved the best results in primary education since the MDGs were established. This region increased its net enrollment rate by 20 percentage points between 2000 and 2015, compared with a gain of 8 percentage points between 1990 and 2000 [97]. There is, however, inequality between boys and girls. Indeed, the gender parity index, primary education ranges from 0.84 (Côte d'Ivoire, Niger, Nigeria) to 1.07 (The Gambia). However, while the net enrollment rate is encouraging, keeping pupils in school (to complete primary and beyond primary) is still a real challenge.

On the other hand, as shown in Table 2.24, net enrollment in secondary education is still a major challenge in the ECOWAS region.

The quality of education is also a major challenge in the region; indeed, the percentage of respondents who answered "satisfied" to the question posed by the Gallup Survey Institute in a global survey: "Are you satisfied with your educational system?"[48], varies from 22% (Guinea) to 66% (Côte d'Ivoire). In 14 of the 15 ECOWAS countries, this rate is below the world average.

Non enrollment in School and Dropping out-of-school (NSD) are a major challenge in Sub-Saharan Africa in general and in the ECOWAS Region in particular. Figure 2.5 from the World Bank Report " Youth Non enrollment in School and Dropping out-of-school in Africa Sub-Saharan Africa published in 2015 [55]. This graph shows the situation of NSDs in 12 of the 15 countries of ECOWAS. This graph shows that a large percentage of young people aged between 12 and 24 years have never attended school. According to the report, for the 89 million young people, Non enrollment in School and Dropped out-of-school (NSDs), almost half of all the young people in sub-Saharan Africa, the economic and social prospects are distressing. In the next decade, when this group will comprise the bulk of the working population, an additional 40 million young people are likely to drop out of school to face an uncertain future with no work and no practical skills. Without skills, they will not be able to

access decent jobs in attractive trades, which will result in insufficient and precarious income and will certainly expose them to long periods of unemployment. The perverse effects of their lack of education will also be felt in the next generation because they will not be able to offer favourable conditions to their own children because of their own economic instability.

This report highlights six key factors that decision-makers must address: (a) most of the young people drop out before high school; (B) early marriage is an enormous obstacle to the education of young girls; (C) living in a rural area systematically increases the probability of not attending school; (D) the level of education of parents and (e) the number of adults working in the household are important factors; and (f) in terms of supply, the difficulty of access to school and the poor quality of teaching are major constraints.

These findings revealed by these data on education in the ECOWAS region have present and future political, strategic and programmatic implications for the health of adolescents and young people.

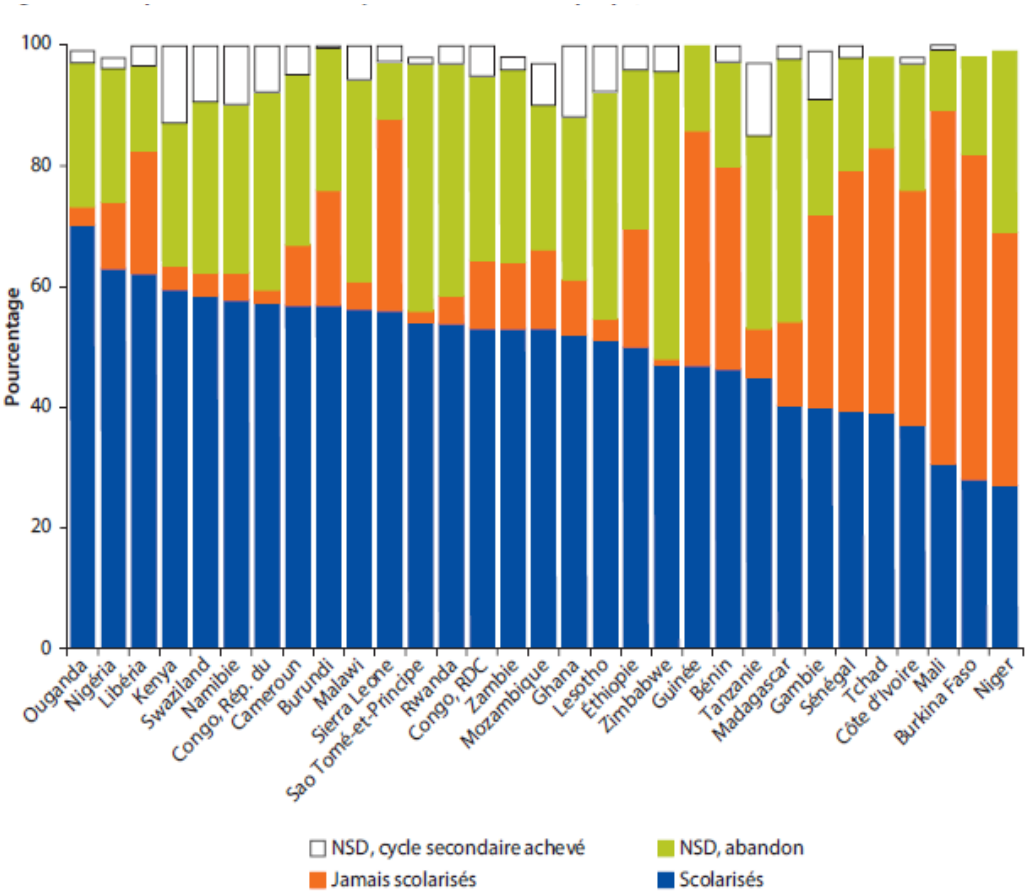
Table 2.24: Education in ECOWAS Countries

Countries	Net Enrollment Rate in Primary Education, in %, 1999-2013 [1]		Gender Parity Index in Primary Education, 1999-2013[1]	Net Enrollment Rate in Secondary Education in %, 2000-2013[1]		Gender Parity Index, Secondary Education, 2000-2013[1]	Youth Literacy Rate 2005-2012 (% 15-24 years) [36]	Quality of Education [36]
	Male	Female		Male	Female			
1. Benin	100	88	0.88	25	12	0.47	42.4	52
2. Burkina Faso	68	65	0.95	22	18	0.83	39.3	66
3. Cape Verde	99	96	0.97	64	74	1.15	98.4	-
4. Côte d'Ivoire	67	56	0.84	–	–	–	67.5	-
5. Gambia	71	76	1.07	–	–	–	68.1	-
6. Ghana	87	88	1.00	53	50	0.95	85.7	59
7. Guinea	81	70	0.86	37	23	0.63	31.4	22
8. Guinea-Bissau	73	69	0.95	11	6	0.56	73.2	-
9. Liberia	42	40	0.95	–	–	–	49.1	-
10. Mali	78	68	0.88	40	28	0.71	46.9	35
11. Niger	69	58	0.84	15	10	0.66	36.5	47
12. Nigeria	71	60	0.84	–	–	–	66.4	55
13. Senegal	77	82	1.08	24	18	0.76	65.0	31
14. Sierra Leone	–	–	–	–	–	–	61.0	-

15. Togo	98	87	0.89	32	15	0.48	79.9	-
World	92	90	0.98	–	–	0.97 *		64

* Gross Enrollment Rates

Source: UNFPA REPORT 2014 [1] HUMAN DEV. REPORT 2014** [48]



Source: [43]

Chart 2.5: School Attendance of Young People aged between 12 and 24 years.

2.3.2.5 Employment and Vulnerability in ECOWAS Countries

The young people (aged 15-24) are a key transition period, during which children learn to integrate into society and the world of work. As described above, many countries are witnessing an increase in the number of young people. All over the world, young people are particularly vulnerable to marginalization in the labour market because they lack experience, social networks, capacities to search for jobs and financial resources to enable them find jobs. They are therefore very likely to find themselves unemployed, underemployed or under precarious contracts [48, 54, 55].

About a quarter of the world's population today is between 10 and 24 years of age. The aspirations and accomplishments of this generation will be decisive for the future of the

planet. In addition, fertility rates are declining in many parts of the world. A country in which the proportion of young people in the population increases while the fertility rate declines can reap the benefits of a "demographic dividend", a phenomenon of an increase in economic productivity that occurs when the ratio of the working population to the number of dependants increases [56].

Demographic dividend is defined as the rapid economic growth resulting from the decline in mortality (especially infant mortality) and the fertility of a given country, and the changing age structure of the population. The decline in the annual birth rate results in changes in the age distribution of a population; dependant young people are fewer in relation to the population that has attained the working-age, which means fewer investments are needed. This phenomenon creates an opportunity for faster economic growth provided social and economic policies and appropriate investments are implemented [56].

The youth unemployment rate is generally higher than that of adults and more sensitive to macroeconomic shocks. In 2012, the youth unemployment rate worldwide was estimated at 12.7 per cent, almost three times that of adults. In the event of a crisis, the youth are more likely to be unemployed than adults and the gap is high between youth and adult unemployment rates even after the economy has recovered [48, 54, 55].

Table 2.25 presents the employment situation of young people in Africa in general and the ECOWAS region.

Table 2.15 shows the following findings:

- The employment-to-population ratio defined by the percentage of the population aged 25 years or more that has work varies from 62% (Nigeria) to 86% (Côte d'Ivoire). It should be noted, however, that a large proportion of jobs are precarious jobs (persons employed as unpaid family workers and self-employed persons), precarious employment as a % of total employment is close to 80% in most ECOWAS countries;
    - The rate of participation of young people in the labour market varies from 36% (Liberia) to 80% (Senegal) [4] and from 35% (Nigeria) to 73% (Burkina Faso);
    - Unemployment rate (defined as the percentage of the working population aged 15 years and more who are not employed or self-employed but are available to work and have taken steps to find paid jobs or self-employment) ranges from 2.3% (Cape Verde) to 23.9% (Nigeria).
    - Youth unemployment (defined as the percentage of the working population aged from 15 to 24 years that is not employed or self-employed but is available for work and has taken steps to find paid jobs or self-employment), is 5% in Liberia.
    -

It should be noted that the availability of data on employment and youth unemployment is a real challenge.

Table 2.25: Employment and Vulnerability of Young People in the ECOWAS Region

Countries	**Employment/ Population Ratio** (% 25 years and plus) *	**Precarious Jobs** (% of total Employment)*	Rate of Participation in Labour Market (% 15-24 years) [4]**	**Youth Unemployment** (% 15-24 years)*	**Unemployment Rate** (% 15 years and plus)*	**Child Labour** (% 5-14 years) *
1. Benin	80.8	89.9	M 56 F 58	-	-	45.6
2. Burkina Faso	85.5	89.6	M 81 F 73	-	2.3	39.2
3. Cape Verde	66.8	-	**M 73** **F** 46	-	-	
4. Côte d'Ivoire	73.1	-	M 62 F 41	-	-	26.0
5. Gambia	80.4	-	M 65 F 64	-	-	19.2
6. Ghana	81.6	76.8	M 39 F 39	-	5.3 [e]	33.9
7. Guinea	79.0	-	M 57 F 52	-	1.7	40.1
8. Guinea-Bissau	77.8	-	M 57 F 54	-	-	38.0
9. Liberia	72.0	78.7	M 36 F 35	5.1	3.7	20.8
10. Mali	65.5	82.9	M 50 F 31		7.3	21.4
11. Niger	66.0	84.8	M 80 F 35	-	-	42.8
12. Nigeria	61.7	-	M 40 F 35	-	23.9 [l]	24.7
13. Senegal	75.5	-	M 80 F 53	-	10.4	16.5 [d]
14. Sierra Leone	76.7	-	M 40 F 49	-	2.8	26.0
15. Togo	83.9	89.1	M 64 F 68	-	-	28.3
Sub-Saharan Africa	75.0	-		-	-	26.2

*Source: UNDP Table 11 [48]

** Source PRB Report [4]

2.3.2.6 Physical Environment: Urbanization, Settlements and Migration of Young People

Urbanization is an inevitable phenomenon. While the city is necessary for economic development, it poses many serious problems. Managing urban growth, including the provision of adequate infrastructure and services for increasingly large and demanding urban dwellers, should be seen as a priority of public policy. [57]

A protective neighborhood provides social support, access to resources and a sense of solidarity by encouraging community participation and promoting healthy relationships across all age groups and social groups. In recent years, the rapid growth of poor and overcrowded urban areas that do not generally have these safety mechanisms has exposed many young people to health risks. [15]

By 2030, the urban population will have doubled in Sub-Saharan Africa [13 WHO Afro 2015]. It is very likely that the vast majority of these populations are adolescents and young people as young people are often looking for opportunities in the region where there is rapid peri-urban and urban growth [58].

As shown in Table 2.26, the ECOWAS countries cannot avoid the trend of increasing populations in urban areas with the attendant consequences.

In a study carried out in Burkina Faso on urbanization and internal migrations in sub-Saharan Africa, Bruno SCHOUMAKER of the Institute of Demography, Catholic University of Louvain, BELGIUM shows that young migrants are generally between the ages of 15 and 35 years and more educated than the rural sedentary young people [59]. The factors of attraction and repulsion are the economic opportunities in the cities, in particular, the more remunerative jobs. Nearly 50% of migrants state reasons related to work or the quest for money), opportunities for further education (secondary schools, colleges, universities); generally more favourable living conditions in the city (Generally more favourable living conditions in the city (access to water, electricity, health services, etc.).

However, the majority of adolescents and young migrants living in urban areas live in substandard housing and in slums. Approximately 62% of urban populations in Sub-Saharan Africa live in low-cost high population density areas with insecure and unhealthy housing. Rapid urbanization in Africa is resulting in increasing overcrowding, coupled with poor housing and scarcity and poor water quality. In 2009, 62% of Africans lived in improvised dwellings, slums or in rural areas, with hardly any access to health services. Only thirty-eight per cent (38%) lived in urban areas with satisfactory access to health services [51].

The growing trend of urbanization has and will have implications for adolescent and youth health promotion policies, strategies and interventions.

Table 2.26: Percentage of the Population Residing in Urban Areas

Countries	1950	1980	2015	2030	2050
1. Benin	5.0	27.3	44.0	51.3	61.3
2. Burkina Faso	3.8	8.8	29.9	41.0	52.0
3. Cape Verde	14.2	23.5	65.5	73.0	77.6
4. Côte d'Ivoire	10.0	36.8	54.2	63.0	70.9

5. Gambia	10.3	28.4	59.6	66.0	71.3
6. Ghana	15.4	31.2	54.0	62.6	70.5
7. Guinea	6.7	23.6	37.2	45.1	56.3
8. Guinea-Bissau	10.0	17.6	49.3	58.4	64.7
9. Liberia	19.5	70.1	78.6	81.8	85.7
10. Mali	8.5	18.5	39.9	50.3	60.3
11. Niger	4.9	13.4	18.7	24.6	35.4
12. Nigeria	7.8	22.0	47.8	58.3	67.1
13. Senegal	17.2	35.8	43.7	50.3	60.5
14. Sierra Leone	12.6	29.8	39.9	46.7	57.2
15. Togo	4.4	24.7	40.0	47.7	57.9

Source: UNICEF [60]

2.3.2.7 Cultural Background

Cultural factors are determinants of adolescent and youth health that are often trivialized in adolescent and youth health strategies and programmes.
According to the 50 keywords of sociology published by Jean Golfin, culture is the way of conceiving life, organizing it and living it, that characterizes a given society, confers on it its original face and, as it were, its personality. For each member of this society, it is an endowment received at birth, which informs him in its depths, and which can never be completely denied. Phenomenon of participation, it creates the basic resemblance; it unites and thereby distinguishes its members from those of a different culture [61].

In sociology, culture is defined more narrowly as "what is common to a group of individuals" and "what binds it", that is to say, what is learned, transmitted, produced and created. Thus, for an international institution such as UNESCO: *"In its broadest sense, culture can be considered today as the set of distinctive spiritual, material, intellectual and emotional features that characterize a society or social group. It encompasses, in addition to the arts, letters and sciences, lifestyles, fundamental human rights, value systems, traditions and beliefs."* This "common reservoir" evolves in time through the forms of exchanges. It is constituted in distinct ways of being, thinking, acting and communicating [96].

Some international organizations have developed new, “culturally sensitive”, integrated approaches because they recognize the influence of culture and spirituality on people's attitudes, practices and behaviours in terms of health. According to these approaches, the health of individuals is linked to a set of structural elements defined by their society or community of origin - traditions, beliefs, taboos, education - which all health strategies to fight HIV, AIDS and other SRH issues must take into account. Culture can be understood here as "collective experience and knowledge of communities, which provide the tools of human adaptation to its environment. It is the means through which we filter new information and knowledge". Thus, the role of culture in the spread of HIV has been the subject of numerous studies since the 1990s and some researchers have highlighted the importance of taking cultural aspects into account in strategies and programmes to combat HIV and AIDS

(promotion of dialogue and local participation in project preparation, identification of the needs and expectations of the targeted community, etc.). Nevertheless, the cultural dimension of the SRH is still insufficiently explored and evaluated in the development processes, and in particular the promotion of SRH [62].

At the global level, in the context of HIV and AIDS prevention, the search for a partnership with the religious sector is one of the main lines of action of the Joint United Nations Programme on HIV / AIDS and family planning. At the local level, the application of cultural-specific approaches has yielded encouraging results in the acceptance and ownership of the promotion of SRH by communities in religious contexts.

Depending on cultural-specific approaches, the mere fact of working in partnership with religious organizations to address sensitive health issues (rights and reproductive health, relationships between both sexes....) may be considered as a strategy that is respectful of the cultural sensitivity of the community [62].

The framework of social and cultural norms related to religion as well as beliefs and traditional practices has emerged as one of the main influences on the health of young people, including sexual and reproductive health (SRH). [62] Studies on the culture and health of adolescents and young people are few.

A study carried out in Mali on religion and sexual and reproductive health of young people showed that: The support of religious leaders for the promotion of young people's SRH has made some progress in this area (improving access to prevention of HIV, adoption of healthy behaviours such as delay in the age of sexual activity, etc.). Nevertheless, in the wider context of reproductive rights and adolescent sexual health, the examination of significant initiatives has highlighted the difficulty of overcoming some traditional cultural practices, the consequences of which are harmful to young people.

Gender inequality and the imbalance in the roles and functions that society ascribes to girls and boys under the influence of socio-cultural and religious factors are key issues that need to be addressed in religious discourse because they affect the unequal access of girls to SRH information, opportunities for access to education and equal opportunities for girls and boys.

The distance between international human rights standards, i.e. adolescents, and norms of gender and procreation based on cultural, spiritual or social values and beliefs often appears to be an abyss. This fact should motivate NGOs to involve religious organizations in their efforts to ensure the well-being of young people because these organizations are capable of shaping and transforming the values transmitted in their cultural contexts. However, the mobilization of religious leaders must meet several challenges. On the one hand, the behaviour patterns and the values prevailing in societies change very quickly, which forces the leaders of the religious communities to be attentive and realistic when studying and interpreting them. On the other hand, religious authorities are themselves confronted with these differences in norms and gender inequality within their structures, which requires them to keep a distance from their proper functioning. The issue is to challenge certain beliefs while respecting the sacred teachings [62].
In addition to the influence of religion, there are several other cultural factors that influence adolescent/youth health in the sub-region:

- The taboo relating to the sexuality of adolescents/young people that contributes to the stigmatization and discrimination of adolescents and young people who seek SRH-related information or services
- Stigmatization and discrimination against certain groups of marginalized youth (e.g. young people living with HIV, young people with disabilities, young sex workers, young refugees, etc.)
- Cultural norms that promote gender-based violence.

2.3.2.8 Health Equity (Health Inequalities) and Gender in ECOWAS Countries

The social and economic policies of States generate health inequalities or inequities. Targeting health inequalities comes with the challenge of changing the trend by improving the health opportunities of disadvantaged nations and groups". Health equity is defined as: 1) equal access for equal need to available health care, 2) equal use for equal need, and 3) equal quality of health care for all [63].

In this section we have adopted the UNICEF approach which promotes a multidimensional approach to poverty that is not only based on monetary poverty but also takes into account other shortcomings such as access to food, water, health, education, housing and information. We will use the terms equity and equality interchangeably. We will discuss two types of inequalities with direct impacts on the health of adolescents and young people. These include: 1) income inequality, and 2) health inequality.

A. Income Inequalities

Sub-Saharan Africa is one of the regions in the world where income inequalities and inequalities between women and men are among the highest, even taking into account its lower levels of per capita income [64]. The same is true of children and young people. In a report on global inequality, UNICEF emphasizes that at the global level, the majority of children belong to the lowest-income quintiles. By comparing the concentration of young populations across the income distribution quintiles around the world, almost half (48.5%) of the world's young people are confined to the two lowest income quintiles. More than two thirds of the world's youth have access to less than 20% of the world's wealth, and 86% live on nearly a third of the world's income. On the other hand, nearly 400 million young people living in families at the top of the income pyramid have the chance to access more than 60% of world income. [64]

It is therefore clear that, like Sub-Saharan Africa, the countries in the ECOWAS region are also confronted with inequalities or inequities of all kinds, including health. Indeed, in the report on health in the African Region 2014, the Africa Office of WHO states: "It is clear that the Region still has too many gaps, one of the most striking ones is the gap between the level of services offered to the richest and the impossibility of access to health care for the poorest". In too many countries of the Region, the poorest people proportionately pay the highest for health care. In 22 countries of the Region, expenditure directly paid by households accounts for more than 40% of total health expenditure. In countries where public investment in health

is low, direct payments tend to reach a high level, which is a major barrier to access to health care.

B. **Health Inequalities**

There is a link between income and health inequalities. Health inequalities are "unjust and avoidable" disparities found both within national borders and between different countries. Health inequalities are systemic, as they generally affect particular groups of individuals. They often have a particularly acute impact on the most vulnerable people who have the least access not only to health services but also to the resources needed to enjoy good health. [65]

According to a document published by the International Federation of the Red Cross in partnership with the Partnership for Maternal, Newborn and Child Health [65], which analyzed this issue, the elements that constitute health inequalities are: (1) Public health systems, as the source and solution of health inequalities, (2) Poverty as an aggravating factor in health inequalities, (3) Equity-oriented public policies are conducive to health equality.

- **Public health systems, as the source of and solution to health inequalities**
  While health systems contribute to the general well-being of populations, they can also contribute to inequalities. For example, investment in hospitals with high-tech equipment and specialized medical centers benefit mainly the wealthiest, to the detriment of the poorest. In order to reduce health inequalities, everyone must have easy access to acceptable and quality services. This implies that health care facilities should be located at the right places, people should be aware of their existence and the services available in those structures and they should be open to all, irrespective of their place of residence and their financial means;

- **Poverty as a factor aggravating health inequalities**
  Combined with global trends such as urbanization, migration, ageing, unhealthy lifestyles and an increase in non-communicable diseases, poverty contributes significantly to health inequalities, especially when it coincides with limited access to the resources needed for good health- balanced nutrition, decent housing and improved water and sanitation services.

- **Changing public policies and customs would reduce health inequalities**
  Some laws and public policies promote health inequalities; this includes laws that impede access to maternal and perinatal health services, those requiring the consent of the spouse to use reproductive health services (including contraceptive services), or those that impede access to vital interventions in case of pregnancy-related complications.

2.3.3 Analysis of Adolescent and Youth Health Primal Social Determinants

It should be recalled that proximal social determinants are the circumstances of everyday life that more directly influence a person's attitudes and behaviours. Examples of proximal determinants include the quality and nature of family relationships and peer relationships, availability of food and housing, recreational opportunities and school environment. Since intermediate determinants are shaped partly by stratification resulting from structural

determinants and cultural, religious and community factors, they can lead to significant variations in exposure and vulnerability of young people to health risks.

We distinguish: 1) the family environment of the adolescent and young people, 2) the school environment of the adolescent and young people and 3) the adolescent from the young person himself.

2.3.3.1 Proximal Social Health Determinants related to the Family Environment

According to the lexicon of legal terms, 10th edition 2010, the family is understood in the broad sense as all persons descended from a common ancestor and linked by marriage and descendance. In the narrow sense, it is a group formed by parents and their descendants, or even in a more restrictive sense, by parents and their minor children. The notion of family is in itself extensive. We can distinguish the single-parent family from the reconstituted family. In Africa, the notion of family extends to uncles, aunts and other cousins. Indeed, according to the *Petit Robert [40]* dictionary the family is a group of persons united by blood or by alliance. In Africa it is composed of father, mother, children, paternal and maternal uncles, paternal and maternal aunts, grandfather, grandmother, step-parents, etc. In other words, it is the extended family. This is not the case in Western countries.

According to the sociologist Baguirir of Benin, the family is the basic institution of society under all over the world but it is also the oldest and it has extended over all the ages. Most of the social interactions revolve around it. So it is the pedestal if not the foundation of social life

Changes in family contexts in Africa influence the development and health of adolescents and young people.

A. Transformation of the Family Unit in Sub-Saharan Africa

The African family has undergone many changes during the 21st century. From the traditional polygamous family, we now see monogamous families, mononuclear or single-parent families and, finally, reconstituted families.

Sub-Saharan Africa, in its initial way of life, especially before colonization, had a high rate of polygamous families, and this was practically a norm; at least it was a standard social practice. Contact with Western civilization, the emergence of the concept of gender promotion, the emancipation of women, the adoption of new family codes aimed at the affirmative action of social minorities, the promotion of family planning, etc, are factors that have increasingly led to the decline of this social practice [66].

This trend has ever since placed the monogamous family unit in an ideal position. This tendency has its support in two realities, namely, conformism and necessity. The conformism is linked to the new image maliciously imposed by the unconscious imitation resulting from external contacts which espouses the idea that the young African should develop a suitable reputation. With regard to necessity, it is based on economic foundations. Thus, if in times past, having a large family was a sign of wealth, this is no longer the case today. Here, youth unemployment, economic recession and the practice of city life are factors to be taken into account.

We are now increasingly witnessing the emergence of the mononuclear or single-parent family. We note the presence of this type of family in Africa, especially in urban areas. Generally it is characterized by the absence of the father, so we have the mother who is the only centre of the family and manages to take care of its offspring. In this regard, one can cite the level of abandonment of responsibilities by certain young people who are in the throes of the unfavourable economic situation. There is also the depravity of social values and norms as a result of the relaxation of family education and the impact of the various types of media and the increasingly numerous social media that are difficult to control.

The last type of family that is growing in Sub-Saharan Africa is the reconstituted family (a family made up of parents with children from a previous union [67]).

B. Family Structure and Dynamics in ECOWAS Countries

Table 2.27 shows the distribution of households in ECOWAS countries by gender of head of household and the practice of polygamy. This table shows the percentage of households with a woman as Head of household from 9.3% (Mali) to 46% (Cape Verde). In 9 out of the 15 countries in the region, more than one-fifth of households have a woman as head of household. The 3 countries with the highest percentages are Cape Verde, Liberia and Ghana. The 3 countries with the lowest percentages are: Mali, Burkina Faso and Niger. The percentage of polygamous households ranges from 12.5% (Liberia) to 47.8% (Guinea). These different family developments have and will have implications for education and health of adolescents and young people in Sub-Saharan Africa in general and in the countries of the ECOWAS region in particular.

Table 2.27: Distribution (in %) of Households by Gender of Head of Household and Practice of Polygamy

Countries	Head of Household		Average Size of Household	Practice of polygamy % living in polygamous households
	Male	Female		
1. Benin	77.1	22.9	5.0	34.8
2. Burkina Faso	90.1	9.9	5.7	42.2
3. Cape Verde	53.8	46.2	4.7	-
4. Côte d'Ivoire	82.0	18.0	5.1	27.8
5. Gambia	77.7	22.3	8.2	38.7
6. Ghana	66.3	33.7	3.7	18.2
7. Guinea	82.7	17.3	6.3	47.8
8. Guinea-Bissau	79.2	20.8	-	
9. Liberia	64.8	35.2	5.0	12.5
10. Mali	90.7	9.3	5.7	34.8

11. Niger	84.1	15.9	5.9	36.1
12. Nigeria	81.5	18.5	4.6	32.5
13. Senegal	75.2	24.8	9.3	39.5
14. Sierra Leone	72.0	28.0	5.9	34.8
15. Togo	72.5	27.5	4.5	32.3

2.3.3.2 Analysis of proximal social determinants related to the school environment.

Besides the family, the school environment is the second social institution where adolescents and young people spend a greater part of their lives. Connections and social relationships may either protect adolescents from or increase their exposure to risky behavioural patterns. Violence, the misuse of psychoactive substances and risky sexual behaviour pose a health risk to adolescents, while connections and social support are key protective factors for them. For instance, young people easily cultivate good health habits and proper behavioural patterns in that domain when they feel connected to their school and when the same school provides a safe haven for them. The same applies when adolescents feel connected to their families and when their parents or legal guardians are involved in their lives, know about their activities and show them how to lead a healthy lifestyle as well as how to adopt a healthy behavioural pattern [15].

2.3.3.3 Analysis of proximal social determinants related to adolescents and young people

Man does not live in isolation; rather, he lives within a society. Therefore, he adapts to his social environment.

Peer influence is particularly strong during adolescence. Adolescents are better protected from risky behaviour when their friends maintain strong social relationships and adopt healthy lifestyles. The magnitude of both positive and negative peer influence has increased dramatically in recent years due to the easy means of communication and interaction offered by social networks and the media (Lancet Fact Sheet 2). The section on adolescents or young people and the media will be discussed much later.

2.4 ANALYSIS OF BIOLOGICAL, MENTAL AND PSYCHOLOGICAL DETERMINANTS AND SOCIAL TRANSITION: PSYCHOANALYTICAL PERSPECTIVE

It should be recalled that adolescence involves physiological, psychological, cultural and social data, which interact differently depending on the era and society. In his book titled *Adolescence*, Emmanuelli [42] states as follows: "One cannot understand what takes place at adolescence without a psychoanalytical enlightenment. At the end of the nineteenth century, psychoanalysis triggered off a revolution in the way children and adolescents are perceived, revealing the existence of child sexuality and the Oedipus complex. Physiological sexuality and psycho-sexuality, as highlighted by psychoanalysis, are the pivots of what constitutes a period of decisive changes of a person with regard to relations with himself and with others. Puberty drastically alters the body and status of the individual; the resultant access to genital sexuality must be psychologically developed by the individual who is grappling with the narcissistic and relational consequences thereof. Adolescence is, therefore, a development process pertaining to the integration of the individual's sexual identity, the readjustment of child relations and the start of the task of separation, and it results in a reorganization of the

mental faculties. From this standpoint, it is the breakdown of this process that leads the adolescent to a dead end and which is likely to result in pathological outcomes. Change is at the centre of the adolescence process, it has to do with the individual, his entourage and society: it therefore calls for psychological preparation on the part of the individual and the family, and development through social organization, failing which it may cause various kinds of disorders. On this point, the contributions of anthropology and history, though they show us the relativity of adolescent status and the diversity of social developments underpinning the change, also reveal the existence of a constant: any society must, in one way or another, take into account young people's access to sexuality and foresee the role they will play as adults ".

This passage from Emmanuelli's document shows the complexity and interactions of various realities to be properly appreciated before deciding on political, strategic and programmatic choices to promote the health of adolescents and young people. In this section of the report, we will examine the biological, mental and psychological determinants of adolescence in the light of psychoanalysis. It should be noted that psychoanalysis is a process of investigating psychological processes, which are otherwise hardly accessible. Emmanuelli's document served as the main source of information written in this section. For more detailed information, the reader is advised to consult the original document.

From a psychoanalytical perspective, adolescence is a process that encompasses several phases: 1) latency, 2) puberty proper, 3) mental and psychological aspects, and 4) social transition.

- **The latency phase**

Coming between the end of the fifth year and the early signs of puberty, this period of suspension of instinctual activity is, in actual fact, an important moment of reorganization of conflicts, defensive processes and the relation of objects. The period of latency begins with the decline of the Oedipus complex. This expression refers to a set of feelings that a child has for his parents seen as distinct from each other. The complex is said to be positive in its heterosexual aspect (attachment to opposite-sex parent and hostility towards same-sex parent considered to be a rival): This is how it is most widely known. It also has a negative or homosexual aspect. The two coexist but the trend is generally towards the positive complex. The incestuous and parricidal fantasies that are associated with this phase arouse intense anxiety and strong guilt due to the ambivalence of the child's feelings. The fear of retaliation engenders in the child the fantasy of castration, an attack against his narcissistic integrity. The resolution of the Oedipus complex, under the pressure of the ensuing anxiety of castration, is the outcome of latency. This then gives the adolescent right to topics like the "ego," the "superego," the "id" and the "ideal of the self," according to Freud. The mental balance of the child and the future of the adolescent depend on the harmonious formation of these traits. The work of the ego - the mediator between the contradictory demands of the external world, the superego and the id – enables the interplay between primary and secondary processes and leads to positive adjustments for intellectual and mental development. Fantasizing, resorting

to daydreaming and play offer the child in the latency period ways of unleashing instincts which compensate for the don'ts of satisfaction and authorise mental work on conflicting ideas. These positive achievements, which provide an opening to the world of ideas and peer groups can be possible only if representations related to oedipal sexuality as well as the prohibition of incest are guaranteed. Consequently, the environment plays a non-negligible role.

- **Puberty: the critical turning-point in biological and mental development and social transition**

Puberty is the last stage of sexual development and marks the beginning of the period of fertilization. At the biological level, it depends on the action of the hypothalamus and hypophysis on the sexual glands which, upon stimulation by neuro-hormonal secretions, produce sex hormones (testosterone and oestradiol) in increasing quantities, with the appearance of primary and secondary sexual characteristics – hair growth – the development of the genitals, followed by physical changes - in boys – all of which highlight the differences between the sexes).

The impact of these transformations on the mind is considerable, with visible changes suddenly appearing in all domains: relationships with parents and friends, tastes, recreational activities, clothing, interest in own physical appearance and concerns, changes in mood and behaviour. Thus, from the biological perspective, puberty becomes a mental phenomenon. In some cases, the pre-adolescent, even before the apparent physical manifestations of his development, changes in the eyes of his relatives. The physical and biological changes thus induced by puberty take place within a time-lag that varies according to the sexes and individuals. The more rapid these changes are, the more difficult it is for the young pubescent person to cope with them. These internal and external changes in his body modify his perception of self and that which others have of him: a child who was hitherto asexual suddenly becomes an object of desire. His relationship with himself and others changes: consequently, the axis of narcissism (self-love, self-investment) and that of relationships with others are at stake. Current data in the West reveal an increasing trend in the early appearance of puberty. As a result, there is a growing dissociation between social adolescence and biological adolescence. The same trend is certainly observed in Africa. Pubertal adjustments attest to the magnitude of what is happening at the somatic and mental levels: desires, especially sexual and destructive desires.

Adolescence is a necessary stage of change: sexual life takes its definitive form and opens up to adult sexuality; relations with the parents change and a move towards separation begins; the young person establishes new ties outside the family and gradually puts in a lot looking for an occupation that should lead to his autonomy. The changes with which he has to grapple with thus take place at the biological, mental and social levels, and the demands of these different domains sometimes conflict. After the latency consolidation period comes the time for radical reorganization at the end of which the adolescent adjusts own self-discipline, own place within the family and in the world, and the status hitherto given to his parents and third parties.

• **Biologically, mentally and psychologically, puberty marks the beginning of the social transition of the adolescent**

Traditional societies - which codify and organize this transition - help the adolescent in the psychological work vis-à-vis the conflicts which it entails. Indeed, this means preparing to assume the role of an adult; and it cannot be done without anxiety on both sides. The abolition of initiation rites in modern society leaves the young adolescent with all the burden of anxiety which lies in the sexual and aggressive nature of unconscious puberty fantasies.

In short, puberty profoundly alters the body and status of the individual. The resultant access to genital sexuality must be mentally developed by the individual grappling with the narcissistic and relational consequences thereof. Adolescence is, therefore, a development, process pertaining to the individual's sexual identity, the readjustment of child relations and the start of a move towards separation which results in the reorganization of the mental faculties. From this standpoint, it is the breakdown of this process that leads the adolescent to a dead end and which is likely to result in pathological outcomes. Change is at the centre of the adolescence process, it has to do with the individual, his entourage and society: it therefore calls for psychological preparation on the part of the individual and the family, and development through social organization, failing which it may cause various kinds of disorders. On this point, the contributions of anthropology and history, though they show us the relativity of adolescent status and the diversity of social developments underpinning the change, also reveal the existence of a constant: any society must, in one way or another, take into account young people's access to sexuality and foresee the role they will play as adults.

2.5 ANALYSIS OF KNOWLEDGE, BEHAVIOURAL PATTERNS AND MODES OF LIFE OF ADOLESCENTS AND YOUNG PEOPLE

Adolescence is a stage in life where the opportunities for good health are tremendous and the bases of good health in adulthood are established. The state of health during adolescence is in fact the outcome of interactions between prenatal development, early childhood, biological and psychological changes, and social transition associated with puberty. These factors are shaped by social and family determinants, and risk protective factors that ultimately condition the adoption of protective and risky behaviour by adolescents and young people.

In this section of the report, we will examine the knowledge, attitudes and modes of life of adolescents and young people in the following areas:

- sexuality and reproduction;
- knowledge of and practice concerning HIV and sexually transmitted infections;
- violence risk factors, road accidents, non-communicable diseases in adolescents and young people.

2.5.1 Sexuality and reproduction

Puberty is the last stage of sexual development and marks the beginning of the period when one is ripe for fertilization. Transformation in sexual function at this age of adolescence is not only the capacity to procreate, but the desire for sexual intercourse, the desire to begin the act [97]. Sexuality is also the possibility of building another family, of procreating, of leaving one's family through procreation. But it is equally the period of sexual drift with happy or unfortunate consequences for the health of adolescents and young people, including those in the ECOWAS region.

In this section, we will examine some parameters of adolescent and youth sexuality.

2.5.1.1 Adolescent and Youth Birth Rate and Fertility

Despite the slight decline in the birth rate among female adolescents in developing countries over the past two decades, sub-Saharan Africa continues to have the highest adolescent fertility rates in the world, with no sign of a decline since 1990. Out of the 14.3 million adolescent girls who gave birth in 2008, one in three lived in sub-Saharan Africa [4].

Table 2.28 shows the birth rates and fertility rates among young people aged 15-19 years in the ECOWAS countries. The following salient points emerge from a look at this table:

- The birth rate for female adolescents aged 15-19 years varies from 70 per thousand (Ghana) to 206 per thousand (Niger). The 3 countries with the highest rates are in descending order: Niger, Mali and Guinea. The 3 countries with the lowest rates are in ascending order: Ghana, Gambia and Togo,
- The fertility rate for adolescent girls aged 15-19 years varies from 66 per thousand (Ghana) to 206 per thousand (Niger). In descending order, the 3 countries with the highest rates are: Niger, Mali and Liberia. In ascending order, the 3 countries with the lowest rates are: Ghana, Togo and Gambia.

Table 2.28: Birth rate and fertility of female adolescents and young people in ECOWAS countries

Country	Birth rate among female adolescents, per 1 000 women aged 15 to 19 years, 1999-2012 [1] *	Fertility rate among adolescents aged 15-19 years (per 1000 women) 2006-2011** [51]
1. Benin	98	94
2. Burkina Faso	136	130
3. Cape Verde	92	90
4. Côte d'Ivoire	125	128
5. The Gambia	88	118
6. Ghana	70	70
7. Guinea	154	146
8. Guinea-Bissau	137	
9. Liberia	149	177
10. Mali	172	
11. Niger	206	206
12. Nigeria	122	113
13. Senegal	80	96
14. Sierra Leone	125	122
15. Togo	88	88

Source: * Report on the 2014 world population, UNFPA [1]
** WHO Report on Health in the African Region [51]

2.5.1.2 Sexual Practices

A. Age of first sexual intercourse among young people

The age of first intercourse is not only an important indicator of exposure to the risk of pregnancy, but it is also an important indicator of the risk of exposure to the risk of contracting an STI. We deem that young people who have early sex have an increased risk of contracting STIs, including HIV. The postponement of the age of first sexual intercourse and regular use of condoms are among the effective means of prevention that reduce the risk of contracting the AIDS virus.

Table 2.29 shows the percentage of young women and men aged 15-24 years who had sex before the age of 15 and the percentage of young women and men aged 15-24 who had sex before the age of 18.

The analysis of this table reveals the following salient facts:

- **For women aged 15-24 years**

    - The percentage who had sex before reaching 15 years ranges from 7.8 (Ghana and Gambia) to 25.5 (Niger);
    - The percentage who had sex before reaching 18 years ranges from 32.1 (Gambia) to 84.8 (Liberia).

- **For men aged 15-24 years**

    - The percentage who had sexual intercourse before reaching 15 years ranges from 1.1 (Niger) to 41.4 (Cape Verde);
    - The percentage who had sex before reaching 18 years varies from 10.9 (Niger) to 54.6 (Sierra Leone).

Table 2.29: Percentage of young women and men aged 15-24 years who had sex before 15 years and the percentage of young women and men aged 15-24 years who had sex before the age of 18.

Country	Percentage who had sex before 15 years (overall: 15-24 years)		Percentage who had sex before 18 years (overall : 15-24 years)	
	W	M	W	M
1. Benin	11.8	16.2	50.5	48.2
2. Burkina Faso	9.3	1.9	59.8	23.0
3. Cape Verde	24.0	41.4	na	na
4. Côte d'Ivoire	20.2	13.8	68.7	47.6
5. Gambia	7.8	4.6	32.1	24.2
6. Ghana	7.8	4.3	43.9	27.7
7. Guinea	24.7	9.6	67.2	40.5
8. Guinea-Bissau				
9. Liberia	23.1	9.1	84.8	57.8
10. Mali	21.2	4.5	64.6	24.2
11. Niger	25.5	1.1	73.9	10.9
12. Nigeria	17.0	3.4	51.8	19.4
13. Senegal	10.7	4.9	34.2	21.2
14. Sierra Leone	19.5	10.5	71.9	54.6
15. Togo	9.6	9.0	49.7	33.3

Source: DHS of countries [25-39]

B. Premarital sex and use of condoms

Table 2.30 shows the percentages of unmarried young men and women aged 15-24 years who never had sex and the percentages of those who had sex in 12 months prior to the survey, including the percentages of those who used a condom during their recent intercourse.

One notes that the percentage of spinsters aged 15-24 years who had sex in the past 12 months ranges from 1.8% (Niger) to 68.1 (Liberia). In decreasing order, the 3 countries with the highest percentages are: Liberia, Sierra Leone and Cote d'Ivoire. In ascending order, the 3 countries with the lowest percentages are: Niger, Gambia and Senegal. Among those who had sex, the percentage which declared that they used a condom in their recent intercourse varies from 6.6% (Sierra Leone) to 61.6% (Burkina Faso). In descending order, the 3 countries with the highest percentages are: Burkina Faso, Cape Verde and Togo. In ascending order, the 3 countries with the lowest percentages are: Sierra Leone, Mali and Liberia.

With regard to the boys, it emerges that the percentage of bachelors aged 15-24 years who had sex in the past 12 months ranges from 5.8% (Niger) to 62.8% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Liberia and Sierra Leone. In ascending order, the 3 countries with the lowest percentages are: Niger, Senegal and Gambia. Among those who had sex, the percentage which declared that they used a condom in their recent intercourse varies from 16.4% (Sierra Leone) to 77.4% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Burkina Faso and Togo. In ascending order, the 3 countries with the lowest percentages are: Sierra Leone, Mali and Ghana.

Table 2.30: Premarital sex and use of condoms during premarital sex among young bachelors and spinsters aged 15-24 years.

Country	SPINSTERS AGED 15-24			BACHELORS AGED 15-24		
	Percentage who never had an intercourse	Percentage who had intercourse in the past 12 months	Percentage who declared that they used a condom in their recent intercourse	Percentage who never had an intercourse	Percentage who had intercourse in the past 12 months	Percentage who declared that they used a condom in their recent intercourse
1. Benin	51.8	36.7	38.4	48.1	39.7	46.0
2. Burkina Faso	73.9	21.5	61.6	65.9	27.4	75.9
3. Cape Verde		46.3	57.7		62.8	77.4
4. Côte d'Ivoire	33.1	57.7	38.9	38.7	51.7	60.4
5. Gambia	90.8	5.2	28.0	63.8	21.8	59.2

6. Ghana	54.8	34.2	29.0	60.2	29.5	45.1
7. Guinea	57.9	33.7	31.9	46.0	45.4	50.5
8. Guinea -Bissau						
9. Liberia	26.2	68.1	23.2	40.4	56.4	45.2
10. Mali	67.0	26.7	18.1	69.1	24.7	32.3
11. Niger	97.0	1.8		91.2	5.8	56.3
12. Nigeria	68.2	25.5	43.6	71.5	22.2	57.9
13. Senegal	90.3	6.8	40.2	71.5	18.0	63.6
14. Sierra Leone	35.1	59.7	6.6	40.4	54.9	16.4
15. Togo	48.5	42.3	49.4	53.3	35.8	64.5

C. **Multiple sexual partners among people aged 15-24 years**

Table 2.31 shows the percentages of women and men aged 15-24 years who declared that they had sex with more than one partner in the 12 months prior to the interview and the percentages who declared that they used a condom in their recent intercourse.

The results show that multi-partnership is less frequent among women aged 15-24 years compared to men in all ECOWAS countries.

This practice is rather more frequent among men and the percentage varies from 1.1% (Niger) to 22.6% (Cote d'Ivoire). In descending order, the 3 countries with the highest percentages are: Cote d'Ivoire, Sierra Leone and Benin. In ascending order, the 3 countries with the lowest percentages are: Niger, Senegal and Gambia.

Table 2.31: Multiple Sexual Partners over the Last 12 months among Young People (15-24 years)

Country	Women		Men	
	Percentage who had two or more sexual partners in the past 12 months	Percentage who declared that they used a condom during their recent intercourse	Percentage who had two or more sexual partners in the past 12 months	Percentage who declared that they used a condom during their recent intercourse
1. Benin	2.2	34.6	12.9	43.8
2. Burkina Faso	0.9	65.3	6.0	74.7
3. Cape Verde				
4. Côte d'Ivoire	4.8	34.2	22.6	56.5
5. Gambia	1.1		2.4	51.1
6. Ghana	1.4	28.2	5.9	42.0

7. Guinea	2.9	36.6	10.0	54.0
8. Guinea-Bissau				
9. Liberia	8.6	25.6	12.1	32.4
10. Mali	0.9	7.9	4.9	38.0
11. Niger	0.2		1.1	
12. Nigeria	1.1	40.6	3.9	50.5
13. Senegal	0.3		2.4	48.8
14. Sierra Leone	6.2	5.9	15.7	20.9
15. Togo	1.3	59.2	7.5	63.1

Source: DHS of countries [25-39]

2.5.1.3 Family Planning

Family planning is one of the major strategies of reducing maternal mortality among women of reproductive age, including female adolescents and young people [99, 100]. WHO and UNFPA recommend an increase in the use of contraception by female adolescents who are exposed to unwanted pregnancy [91]. Increased access to family planning is a strategy of protecting adolescents and young people and reducing the number of unwanted pregnancies, maternal deaths and unsafe abortions.

A. Knowledge of contraceptive methods

Table 2.32 shows the level of knowledge of respondents in respect of contraceptive methods concerning those who are currently in union.

Among women aged 15-19 years, the percentage who had knowledge of a family planning method ranges from 84.5% (Benin) to 99.7% (Cape Verde). The percentage of women who had knowledge of a modern method of contraception ranges from 82.4% (Benin) to 99.7% (Cape Verde).

Among men aged 15-19 years, the percentage who heard of a method ranges from 91.6% (Niger) to 99.8% (Cape Verde). The percentage of men who heard of a modern method varies from 90.5% (Niger) to 99.8% (Cape Verde).

Table2.32: Knowledge of contraceptive methods by respondents currently in a union

Country	Women		Men	
	Who heard of a method	Who heard of a modern method	Who heard of a method	Who heard of a modern method
1. Benin	84. 5	82. 4	92. 5	90. 9
2. Burkina Faso	97. 6	97. 5	99. 5	99. 5
3. Cape Verde	99. 7	99. 7	99. 8	99. 8
4. Côte d'Ivoire	93. 7	93. 2	98. 5	98. 5
5. Gambia	96. 3	95. 8	98. 9	98. 1
6. Ghana	97. 9	97. 8	99. 5	99. 5
7. Guinea	91. 2	90. 4	-	-
8. Guinea-				

Bissau				
9. Liberia	98. 2	98. 2	94. 8	94. 8
10. Mali	85. 2	85. 0	97. 2	96. 9
11. Niger	90. 7	89. 3	91. 6	90. 5
12. Nigeria	84. 6	82. 8	97. 0	95. 8
13. Senegal	92. 7	92. 5	98. 3	96. 1
14. Sierra Leone	92. 7	92. 5	98. 3	96. 1
15. Togo	96. 3	96. 2	98. 3	98. 1

Source: DHS of countries [25-39]

B. Current use of contraception

The level of contraceptive use is one of the indicators used to assess the efficiency of family planning programmes. During the DHS, the data collected was used to estimate the current level of contraceptive use or contraceptive prevalence.

Table 2.33 provides the current contraceptive prevalence, that is, the proportion of women who used contraception at the time of the survey.

The percentage of women aged 15-19 years who declared that they had used any contraceptive method ranges from 1.1% (Gambia) to 39.1 (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Sierra Leone and Ghana. In ascending order, the 3 countries with the lowest percentages are: Gambia, Senegal, and Niger.

The percentage of women aged 15-19 years who declared that they had used a modern contraceptive method ranges from 0.8% (Gambia) to 39.0 (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Sierra Leone, and Liberia. In ascending order, the 3 countries with the lowest percentages are: Gambia, Senegal, and Niger.

Table 2.33: Current contraceptive prevalence: Distribution (in %) of women aged 15-19 years by contraceptive method currently used.

Country	Any method	A modern method	Not currently used
1. Benin	14. 4	9. 5	85. 6
2. Burkina Faso	6. 3	5. 9	93. 7
3. Cape Verde	39. 6	39. 0	60. 4
4. Côte d'Ivoire	15. 5	11. 9	84. 5
5. Gambia	1. 1	0. 8	98. 9

6. Ghana	19. 5	15. 2	79. 5
7. Guinea	5. 6	4. 4	94. 4
8. Guinea-Bissau			
9. Liberia	17. 2	16. 4	82. 8
10. Mali	5. 8	5. 5	94. 2
11. Niger	4. 4	3. 7	95. 6
12. Nigeria	6. 1	4. 8	93. 9
13. Senegal	2. 1	1. 9	97. 9
14. Sierra Leone	21. 7	20. 7	78. 3
15. Togo	11. 6	10. 1	88. 4

Source: DHS of countries [25-39]

Table 2.34 shows variations in contraceptive prevalence among women in union.

The percentage of women aged 15-19 years in union who declared that they had used any contraceptive method varies from 2.1% (Nigeria) to 82.5% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Ghana and Liberia. In ascending order, the 3 countries with the lowest percentages are: Nigeria, Guinea and Gambia.

The percentage of women aged 15-19 in union who declared that they had used a modern method of contraception ranges from 1.2% (Nigeria) to 81.6 (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Ghana, and Liberia. In ascending order, the 3 countries with the lowest percentages are: Nigeria, Gambia and Guinea.

Table 2.34: Distribution (in %) of women aged between 15 and 19 years currently in union by contraceptive method currently used

Country	Any method	A modern method	Not currently used
1. Benin	8.2	4.2	91.8
2. Burkina Faso	6.6	6.2	93.4
3. Cape Verde	82.5	81.6	17.5 6.7
4. Côte d'Ivoire	11.0	6.9	89.0
5. Gambia	3.3	2.2	96.7
6. Ghana	55.2	41.0	44.8
7. Guinea	2.8	2.6	97.2
8. Guinea-Bissau			
9. Liberia	13.2	13.2	86.8
10. Mali	6.7	6.5	93.3
11. Niger	7.0	5.9	93.0
12. Nigeria	2.1	1.2	97.9
13. Senegal	5.8	5.0	94.2
14. Sierra Leone	7.8	7.8	92.2
15. Togo	8.4	7.7	91.6

Source: DHS of countries [25-39]

Table 2.35 shows the Distribution in contraceptive prevalence among women who are not in a union.

The percentage of non-unionized women aged between 15 and 19 years who declared that they had used a contraceptive method ranges from 26.8% (Guinea) to 93.6% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Ghana and Nigeria. In ascending order, the 3 countries with the lowest percentages are: Guinea, Liberia and Cote d'Ivoire.

The percentage of women aged between 15 and 19 years in union who declared that they had

used a modern method of contraception ranges from 22% (Guinea) to 92.3% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Sierra Leone and Ghana. In ascending order, the 3 countries with the lowest percentages are: Guinea, Benin and Cote d'Ivoire.

Table 2.35: Distribution (in %) of women aged between 15 and 24 years who are not in a union and who are sexually active, by contraceptive method currently used

Country	Any method	A method	Not currently used
1. Benin	39.0	23.6	61.0
2. Burkina Faso	51.1	48.8	
3. Cape Verde	93.6	92.3	
4. Côte d'Ivoire	35.1	28.7	64.9
5. Gambia			
6. Ghana	66.6	51.4	33.4
7. Guinea	26.8	22.0	73.2
8. Guinea-Bissau			
9. Liberia	32.9	31.0	67.1
10. Mali			
11. Niger			
12. Nigeria	61.1	49.7	38.9
13. Senegal			
14. Sierra Leone	56.4	53.9	43.6
15. Togo	39.6	41.5	58.5

Source: DHS of countries [25-39]

2.5.2 Knowledge of and practice concerning HIV and sexually transmitted infections

2.5.2.1 Knowledge of HIV/AIDS, means of prevention and transmission

The knowledge of the means of prevention by adolescents and young people is essential if we are to efficiently combat the spread of the virus that causes AIDS. Limiting sexual intercourse to a single faithful and uninfected partner as well as condom use at each intercourse are some of the major ways of preventing HIV infection.

Table 2.36 shows the results of knowledge of HIV/AIDS, means of prevention and transmission by adolescents and young people aged between 15 and 24.years

With regard to women, the percentage which declared that they had heard of AIDS ranges from 82.3% (Niger) to 99.6% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Ghana and Burkina Faso. In ascending order, the 3 countries with the lowest percentages are: Niger, Mali and Benin.

As far as women are concerned, the percentage which declared that they had used condoms during sexual intercourse ranges from 45.5% (Niger) to 87.4% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Togo and Burkina Faso. In ascending order, the 3 countries with the lowest percentages are: Niger, Nigeria and Mali.

Concerning men, the percentage which declared that they had heard of AIDS ranges from 91.9% (Guinea) to 99.8% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Ghana, and Cote d'Ivoire. In ascending order, the 3 countries with the lowest percentages are: Guinea, Nigeria and Benin.

In the case of men, the percentage which declared that they had used condoms during each intercourse ranges from 64.5% (Niger) to 93.3% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Burkina Faso and Benin. In ascending order, the 3 countries with the lowest percentages are: Niger, Liberia and Mali.

Table 2.36: Knowledge of HIV/AIDS, means of prevention and transmission (15-24 years)

Country	Knowledge of AIDS (Have heard of of AIDS)		Knowledge of means of preventing HIV (by using condoms during each intercourse)	
	W	M	W	M
1. Benin	89.4	92.5	68.8	83.4
2. Burkina Faso	97.3	95.4	77.5	86.1
3. Cape Verde	99.6	99.8	87.4	93.3
4. Côte d'Ivoire	93.1	96.4	61.0	77.5
5. Gambia	97.8	96.9	69.1	74.9

6. Ghana	98.2	98.8	74.9	82.5
7. Guinea	94.4	91.9	67.4	76.9
8. Guinea-Bissau				
9. Liberia	97.1	92.8	73.2	66.9
10. Mali	83.9	93.5	55.8	68.4
11. Niger	82.3	93.2	45.5	64.5
12. Nigeria	91.4	92.1	55.8	70.0
13. Senegal	94.9	95.1	67.8	75.0
14. Sierra Leone	94.6	95.3	70.7	78.4
15. Togo	96.4	97.9	77.8	76.6

Source: DHS of countries [25-39]

2.5.2.2 “Indepth” knowledge of HIV/AIDS and knowledge of where to obtain a condom

The data collected on HIV/AIDS and sexual behaviour helped in the calculation of indicators specific to the population of young people aged between 15 and 24 years: “indepth” knowledge of HIV/AIDS and knowledge of where to obtain a condom.

Men who know that the use of a condom during each intercourse and the limitation of sexual intercourse to a single faithful and uninfected partner are considered to have "indepth" knowledge, as these factors reduce the risk of contracting the AIDS virus, those who know that a healthy person could however have contracted the AIDS virus and those who reject the two most common erroneous local ideas about the transmission or prevention of the AIDS virus.

Table 2.37 shows the results of "indepth" knowledge of HIV/AIDS and knowledge of where to obtain a condom for adolescents and young people aged 15-24.

Concerning women, the percentage with”indepth" knowledge of AIDS varies from 14.1% (Niger) to 35.7% (Liberia). In descending order, the 3 countries with the highest percentages are: Liberia, Burkina Faso, and Senegal. In ascending order, the 3 countries with the lowest percentages are: Niger, Cote d'Ivoire and Guinea.

With regard to women, the percentage which knows where to purchase condoms ranges from 14.7% (Niger) to 76.4% (Burkina Faso). In descending order, the 3 countries with the highest percentages are Burkina Faso, Ghana and Liberia. In ascending order, the 3 countries with the lowest percentages are: Niger, Gambia and Mali.

As far as men are concerned, the percentage with “indepth" knowledge of AIDS varies from 24.6% (Cote d'Ivoire) to 35.8% (Burkina Faso). In descending order, the 3 countries with the highest percentages are: Burkina Faso, Guinea and Gambia. In ascending order, the 3 countries with the lowest percentages are: Cote d'Ivoire, Niger and Liberia.

With regard to men, the percentage which knows where to obtain condoms varies from 46.5% (Niger) to 89.9% (Burkina Faso). In descending order, the 3 countries with the highest percentages are: Burkina Faso, Cote d'Ivoire and Ghana. In ascending order, the 3 countries with the lowest percentages are: Niger, Nigeria and Liberia.

Table2.37: "Indepth" knowledge of HIV/AIDS and knowledge of where to obtain a condom (15-24 years)

Country	W		M	
	Percentage with a “ indepth” knowledge of AIDS	Percentage knowledgeable of where to obtain condoms	Percentage with a "indepth" knowledege of AIDS	Percentage knowledgeable about where to obtain condoms
1. Benin	25.5	37.1	27.1	59.3
2. Burkina Faso	31.1	76.4	35.8	89.9
3. Cape Verde				
4. Côte d'Ivoire	15.7	67.2	24.6	87.6
5. Gambia	25.8	28.2	32.3	68.3
6. Ghana	28.3	73.9	34.2	86.8

7. Guinea	22.5	37.5	33.8	
8. Guinea-Bissau				
9. Liberia	35.7	71.3	28.5	68.3
10. Mali	23.7	29.9	33.0	58.1
11. Niger	14.1	14.7	25.4	46.5
12. Nigeria	24.2	45.5	33.5	67.8
13. Senegal	29.4	44.3	30.7	75.0
14. Sierra Leone	28.8	64.3	30.0	79.9
15. Togo	23.3	54.7	31.6	78.3

Source: DHS of countries [25-39]

2.5.3 Factors of the Risk of Violence, road accidents, non-communicable diseases among adolescents and young people

As highlighted in the WHO Adolescent Global Status Report on Non-Communicable Diseases 2014 [68, 69], the consumption of alcohol, tobacco and drugs, malnutrition and physical inactivity are the main risk factors of non-communicable diseases (NCDs), the incidence of which is increasing in sub-Saharan Africa. In this section of the report, we will focus on the risks of non-communicable diseases.

The World Health Organization (WHO) [68] has identified four main categories of NCDs: cardiovascular diseases such as heart attacks and strokes, chronic respiratory diseases such as chronic obstructive pulmonary diseases and asthma, cancers and diabetes. These diseases have four key risk factors in common - tobacco use, harmful use of alcohol, physical inactivity and poor diet - all modifiable behaviours, usually cultivated during adolescence or adulthood and those that facilitate the emergence of NCDs at a later stage in life [68]. Monitoring trends in the four risk factors and intensifying high-impact and cost-effective interventions to create conducive environments for young people are important strategies of curbing NCDs. These activities are particularly crucial in Africa given that the continent has the youngest population in the world, as well as a growing group of young people. If risk behaviours can be prevented in young Africans, the region will have a chance in future to mitigate the potentially high and costly NCD epidemics.

2.5.3.1 Tobacco consumption

Tobacco use is the most preventable cause of illness, disability and death in the world. Each year, 6 million people worldwide die from diseases such as lung cancer and chronic and cardiac respiratory diseases caused by tobacco consumption. In addition, the number of tobacco-related deaths is expected to increase to 8 million by 2030. Smoking is a risk factor for four of the top 10 causes of death in Africa, and tobacco use and dependency of most adult smokers usually begin during adolescence. More than 40 million people smoke in Africa and this number is likely to increase as tobacco companies expand their marketing in the region; [68] but there is not yet adequate legislation in that regard.

Africans start smoking at younger ages. This increases their exposure to NCDs or NCD risks. Although there are significant variations between countries, about one in ten adolescents in Africa smokes cigarettes and the same proportion uses other tobacco products (chewing tobacco or snuff, pipes). Half of all adolescents in Africa are exposed to passive smoking. In many African countries, levels of tobacco use were previously higher in young men than in young women. However, girls are now bridging the gap and, in some places, they are consuming tobacco at even higher rates than boys. And it is common to see that, even when smoking rates are low, the use of other tobacco products is often high, especially amongst girls [[68, 69].

2.5.3.2 Harmful alcohol consumption

In 2012, about 3.3 million deaths worldwide were attributable to alcohol. Drinking also increases the risk of road accidents, unprotected sex, intentional and unintentional injuries, poor mental health and acts of gender-based violence. The number of alcohol consumers is about rising in Africa as multinational beverage companies are taking advantage of the ideal conditions in emerging markets on the continent, especially the high proportion of young people from economic growth and income available to a larger segment of the population.

The commercialization of alcohol in Africa often targets adolescents and young adults with messages that portray alcohol as a symbol of heroism, courage and virility. Non-commercial alcohols such as traditionally-brewed alcohols that are easily accessible to young people are also common in Africa where about one-third of the alcohol consumed is not registered. Studies show that young people who start drinking in early adolescence are much more likely to become addicted to alcohol in the space of 10 years than those who start drinking in their late teens and early twenties, even taking into account the family history of alcohol abuse [68, 69].

2.5.3.3 Poor diet and sendentary lifestyle

Generally, poor nutrition and inadequate physical activity contribute to approximately 12 million deaths per NCDs each year. Diets in many sub-Saharan African countries lack diversity, which means that meals often include a limited number of food nutrient groups. High salt levels, which increase blood pressure, are all the more common as salt is used to preserve food and enhance its taste. The fact that sub-Saharan Africa is urbanizing faster than any other region compounds these problems. Urbanization and increased access to commercially-prepared foods lead to diets that have become poor in fruits, vegetables, proteins and nutritional cereals, and rich in processed foods that contain excessive amounts of sodium, sugar and saturated fats. This change in eating habits is particularly common among low-income earners.

Although levels of physical activity have been relatively high in Africa as part of work and transport, urbanization is making people to become more sedentary. This change also means that some regions lack safe places for children and young people to play outside and exercise together. Changes in eating habits and physical exercise lead to an increase in the number of overweight and obese Africans and the increasing prevalence of lifestyle-induced NCDs such as type 2 diabetes, cardiovascular diseases, stroke and certain cancers. Some countries in sub-Saharan Africa are currently undergoing a nutritional transition, to the extent that obesity is emerging as an essential public health problem, while malnutrition remains a heavy burden. In some areas, the two conditions can also be found within the same household.

Young people are caught in the changes of the world around them and have more and more trouble eating healthily and doing enough exercise. **Sierra Leone** is undergoing a nutritional transition. Indeed, about 22 percent of girls aged between 15 and 19 years are overweight or obese, while 16 percent are underweight.

Among adolescents aged between 13 and 15 years attending a secondary school in **Ghana**, 54 percent of boys and 58 percent of girls consume soft drinks one or more times a day.

2.6 TRADITIONAL PRACTICES HARMFUL TO THE HEALTH OF ADOLESCENTS AND YOUNG PEOPLE

Early marriages and female genital mutilation or excision are traditional practices that are detrimental to the health of adolescents and young people.

2.6.1 Early marriages

The traditional and harmful practice of child marriages persists on a global scale. In developing countries, more than 30 per cent of girls are married before the age of 15. Defined as a customary, religious or legal marriage of anyone under the age of 18, child marriage takes place before a girl is physically and psychologically ready to assume the responsibilities of marriage and motherhood. [70]

As shown in Table 2.38, the percentage of women aged between 15 and 19 years married in 2010 was 8.3% in Ghana and 59.1% in Niger. In descending order, the 3 countries with the highest percentages are: Niger, Mali and Guinea. In ascending order, the 3 countries with the lowest percentages are: Ghana, Cape Verde and Liberia. Note that the rate of Niger is particularly high.

Table 2.38: Girls aged between 15 and 19 years married in ECOWAS countries in 2010

Country	% of women aged 15 to 19 years currently married
1. Benin	21.7
2. Burkina Faso	23.5
3. Cape Verde	9.5
4. Côte d'Ivoire	24.7
5. Gambia	38.8
6. Ghana	8.3
7. Guinea	35.6
8. Guinea-Bissau	21.7
9. Liberia	19.1
10. Mali	50.4
11. Niger	59.1
12. Nigeria	28.7
13. Senegal	24.3
14. Sierra Leone	23.0
15. Togo	21.9

Source: Ford Foundation Report [70]

2.6.2 Female genital mutilation/excision (FGM / E)

Female genital mutilations are interventions that intentionally modify or injure the external genitalia of the woman for non-medical reasons. Such practices have no health benefits for girls and women. They can cause severe haemorrhage and urinary problems, and subsequently cysts, infections, infertility, complications during childbirth, and increase the risk of death of a newborn. Most often, they are carried out on young girls between childhood and the age of 15 years. Female genital mutilation is seen as a violation of the rights of girls and women. In Africa, it is estimated that more than three million girls are threatened with these practices every year.

As shown in Table 2.39, the percentage of women who have undergone FGM / E varies from 1.4% (Niger) to 94% (Guinea). In descending order, the 3 countries that seem to have the highest percentages are: Guinea, Mali and Gambia. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Togo and Benin.

Table 2.39: Female genital mutilation

Country	Percentage of women who have been subjected to female genital mutilation
1. Benin	2.0
2. Burkina Faso	57.7
3. Cape Verde	
4. Côte d'Ivoire	31.3
5. Gambia	76.3
6. Ghana	
7. Guinea	94.0
8. Guinea-Bissau	
9. Liberia	
10. Mali	90.3
11. Niger	1.4
12. Nigeria	15.3
13. Senegal	24.0
14. Sierra Leone	74.3
15. Togo	1.8

Source: DHS of countries [25-39]

2.7 ACCESS OF ADOLESCENTS AND YOUNG PEOPLE TO INFORMATION AND COMMUNICATION TECHNOLOGIES AND SOCIAL NETWORKS

The adolescence landscape is also changing dramatically. Traditional family and community influences remain important, but today's youths are equally influenced by new factors, particularly the rapid spread and pervasiveness of the social media. Young people were the first and most numerous users of the social media, such as *Facebook and Twitter*. These modes of communication have changed the nature and interaction of adolescent groups and have accelerated the rate at which socio-cultural norms are transformed and spread. Social media offers opportunities to increase youth participation and visibility in policy formulation and programme design and can be a new and effective way of reaching a large number of youn people with regard to interventions in the area of promoting health. Nevertheless, the intensive use of the social media and other new technologies can have negative effects (for instance, decreased physical activity and even schooling or online harassment) in the absence of parental control in particular [14].

2.7.1 **Exposure of young people to the media (electronic and print**)

Data on the exposure of women and men to the media (electronic or print) are particularly important for instituting education and information dissemination programmes in all domains, especially those relating to health and family planning.

Table 2.40 presents the results of media exposure of women aged between 15 and 19 years and 20-24 years. (Percentage of women aged 15-19 years and 20-24 years who usually read newspapers, watch Television and/or listen to the radio, at least, once a week).

- **Women aged between 15 and 19 years**

In Table 2.40, we note the following salient facts:

- The percentage of women aged 15-19 years who read newspapers at least once a week is generally low in all the countries. This percentage ranges from 4% (Niger) to 25.6% (Ghana). In descending order, the 3 countries with the highest percentages are: Ghana, Benin and Senegal. In ascending order, the 3 countries with the lowest percentages are: Niger, Guinea and Burkina Faso.
- The percentage of women who watch television on a monthly basis varies from 17.4% (Sierra Leone) to 70.1% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Senegal and Ghana. In ascending order, the 3 countries with the lowest percentages are: Sierra Leone, Niger and Liberia.
- The percentage of women who listen to the radio at least once a week ranges from 23.6% (Cote d'Ivoire) to 73.9% (Ghana). In descending order, the 3 countries with the highest percentages are: Ghana, Cape Verde and Senegal. In ascending order, the 3 countries with the lowest percentages are: Cote d'Ivoire, Niger. Nigeria.
- The percentage of women who consult the three media networks at least once a week varies from 2.6% (Niger) to 19.4% (Ghana). In descending order, the 3 countries with the highest percentages are Ghana, Benin and Senegal. In ascending order, the 3 countries with the lowest percentages are: Niger, Burkina Faso and Sierra Leone.
- The percentage of women who do not consult any media network at least once a week varies from 12.5% (Cape Verde) to 56.1% (Niger). In descending order, the 3 countries with the highest percentages are: Niger, Liberia and Sierra Leone. In ascending order, the 3 countries with the lowest percentages are: Cape Verde, Ghana and Senegal.

- **Women aged between 20-24 years**

In Table 2.44, we note the following salient facts:

- The percentage of women aged between 20 and 24 years who read newspapers at least once a week is generally very low in all the countries. This percentage ranges from 2.1% (Niger) to 18.8% (Ghana). In descending order, the 3 countries with the highest percentages are: Ghana, Senegal and Cote d'Ivoire. In ascending order, the 3 countries with the lowest percentages are: Niger, Burkina Faso and Mali.

- The percentage of women who watch television on a monthly basis is relatively high, depending on the country, and ranges from 15.8% (Niger) to 66.5% (Cape Verde). In descending order, the 3 countries with the highest percentages are: Cape Verde, Senegal and Ghana. In ascending order, the 3 countries with the lowest percentages are: Niger, Sierra Leone and Liberia.
- The percentage of women who listen to radio at least once a week, which is relatively high in different countries, ranges from 26.9% (Cote d'Ivoire) to 73.9% (Ghana). In descending order, the 3 countries with the highest percentages are: Ghana, Cape Verde and Senegal. In ascending order, the 3 countries with the lowest percentages are: Cote d'Ivoire, Niger and Nigeria.
- The percentage of women who consult the three media networks at least once a week is generally very low in all the countries. This percentage ranges from 1.4% (Niger) to 14.4% (Ghana). In descending order, the 3 countries with the highest percentages are: Ghana, Benin and Senegal. In ascending order, the 3 countries with the lowest percentages are: Niger, Burkina Faso, and Sierra Leone.
- The percentage of women who do not consult any media network at least once a week varies from 12.7% (Ghana) to 61% (Niger). In descending order, the 3 countries with the highest percentages are: Niger, Liberia and Sierra Leone. In ascending order, the 3 countries with the lowest percentages are: Ghana, Cape Verde, and Senegal.

Table 2.40: Exposure to the Media: Women: Percentage of women aged between 15 and 49 years who usually read newspapers, watch television and/or listen to the radio, at least once a week (Adolescents and Young People between 15 and 19 years and 20-24 years).

Country	Age Group	Read newspaper at least once a week	Watch TV at least once a week	Listen to the radio at least once a week	The three media networks at least once a week	None of the media networks at least once a week
1. Benin	15-19 years 20-24 years	16.2 10.4	42.0 40.4	47.6 46.7	11.8 8.6	40.6 42.0
2. Burkina Faso	15-19 years 20-24 years	6.7 6.1	28.9 23.4	42.5 47.4	3.6 3.6	44.9 44.9
3. Cape Verde	15-19 years 20-24 years	8.2 9.2	70.1 66.5	68.8 65.4	5.7 5.5	12.5 13.8
4. Côte d'Ivoire	15-19 years 20-24 years	10.1 12.4	56.4 52.1	23.6 26.9	4.9 7.9	37.8 42.0
5. Gambia	15-19 years 20-24 years	9.3 11.9	48.6 51.8	58.6 64.7	7.1 8.6	30.3 25.3
6. Ghana	15-19 years 20-24 years	25.6 18.8	62.1 61.1	73.9 79.5	19.4 14.4	15.2 12.7
7. Guinea	15-19 years 20-24 years	6.4 7.8	36.0 36.1	41.9 44.1	4.7 5.9	47.1 46.3
8. Guinea-Bissau	15-19 years 20-24 years					
9. Liberia	15-19 years 20-24 years	10.2 11.1	24.3 20.8	39.6 40.7	6.3 6.4	52.7 53.7
10. Mali	15-19 years 20-24 years	10.4 7.2	40.9 36.9	48.8 48.4	7.9 4.9	40.5 41.8

11. Niger	15-19 years 20-24 years	4.0 2.1	20.7 15.8	36.2 33.0	2.6 1.4	56.1 61.0
12. Nigeria	15-19 years 20-24 years	9.8 10.0	37.3 37.1	37.3 39.3	7.0 7.2	50.0 49.5
13. Senegal	15-19 years 20-24 years	15.5 14.5	66.0 65.2	61.7 64.9	11.0 11.3	18.9 17.7
14. Sierra Leone	15-19 years 20-24 years	9.6 9.3	17.4 18.8	43.5 41.9	4.5 4.7	51.1 52.2
15. Togo	15-19 years 20-24 years	9.2 8.9	43.7 49.3	44.0 53.2	5.3 5.6	37.4 30.4

Source: DHS of countries [25-39]

- **Men aged between 15 and 19 years**

Table 2.41 shows the results of exposure to the media of men aged between 15 and 19 years and 20-24 years (Percentage of men aged between 15 and 24 years who usually read newspapers, watch TV and/or listen to radio at least once a week).

In Table 2.41, we note the following salient facts:

- The percentage of men aged between 15 and 19 years who read newspapers at least once a week is generally low in all the countries. This percentage ranges from 2.8% (Niger) to 22.3% (Liberia). In descending order, the 3 countries that seem to have the highest percentages are: Liberia, Ghana and Benin. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Cape Verde and Togo.
- The percentage of men who watch TV on a monthly basis varies from 20.4% (Sierra Leone) to 75.2% (Senegal). In descending order, the 3 countries that seem to have the highest percentages are: Senegal, Cape Verde and Cote d'Ivoire. In ascending order, the 3 countries that seem to have the lowest percentages are: Sierra Leone, Niger and Burkina Faso.
- The percentage of men who listen to the radio at least once a week ranges from 22.8% (Niger) to 83.7% (Ghana). In descending order, the 3 countries that seem to have the highest percentages are: Ghana, Gambia and Cape Verde. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Cote d'Ivoire and Guinea.
- The percentage of men who consult the three media networks at least once a week varies from 1.7% (Niger) to 16.0% (Ghana). In descending order, the 3 countries that seem to have the highest percentages are: Ghana, Senegal and

Liberia. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Cape Verde and Burkina Faso.

- The percentage of men who do not consult any media network at least once a week varies from 10.2% (Ghana) to 65.4% (Niger). In descending order, the 3 countries that seem to have the highest percentages are: Niger, Nigeria and Guinea. In ascending order, the 3 countries that seem to have the lowest percentages are: Ghana, Cape Verde, and Senegal.

- **Men aged 20-24 years**

In Table 2.41, we note the following salient facts:

-
  The percentage of men aged between 20 and 24 years who read newspapers at least once a week is generally very low in all the countries. This percentage ranges from 6.7% (Cape Verde) to 41.2% (Liberia). In descending order, the 3 countries that seem to have the highest percentages are: Liberia, Ghana and Senegal. In ascending order, the 3 countries that seem to have the lowest percentages are: Cape Verde, Niger and Togo.
- The percentage of men who watch TV on a monthly basis, which is relatively high by country, ranges from 24.0% (Sierra Leone) to 79.8% (Senegal). In descending order, the 3 countries that seem to have the highest percentages are: Senegal, Cape Verde, and Cote d'Ivoire. In ascending order, the 3 countries that seem to have the lowest percentages are: Sierra Leone, Niger and Liberia.
- The percentage of men who listen to the radio at least once a week, which is relatively high in different countries, ranges from 43.6% (Niger to 87.8% (Ghana). In descending order, the 3 countries that seem to have the highest percentages are: Ghana, Senegal and Cape Verde. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Cote d'Ivoire and Nigeria.
- The percentage of men who consult the three media networks at least once a week is generally very low in all the countries. This percentage ranges from 4.8% (Niger) to 26.2% (Ghana). In descending order, the 3 countries that seem to have the highest percentages are Ghana, Senegal and Benin. In ascending order, the 3 countries that seem to have the lowest percentages are: Niger, Burkina Faso and Togo.
- The percentage of men who do not consult any media network at least once a week varies from 8.1% (Ghana) to 50.1% (Niger). In descending order, the 3 countries that seem to have the highest percentages are: Niger, Liberia, and Sierra Leone. In ascending order, the 3 countries that seem to have the lowest percentages are: Ghana, Cape Verde, and Senegal.

Table 2.41: Exposure to the Media: Men: Percentage of men aged between 15 and 49 years who usually read newspapers, watch TV and/or listen to the radio, at least once a week (Adolescents and Young People between 15 and 19 years and between 20 and 24 years).

Country	Age group	Read newspapers at least once a week	Watch TV at least once a week	Listen to the at least once a week	The three media networks at least once a week	None of the networks at least once a week
1. Benin	15-19 years 20-24 years	17.0 21.6	44.3 52.3	54.1 63.2	12.2 17.8	32.8 23.9

	20-24 years					
2. Burkina Faso	15-19 years 20-24 years	8.8 13.4	28.7 38.3	51.0 70.5	3.7 8.2	38.8 22.8
3. Cape Verde	15-19 years 20-24 years	5.3 6.7	75.1 71.1	64.4 74.1	3.1 5.4	12.0 9.7
4. Côte d'Ivoire	15-19 years 20-24 years	14.4 20.5	63.5 64.4	37.5 50.5	10.0 16.8	27.5 23.8
5. Gambia	15-19 years 20-24 years	11.7 22.0	58.9 66.6	68.2 75.7	7.0 17.0	17.8 14.5
6. Ghana	15-19 years 20-24 years	20.5 32.1	62.8 67.7	83.7 87.8	16.0 26.2	10.2 8.1
7. Guinea	15-19 years 20-24 years	10.8 20.7	35.7 43.8	41.2 56.7	6.9 13.6	45.3 33.9
8. Guinea-Bissau	15-19 years 20-24 years					
9. Liberia	15-19 years 20-24 years	22.3 41.2	30.7 29.6	48.0 62.2	12.7 17.9	41.4 29.5
10. Mali	15-19 years 20-24 years	13.6 20.1	54.6 54.3	57.3 73.8	10.2 16.3	26.1 18.3
11. Niger	15-19 years 20-24 years	2.8 7.9	23.5 26.2	22.6 43.6	1.7 4.8	65.4 50.1
12. Nigeria	15-19 years 20-24 years	10.2 21.9	35.7 40.2	44.1 53.0	7.3 15.7	46.1 37.8
13. Senegal	15-19 years 20-24 years	16.4 24.9	75.2 79.8	57.0 74.8	13.2 22.2	14.5 9.0

14. Sierra Leone	15-19 years 20-24 years	13.9 21.9	20.4 24.0	50.8 60.7	8.1 12.4	44.7 34.7
15. Togo	15-19 years 20-24 years	7.8 11.6	43.1 50.8	58.6 68.1	6.2 8.7	33.5 24.0

Source: DHS of countries [25-39]

2.7.2 Access to Mobile Phones

According to the 2012 Report of the Observatory of mobile telephony in sub-Saharan Africa [104], since 2000, the number of mobile phone connections in sub-Saharan Africa has increased by 44%, while the average for the same period is 34% in developing regions and only 10% in developed regions (Chart 2.6).

The mobile telephone network growth, which reflects the region's economic expansion, is expected to continue in the medium term. Operators in five main markets in sub-Saharan Africa (Nigeria, Tanzania, South Africa, Kenya and Ghana) invested US$ 16.5 billion in the last five years and US$ 2.8 billion in 2011 alone. This investment enabled the deployment of new base stations in order to increase the total capacity of the mobile networks. For example, the number of base stations installed in SSA increased by more than 250% between 2007 and 2012 in the five countries mentioned above (Chart 2.7).

Investment in mobile network infrastructure is essential for the population of sub-Saharan Africa. Mobile telephone services are the main means of communication. For instance, in 2010, all SSA countries had an average of 28 mobile subscriptions to a fixed line.

It has been established that adolescents and young people in sub-Saharan Africa constitute the segment of the population that has contributed to this growth of mobile phones.

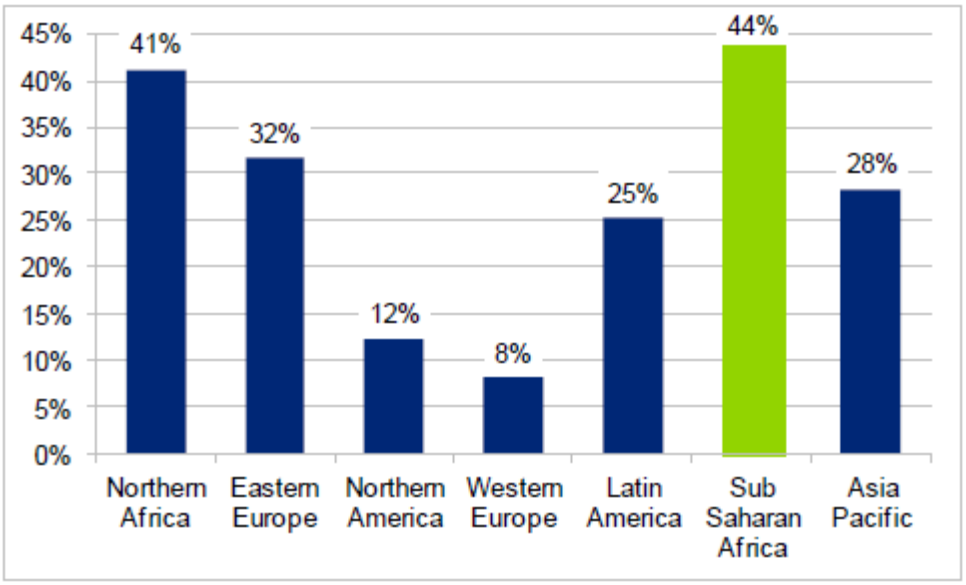


Chart 2.6: Growth in the number of mobile connections, in%, 2000-2012

Table 2.42 based on the 2010 Human Development Report [105] shows the level of access to mobile phones in ECOWAS countries from 2000 to 2008.

Mobile telephony access varies from 22% (Mali) to 96% (Cape Verde). The access rate is above 50% in 13 out of the 14 countries on which data is available.

Table 2.42: Access to mobile telephones in ECOWAS countries (2010)

Country	**Population served by a mobile telephone network (%)**
1. Benin	80
2. Burkina Faso	61
3. Cape Verde	96
4. Côte d'Ivoire	59
5. Gambia	85
6. Ghana	73
7. Guinea	80
8. Guinea-Bissau	65
9. Liberia	
10. Mali	22
11. Niger	45
12. Nigeria	83
13. Senegal	85
14. Sierra Leone	70
15. Togo	85

Source: 2010 UNDP Report[72]

2.7.3 Access to the Internet and social networks (Facebook)

Table 2.43 presents the statistics of Internet and network users in ECOWAS countries. We note that the internal penetration rate in the ECOWAS countries ranges from 2.0% (Niger) to 51.9% (Senegal). It should be noted that the vast majority of users are adolescents and young people.

Table 2.43: Internet users in ECOWAS countries

Internet users by the third quarter of 2015 in ECOWAS countries						
ECOWAS countries	**Population (2015 Est.)**	**Internet users 31-Dec-2000**	**Internet 15-Nov-2015**	**Penetration (% Population)**	**Internet % Africa**	**Facebook 15-Nov-2015**
Benin	10,448,647	15,000	**1,232,940**	11.8 %	0.4 %	570,000
Burkina Faso	18,931,686	10,000	**1,779,578**	9.4 %	0.5 %	490,000
Cape Verde	545,993	8,000	**219,817**	40.3 %	0.1 %	190,000
Cote d'Ivoire	23,295,302	40,000	**5,230,000**	22.5 %	1.6 %	1,800,000
Gambia	1,967,709	4,000	**373,865**	19.0 %	0.1 %	180,000
Ghana	26,327,649	30,000	**5,171,993**	19.6 %	1.6 %	2,900,000
Guinea	11,780,162	8,000	**770,000**	6.5 %	0.1 %	770,000
Guinea-Bissau	1,726,170	1,500	**70,000**	4.1 %	0.0 %	70,000
Liberia	4,195,666	500	**348,240**	8.3 %	0.1 %	260,000
Mali	16,955,536	18,800	**1,186,888**	7.0 %	0.4 %	770,000
Niger	18,045,729	5,000	**351,892**	2.0 %	0.1 %	230,000
Nigeria	181,562,056	200,000	**92,699,924**	51.1 %	28.2 %	15,000,000
Senegal	13,975,834	40,000	**7,260,000**	51.9 %	2.2 %	1,700,000
Sierra Leone	5,879,098	5,000	**260,000**	4.4 %	0.1 %	260,000
Togo	7,552,318	100,000	**430,482**	5.7 %	0.1 %	280,000
TOTAL AFRICA	**1,158,355,663**	**4,514,400**	**328,180,311**	**28.3 %**	**100.0 %**	**124,568,500**

Source: Internet World Stats [73]

PART THREE: RESULTS OF THE ANALYSIS IN FIVE ECOWAS COUNTRIES

The part three reports on the results of the analysis in the 5 selected countries: Benin, Cape Verde, Nigeria, Senegal and Sierra Leone. It is structured into three sub-parts. The first sub-part presents the results of the interview with the managers of Adolescent and Youth Reproductive Health (AYRH) Directorates or Divisions in the countries (AYRH). The second sub-part outlines the views of the major stakeholders in the area of adolescent and youth health in the countries. The third sub-part presents the facts observed in national reference documents and in the structures providing health services to adolescents and young people.

3.1 RESULTS OF INTERVIEW WITH MANAGERS OF ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH (AYRH) DIRECTORATES OR DIVISIONS OF THE COUNTRIES

This section presents the various pieces of information collected from the Adolescent and Youth Reproductive Health Directorates or Divisions of the Ministries of Health in the countries visited.

3.1.1 Definitions adopted by the countries

The definition of adolescence is uniform in all the countries visited. Indeed, in all the countries visited, it is defined as people within the 10 to 19 year age group.
However, a few differences persist in respect of the use of young and youth. Whereas the French and Portuguese-speaking countries (Benin, Senegal and Cape Verde) have adopted the definition proposed by WHO for young and youth, the English-speaking countries (Nigeria and Sierra Leone) use the terms "young people" and "youth" in a different way.
The definitions adopted by the countries are summarized in Table 3.1 below.

Table 3.1: Definition of the Adolescent, Young and Youth Concepts, according to the Countries.

Countries	Country definitions	WHO definition
Benin	Adolescent : 10-19 years Young person : 15-24 years Youth (adolescents and young people):10-24 years	Teenager (Adolescent): 10-19 years "Young people": 15-24 years "Youth": 10-24 years
Cape Verde	Adolescent : 10-19 years Young person : 15-24 years Youth (Adolescents and young people:10-24 years	
Nigeria	Adolescent: 10-19 years "Young people": Young person : 10-24 years "Youth" : 15 to 35 years	
Senegal	Adolescents : 10-19 years Youth (Adolescents and young people): 10-24 years	

	Young people : 18--35 years (Youth Ministry)	
Sierra Leone	Adolescent: 10-19 years “Young people” : 10-24 years “Youth” : 15 to 35 years	

3.1.2 Existence of adolescent and youth health strategic and/or operational partners

As indicated in Table 3.2, the countries have different types of strategic or operational partners (implementing partners) in the area of adolescent and reproductive health. They include the Ministries (public sector), United Nations institutions, bilateral institutions, international and national NGOs.

The total number of partners listed by the countries varies between 18 (Senegal) and 30 (Benin). It must however be noted that in Cape Verde, the profit-making private sector contributes to AYH. The list of partners per country can be seen in Annex 1.

Table 3.2: Existence of strategic/operational partners supporting adolescent and youth health interventions

Stakeholders	**Benin**	**Cape Verde**	**Nigeria**	**Senegal**	**Sierra Leone**
Existence of partners					
1 Ministry of Health	YES	YES	YES	YES	YES
2 Ministry of Youth	YES	YES	YES	YES	YES
3 Other Ministries	YES	YES	YES	YES	YES
4 United Nations Agencies (UN)	YES	YES	YES	YES	YES
5 Bilateral Institutions (BI)	YES	YES	YES	YES	YES
6 International NGOs (INGOs)	YES	YES	YES	YES	YES
7 National NGOs (NNGOs)	YES	YES	YES	YES	YES
8 Profit-making Private sectors (PS)	**NO**	YES	**NO**	**NO**	**NO**
9 Academic Institutions (AI)	YES	YES	YES	YES	**NO**
10 Civil Society Organizations (CSOs)	YES	YES	YES	YES	YES
Total number of partners					
Number of partners cited	30	22	23	18	20

3.1.3 Management structure and coordination mechanism

All the countries visited have a unit within the Ministry of Health responsible for managing adolescent and youth health activities. Apart from the management unit, every country has an adolescent and youth health activity coordination mechanism.

Benin

Management structure

Adolescent and Youth Reproduction Division (AYRH) located within the Adolescent and Youth Reproductive Health and Family Planning Service.
It falls under the mandate of the Manager of the FP and AYRH Service and the Manager of the AYRH Division who is a public health medical officer.

Coordination Mechanism

National Coordination Committee for intervention and dialogue with the departmental and local divisions.
As the technical steering structure for the strategy, it provides useful information concerning the strategy; it provides useful information to the National Policy Committee for strategic decision-making and technical support for the sector Committees in order to promote prudent implementation of the multi-sectoral programs.
The National Policy Committee is made up of representatives of the sector Ministries, **CSOs** operating **in AYRH** with a national coverage, national youth organizations, the national Anti-AIDS Program (PNLS) and its decentralized organs at the departmental level. II is chaired by the Mother and Child Health Directorate. The Coordination Committee meets once on quarterly basis. It is decentralized at the departmental level (departmental Coordinating Committee and health zones (local development committee) with the same mission.

Management Body

"Gender, Adolescence, and Elderly Division" (GAED) located at the Family Health Directorate headed by a medical officer.

Coordination Mechanism

"National Adolescent Technical Working Group" with its divisions in 32 States. It is a body for strategic decision-making and technical support for adolescent and youth health. The Technical Working Group comprises of the main stakeholders of the AYRH of the country.

Cape Verde

In addition to preventing diseases and improving access to specific quality healthcare, the general objectives of the partnership or rather of the coordination, consist of promoting and adopting healthy lifestyles.
The Ministry of Health, through the National Health Directorate and the National Adolescent Health Program established a national health policy by drawing up a national health development plan and ensuring coordination and support for activities with the various partners.

At the local level, the health representatives coordinate the health centres which provide primary health care and also work with the community.
The Ministry of Justice operates in the area of legislation by ensuring that adolescent protection rights are updated (for example, the Statute on Childhood and Adolescence). It also coordinates actions aimed at combating the use of drugs.

The international organizations and bilateral partners also provide technical support and/or financial assistance to Nigeria.

Senegal

Management body

The Adolescence and Youth Reproductive Health Division (AYRH) is located within the Directorate of Reproductive Health and Child Survival (DSRSE). It is headed by the Manager of the AYRH Division who is a medical officer.

Coordination Mechanism

Multisectoral consultative framework

It is a consultative and strategic decision-making and technical support body for adolescent and youth health. The Technical Working Group is made up of the main stakeholders involved in AYRH in the country.

Sierra Leone

Management body

"National School and Adolescent Health Program "located within the National Reproductive and Child Health Directorate. It is headed by a "Sister" (or a specialist nurse)

Coordination Mechanism

Multisectoral Technical Committee (MTC)

It is a consultative and strategic decision-making and technical support body for adolescent and youth health.

The MTC is made up of focal persons of Ministers (Ministries of Education, Science and Technology, Ministries of Social Welfare, Gender and the Child), Ministry of Youth, Ministry of Local Government and Rural Development, Ministry of Health and Sanitation), the technical staff of United Nations Agencies and NGOs.

3.1.4 National Leadership, Resource Mobilisation and Advocacy

In this section, the following parameters relating to adolescent and youth health are explored at the Ministries of Health of the countries visited: national leadership, resource mobilization and national adolescent and youth legal protection instruments.

3.1.4.1 Existence of National Leadership for Adolescent and Youth Health

National leadership was assessed by the answers provided for 8 questions put to adolescent and youth health leaders. The common points and specificities were noted.

Common points among the countries

All the countries provided postive responses concerning the following points:

- Adolescent and youth health is a matter of concern at the highest strategic level of the country?
- Has the country developed a national strategic document or roadmap to reduce maternal and neonatal mortality?
- Has the country developed a national strategic document for adolescents and young people?

- Has the country developed standards of quality friendly health services for adolescent and youth health?
- In addition to being beneficiaries of interventions, how are adolescents and young people involved in the decision-making process concerning their health problems?

Differences among the countries

Nigeria indicated that adolescent and youth health is not a priority at the country's highest strategic level (National Authorities) in view of the under-financing or lack of financing of the sector by the State. The other countries answered in the affirmative.

Benin indicated that the country had not established any plan of action for adolescents and young people, neither had it got any budget in place for that heading; however the other countries responded in the affirmative.

Modalities for the involvement of adolescents and young people in decision-making concerning their health issues:

Benin: The young people are represented at all levels of the institutional framework.
Cape Verde: Young people are represented at all levels of the institutional framework.
Nigeria: Youth groups participate and contribute to discussions at meetings.
Senegal: Some young people are involved in the development of the PSSRAJ
Sierra Leone: Young people are brought on board at multi-sectoral committee meetings and during the activity implementation process.

3.1.4.2 Advocacy and resource mobilization

Advocacy and resource mobilization were assessed by answers to 2 questions addressed to adolescent and youth health officials. The common points and the specificities were noted.

All the countries provided positive answers to the following two questions asked:
- Are the authorities engaged in the process of resource mobilization (internal and external) in order to tackle adolescent and youth health problems?
- Is the health of adolescents and young people a topical issue for advocacy at the highest strategic level of the country (national authorities)

3.1.5 Legal measures

The legal measures were evaluated by the answers to 4 questions directed at the officials concerned with adolescent and youth health. The common points and specificities were noted.

Common points among the countries
- The right to health is recognized in the country's policies, strategies and health plans including those touching on adolescent and youth health
  The legal age of majority is 18 in all the countries
- The minimum marital age is 18 for boys in all the countries
- For unmarried adolescents, the HIV law exists and it enjoins minor adolescents to give their consent for HIV testing and counseling
- No provision has been set out in the laws and regulations to enable minors to give their consent for medical procedures.

Differences among the countries

- The minimum age for marriage is 18 years for girls in all the countries visited except Senegal where the age for girls is 16 years (thus lower than that of boys)
- For unmarried adolescents, the RH law exists and it enjoins minor adolescents to give their consent for contraceptive services with the exception of sterilization in all the countries except Nigeria.
- For unmarried adolescents, the RH law exists and it enjoins minor adolescents to give their consent for emergency contraception in all the countries except Nigeria.

3.1.6 Adolescent and Youth Health Policies, Strategies and Guidelines

In this section, we explored the main parameters concerning adolescent and youth health policies, strategies and guidelines in ECOWAS countries.

3.1.6.1 Conduct of an Adolescent and Youth Health Situational Analysis

Four countries confirmed that they had conducted an adolescent and youth reproductive health situational analysis. However, the reports on these studies were not available. According to the descriptions made by the respondents, it can be concluded that in most cases, they were very brief analyses; indeed they are more of literature review than a formal situational analysis. Furthermore, it does not contain disaggregated data concerning, for example: age groups, rural/urban divide, socio-economic factors, socio-political factors, political/strategic environment of the country and the coverage at all levels (national, intermediate and local levels.

We must point out that the AYH concept and all other health aspects concerning this social stratum, to a large extent, are not in place in the countries visited; the AYSRH still remains the dominant theme.

3.1.6.2 Place of Adolescent and Youth Health in the Country's Policies/Strategies

Table 3.3 shows only the health problems for which adolescents and young people have been mentioned as target groups.

Common points among the countries

The respondents from all the countries indicated that adolescents and young people are mentioned as target groups as far as the following health problems are concerned: sexual and reproductive health problems including pregnancies among adolescent girls, sexually transmitted infections (STIs)/HIV, excessive use of tobacco and alcohol, consumption of harmful substances.

Differences among the countries

Poor nutrition, the lack of physical exercises, mental health problems, injury caused by motor traffic accidents, violence, autolysis and lack of communication between parents and adolescents and young people were mentioned by all the countries except Benin.
Furthermore, adolescents and young people are not mentioned as a target group in Cape Verde in respect of injury caused by motor traffic accidents.

Table 3.3: Main health problems in which adolescents and young people have been mentioned as target groups

Main health problems	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Sexual and reproductive health including teenage pregnancies	YES	YES	YES	YES	YES
2. Sexually Transmitted Infections/HIV	YES	YES	YES	YES	YES
3. Poor nutrition	NO	YES	YES	YES	YES
4. Lack of dieting and physical activity (Inactivity)	NO	YES	YES	YES	YES
5. Excessive use of tobacco	YES	YES	YES	YES	YES
6. Excessive use of alcohol	YES	YES	YES	YES	YES
7. Consumption of harmful substances	YES	YES	YES	YES	YES
8. Mental Health	NO	YES	YES	YES	YES
9. Injuries caused by motor traffic accidents	NO	NO	YES	YES	YES
10. Violence including autolysis	NO	YES	YES	YES	YES
11. Lack of communication between parents and young people	NO	YES	YES	YES	YES

3.1.6.3 Availability of specific adolescent and youth health strategies

As shown in Table 3.4, the respondents in all the countries mentioned as having establishd specific strategies to address adolescent and youth health problems. However, Cape Verde indicated that it does not have specific strategies for injuries on public roads. Benin stated that such a strategy has not been formulated for difficult communication between parents and their children.

Table 3.4: Availability of specific adolescent and youth health strategies

Main Health Problems	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Sexual and reproductive health including teenage pregnancy	YES	YES	YES	YES	YES
2. Sexually Transmitted Infections/HIV	YES	YES	YES	YES	YES
3. Poor nutrition	YES	YES	YES	YES	YES
4. Lack of dieting and physical activity (Inactivity)	YES	YES	YES	YES	YES
5. Excessive use of tobacco	YES	YES	YES	YES	YES
6. Excessive use of alcohol	YES	YES	YES	YES	YES
7. Consumption of harmful substances	YES	YES	YES	YES	YES
8. Mental health	YES	YES	YES	YES	YES
9. Injuries caused by motor traffic accidents	YES	**NO**	YES	YES	YES
10. Violence including autolysis	YES	YES	YES	YES	YES
11. Problem of communication between parents –adolescents and young people	**NO**	YES	YES	YES	YES

3.1.6.4 Availability of national standards for the provision of services to adolescents and young people

According to the respondents, all the countries visited indicated that they had national standards for the provision of services to adolescents and young people that meet the following criteria:

- Clear definition of adolescent and youth health risks.
- Package of well-defined health services except in Cape Verde
- Specification of adolescent groups for which services will be provided except in Cape Verde.
- Training of service providers on adolescent and youth health.

Concerning the inclusion of the main adolescent and youth health as shown in Table 3.5, the respondents in all the countries indicated that the standards developed have taken into account the sexual and reproductive health including teenage pregnancies, sexually transmitted infections/HIV and violence including autolysis. The 8 other health problems were indicated to have been taken into account by all the countries except in Benin.

Table 3.5: Consideration of Adolescent and Youth Health Problems by Standards

Main Health Problems	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Sexual and reproductive health including teenage pregnancies	YES	YES	YES	YES	YES
2. Sexual and reproductive health including teenage pregnancies	YES	YES	YES	YES	YES
3. Poor nutrition	**NO**	YES	YES	YES	YES
4. Lack of dieting and physical activity (Inactivity)	**NO**	**NO**	YES	YES	YES
5. Excessive use of tobacco	**NO**	**NO**	YES	YES	YES
6. Excessive use of alcohol	**NO**	YES	YES	YES	YES
7. Consumption of harmful substances	**NO**	YES	YES	YES	YES
8. Mental Health	**NO**	YES	YES	YES	YES
9. Injuries caused by motor traffic accidents	**NO**	**NO**	YES	YES	YES
10. Violence including autolysis	YES	YES	YES	YES	YES
11. Problem of communication between parents –adolescents and young people	**NO**	YES	YES	YES	YES

3.1.7 Interventions and provision of services to adolescents and young people

3.1.7.1 Availability of services for adolescents and young people

Table 3.6 shows the availability of interventions to address the main health problems of adolescents and young people in the countries visited.

Common points among the countries

The respondents from all the countries indicated the availability of interventions to address the following main health problems: sexual and reproductive health problems including teenage pregnancies, sexually transmitted infections/HIV and violence including autolysis.

Differences among the countries

The interventions to address the following health problems are available only in Nigeria but not in the other countries: Poor nutrition, lack of dieting and physical activity (inactivity), excessive use of tobacco and abuse of alcohol, consumption of harmful substances, mental health, injuries caused by motor traffic accidents and problem of communication between parents and adolescents and young people.

Table 3.6: Availability of interventions to address the main health problems

Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Sexual and reproductive health including teenage pregnancies	YES	YES	YES	YES	YES
2. Sexual and reproductive health including teenage pregnancies	YES	YES	YES	YES	YES
3. Poor nutrition	**NON**	YES	YES	YES	**NO**
4. Lack of dieting and physical activity (Inactivity)	**NO**	YES	YES	YES	**NO**
5. Excessive use of tobacco	**NO**	NON	YES	**NO**	**NO**
6. Excessive use of alcohol	**NO**	YES	YES	**NO**	**NO**
7. Consumption of harmful substances	**NO**	YES	YES	**NO**	**NO**
8. Mental health	**NO**	NO	YES	YES	YES
9. Injuries caused by motor traffic accidents	**NO**	NO	YES	**NO**	**NO**
10. Violence including autolysis	YES	YES	YES	YES	YES
11. Problem of communication between parents and adolescents and young people	**NO**	YES	YES	**NO**	**NO**

3.1.7.2 Availability of welfare/counselling structures for adolescents and young people.

In all the countries visited, there are welfare and counselling structures (equivalents) for adolescents and young people including adolescent and youth associations. All the countries have health service plans suitable for adolescents and young people except in Benin. Only Sierra Leone mentioned the availability of parental associations or groups for adolescents and young people (Table 3.7).

Table 3.7: Availability of Counselling and Welfare/Service Structures for Adolescents and Young People

Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Availability of a health service plan suitable for adolescents and young people	NO	YES	YES	YES	YES
2. Existence of adolescent and youth welfare and counselling structures or (equivalents) in the country	YES	YES	YES	YES	YES
3.Existence of adolescent and youth associations in the country	YES	YES	YES	YES	YES
4.Existence of Parental Associations/Groups for Adolescents and Young People in the country	**NO** but there are Parent-Teacher Associations	YES	**NO**	**NO** but there are Parent-Teacher Associations	YES

3.1.7.3 Provision of Services to Female Adolescents and Young People

As shown in Table 3.8, the following services are provided to adolescents and young people in all the countries visited: taking care of sexually transmitted infections, pregnancy and delivery-related health services, care and support for young people who are HIV positive including addressing issues of sexual violence.
Information and counseling services on emergency contraception are provided to adolescent and young girls only in Senegal and Sierra Leone. On the other hand, abortion care services are not provided to adolescents and young people in any of the countries. Abortion is illegal in the countries visited.

Table 3.8: Provision of services to female adolescents and young girls

	Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1	Do care services for sexually transmitted infections exist for adolescents and young clients?	YES	YES	YES	YES	YES
2	Are health services for pregnancy and delivery-related services provided for female adolescents and young girls?	YES	YES	YES	YES	YES
3	Are abortion services provided to female adolescents and young girls? (in a situation where it is legal)	**NO**	YES	**NO**	**NO**	**NO**
4	Are information and counseling services on emergency contraception provided to female adolescents and young girls?	**NO**	YES	**NO**	YES	YES
5	Are care and support services provided to female adolescents and young girls who are HIV positive?	YES	YES	YES	YES	YES
6	In case of sexual violence, is there any provision that allows for adolescents and young people to be cared for?	YES	YES	YES	YES	YES

3.1.7.4 Use of services by adolescents and young people

The data on the use of services by adolescents are seriously lacking in all the countries visited. Indeed, Table 3.9 shows that services on the following main indicators are not available:

- Percentage of adolescent girls between the ages of 15 and 19 years having received at least 4 antenatal consultation (CPN)
- Percentage of female adolescents between the ages of 15 and 19 having been delivered by a professional service provider

- Percentage of pregnant adolescents between the ages of 15 and 19 years having been screened for HIV and undergone counseling services
- Percentage of pregnant adolescents between the ages of 15 and 19 years having used a modern method of contraception.

Table 3.9: Data on Use of Services by Adolescents and Young People

	Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1	Percentage of adolescents between the ages of 15 and 19 years having received at least 4 antenatal consulation (CPN)?	Not available	Not available	DHS 25% in 2008 51.1% in 2013 GHS	Not available	Not available
2	Percentage of pregnant adolescents between the ages of 15 and 19 years having been delivered by a professional health care provider	Not available	Not available	43% in 2008 DHS 47.8 % in 2013	58.2 EDS Continue 2014	Not available
3	Percentage of pregnant adolescents between the ages of 15 and 19 years having received HIV screening and counseling services	Not available	>90%	Not available	Not available	Not available
4	Percentage of adolescents aged between 15 and 19 years using a modern method of contraception	5.6% (EDS 2011-12)	Not available	9.1% in 2008 4.8% in 2013 DHS	Not available	Not available

3.1.8 School health

Apart from Cape Verde and Nigeria which indicated that they have a school health policy/strategy and programme for adolescents and young people, the other countries undertake school health activities without any real policy and programme in place.

3.1.9 Financing

Table 3.10 summarizes some aspects of health financing related to the mother, the new-born , the child in the countries visited. It was observed that the percentage of the national budget allocated to the Ministry of Health varies from 7% (Nigeria) to 11% (Senegal), therefore lower than 15%.

The percentage of the budget allocated to the Ministry of Health for maternal health, the new born, the child and adolescent and young person is around 3% in the countries.

There is no budgetary provision for activities relating to the health of adolescents and young people in Benin and Nigeria. Furthermore, there are no exemptions from charges for care based on somebody's status as an adolescent or young person.

Table 3.10: Financing the health of Mothers, Newborn Babies and Children

Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. Percentage of the national budget allocated to the Ministry of Health	7.1%*	**8%**	**7%***	**11%***	**8.5%***
2. Percentage of the Ministry of Health's budget allocated for maternal health, newborn babies, children, adolescents and young people	200 000 000 Francs planned for 2015	Not available		**3%**	3%
3. Has any budget been allocated for adolescent and youth health activities	NO	Not available	NO	YES	YES
4. Are adolescents between the ages of 15 and 19 years exempted from charges for the following health services?:					
a. Antenatal consultation (CPN)	NON	YES	NO	NO	OUI
b. Deliveries?	NON	YES	NO	NO	OUI
c. Consultations for primary healthcare?	NON	YES	NO	NO	NON
d. Insecticide mosquito nets?	NO	NA	NO	YES**	YES
e. HIV screening and counselling?	YES *	YES **	YES**	YES**	YES**
f. PMTCT?	YES *	YES	YES**	YES**	YES**

Source: The Ministry of Health of the countries

**Free throughout the world

3.1.10 Health Information System

All the countries have statistical yearbooks published. However, these statistical yearbooks do not provide coverage for adolescent and youth health.

3.1.11 Research, monitoring and evaluation

All the countries visited have a list of indicators for adolescent and youth health. An indepth analysis of the definition process for adolescent and youth health reveals that this process is still ongoing in most of the countries and that actual consensus has not yet been reached among the countries.

None of the countries undertakes half-yearly/annual monitoring of the coverage of interventions for adolescents and young people (Table 3.11). In all the countries, the data on adolescents and young people were taken into account in the last EDS.

All the countries indicated that they had adolescent and youth health research needs.
All the countries indicated that they had adolescent and youth health research needs.

Table 3.11: Research, monitoring and evaluation

Description	Benin	Cape Verde	Nigeria	Senegal	Sierra Leone
1. What adolescent andyouth indicators have been retained by the country?	YES See Annex	YES See Annex	YES See Annex	YES See Annex	YES See Annex
2. Does the country carry out half-yearly/annual monitoring on the coverage of adolescent and youth-oriented interventions?	NO	NO	NO	NO	NO
3. Were adolescent and youth data taken into account in the last DHS?	YES	YES	YES	YES	YES
4.Has the country carried out national adolescent and youth surveys?	YES	YES	NO	YES	NO
5. Does the country have research needs?	YES	YES	YES	YES	YES

3.2 OPINIONS OF ADOLESCENT AND YOUTH HEALTH STAKEHOLDERS

Table 3.12 presents the list of four groups of stakeholders operating in the area of adolescent and youth health which the survey team met in the countries visited. They include:

1. Strategic and/or operational partners (or implementing partners) providing support at the technical and financial levels to structures responsible for adolescent and youth health at all levels of the health system in the countries.
2. Heads of adolescent and youth centres
3. Adolescents and young people
4. Parents of adolescents and young people

On the whole, a total of 25 strategic and/or operational partners, four heads of adolescent and youth centres, two young persons, a group of adolescents and a group of parents were

interviewed. The largest number of partners was "recorded" in Senegal (10), then Benin (7) and Cape Verde (6). Only one (1) partner was interviewed in Nigeria and Sierra Leone due to various constraints. It must be noted that the number of partners interviewed had an influence on the quantity of information generated.

The main objective of the interviews with the stakeholders was to collect and collate the points of view of stakeholders on the issue of adolescent and youth health in the different countries.

Table 3.12 Adolescent and Youth Health Stakeholders Surveyed

Countries	Strategic and/or operational partners (implementing)	Adolescent and Youth Centres	Adolescents and Young People	Parents
Benin	1. WHO 2. UNFPA 3. Netherlands Embassy 4. NGO Association Béninoise pour la Promotion de la Famille (ABPF) 5. NGO ABMS/PSI 6. NGO CERADIS 7. Université Nationale du Benin	Centre Jeunes Amour et Vie	Jeunes Ambassadeurs	
Cape Verde	1. UNFPA 2. WHO 3. Ministry of Education 4. Network of NGOs 5. Cape Verdian Institute for Gender Equality and Equity 6. Verde Fam			
Nigeria	Planned Parenthood America	1. Women Friendly Initiative 2. Adolescent Friendly Clinic Kuje General Hospital		
Senegal	1. UNFPA 2. WHO 3. UNESCO 4. Division Contrôle Médicale scolaire 5. Projet Promotion Jeunes (Min Jeunesse) 6. NGO Marie Stopes International 7. NGO ASBEF 8. NGO ACDEV 9. NGO AMREF Health Africa 10. *Réseau Islam et Population (RIP)*		Groupe Ado	Parents Group
Sierra Leone	UNICEF	School Health Adolescence Health Clinic	Coalition of Young Intelligent Quotient	

3.2.1 Opinions of strategic and/or operational partners

The main topics for the interviews with the strategic and/or operational partners were:

- Health and risk behavioural problems observed among the adolescents and young people and determining factors
- Strategies used
- Coordination of adolescent and youth activities in the country
- Main strengths and weaknesses of the organization and the implementation of adolescent and youth health activities in the country
- Difficulties or challenges faced
- Suggestions of strategies to improve adolescent and youth health in the country

3.2.1.1 Health problems, risk behaviours among adolescents and young people and the determining factors

Table 3.13, provides a summary of the various health problems facing adolescents and the youth as per the partners in each country, the risk behaviours observed among this group of the population and their main or determining factors.

Table 3.13: Health problems according to strategic and/or operational partners

Similarities among the countries	- Sexual and reproductive health (Early pregnancy, unwanted pregnancies characterized by unsafe abortions) - Sexually Transmitted Infections/HIV - Poor nutrition with its consequences - Lack of physical activity (Inactivity) - Excessive use of tobacco - Excessive intake of alcohol - Use of harmful substances - Mental health - Injuries caused by motor traffic accidents - Violence including autolyses - Communication problems between parents and children
Specificities	Cape Verde : High frequency of alcohol intake Benin : unwanted pregnancies characterized by unsafe abortions, Senegal : Substance abuse; "toubi" coffee Sierra-Leone : High frequency of early pregnancies

Risk behaviours

Similarities among the countries	- Unprotected sexual relations - Early sexual relations - Low use of contraceptives - Transactional sex: Sex in excange for favours - Multiple sexual partners - Low rate of condom use - Low use of methods of contraception - Low physical activity (inactivity) - Excessive use of tobacco - Alcohol abuse - Substance abuse - Violence including autolyses - Failure to use helmets
Specificities	Cape Verde : High frequency of alcohol use Senegal : Infanticide, lack of personal hygiene Sierra-Leone : High level of early pregnancies

Determinants

Similarities among the countries	- Addiction to ICT - Poverty - Low access to good quality information - Low enrollment of girls - Beliefs, taboos and traditions - Ambitions of young people - Resignation of parents who no longer engage their children in conversations - Abandonment by the State - Loss of culture

	- Lack of parent-child dialogue - Peer influence or pressure - Unemployment and idleness
Specificities	Senegal : Increased importance of beliefs, taboos and traditions

3.2.1.2 Strategies used

The strategies used in the 5 countries are almost similar as shown in Table 3.14. The basic strategies are awareness-raising, advocacy, peer educators' approach; youth centres and provision of care. As emphasized by some partners we met, most of the strategies used are not evaluated to ascertain their effectiveness.

Table 3.14: Strategies used

Country	Strategies	
Benin	**1.** Advocacy 2. Peer educator: Not a factual assessment but the results are tangible 3. Establishment of units for youth activities in schools and colleges 4. Introduction of sexual education in the school curriculum (secondary) (it is a complicated work with the Ministry of Education; however there is the need to ensure the inclusion of sexuality in the school curriculum) 5. Cyber café : information on the net 6. Establishment of clubs : sports, music 7. Involvement of journalists **8.** Provision of services: youth centres and mobile clinics	9. Creation of demand: Media, Interpersonal Communication (radio broadcasts magazine, television broadcasts 10. Use of social networks: Facebook page 11. Promotion of dialogue between parents and children: 12. Training of peer-parents: The peer parents undertake home visits 13. Involvement of religious leaders 14. Strategy for the identification of youth leaders at the community level. 15. Intervention on the educated, uneducated and school dropouts because they do not have the same needs 16. Gender Approach: Promotion of gender equity: Emphasis on girls
Cape Verde	1. Development of curriculum for primary and secondary education: 2. Existence of youth centres 3. Existence of mobile youth centres 4. Library: is a strategy: The young people say they are going to the library **5.** Organization of a health fair **6.** Education and Health Collaboration	7. Sports as a health strategy. Youth meeting space in the other islands (7 islands) 8. Awareness raising activity 9. Decentralized activities for young people in remote localities
Nigeria	1. Peer Educators 2. Youth Centre 3. Interpersonal Communication **4.** Awareness raising	5. Advocacy 6. Sporting and recreational activities 7. Cyber café 8. Education **9.** Use of social networks
Senegal	1. Youth Space in the Universities 2. Provision of service 3. Adolescent Counseling Centres 4. Sporting activities (GAMES? Concerts, Summer Tours : To attract demand: Strategy to attract demand) 5. Use young midwives 6. The staff is young to receive	9. Sporting and cultural: Football Tournaments 10. Adolescent Counselling Centre as a medium 11. Peer educators trained in IEC, 12. Clic Info Ado Platform 13. 211000 Mail System 14. Peer educators' strategy 15. Hotline: Mbour

	young persons 7. Communication on social networks : Facebook is working incredibly as well as sms 8. Concerts	16. Association Parler aux Jeunes:
Sierra Leone	1. Peer educators 2. Youth Centre 3. Interpersonal communication 4. Awareness raising 5. Advocacy	6. Sporting and recreational activities 7. Cyber café 8. Education 9. Use of social media

3.2.1.3 Coordination of Adolescent and Youth Health in the Country

The coordination of adolescent and youth health is a major challenge in all the countries as shown in Table 3.15. As was emphasized by one of the partners: "all the structures are doing an extraordinary work, but each is doing so in its own way; it would be better to come together; but to accomplish that purpose, there is the need for good leadership, coordination, willingness on the part of stakeholders and an effective involvement of the youth".

The main coordination problems raised are as follows:

- The Ministry of Health does not know all the stakeholders working in the area of adolescent and youth health.
- The coordination of stakeholders
- The coordination of stakeholders' interventions
- The non functionality of consultative or coordination frameworks
- The multiplicity of youth groups created through financing and coordination

Table 3.15: Coordination of AYH in the countries

Countries	**Coordination of AYH**
Benin	1. Low coordination at all levels by the MH system 2. Very low level of interministerial coordination 3. Inter-Agency coordination of AYH issues 4. Effectiveness of ongoing experiences: Centre Amour et Vie…. 5. Something is underway, but it has still not crystallized 6. Health is not the Government's priority 7. The strategy document provides clearly for an operational framework but up to this point the coordination framework is not operational and is even non-existent 8. Multitudes of youth groups : It seems each partner has its own youth group 9. Groups established and financed can die off at the end of the financing period 10. The Ministry does not know all the stakeholders working in the area of adolescent and youth health
Cape Verde	1. "We have some coordination issues between the Ministry of Health and the Ministry of Education" 2. There is no effective linkage between the Youth, Health

	and other sectors" 3. Good leadership by the Ministry of Health
Nigeria	**1.** Coordination has to be strengthened
Senegal	1. Coordination must be strengthened 2. Ensure that the multisectoral collaborative framework contained in the AYRH Strategic Plan (DRSSE) is made operational 3. All the structures are doing an extraordinary work, but each one is operating in its small way. It is better they work together; to achieve this, there is the need for good leadership, coordination, willingness on the part of the stakeholders and involvement of young people: Multi-sectoral approach 4. Coordination of stakeholders 5. Coordination of donors **6.** Coordination of supply
Sierra Leone	1. Weak coordination "Multi-sectoral appraoch calls for strong coordination"

3.2.1.4 Main strengths and weaknesses of the organization of the implementation of adolescent and youth health activities in this country

The main strengths and weaknesses in organizing and implementing adolescent and youth health are summarized in Table 3.16.

The main strengths identified in most of the countries are: the existence of a consultative and coordination framework, the availability of a large number of stakeholders and strategic documents and the existence of youth centres.

The weaknesses are similar in all the countries: poor coordination of stakeholders, unavailability or lack of trained service providers, poor reception by the service providers, overlapping of interventions by the various partners, failure to integrate interventions, competition among stakeholders, inability to disseminate strategic documents, lack of research and advocacy with the religious leaders etc..

Table 3.16: Main strengths and weaknesses of adolescent and youth health in the countries

Country	Strengths	Weaknesses
Benin	1. Existence of an adolescent and youth service 2. Existence of standard documents 3. Existence of a sexual health strategic document 4. Existence of motivated partners 5. Existence of NGOs which can work with the Ministry 6. Existence of an Adolescent and Youth Technical Working Group 7. A coalition exists to improve the abortion law **8.** There are a lot of stakeholders; this is an asset but it can be a hindrance if there is no effective coordination as is currently the case	1 Packages of Adolescent Health services (Santé Ado) have not yet been taken into account 2 Untrained personnel 3. Sexual education not integrated into the training curricula 4. Dialogue between parents and children not operational 5. There are NGOs which want to work with the Ministry but the coordination framework is not operational 6. Lack of proper involvement of the private sector 7. The Ministry of Health must review its vision, role and philosophy : it looks as if the private sector does not exist in the country 8. Incompetent service providers in the area of adolescent and youth health 9. Non-existence of a monitoring and evaluation framework 10. Non-existence of data on adolescents and young people 11. Diversity of stakeholders but poor coordination 12. There is a lot of overlapping in NGOs interventions 13. Most of the NGOs have focused their interventions on behaviours and fail to focus on the cause of these behaviours 14. The NGOs have centred their activities on precise areas, but there is a lot of overlapping
Cape Verde	1. Very good health system 2. "The youth are highly educated in Cape Verde" 3. Existence of youth centres	1. Some coordination problems exist between the Ministry of Health and the Ministry of Education 2. The public health facilities are not prepared to receive the youg people 3. There is lack of linkage between the youth and health sectors and others 4. The officials do not have the capacity to provide care for the youth 5. Health structures exist but their focus to reach out to young people is still low: 6. There is the need to strengthen the capacity of the structures **7.** Lack of a specific structure for young people **8.** The young people do not want to go to the centres because every one knows everyone and there is no confidentiality
Nigeria	1. Existence of a National Technical Group for Adolescents and the Youth 2.Existence of national	1. Competition among the stakeholders 2. There is no research 3. There is no dissemination

	forums for adolescents and young people 3. Existence of strategic documents	
Senegal	1. Existence of Youth Spaces 2. Social mobilization 3. Availability of data 4. Regular monitoring and evaluation of what is done 5. Existence of Adolescence Counselling Centres (CCA)	1. Impression that the youth is stigmatized 2. All the structures are doing an extraordinary work but each one operates single-handedly. It is better to ensure coordination : To ensure this, there is the need for good leadership, coordination, willingness on the part of the stakeholders and the involvement of young people: Multi-sectoral approach 3. The out-of-school environment is not organized: apprentices, dressmakers, hairdressers etc. 4. Poor reception by the service providers : hinders the youth from visiting these structures 5. The lack of means: Most of the young people are unemployed and they depend on their parents : Even up to the age of 30 years, the young people still depend on their parents 6. Lack of a good religious advocacy
Sierra Leone	1. Large number of partners in AYH 2. Political will at the highest level of the country 3. Favourable environment to review policies, laws and regulations 4. Improvement of the knowledge of adolescents and young people 5. Involvement of the communities	1. Poor coordination 2. Lack of and low enforcement of laws

3.2.1.5 Suggested strategies for the Improvement of Adolescent and Youth Health

The partners we met in the different countries made relevant suggestions to improve the health of adolescents and young people. The main suggestions made by the partners are summarized below:

- Benin
    - Ensure the operationalization of the intra and inter-sectoral coordination framework
    - Train all the stakeholders in services suitable for young people and adolescents: "Everyone is talking about the youth but does everyone really know what it is all about?"
    - Ensure that adolescents are captured in the annual working plan of every health zone

- Strengthen the knowledge of the youth on reproductive and sexual matters,
- Promote friendly services
- Promote monitoring-evaluation

- Cape Verde
  - Create spaces where young people can find all the services: lots of services concentrated in the same space: integrated services
  - Respect the specificities of every country
  - Ensure coordination among the partners (this is a basic requirement)
  - Educate the parents (Adult Education)
  - Establish effective linkage between Education and Health

- Nigeria
  - Disseminate documents
  - Ensure monitoring and evaluation
- Senegal
  - Strengthen the peer education strategy
  - Promote the CCA
  - Promote the green lines
  - Ensure a culture of documentation and evidence
  - Create adolescent and youth space) in the health structures
  - Include the needs of the disadvantaged youth
  - Involve the youth in decision-making bodies
- Sierra Leone
  - Involve the youth effectively
  - Start at the family level, then to the schools

3.2.2 Opinion of heads of adolescent and youth centres

The main topics for the interviews with the heads of the adolescent and youth centres:

1. Characteristics of centres and user adolescents and young people
2. Services provided
3. Strategies used
4. Difficulties encountered
5. Statistics on activities of the structure
6. Suggestions of strategies to improve the provision of adolescent and youth health services.

3.2.2.1 Characteristics of user adolescent and youth centres

The characteristics of centres visited are summarized in Table 3.17.

- The Centre Amour et Vie de Suru Léré in Benin was established by an International NGO to receive young people who are not attending school in the premises of the Social Welfare Centre. The characteristics of young users are summarized in the Table.
- The Women Friendly Initiative of Abuja in Nigeria is a national NGO designed to receive all young people. The characteristics of user young people are summarized in the Table.
- Adolescent Friendly Clinic of Kuje in Abuja is a public centre established within the Kuje General Hospital and it is designed to receive all the young people. The characteristics of young users are summarized in the Table.

- Broderick School Health Adolescence Health Clinic is a public health centre established within a school in Freetown and it is designed to receive all the young people. The characteristics of the young users are summarized in the Table.
- It must be added that we also (quickly) visited four youth centres in Cape Verde. They include: Centro de Saude Reproductive de FAZENDA, Centro de Jeune (Ministry of Youth), Centro Saudo TIRA CHAPEU of the Verde Fam centre. As a result of time constraints, we did not hold formal discussions with the officials of the centres, but we were impressed by the organization, the type of service providers (for instance, there were psychologists and physiotherapists).

Table 3.17: Characteristics of user adolescent and youth centres

Centres	**Characteristics of centres and users**
Benin (Amour et Vie Suru Leré)	- Type of Centre : National/International NGO - Age group : from 10 to 24 years but older ones also visit the centre - Gender: Boys frequent the centre more because they are attracted by the games, "the girls are timid and the parents do not leave their girl children to go there". "For the parents, it is a Centre to address depravity". - Religion: All religions - Education : Centre for young ones who are out of school but the ones in school also go there because of games and the internet - Socio-economic class: All classes
Nigeria 'WFI)	- Type of centre : National NGO - Age group : 4 to 10 years and 10 to 24 years - Gender: Boys are greater in number; cultural barriers (religion) prevent the girls from visiting the centre - Religion: Christians outnumber Muslims - Education: More of school children; it is rare for the out of school children to visit the centre - Socio-economic level: especially the middle class
Nigeria (AFC)	- Type of centre : Public, established within a regional hospital - Age group : 10-24 years - Gender: Boys constitute the largest number: cultural barriers (religion) prevent the girls from visiting the centre. - Religion: Christians outnumber Muslims (It must be noted that it is a predominantly Muslim locality) - Education: Only school children visit the centre; children who are out of school do not visit the centre - Socio-economic level : especially the poor
Broderick School Health Adolescence Health Clinic Sierra Leone	- Type of centre : Public, established within a school - Age group: 10-35 years - Gender: Girls constitute the largest number - Religion: All religions - Education: Everyone but school children are the most numerous but they do not visit the centre - Socio-economic level: All classes

3.2.2.2 Services provided

Table 3.17 shows the services provided by the centres visited.

Table 3.18 shows that the following services are provided in the 4 centres:

- Sexual and reproductive health including the prevention of pregnancies among the adolescents.
- Sexually Transmitted Infections/HIV
- Alcohol
- Harmful substances

The analysis of the number of services provided by the various centres shows that:

- The WFI provides 10 out of 11
- AFC provides 9 out of 11
- Broderick Health Adolescence Health Clinic provides 8 out of 11 services
- The Amour et Vie Centre of Benin provides 7 out of 11 services

Table 3.18: Services provided by the youth centres

Service	Centre Amour et Vie Suru Léré Benin	Women Friendly Initiative (WFI) of Nigeria)	Nigeria (AFC)	Sierra Leone School health adolescence health clinic
1. Sexual and reproductive health including the prevention of pregnancies among adolescents?	YES	YES	YES	YES
2. Sexually Transmissible Infections/HIV	YES	YES	YES	YES
3. Nutrition	YES	YES	NO	YES
4. Dieting and physical activity	NO	YES	NO	NO
5. Tobacco	NO	YES	YES	YES
6. Alcohol	YES	YES	YES	YES
7. Harmful substances	YES	YES	YES	YES
8. Mental health	YES	NO	YES	YES
9. Prevention and Injuries caused by motor traffic accidents	NO	YES	YES	NO
10. Violence	NO	YES	YES	YES
11. Lack of communication between Parents-Adolescents and the Youth	YES	YES	**YES**	NO

3.2.2.3 Opening hours

As shown in Table 3.19, the majority of centres operate at a time majority of the young people are in school or are learning a trade. This situation can create an impediment for their use by adolescents and young people. Only the Centre Amour et Vie de Suru Léré opens for part of the weekend, i.e. on Saturday.

Table 3.19: Opening hours

Centres	Day and opening hours
Centre Amour et Vie Suru Léré, Benin	From Tuesday to Saturday 10.00 a.m. to 7 p.m. but on Thursdays, the Centre closes at 5p.m.
Women Friendly Initiative (WFI) of Nigeria	Monday to Friday: 8a.m. to 5p.m.
Adolescent Friendly Clinic Nigeria (AFC)	Monday to Friday: 9a.m. to 4p.m.
Broderick School Health Adolescence Health Clinic, Sierra Leone	Monday to Friday: 8a.m. to 5p.m.

3.2.2.4 Strategies used

The strategies used are almost the same in the 4 centres visited (Table 3.20). They include: Peer educators, counselling, interpersonal communication, awareness raising, advocacy, games and recreational activities, cyber-café and use of social networks.

Table 3.20: Strategies used

Centres	Strategies used
Centre Amour et Vie Suru Léré Benin	**1.** Attracive Games: Internet, Play Station, Babyfoot, Scrabble, Domino, Cards, photocopy and printing 2. Awareness raising in the colleges 3. Recreational nights: we seize the opportunity to raise awareness among them **4.** Service provision
Women Friendly Initiative (WFI) of Nigeria	1. Peer educators 2. Interpersonal communication **3.** Awareness raising 4. Advocacy 5. Leisure and recreational activities 6. Cyber café 7. Education **8.** Use of social media 9. Micro-finance
Adolescent Friendly Clinic Nigeria (AFC)	1. Advanced strategy in the schools 2. Advanced strategy in the communities 3. School Talk
Broderick School Health Adolescence Health Clinic Sierra Leone	1. Diagnosis and treatment of diseases (malaria, respiratory infections, STIs etc. **2.** Counselling on prevention of pregnancies, violence, nutrition, alcohol consumption, tobacco and drug use, HIV, mental health, rape, etc.

3.2.2.5 Difficulties Encountered

As shown in Table 3.21, the centres visited encounter difficulties related to attendance by certain youth groups, girls and in particular young people who are not attending schools. The public centres seem to have a lot of financial and material difficulties.

Table 3.21: Difficulties Encountered

Centres	Difficulties Encountered
Centre Amour et Vie Suru Léré, Benin	1. Non-attendance by people who are out of school 2. The managers do not want to allow the young people to leave the workshops
Women Friendly Initiative (WFI) of Nigeria	1. Socio-cultural barriers prevent girls from patronising such locations **2.** Remuneration of volunteers as a result of the growing financial problems
Adolescent Friendly Clinic Nigeria (AFC)	1. Lack of support from the Ministry of Health (not necessarily financial support but also in the form of supervision, documentation, equipment, participation in conferences etc.. 2. Lack of human resources 3. The young ones are afraid of going to the centre even though an entrance has been made available at the back of the hospital **4.** The location of the centre prevents young people from going there: a more isolated place would be preferable: Fear of being seen by a relation or an acquaintance.
Broderick School Health Adolescence Health Clinic Sierra Leone	Lack of medicines, Lack of electricity Non-existence of HIV KIT Non-existence of malaria kit

3.2.2.6 Statistics of the Centre's activities

The statistics on the centre's activities are a major problem in the centres we visited. Most of the centres have data carriers but there is no reliable data collection system. The situation is far from being better at the WFI, but a lot of efforts are still needed.

3.2.2.7 Suggested strategies for the improvement in the provision of health services

The suggestions made by the heads of the centres to improve the provision of services are summarized in Table 3.22. They range from the widening of the types of services provided; ensuring that contraceptives are freely made available, free education to address the issue of idleness of young people.

Table 3.22: Suggestions for the improvement in the provision of services

Centres	Suggestions
Centre Amour et Vie Suru Léré, Benin	1 The young people want to know their blood group , haemoglobin electrophoresis 2 Vaccination against hepatitis C

	3 Permanent internet connectivity at the centre **4** Television movies on adolescents and young people
Women Friendly Initiative (WFI) of Nigeria	1. To go into the communities 2. Advocacy at the community level **3.** Generation of revenue
Adolescent Friendly Clinic Nigeria (AFC)	1. Combating the phonomenon of idleness among young people: by occupying them with leisures, games and employment 2. Encouraging primary, secondary and university education 3. Free schooling 4. Girl child education
Broderick School Health Adolescence Health Clinic Siérra- Leone	1. Awareness raising 2. Posters **3.** Advanced strategy **4.** Free medicines **5.** Free availability of contraceptive products **6.** Distribution of condoms

3.2.3 Opinions and perspectives of adolescents and young people

In the course of this situational analysis, we were able to discuss with 2 young people and a group of adolescent girls who were out of school. They include:
A Beninese who forms part of the "Presidents of Jeunes Ambassadeurs for the SR/PF" in Benin
A Sierra Leonean "President of the Coalition of Young Intelligent Quotient"
A group of girls who are out of school

The main topics for the discussions with the adolescents and young people were:

1. Health problems and risk behaviours observed among adolescents and young people
2. Remedy in case of health problems
3. Health needs of adolescents and young people
4. Sources of information on the health of adolescents and young people
5. Social media and the health of adolescents and young people
6. Participation of adolescents and young people in solving their health issues
7. Suggestions of strategies to improve the health of adolescents and young people in your country

3.2.3.1 Health Problems, Risky Health Bahavioural Patterns Observed among Adolescents and Young People and Determinants

According to the youtng people with whom we had the discussions, the main health problems of adolescents and young people revolve around sexuality and its harmful consequences, lack of information, leisure and healthy occupations. (Table 3.23).

The risky behaviours listed are early sexual intercourse, unprotected sexual relations, multiple sexual partners and even infanticide.

The determinants of these problems and behaviours are:

- Poverty is one of the major problems of young people; it includes lack of support
- Lack of parent-child dialogue,
- ICT
- Peer pressure: Imitation; the desire to have the "latest" mobile telephones, expensive clothing and fashion.
- Drinking of alcohol which induces people to commit rape and adopt risky behaviours and to motor traffic accidents
- Lack of support

Table 3.23: Health Problems

Adolescents and young people	Problems	Behaviours	Potential causes
Benin	1. Early sexual report 2. Early pregnancy 3. The youth do not have reliable information : The only information they have are hearsays: The youth must be at the centre of information 4. The youth are left to their own devices. They do not have leisure: The devil finds mischief for idle hands: There is the need for pasttimes: Leisure allows the youth to occupy themselves healthily: They have no time to think about other things: The lack of leisure activities makes the youth develop ideas: Therefore, the health stakeholders must be associated with the promotion of adolescent and youth health. **5.** The youth lack healthy activities	1. Multiple sexual partners 2. Sex is found everywhere: Our television networks, 3. Social media	1. Lack of parent-child dialogue, 2. But today sex is present everywhere : Net, Telephone, TV, Pornographic videos 3. Sex is really everywhere: incredible images: This turns the heads of the young ones. 4. It is true that there is nothing that can be done about technology but it must be regulated.
Senegal	1. Menstrual cycle 2. Personal hygiene 3. Taboos 4. Sexual relations 5. Information 6. Unwanted pregnancies 7. Childbirth **8.** Early marriage **9.** Information on methods of	1. Unsafe abortions 2. Unprotected relations 3. Infanticide **4.** Early pregnancy	1. Flirtation 2. Fashion 3. Make friends in order to have fun 4. Poverty 5. Lack of support 6. Lack of education 7. Ignorance 8. Parents send their girls who become pregnant out of the home

	contraception		
Sierra Leone	1. Early pregnancy 2. Vesico-vaginal fistula	1. Sexual intercourse at an early age **2.** Alcohol and substance abuse	1. Poverty is one of the major problems of the youth **2.** Peer pressure: Imitation; desirous of having the latest mobile phone, expensive clothing etc. **3.** Alcohol abuse which leads to rape and risky behaviours

3.2.3.2 Remedies in the Event of Health Problems

According to the young people who were interviewed, adolescents and young people fear to go directly to a health centre for fear of meeting a relative there or being reprimanded by the health officials. Generally, the first reflex of the young people in case of any problem is to discuss it with a friend, who can sometimes mislead them by giving them inappropriate advice. The young ones also use the free and anonymous hotlines and existing youth platforms and networks. They contend that the health centres are not welcoming and they do not receive any support (Table 3.24).

Table 3.24: Remedies in the Event of Health Problems

Adolescents and young people	**Remedies in the Event of Health Problems**
Benin	1. They fear to go directly to a health centre for fear of being seen by a relation or being rebuked by the health officials. **2.** Generally, their first thought is to talk to a friend about it: then without informing the parents, they head towards the health centre when the situation becomes serious
Senegal	1. Call the hotline: send an SMS 2. I talk about it with my mother 3. I talk about it with a colleague 4. Buy a pregnancy test at the pharmacy **5.** I avoid the health facilities because you can meet an acquaintance there
Sierra Leone	1. Non-existence of Parent-Child Dialogue 2. Parents do not have time to hold discussions with the children 3. Friends are the first option 4. Hotline **5.** Existing platforms and social media; the health centres are not friendly destinations and they have no support to provide

3.2.3.3 Adolescent and Youth Health Needs

According to the respondents, young people need moral support from their parents in order to effectively manage their sexual life, entertainments and healthy leisure activities in order to occupy themselves in a healthy manner with regard to care, counselling and information on the prevention of pregnancy without going to a health centre, on sports and natural methods of contraception, education, protection, awareness of parents and nutrition.

3.2.3.4 Sources of information and social networks on adolescent and youth health

The sources of information on health are friends, social media; rarely do they contact brothers, sisters or parents.

The social networks prioritized by young people are Facebook, WhatsApp and SMS (the SMS is much more discreet). However, one of the respondents stated that the young people find the messages on health tedious and they "zap" it more often.

The respondents indicated the level of involvement of young people in decision-making bodies is still very low. A lot of efforts are still needed to be made by the authorities.

3.2.3.5 Suggested Strategies for the Improvement in Adolescent and Youth Health in your Country

The main suggestions made by the respondents are:

- Effectively promote the peer educator approach: The young people are not very willing to receive information from adults
- Strengthen the existing youth structures and associations
- Create cultural events to occupy the time of adolescents and young people.
- There are already real friendly and confidential centres
- Support for the advocacy group
- Involvement in the community

3.2.4 Opinions of parents of adolescents and Young People

In the course of this situational analysis, we were able to hold discussions with an adhoc group of parents of adolescents in Senegal.

The main topics for the discussions with the adolescents and young people were:

1. Health problems and health risk behaviours observed among young people and their determinants
2. Communication between parents and young people
3. Suggested strategies for the improvement of adolescent and youth health in your country.

A. Health problems and health risky behavioural patterns observed among adolescents and young peple and determinants

Apart from issues bordering on sexuality, the health problems cited by the parents include malaria, malnutrition, drinking of alcohol and the use of tobacco.

The main risks raised are early sexual relations, paedophilia, incest, rape, negative peer associations and motor traffic accidents.

The alleged causes are: ICT and television, poverty, urbanization and conservative attitudes of adults (Table 3.26).

Table 3.26: Health problems and risky health behavioural patterns observed among adolescents and young people and determinants

Health problems	Risky behaviours	
1. Malaria 2. Malnutrition 3. Substance abuse 4. Unwanted pregnancy 5. Mental health 6. STIs 7. Communication problems between parents and children 8. Access to ICT	1. Early sexual relations 2. Unprotected sexual relations 3. Paedophilia 4. Incest 5. Rape 6. Negative peer associations 7. The adolescents want to do things that are above their age 8. Internal family conflicts 9. Motor traffic accidents 10. Drinking of alcohol and tobacco use 11. Communication between adults and the youth 12. Addiction to ICT	1. Development of ICT 2. Imitation of fashion 3. Urbanisation 4. Breakup of family unit 5. Lack of control by parents: 6. Television 7. Family's level of income 8. Demographic weight 9. Poverty : street child 10. Lack of education 11. Inability of adults to adapt to current realities: many parents are still conservative 12. Loneliness

B. Communication between parents and adolescents and young people

The parents indicated that it is difficult to speak about sexual matters with the children in the African context. This task was the preserve of uncles and aunts, but today in the face of breakdown of family relations and especially due to the advent of ICT which provides behaviours opposed to African values, the communication links between parents and young people have become difficult.

C. Suggestions

The suggestions made by the parents are to:

- Train the parents on how to communicate with their children: School of Parents
- Train young people to communicate with their parents
- Take African values into account: Not modern communication
- Strengthen the role of mothers
- In the past, education was taken care of by the larger family but, today the nuclear family takes charge of that. Parents are not prepared and look powerless vis-à-vis their adolescent children
- The Government has a duty to assist the parents to remove the taboos.

3.3 REVIEW OF NATIONAL REFERENCE DOCUMENTS AND OBSERVATIONS IN THE YOUTH CENTRES

3.3.1 Review of national documents

Table 3.26 presents the main standard documents prepared by the countries. As can be observed, Nigeria is one country that has prepared more documents for adolescent and youth health.

It has been noted that there is no standardization of the types of documents to be prepared by the countries in the area of AYSRH/AYH. For instance, whereas Benin has prepared a strategic document, Senegal, Nigeria and Sierra Leone have on the other hand prepared strategic plans consisting of a section on the plan of action and the budget. Most of the countries have established service standards but only Nigeria has training modules on these standards.

We reviewed three of these documents: situational analysis document, strategy/strategic plan and documents on standards.

- **Situational analysis document**
  Though some countries affirmed to have carried out a situational analysis, the related reports were not available. But the description provided by the respondents shows that it applies to document reviews rather than a formal situational analysis.

- **Strategic document/strategic plan**
  In its form, the documents have been very well presented. In substance, a number of impressive strategies have been listed but they do not actually have a factual basis. Most of them are rather interventions marked by "good practices". However, practices that have produced good results in one context can fail in others.

- **Strategic document/strategic plan**
  There is no standardization in the approach to developing the standards. The documents on standards vary in content and presentations. Nigeria and Benin have followed a systematic approach designed by the WHO using as a guide a document entitled: "Core competencies in adolescent health and development for primary health care providers" which is based on key competencies to be acquired by the service providers.

Table 3.26: Documents prepared by the countries for adolescent and youth health

Country	Standard documents prepared by the Ministries in the countries visited
Benin	1. National Sexual and Reproductive Health Multi-Sectoral Strategy for Adolescents and Young People of Benin 2010-2020. 2. Studies on the Feasibility of Direct Payment Exemptions for the Improvement of FP Services to Adolescents and Young People in Benin 3. Quality Health Service Standards for Adolescents and Young People in Benin, 2015.
Cape Verde	1. Ministério da SAUDE. Plano National de Desenvolvimento Sanitario 2012-2016. Volume 1 and 2.Praia :2013
Nigeria	1. National Guidelines on Promoting Access of Young People to Adolescent & Youth-Friendly Services in Primary Health Care Facilities in Nigeria. Abuja: 2013. 2. National Guidelines fot the Integration of Adolescent and Youth Friendly Services into Primary Health Care Facilities in Nigeria. Abuja: 2013. 3. National Policy on the Health & Development of Adolescents & Young People in Nigeria. Abuja: 2007 4. National Strategic Framework on the Health & Development of Adolescents & Young People in Nigeria. Abuja: 2007 5. Action Plan for Advancing Young People's & Development in Nigeria 2010-2012. Abuja: 2010. 6. National Adolescent & Youth Friendly Job Aids for Service Providers in Primary Health Care Facilities in Nigeria.. Abuja: 2015. 7. Federal Ministry of Health. Frequently Asked Questions (FAQs) Booklet on Adolescent & Youth Health Concerns in Nigeria. Abuja: 2015 8. National Training Manual for the Health &Development of Adolescent & Young People in Nigeria. Abuja: 2011. 9. Clinical Protocol for the Health and Development of Adolescent & Young People in Nigeria. Abuja: 2011. 10. National Training Manual on Peer-To-Peer Youth Health Education. Abuja: 2014. 11. National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria. Abuja: 2013.
Senegal	1. Sexual and Reproductive Health Strategic Plan for Adolescents and Young People in SENEGAL (2014-2018) 2. Standards of Health Services for Adolescents and Young People, (SSAAJ) of Senegal.
Sierra Leone	1. Strategic Plan for Adolescent and Young People's Health and Development 2010-2015. Freetown: 2010. 2. National Standards for Adolescent and Young People's Health and Development. Freetown: 2011. 3. Let Girls Be Girls, Not Mothers!: National Strategy for the reduction of Teenage Pregnancy (2013-2015). Freetown: 2013.

3.3.2 A Few Observations made in the Youth Centres Visited

The salient facts observed are:

- The despair of the heads of the public centres in the face of the multiplicity of material and financing problems.
- The centres operated by NGOs are more functional as a result of the multiplicity of their sources of financing
- The youth centres (rapidly visited) in Cape Verde and the WFI Centre in Abuja caught our attention by their organization, infrastructure, the types of service providers and the range of services provided to the young people.

PART FOUR: SUMMARY

The main task of the ministries of health is to ensure leadership of the health system of the countries. According to the WHO [49] World Health Report of 2000, a health system comprises of all the organizations, institutions and resources generating measures with the main aim of improving health.The broad definition includes but goes beyond the direct competencies of the Ministry of Health. However, as the latter is the main stakeholder, it must take up leadership and governance. Since the health of adolescents and young people is a sub-system under the health system, its improvement depends on its leadership and its capacity to play certain key roles including inter-sectoral coordination and collaboration.

According to the conceptual framework proposed in the first part of this report, the major components of the health sub-system on adolescents and young people may be summed up as follows:

- Status of mortality, morbidity and DALY
- Status of structural social determinants
- Status of proximal social determinants
- Status of knowledge, behaviours and lifestyle of adolescents and young people
- Country Response: Efforts of the Ministry of Health
- Country Response: Efforts and opinions of other stakeholders of the health sub-system of adolescents and young people.

The biological, mental and psychological determinants have no longer been mentioned explicitly in this summary because they work through the behaviours and lifestyles of adolescents and young people.

4.1 STATUS OF ADOLESCENT AND YOUTH MORTALITY, MORBIDITY AND DALY

A. Adolescent and Youth Mortality

With an adolescent mortality of those in the 10 to 19 year age group of 282.5 per 100 000 adolescents as against the world average of 110.7 per 100 000, Africa is a continent where a lot of adolescents do not attain adulthood. It has also been observed that at the global level, mortality is highest among boys than girls and and among older adolescents aged between 15 and 19 years than the younger ones aged between 10 and 14 years.
The first five causes of deaths at the global level are as follows in terms of their magnitude: road accidents, HIV, suicide, lower respiratory tract infections and interpersonal violence. It can also be noted that pregnancy and delivery complications are the second cause of mortality in the world among young girls aged between 15 and 19 years. The African Region recorded the highest rate of deaths from pregnancy and delivery complications: 34 for 100 000. According to the same report, the African Region has by far the highest mortality rate among adolescents; HIV accounts for 16% of these deaths.

With regard to the ECOWAS region, some data identified in the course of the document review showed that death rates caused by road accidents vary between 20.5 per 100 000 population (Nigeria) and 33.7 for 100 000 (Liberia). Generally, the young citizens are the most affected. Even though the world report on adolescent health did not provide disaggrgated data per country, we suspect that the causes of deaths in the ECOWAS region would be similar to those of the Africa region, namely pregnancy and delivery-related

complications, HIV, road accidents, suicide, lower respiratory tract infections and interpersonal violence with varied magnitudes depending on the country. The discussions in the countries visited revealed the high frequency of deaths caused by pregnancy and delivery complications in most of the countries, especially in Sierra Leone.

B. DALY among adolescents

With a DALY rate of 300 per 1000 among adolescents aged between 10 and 19 years of age as against a world average of 152 per 1000, Africa is a continent where large numbers of adolescents lose the highest number of years of healthy life caused by disease, disability or premature death. The most frequent causes of DALY in the Africa region are HIV, motor traffic accidents and pregnancy and delivery-related complications.

Though the world report on adolescent health did not provide disaggregated data on country basis, we suspect that the situation in the ECOWAS region would be similar to those in the Africa Region. The discussions in the countries visited revealed the very high frequency of health problems related to pregnancy and delivery complications, road accidents, alcohol, tobacco and other substance abuse in most of the countries in the ECOWAS region at various levels depending on the country. Alcoholism among young people has been described as a public health problem in Cape Verde.

C. Morbidity

The information collected from the DHS in 15 countries and the discussions with stakeholders in the countries clearly showed that health problems related to sexuality (early pregnancies, STIs and HIV), road accidents, use of harmful substances (alcohol, tobacco and drugs), violence, anaemia and malnutrition are frequent among adolescents and young people in the ECOWAS region.

D. Conclusion

From the point of view of the SWOT approach, all these observations show that mortality, the DALY and morbidities are a major weakness in the adolescent and youth health sub-system in the ECOWAS countries with the Ministries of Health being the leading stakeholders. This situation has implications at the political, strategic and programming levels. However, a good knowledge and understanding of the main determinants is important for the development of an appropriate country response. It is also necessary to take into account the specificities of risks of death among adolescents and young people, including DALY and gender disaggregated morbidity and the groups during national discussions on policy choices and formulation of strategies, programmes and projects for the promotion of adolescent and youth health. This weakness is first of all a matter for the Ministry of Health of ECOWAS countries whose main task is to restore, protect and promote the health of the population in general, and the health of adolescents and young people in particular.

4.2 STATUS OF STRUCTURAL SOCIAL DETERMINANTS

Though the Ministries of Health do not directly control the social determinants, their leadership and stewardship, coordination and collaboration with the sectors responsible for these determinants are cardinal for the effective performance of the health system in general and the adolescent and youth sub-system in particular. In the Alma-Ata Declaration, it was clearly highlighted that "primary health care, involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works and communications"

[74]. This list can also be complemented by legislation, justice and public security. The Ministries of Health are like production managers in businesses, but in this particular instance, they are responsible for promoting the health of the population in general and that of adolescents and young people in particular. They have to seize the opportunities and minimize threats from these sectors and related areas.
Against this background, we shall focus on the following structural social determinants: demography, economy, health care system, education, employment, culture and equity in health.

A. Demography

In all the ECOWAS countries, adolescents and young people in the 10 to 24 year group varies between 31% (Ghana, Niger and Nigeria) and 33% (Burkina Faso); thus they constitute more than one-third of the total population of each of these countries. This demographic trend is both an asset and a threat for adolescent and youth health and for the development of countries and the region.

Indeed, this trend has repercussions on the current and future development of adolescents and young people. The very young adolescents (10 to 14 year group) are still viewed as dependent children who need access to the educational system, health and social services, but all the same they remain invisible in the policies and programmes. On the one hand, this group is not taken into account by the programmes targeted at children, such as in the immunization campaigns and efforts to enrol children in schools. On the other hand, the peer education programmes and the youth centres tend to attract older young ones and their goal is hardly to meet the specific needs of the very young adolescents and young people. In view of the fact that the size of this age group is likely to continue to grow in the coming decades in ECOWAS countries, it will put increasing pressure on the education systems (secondary and university and even on non formal vocational education and health looking at the demand and supply of services.

This galoping population of adolescents and young people can also be an opportunity. Indeed, a country with an increasing proportion of young people but a decreasing fertility rate can reap the benefits of “demographic dividend”, that is a phenomenon of increase in economic productivity which is produced when the ratio of the active population increases as compared to the number of dependent persons.

The trajectory that this sub-component will take depends on the policies and strategies that will be rationally designed and efectively implemented by the leaders of each of these countries.

B. Economic Context

All the economic indicators, namely, income level, GDP per capita and the human development index (HDI) point to the same direction and indicate that adolescents and young people live in an environment characterized by poverty in most of the ECOWAS countries except Cape Verde and Ghana and to some extent in Nigeria (low HDI). The economic problems and poverty in particular are mentioned as the cause of risk behaviours in discussions held with stakeholders. However, as shown in the examples of Sri Lanka and

Cuba, in fact, the determining factors are wealth distribution and the nature of investments more than the level of GDP. Furthermore, Cape Verde can be a case study for ECOWAS countries as far as performance of most of the social and health indicators are concerned.

C. Health care system

All the health indicators, i.e.: maternal mortality, neo-natal mortality, mortality rate of children below 5 years of age, access to health care in terms of quality and quantity of care, quality of human resources in the area of health and health expenses show that adolescents and young people live in an insecure health environment in most ECOWAS countries, with the exception of Cape Verde. However, Cape Verde stands out from the other 14 ECOWAS countries judging by the level of performance of its health indicators. According to a recent WHO report, Cape Verde is the only country in the ECOWAS region to have attained the MDG 5 [50]. But it must be pointed out that most of the countries in the ECOWAS region have made progress in achieving the MDG 4 in respect of the health of children below 5 years of age. This sub-component is currently a weakness for the health of adolescents and young people in all the ECOWAS countries except Cape Verde where it is an asset.

D. Education

Though the net rate of enrolment at the primary level has improved considerably due to efforts made by the countries within the framework of MDG 2, the same enrolment has not been recorded at the secondary level. Only Cape Verde and to some extent, Ghana have achieved a good performance in enrolment at the secondary level, leading to an opportunity to improve adolescent health. The lack of education came up during discussions as a source of health problem and risky behaviours among young people. The improvement in the level of enrolment (and maintenance at school) in primary school is an opportunity for the promotion of adolescent and youth health. However, this opportunity must be consolidated at the secondary stage. The low level of secondary enrolment is a threat to the health of adolescents and young people.

E. Youth Employment

Reliable data on under-employment and unemployment among the youth in the ECOWAS region are difficult to obtain. It is obvious that youth unemployment is a major problem in Sub-Saharan Africa, in particular due to the very high levels of poverty. As compared with adults, young people seem to be over-represented among those living in poverty. Data from Senegal show that more than half of all the young people in this country are among the poorest workers. The highest levels of poverty can be seen among young girls and girls who live in the rural communities [4]. As unemployment among the youth increases poverty, it is a real threat for young people. In the 5 countries visited, poverty was cited by all the stakeholders as one of the factors inducing risky health behaviours among adolescents and young people.

F. Culture

Cultural factors are health determinants for adolescents and young people who are often overlooked in adolescent and youth health strategies and programmes. In the 5 countries visited, all the stakeholders recognized the impact of taboos on adolescent and youth health. The social and cultural standards framework related to religion and to traditional and cultural practices appeared as one of the main elements impacting on the health of young people, particularly on sexual and reproductive health (SRH)[62].

G. Equity in health

Health inequalities often seriously affect the most vulnerable people with less access not only to health services but also to the necessary resources for the enjoyment of good health.

H. Conclusion

From the point of view of the SWOT approach, the following conclusions can be drawn from these major findings:

- The galoping population of adolescents and young people in the ECOWAS region can be both an opportunity and a threat for the adolescent and youth health sub-system. As indicated in the recent World Bank Report, the population explosion of the youth in Africa can be an asset or a disaster [75]. As indicated by the authors of this publication entitled "Africa's Demographic Transition: Dividend or Disaster? Everything will depend on policies to be adopted and implemented by the different countries.

- The economic situation of ECOWAS countries now poses a threat to the health of adolescents and young people with the eception of Cape Verde, Ghana and to a certain extent Nigeria where it could be viewed as an opportunity. An option to be considered by the countries is to turn the demographics of the youth into a real dividend.

- The health care system is currently weak for the health of adolescents and young people in all the countries within the ECOWAS region with the exception of Cape Verde where it can be considered as an asset.

- The improvement of the level of enrolment in the primary schools is an opportunity for the promotion of adolescent and youth health. However, the low level of enrolment at the secondary level is a threat to the health of adolescents and young people.

- Unemployment will be a real threat to the health of adolescents and young people unless well-designed and consistent policies underpinned by a real political are put in place to make the youth a demographic asset.

- Integrated approaches that are "culturally-sensitive" can help to minimize the threats and change the cultural factors into opportunities for the promotion of health among adolescents. The cultural factors are seen as threats to the health of adolescents and young people.

- Inequalities in health are therefore a threat to the health of adolescents and young people.

On the whole, the structural social determinants are some of the real challenges for action by the Ministries of Health in their role towards improving the health of adolescents and young people in the ECOWAS region. ECOWAS as an economic development institution has a greater role to play in this.

4.3 STATUS OF PROXIMAL SOCIAL DETERMINANTS

As indicated above, the proximal social determinants are circumstances in daily life which directly impact attitudes and behaviours of a person. Among the examples of proximal determinants are the quality and nature of family relations and with peers, the availability of food and housing and the opportunities offered by leisure and the school environment. The discussions with stakeholders in the countries clearly brought to the fore the negative influence of changes of the family unit and the school environment on the health of the young people, and the positive and negative nfluence of peers. The difficulty in communication between parents and adolescents, sometimes leading to crisis between parents and adolescents was raised by all the stakeholders including parents and the young people themselves. The proximal social determinants can be a threat to the health of adolescents and young people. However, contrary to structural social determinants, the proximal social determinants can be impacted by the actions of the Ministries of Health and other stakeholders, parents, adolescents and young people. Better than the information education and communication approaches (IEC) which have broadly shown their limits, the new communication approaches for behavioural change (CCC), if well-designed and rationally implemented and combined with other approaches will be promising.

On the whole, though the proximal social determinants are currently a major threat to the health of adolescents and young people, these threats can be minimized and even transformed into opportunities for the promotion and improvement of adolescent and youth health. The peer educators' approaches and adolescent and youth counseling centres, though attractive for the countries and abundantly deployed by the NGOs in particular, have showed their limits in changing the behaviours of adolescents and young people as indicated in a recent review carried out by Venkatraman et al [76]. The other authors pointed out that for a sexual and reproductive health of adolescents and young people to be effective, substantial efforts are needed through coordinated and complementary approaches.

4.4 KNOWLEDGE AND MODE OF LIFE OF ADOLESCENTS AND YOUNG PEOPLE

Knowledge, behaviours and modes of life are immediate determinants of the health of adolescents and young people. All the four sources of information consulted during this situational analysis (document review, partners, adolescents, young people and parents) revealed the impact of knowledge, behaviours and modes of life on the health of adolescents and young people.
Sexuality and reproduction are fertile grounds for adolescent and youth health risks in all the ECOWAS countries:

- Birth and fertility are very high among adolescents and young people
- Early sexual relations both among girls and boys, especially in Sierra Leone, Cape Verde, Liberia and Gambia.
- Persistence on a large scale of premarital and unprotected sexual relations,
- Increase in the practice of multiple sexual partners among young people between the ages of 15 and 24 years, more frequent among the boys than the girls.
- Knowledge about family planning has improved tremendously in most of the countries; this effective knowledge of the methods of contraception however contrasts with the rate of use of these methods. One can think that the current policies of access by young girls to methods of contraception supported in most countries by religious lobbies could partly explain this situation.

The knowledge about HIV and sexually transmitted infections by adolescents and young people is improving. However, one can still observe a conflict between the knowledge and practices in the area of HIV and STIs. The STIs are still very frequent among adolescents and young people in all ECOWAS the countries without any exception.

The risk factors relating to violence, motor traffic accidents, non communicable diseases among adolescents and young people are on the increase in all the ECOWAS countries:

- The harmful use of tobacco, alcohol and drugs is on the rise and it is of concern in the ECOWAS region. In Cape Verde, the authorities have declared that alcoholism is a public health problem
- On the whole, alcohol and drugs use, poor nutrition and physical inactivity are paving the way in the coming years for the setting in of non communicable diseases such as: diabetes, cardio-vascular diseases, particularly hypertention, obesity, etc.
- Road traffic accidents are on the rise due to the use of alcohol and drugs and the increasing phenomenon of overspeeding.

Harmful traditional practices such as female genital mutilation and early marriages with all their consequences still persist in the countries:

- Early marriages are still widespread in Mali, Niger, Guinea and the Gambia
- Female genital mutilations are still frequent in Guinea, Mali, Gambia and Sierra Leone.

On the whole knowledge, behaviours and lifestyles of adolescents and young people in the ECOWAS region are a threat to the health of adolescents and young people. As shown in the conceptual framework, behaviours and lifestyles, to a large extent, originate from social determinants, both proximal and structural and are classified by biological, psychological and mental determinants. That is, the complexity of their management and this is exactly what partly explains the discrepances constantly seen between the levels of knowledge and practices. The case of Cape Verde shows to some extent this reality. As indicated in the review carried out by Venkatraman et al [76], strategies and interventions for the

improvement of sexual and reproductive health and a better adolescent and youth health call for fresh thoughts. Peer education, counselling centres and other strategies currently used in large numbers in most African countries must be reviewed. Indeed, as acknowledged by some stakeholders we met in the countries visited, the serious evaluation of strategies and interventions currently used is not a standard practice in the countries. The so-called "good experiments" exported and replicated from country to country can rarely pass the test of factual bases.

4.5 ACCESS TO AND USE OF INFORMATION AND COMMUNICATION TECHNOLOGY AND SOCIAL NETWORKS

Information technology can provide both opportunities and threats in promoting and improving adolescent and youth health in the ECOWAS region.

This analysis indicates that adolescents and young people are mostly neither avid readers of newspapers nor good listeners of radio. The situation concerning television is by far better particularly in Cape Verde, Senegal and Ghana.

The penetration of social networks in Africa in general in the ECOWAS countries is impressive. Indeed, the number of mobile connections in Sub-Saharan Africa has increased by 44 %, whereas the average for the same period stands at 34% in developing regions while it is only 10% in developed regions.

Facebook takes a large proportion of the time of adolescents and the youth. On 15 January 2015, the number of users in the ECOWAS sub-region varied between 70,000 (Guinea Bissau) and 15 000 000 in Nigeria. The adolescents and young people have increasingly become addicted to social media. This situation seems to pose more threats for adolescent and youth health than it creates opportunities. Though some stakeholders use the social media as a means of communication, most of these stakeholders do not appreciate the abusive, disorderly and uncontrolled use of this media by adolescents and young people. This situation is denounced by the partners, parents and by the young people themselves. As was stated by one of the young people we met "Sex is all over the place: the photos are incredible: This spins the heads of young people. It is true that nothing can be done against technology but at least it must be regulated".

On the whole, though adolescents and young people have increasing access to information and communication technology, the way they use it poses more threats than it generates opportunities. The policy and regulation of the use of these networks must be an issue worth thinking about by the authorities in the ECOWAS region.

4.6 COUNTRY RESPONSE IN THE AREA OF ADOLESCENT AND YOUTH HEALTH

4.6.1 Country response: Efforts of the Ministries of Health

The Ministries of Health are the leading stakeholders for the promotion and improvement of adolescent and youth health. The interviews we had with the health officials involved in adolescent and youth health at the Ministries of Health enabled us to identify the important facts regarding their efforts as well as the strengths and weaknesses of the organization and management of adolescent and youth health in the countries.

A. Partnership for adolescent and youth health

As a poor health relation at the beginning of the MDGs, sexual and reproductive health among the youth as well as adolescent and youth health started by gaining more attention and interest within the international community. In the countries visited, various stakeholders (public sectors, bilateral institutions, United Nations institutions, International NGOs, National NGOs, youth associations etc..) are supporting the Ministries of Health to improve adolescent and youth sexual and reproductive health. This incipient enthusiasm of partners is an opportunity to be seized by the Health authorities. But to achieve this, the Ministries of Health must demonstrate genuine leadership and a greater coordination and collaborative capacity.

B. Coordination of adolescent and youth health

All the countries visited have a national health coordination structure for adolescent and youth health. These structures can take different forms and sizes: unit, division, service, but rarely a directorate. Furthermore, all the countries have made provision for or established mechanisms for consultation or coordination of activities with regard to adolescent and youth health. However, as we can see later, these different structures and mechanisms are less operational. In short, lots of efforts must be made by the countries in the area of coordination.

C. National leadership

In most of the countries visited, adolescent and youth health is of concern at the highest strategic level of the country, but with some reservation as a result of under-funding or lack of financing of this sector in Nigeria. All the countries visited and even those that were not visited within the ECOWAS region have a national strategic document or roadmap for the reduction of maternal or neonatal mortality. More specifically, the countries visited and most of the ones not visited in the ECOWAS region have national strategic document for adolescents and young people and have developed standards for quality friendly health services for adolescents and young people. But these documents appear to be focused more on SRH with less attention paid to the major health problems and risk factors of adolescents and young people. The budgeted national health action plans for adolescents and young people could not be found in all the places visited. The officials of adolescent units indicated that in addition to receiving interventions, adolescents and young people are involved in decision-making processes concerning health issues. But this latter assertion is disputed by the young people (see later).

D. Advocacy and resource mobilization

Advocacy and resource mobilization are also other leadership dimensions for the Ministries of Health. However, the effectiveness of the advocacy approaches and the results of the resource mobilization are yet to be demonstrated.

E. Protection of adolescents and young people

The right to health is acknowledged in the health policies, strategies and plans of the country including those touching on the health of adolescents and young people. .However, the major weaknesses identified at this stage are: contraceptive services with the exception of sterilization, emergency contraception and measures for the protection of minors.

F. Policies, strategies and guidelines for adolescent and youth health

The health policies, strategies and plans are part of a larger process which seeks to align national priorities with the real needs of the population in the area of health. They aim at

bringing on board the government, health and development partners, civil society and the private sector. It also intends to make better use of all the resources available for health, such that the entire population, in whichever location they may find themselves, can have access to quality health care, and live healthier and longer lives.

- ***National situational analysis of adolescent and youth health***

A health situational analysis is an evaluation of the current situation; it is fundamental to the formulation and review of national health policies, strategies and plans.

This activity does not seem to have received the attention that it deserves in most of the countries visited, whereas it is the starting point for the development of the relevant national adolescent and youth health strategic document. Indeed, the situational analysis is one of the four criteria for assessing the solidity of a national strategy.

Most of the countries have indicated that they have carried out an adolescent and youth health situational analysis in one form or the other; however, the reports on these studies were not made available. Furthermore, in most cases, it was a very brief situational analysis, which looked more of a literature review than a formal situational analysis. Furthermore, they do not contain any disaggregated data on adolescents and young people except on very rare occasions. This fact is a major weakness in the process of developing the strategic documents in the countries. The inability to carry out a concrete situational analysis may explain the disconnection often noted between the strategies and the realities on the ground. The reasons often advanced for the non realisation of national situational analyses are often of financial nature.

- ***Place of adolescents and young people in the strategies and policies of countries***

In all the countries visited, it can be observed that the adolescents andyoung people have a leading role in policy and strategic documents.
The major weaknesses noted touch on health issues in which adolescents and young people still do not receive all the necessary attention: nutrition, physical activities, tobacco, mental health, prevention of injuries from motor traffic accidents, violence and lack of communication between parents and adolescents/young people.

- **Existence of specific strategies for adolescent and youth health taking into account the main health problems of adolescents and young people**

The countries visited, it was noted that issues of adolescents and young people have been duly incorporated into policy and strategic documents. However, the key strategic lines proposed in most of the strategic documents revolve around peer education, the IEC, youth counselling centres, which are either separate units or services integrated into public health structures. But, it must be recalled that recent publications call into question their effectiveness [76]. Moreover, the process of developing strategic documents is not often inclusive but exludes some stakeholders. However, bringing all stakeholders on board can contribute to strengthening national health strategies and plans and deepen the trust of the partners, thus helping to obtain a more foreseeable and aligned financing.

- ***Availability of national standards for the provision of adolescent and youth health services***

A great effort to develop standards for the provision of services to adolescents and young people is significant; however, these standards still do not take into account the key health problems confronting adolescents and young people.

G. Interventions and provision of services to adolescents and young people

The availability and provision of high impact interventions for the health of adolescents and young people is still a major challenge if not a major gap for the health systems of ECOWAS countries. Some interventions currently implemented to promote and improve adolescent and youth health have not yet been subjected to critical factual analysis.

H. School Health

Scool health is a weak aspect of adolescent and youth health. The school and university environment provides opportunities for the promotion and improvement of adolescent and youth health. Indeed, most countries do not have school health policies or programmes with the exception of Nigeria. However, they are rolloing out school health activities. School and unversity health will necessitate a close collaboration between the Ministries of Health and the Ministries of Education.

I. Health, research, monitoring and evaluation information system

Though all the countries produce statistical yearbooks at varying intervals according to the countries, they do not cover adolescent and youth health data.

The countries visited have a list of indicators for the health of adolescents and young people. However, the indicators vary from country to country but there is no agreed list of indicators for countries in the ECOWAS region. Another weakness noted is that none of the countries conducts a half-yearly/annual monitoring of the coverage of adolescent and youth interventions. Furthermore, health research on adolescents and young people is almost non-existent in countries within the ECOWAS region.

J. Financing

The financing of adolescent and youth health is still in its incipient stages or non-existent in most of the ECOWAS countries.

4.6.2 Country Response: opinions of strategic and/or operational partners

The main strengths identified in most countries are: the existence of a consultative or coordination framework, availability of a large number of stakeholders and of strategic documents and the existence of youth centres.

The weaknesses are similar in all the countries: poor coordination of the stakeholders' communities, unavailability or inadequacy of trained service providers, poor reception by the service providers, overlapping of interventions of the different partners, lack of integration of interventions, competition among stakeholders, lack of dissemination of strategic documents, lack of research and advocacy among the religious leaders etc.

All the partners interviewed raised the issue of low involvement and ineffectiveness of existing coordination mechanisms in the countries.

4.6.3 Country response: opinions of managers of youth centres

The youth counseling centres are one of the flagship strategies of the countries. The implementation of the strategy takes different forms and the activities carried out depend on the country. It was noted that there were isolated centres, centres built within certain social health structures. The trend currently envisaged in most of the countries is the establishment of centres within health structures. But some centres visited had not achieved any success. The models of young centres seen in Cape Verde as well as the Women Friendly Initiative visited in Abuja were quite impressive judging by their organization, their infrastructure and the types of service providers and the range of services provided to young people.

Most of the centres visted face difficulties relating to attendance by certain groups of young people (in particular girls and young people who do not attend school), financial and material problems (in particular public centres) and the sustainability of actions by the NGO-administered centres.
Furthermore, most of the centres do not have reliable statistics on their activities. In addition, as indicated above, a recent review showed that these centres cannot prove to be effective.

On the whole, the strategy of the most popular youth centres in the different countries show more weaknesses than strengths and a rethinking of this strategy is worthwhile in the area of their design and implementation based on new facts.

4.6.4 Country response: opinions of parents

Often, the issue raised is that parents give up on their adolescent and young children. Though this assertion is part of it, it is also necessary to take into account the fact that in the African culture, it is difficult for parents to discuss sexual matters with their children. This inconvenience or inability or embarrassment for most of the parents was one of the key and pertinent issues discussed with the parents. This task, formerly, the preserve of aunts and uncles, is not working out well today because of family breakdown or the transition of families towards nuclear ones, and this is one of the greatest threats to the development of adolescents and young people.
Furthermore, most of the parents admitted their dismay and powerlessness in the face of the advent of ICT which according to them produces behaviours that are at variance with our African values; parent-child communication has become difficult.
It is clear that parents also need to be supported to facilitate the upbringing of their children.

4.6.5 Country Response: opinions of young people

Even though the number of young people we met is quite minimal, the analysis shows that the ones we met appreciate very well the situation in which their peers find themselves.

Obviously, the adolescents and young people hesitate or are unwilling to go directly to a health centre for fear of being seen or met by a relation or being rebuked by a health official. Generally, the first thought of young people in the event of a problem is to confide in a friend. However, having resourse to friends can also be changed to a double-edged sword because friends can be the source of wrong advice; thus exposing the young ones to serious risks. The young people also use the toll free and anonymous lines, the existing chat and social media platforms.

The young people need moral support from their parents for a better management of their sex life, entertainments and healthy leisure in order to engage in healthy activities, care and counselling. They also need information on the prevention of pregnancies without going to a health centre. Finally, they need sporting activities, protection and the attention of relations and good nutrition. All these needs are not adequately covered by the current sub-system of the countries.

The sources of information on health are friends and the social networks, hardly are brothers, sisters and relations consulted. The socialnetworks prioritized by the youth are Facebook, WhatsApp and the SMS (the SMS is more discreet). However, one of the respondents stated that young people find health messages often too boring and "switch" from them very often.

Finally, the level of involvement of the youth in decision-making organs is still very low.

Table 4.1: Recap of Strengths, Weaknesses, Opportunities and Threats

Components	**Strengths/Opportunities**	**Weaknesses/Threats**
Status of adolescent and youth health		Level of mortality, morbidity and DALY
Structural social determinants		
- Demography	Potential Demographic Dividend	Potential threat in the absence of effective policies and strategies (risk of disasters)
- Economy	-	Poverty could lead adolescents and young people to risky behaviours
- Health care system,	-	Non performing in most countries
- Education	Improvement of the rate of enrolment at the primary level	Low level of enrolment at the secondary level
- Employment	-	Serious unemplyment among the youth
- Culture	Integrated approaches referred to as "sensitive to culture"	Taboos and religions
- Equity in health	-	Inequalities in health and incomes
Proximal social	Potential opportunity	Currently more on the side

determinants		of threats
Knowledge, behaviours and modes of life	Potential opportunity	Currently more on the side of threats
Access and use of information and communication technology and social media	Obvious interest for television Impressive penetration into mobile telephony Biggest users of social media	Adolescents and young people are not avid readers of newspapers nor large listeners of radio Addiction to the social media

Table 4.1: Recap of Strengths, Weaknesses, Opportunities and Threats (Continuation and end)

Components	Strengths/Opportunities	Weaknesses/Threats

Responses from countries: Efforts of the Ministries of Health		
A. Partnership for the health of adolescents and young people	Growing existence of strategic and/or operational partners	
B. Coordination of the health of adolescents and young people	Existence of a coordination structure within the Ministry of Health	
C. National Leadership	Concern and priority at the highest strategic level of the country Existence of a national strategic document or roadmap for the reduction of maternal and neonatal mortality Existence of a national adolescent and youth strategic document	Non-existence of budgeted national Action Plan in most of the countries
D. Advocacy and mobilization of resources	Existence of standards of friendly services in some countries	Relative efficiency of approaches used
E. Protection of adolescents and young people	Advocacy and resource mobilization	Laws for the protection of minors
F. Policies, strategies and guidelines for adolescent and youth health	Existence of some laws	Brief national situational analysis or non-existent of situational analysis
G. Interventions and provision of services to adolescents and young people		Effectiveness of interventions
H. School health	-	Inefficiency in most of the countries
I. Health information system, research, monitoring and evaluation	Existence of a list of indicators Production of statistical yearbooks by the countries	Non-existence of an agreed list of indicators Non-existence of data on adolescents and young people in annual statistical directories Lack of research
J. Financing		Weak financing

Strengths and weaknesses identified by the strategic and/or operational partners	Existence of a large number of partners Existence of an adolescent and youth service Existence of documents on standards Existence of strategic documents Existence of sexual health strategic document Existence of motivated partners Existence of youth centres Political will at the highest level	Non operability of coordination frameworks Poor coordination of stakeholders and provision of services Incomplete nature of packages of service Inadequate competent service providers Non incorporation of sex education in the training curricula Failure to effectively involve the private sector Lack of a monitoring and evaluation framework Lack of data on adolescents and young people Overlapping of interventions by NGOs Non inclusion of behaviourial determinants Failure to prepare public structures to receive young people Lack of or inadequate linkage between the ministries of health, youth and education Competition among stakeholders Lack of research and evaluation Lack of or poor dissemination of strategic documents Lack of dialogue between parents and adolescents

GENERAL CONCLUSIONS

Neglected for a longtime by the health systems, adolescents and young people are gradually becoming assertive in the countries in view of their increasing population and their socio-health needs.

This situational analysis carried out through a document review and a visit to five countries enabled us to report on the stauus of the different components of the adolescent and youth health sub-system in the ECOWAS region. The key points identified provide a measurement of the key challenges to be addressed on the one hand, by ECOWAS, through WAHO and on the other hand, by the health authorities of the member countries. We are going to summarize the key points and main challenges.

5.1 SALIENT POINTS OF ADOLESCENT AND YOUTH HEALTH WITHIN ECOWAS

The traditional indicators of the state of health of the adolescent and youth population in the ECOWAS region, namely mortality, morbidity and DALY, are quite alarming.

Most of the structural social determinants of health, that is, the circumstances in which adolescents and young people are born, grow, live, work and grow old in the ECOWAS region, as well as the systems put in place to deal with disease, are far from being optimum. However, these circumstances which reflect political choices depend on the distribution of power, money and resources at all levels, both national and local. They can be improved through a genuine political will and a better social justice. Indeed, the size of the current population of adolescents and young people can be a dividend for the countries. The determinants specifically considered in this report are: demography, economy, health system, education, emplyment, culture and equity in health.

The proximal social determinants, i.e. the circumstances of daily life which more directly influence the attitudes and behaviours of a person, currently pose a huge threat to the health of adolescents and young people. However, these threats can be reduced and even changed into opportunities to promote and improve adolescent and youth health. The peer educators' approaches and the counseling centres for adolescents and the youth, though fascinating for the countries, and abundantly deployed by NGOs in particular showed their limits. The proximal social determinants specifically considered in this report are: the family and the school environment.

The knowledge, behaviours and lifestyle of adolescents and the youth of countries in the ECOWAS region are currently threats to the health of adolescents and young people. Indeed, this analysis revealed that most of the adolescents and young people in the ECOWAS region suffer from a critical lack of sound information and adopt behaviours and lifestyles that are harmful to good health (unprotected sexual relations, physical inactivity, alcohol consumption, tobacco and drug use, poor nutrition and especially addiction to ICT). These behaviours and lifestyles are setting the stage for an epidemic of non communicable diseases in the years to come.

Thoungh they are still underperforming, the Ministries of Health, with their strategic and operational partners, have established a response which will continue to improve over the years. Indeed, in most of the countries, there is a real adolescent and youth health partnership, with a more or less functional coordination mechanism. We noted a national leadership at the highest level, legal measures for adolescents and the youth, advocacies and efforts at resource mobilization for adolescent and youth health. The countries have established policies, strategies and guidelines for the health of adolescents and young people with interventions and the provision of more or less friendly services. The availability of data, especially disaggregated data according to age and gender is still a weakness in the ECOWAS region. The financing of adolescent and youth health is yet to be improved.

The main strengths identified by the strategic and/or operational partners in most of the countries are: the existence of a consultative and coordination framework, the availability of strategic documents and the existence of youth centres. The weaknesses identified by the partners are similar all over the countries: poor coordination of stakeholders, unavailability or lack of trained service providers, poor reception by the stakeholders, overlapping of interventions of the various partners, non integration of interventions, competition among the stakeholders, the lack of dissemination of strategic documents, the lack of research and advocacy among the religious denominations etc..

The problem of low involvement and the ineffectiveness of the existing coordination mechanisms in the countries is one of the major concerns for the partners.

The strategy of most popular youth centres in the different countries presents more weaknesses than strengths and a rethinking is desireable both in its design and implementation in the light new factual bases.

It appears clearly in this analysis that parents also need to be assisted to facilitate support for their children.

Finally, adolescents and young people are claiming to be involved in work of the decision-making bodies.

5.2 MAIN ADOLESCENT AND YOUTH HEALTH CHALLENGES WITHIN ECOWAS

5.3 The 15 major challenges to be addressed by the countries and ECOWAS through WAHO are:

1. Positioning adolescent health as a high priority and allocating to it substantial financial, human and material resources
2. Reducing mortality, DALY and morbidity of adolescents and young people
3. Identifying effective interventions based on evidence that takes into consideration all the components of the adolescent and youth health sub-system
4. Ensuring coordination at the inter-sectoral level (involving the stakeholders from other sectors for the improvement of adolescent and youth health)
5. Ensuring intra-sectoral coordination within the Ministries of Health of the countries.
6. Mitigating threats in respect of the structural social determinants
7. Mitigating threats in respect of the proximal social determinants
8. Ensuring actual involvement of the youth in the design, planning, implementation and evaluation of action that are beneficial to them
9. Adoption of protective behaviours and healthy lifestyles by adolescents and youtng people
10. Combating addiction of adolescents and young people to ICT
11. Developing youth centres that are genuinely friendly and integrated for the the youth
12. Developing appropriate and competent human resources in AYH including AYSRH
13. Defining specific consensus-based adolescent and youth health indicators
14. Promoting the culture of evaluating strategies implemented
15. Ensuring availability of data on adolescents and the youth (gender-based and age disaggregated data)
16. Harmonizing policy, strategic, planning, monitoring and evaluation of documents.

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ANNEXES

ANNEX 1: List of strategic/operational partners in the countries

Benin

Institutions	Type
1. Ministère de la Santé (Direction de la Santé ede la Mere et de l'Enfant	Public
2. Ministère en charge de la jeunesse	Public
3. Ministère en charge de l'enseignement supérieur	Public
4. Ministère en charge de l'enseignement secondaire	Public
5. Ministère en charge de la famille	Public
6. UNFPA	United Nations
7. OMS	United Nations
8. ONUSIDA	United Nations
9. USAID	Bilateral
10. Pays Bas	Bilateral
11. AFD	Bilateral
12. CTB	Bilateral
13. ABMS/PSI	International NGO
14. Plan Benin	International NGO
15. Care Benin Togo	International NGO
16. ABPF/IPPF	National NGO
17. Céradis ONG	National NGO
18. Grafed ONG	National NGO
19. OSV Jordan	National NGO
20. CERD ONG	National NGO
21. MJCD ONG	National NGO
22. CNLS /MS	Public
23. PNLS	Public
24. DPP	Public
25. COUS/UAC	Public
26. Parlement des Jeunes	Civil Society
27. Parlement des Enfants	Civil Society
28. Jeunes Ambassadeurs pour la PF	Civil Society
29. Mouvement d'action des Jeunes de l'ABPF	Civil Society
30. Organe Consultatif de la Jeunesse	Civil Society

Cape Verde

Institutions	Type
31. Ministério da Saúde	Public
32. Ministério da Juventude	Public
33. Ministério da Educação e Ensino Superior	Public
34. Ministério da Justiça e ICIEG	Public
35. Ministério da Cultura e Desporto	Public

36. UNFPA	United Nations
37. WHO	United Nations
38. UNICEF	United Nations
39. UNDP	United Nations
40. Cooperação Luxemburguesa	Bilateral
41. Cooperação Portuguesa	Bilateral
42. IPPF	International NGO
43. VerdeFam	National NGO
44. Morabi	National NGO
45. OMCV	National NGO
46. CV Telecom	Private
47. Cavibel	Private
48. Cavibel	Private
49. Piaget	Public
50. UNICV	Academic Institution
51. UNIMindelo	Civil Society
52. Plataforma das ONG's	Civil Society

Senegal

Institutions	Type
1. Ministère de lqa Santé et de l'Action Sociale: Direction de la Santé de la Reproduction et de la Survie de l'Enfant (DSRSE)	Public
2. Division de Lutte contre le sida (DLSI)	Public
3. Districts sanitaires	Public
4. Ministère de l'Education Nationale : Division du Contrôle Médical Scolaire (DCMS)	Public
5. Ministère de la Jeunesse, de l'Emploi et de la construction Citoyenne: Projet Promotion des Jeunes (PPJ)	Public
6. Ministère de la Jeunesse, de l'Emploi et de la construction Citoyenne: Direction de la Jeunesse et de la Vie associative (DJASE)	Public
7. UNFPA	United Nations
8. WHO	United Nations
9. UNESCO (United Nations Educational, Scientific and Cultural Organization)	United Nations
10. AFD	Bilateral Institution
11. AMREF	International NGO
12. MSI	International NGO
13. Association de Bien-être Familial	Civil Society Organization (NGO)
14. Réseau, Jeunesse, Population et Développement du sénégal (RESOPOPDEV)	NGO
15. INTERMONDES	NGO

16. Action et Développement ACDEV	National NGO
17. Groupe pour l'étude et l'enseignement de la population GEEP	NGO
18. Service Médical du COUD	Academic Institution

Sierra Leone

Institutions	Type
1. Ministry of Health and Sanitation	Public
2. Ministry of Education, Science and Technology	Public
3. Ministry of Youth Affairs	
4. Ministry of Social Welfare, Gender and Childrens	Public
5. Ministry of Local Government and Rural Development	Public
6. World Health Organization	United Nations
7. United Nations Population Funds	United Nations
8. United Nations Childrens Fund	United Nations
9. UNAIDS	United Nations
10. USAID	Institution bilatérale
11. Save the Children International	International NGO
12. Plan Sierra Leone	International NGO
13. CARE Sierra Leone	International NGO
14. Plan Parenthood Association, Sierra Leone	National NGO
15. Marie Stoopes Society, Sierra Leone	International NGO
16. Restless Development	International NGO
17. BRAC	International NGO
18. Fine Men Engage	International NGO
19. Girls to Girls Empowerment	International NGO
20. Helen Keller International	International NGO

Nigeria

	Actor/Partner Name	**Type**
1	UNFPA	
2	WHO	
3	UNICEF	
4	Planned Parenthood Federation of America PPFA	International NGOs
5	AHI Action Health Incorporated	Nat NGO
6	WHI Women friendly International	Nat NGO
7	ARF Association of Reproductive and family Health	Nat NGO
8	Education as A Vaccine (EVA)	Civil Society
9	Brave heart International	
10	Adolescent Health and Information Programmes AHIP in Kano	Civil society Organization
11	FMIN of EDUCATION	
12	F MIN of WOMEN AFFAIRS AND SOCIAL DEVELOPMENT	

13	F MIN OF YOUTH DEVELOPMENT	
14	Girls Power Initiative (GPI)	
15	TSHIP	
16	Kuje Youth Clinic	
17	Association of Reproductive and Family Health (ARFH)	
18	Education	
19	Youth and Sports	
20	Women Affairs and Social Development	
21	Information	
22	NPopC	
23	Nigerian Urban Reproductive Health Initiative (NURHI)	