Jeune S3

Santé, Sexualité, Sécurité

ANNUAL REPORT 2017

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Technical partners:

Cordaid BUILDING FLOURISHING COMMUNITIES

psi Europe

Swiss TPH Swiss Tropical and Public Health Institute Schweizerisches Tropen- und Public Health-Institut Institut Tropical et de Santé Publique Suisse Associated Institute of the University of Basel

World YWCA

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IPPF International Planned Parenthood Federation Africa Region

HEALTHY ENTREPRENEURS

it solutions universal access to essential medicines

TRIGGERISE

In partnership with Ministry of Foreign Affairs of the Netherlands

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ABBREVIATIONS

ACABEF	Association Centrafricaine pour le Bien-Etre Familial
ABMS	L'Association Béninoise pour le Marketing Social et la Communication pour la Santé
ABPF	L'Association Béninoise pour la Promotion de la Famille
ACMS	Association Camerounaise de Marketing Social
AFEM	Aide aux Familles et Entraide Médicale
C3	Commodities, Chain, Care
CAR	Central African Republic
CISPE	Consortium pour la Stabilisation Intégrée et la Paix à l'Est de la RDC
CSE	Comprehensive Sexuality Education
CSW	Commercial Sex Workers
CTMP	Comité Technique de Planification Familiale
DRC	Democratic Republic of Congo
FP	Family Planning
FPU	Free Press Unlimited
GBV	Gender Based Violence
HCD	Human Centred Development
HE	Healthy Entrepreneurs
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HO	Head Office
IDP	Internally Displaced Person
IPPF	International Planned Parenthood Foundation
Jeune S3	Jeune Santé, Sexualité et Sécurité
KP	Key population
LGBT	Lesbian, Gay, Bi-sexual and Transgender
MoFA	Ministry of Foreign Affairs
MSM	Men having sex with men
MYP	Meaningful Youth Participation
NGO	Nongovernmental organization
PBF	Performance Based Financing
PNSA	Programme National de Santé pour Adolescents
PNSR	Programme National de Santé de la Reproduction
RNE	Royal Netherlands Embassy
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SGBV	Sexual and Gender Based Violence
Swiss TPH	Swiss Tropical and Public Health Institute
ToC	Theory of Change
ToT	Training/Trainer of Trainers
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Populations Fund
WYWCA	World Young Women's Christian Association
YES	Youth Eco-System
YFHS	Youth Friendly Health Services
YP	Young Person/people
YPLHIV	Young Persons living with Human immunodeficiency virus
YWCA	Young Women's Christian Association

BUZA Framework

HIV/AIDS	Human immunodeficiency virus and acquired immunodeficiency syndrome
FGM	Female Genital Mutilation

Cordaid Framework

C3	Commodities, Chain, Care
E-LMIS	Electronic Logistics Management Information System
F&M	Female and Male
ICASA	Conférence sur le SIDA et les IST en Afrique
IEC	Information Education Communication
HCD	Human Centred Design
HIV	Human immunodeficiency virus
SCM	Supply Chain Management
UNHLPF	United Nations High Level Political Forum

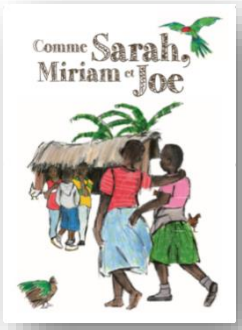
1. SUMMARY

All four program countries, Democratic Republic of Congo (DRC), Central African Republic (CAR), Cameroon and Benin, are fully engaged in the execution of their program activities as planned. The political and security contexts in the countries remain a point of attention and sometimes delay the implementation of activities.

Benin was added as fourth country to the program during 2016, with the knowledge that only a limited budget would be available for implementation of activities. Therefore, it was decided to focus on meaningful youth participation and involvement of religious leaders in the program in Alibori region, a marginalized region in North- Benin. Implementation of activities started in July 2017 after the formulation of the project activities in the selected community of Banikoara.

In CAR, preparations were made during 2017 to include the Bouar area, in the west of CAR, in the program as of 2018 as planned.

Continued capacity building and refresher training took place of all actors involved in CSE in- and out-of-school, YFHS, SRHR and Advocacy skills. Tools and manuals were finalized and validated. The CSE tool for youth between 10-14 years old which was introduced during 2017 was particularly appreciated.



A second edition of the booklet *"Like Sarah, Miriam and Joe"* will be produced in 2018 on the topic of teenage mothers.

Close collaboration continued with the Government to start with CSE in schools and YFHS in the intervention zones.

Young people are actively participating in the programme activities and meetings and are trained and accompanied to fulfil their role as can be read throughout the report. For a meaningful youth voice, an enabling environment is required and in addition to engagement of local and religious leaders, meaningful involvement of parents is crucial to achieve the program coals.

At the end of 2017, the partnership with World YWCA was phased out as it had been concluded that no added value had been generated or was to be expected *(See consultancy report).* The *Safe Space* model as introduced by World YWCA will be evaluated at country level and continued as deemed relevant.
HE will phase out in mid-2018 in DRC as no viable social business is possible in the fragile context of South-Kivu.

2. CONTEXT

Democratic Republic Of Congo

SECURITY CONTEXT

In DRC, political tension exists around the postponement of the general presidential elections, even though an independent national electoral commission has published an electoral agenda, approved by the international community. This resulted in protest demonstrations, by the opposition and general public in various cities in the country, whereby the Catholic Church has chosen to support the general public Violence ensued and the general security situation in the country has deteriorated., Especially during the last quarter of 2017, this affected the security situation in the programme area, particularly in the *"Grand Nord"* of North Kivu (Beni and Mutwanga) and in South-Kivu (Walungu) because of presence of active armed groups. This caused delays in the implementation of activities in *the "Grand Nord".*
Security for young reporters/ journalists has become an issue in DRC because of the lack of press freedom, and a young journalist, trained by AFEM, one of the FPU partner organisations, was detained for a few days.

CSE CONTEXT

There is close collaboration with the government on CSE. The Jeune S3 program facilitated the integration and use of the validated national CSE curriculum in schools. The head of the national program was involved in the training of teachers in Nord and South Kivu. The Provincial Educational Ministries have adopted the curriculum and the inspectors of education have included CSE as part of their supervision of teachers.
In South Kivu, the catholic schools preferred to continue with their own course, although they have not officially rejected the national curriculum. The Provincial Ministry of Education continues the dialogue with catholic schools to include the national curriculum, supported by the Jeune S3 program. Out-of-school materials were validated by the provincial government as well.

HEALTH CONTEXT

In DRC, the CTMP (Comité Technique Multi-sectoriel du Planning Familial) created a conducive environment for the uptake of family planning. In North and South Kivu, the CTMP is active with a specific working group on A&YFHS which focusses on access to contraceptives (for young people) and on religious leaders and breaking barriers for FP. Budgets are made available for FP in both North and South Kivu.

ENABLING ENVIRONMENT

In the Jeune S3 program areas, discussions were held with local/religious leaders and parents (mainly through parent-teacher organisations). Although persuasion was sometimes needed to get everybody to understand and agree on the implementation of the CSE program (in- and out- of-school), the program was not rejected anywhere.

Training of trainers of religious leaders was done to create more understanding by this group. Religious leaders were involved in a pilot to test the national manual for religious leaders on adolescent SRHR that was developed by the PNSR/PNSA in collaboration with Cordaid. A ToT workshop was held in Saugus in which religious leaders were trained. Together they rolled out the training to all 8 zones. Youth leaders of the church were trained to integrate SRHR and SGBV in ongoing activities. Resistance in DRC seems less than in some of the neighbouring countries.

Central African Republic

SECURITY CONTEXT

The security situation in CAR is one of violence, particularly in the Northern and Eastern parts of the country. Armed Muslim and Christian groups are in conflict resulting in violence and displacement of the population (IDPs) towards camps and into Cameroon and Chad. The national government together with the international community continue their efforts to restore the security situation in the country. The intervention zones of Jeune S3 are in Bangui, Mobaye- Mbaiki and Bouar and under state control, which makes those relatively stable and makes it possible to implement activities in these areas.

CSE CONTEXT

No CSE curriculum existed in CAR until now. In collaboration with and validated by the Ministry of Education and other stakeholders, a reference manual on CSE in- and out- of-school was formulated based on the UNESCO guidelines. A dialogue is on-going on which CSE subjects to include in the in-school curriculum and what is acceptable for provincial authorities, heads of schools and teachers. CSE training out-of-school was ongoing in 2017.

HEALTH CONTEXT

The availability of contraceptives in CAR is still a major issue. Collaboration between the Jeune S3 Alliance and UNFPA has been established but has not yet yielded results. It is difficult to come to concrete actions on the availability of contraceptives for the partners in the intervention zones of Jeune S3, especially for young people. Dialogue with UNFPA is ongoing to solve the issue.

ENABLING ENVIRONMENT

Young people are ready to participate and eager to learn. Involvement of parents proved to be essential as is the case in all countries in fact.

Cameroon

SECURITY CONTEXT

The security situation in the Eastern and Far North regions of Cameroon is sensitive because of the actions of Boko Haram in the Far North region and the raids of Central- African armed groups in the Eastern region. This causes a significant destabilisation of the social structure in the regions concerned.

CSE CONTEXT

In Cameroon, the CSE national curriculum is being used and taught by teachers in school, but outside official school hours. Dialogue will continue to gradually integrate the CSE curriculum during official school hours. Peer educators from the local associations have been trained in the provision of out-of-school CSE.

HEALTH CONTEXT

The technical working group on adolescent health, created by the Ministry of Public Health in 2016 in Cameroon has added FP indicators in PBF health programs financed by the World Bank in Cameroon. Further follow up on the link with the Jeune S3 interventions is being made but has not yet resulted in specific activities.

ENABLING ENVIRONMENT

Religious leaders (96) have been trained and have developed plans to work in their communities. Relationships between the youth in the programme and religious leaders were created to enable them to work together for a more enabling environment.

Benin

SECURITY CONTEXT

The department of Alibori in the North-East of Benin suffers from a threat of religious extremism, because of the proximity of Niger, Nigeria and Burkina Faso, countries where Boko Haram, *"Le mouvement pour l'Unicité"* and the *"Jihad"* are active. To prevent potential conflicts and radicalism, all departmental authorities implement activities to promote "Vivre Ensemble" by the population with different religions and ethnic background. At the same time, collaboration is ongoing to address social problems such as alcoholism and drug and stimulant (medicines such as Tramadol) abuse.

CSE CONTEXT

Youth associations exist in all parts of the country and young people are ready to participate in the program activities. Initially, the capacity of these young people is low, which is understandable in this marginalized area, which was deliberately selected as a joint area of collaboration for ABMS and ABPF.

ENABLING ENVIRONMENT

Religious leaders have been trained. They have held information sessions with young people and parents in their congregations. Close collaboration has been established with the health department in Alibori region to support education and to create a more enabling environment.

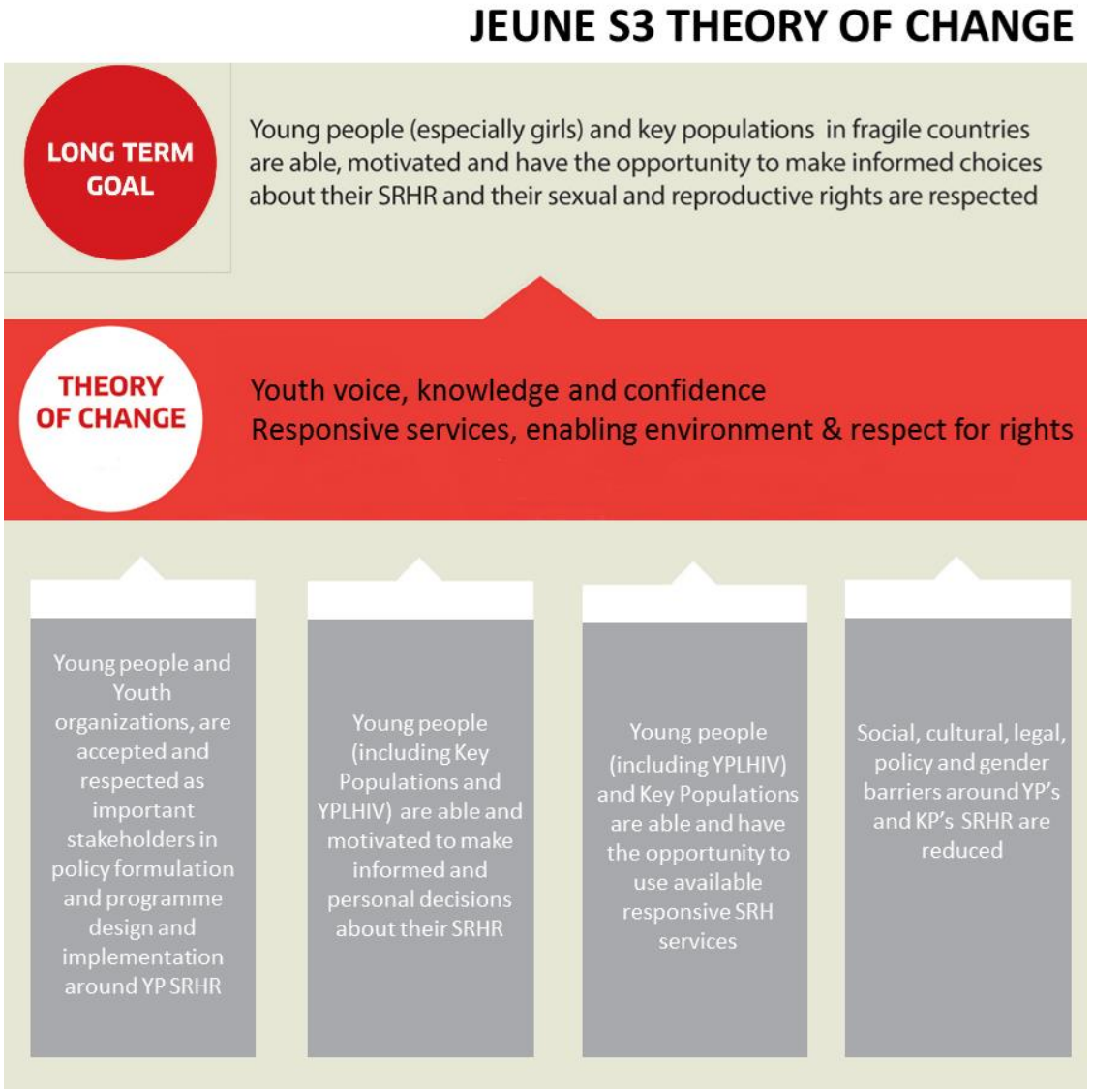
3. ANALYSIS OF RESULTS

The summary of the results of Jeune S3 are in the table below presented in result area 1 and 4 of the result chain of the Dutch MoFA. Some of the activities contribute directly to improved availability, affordability and access to contraceptives (result area 2) and to strengthening public and private health systems (result area 3). As the entry point of the program is to boost access to and use of youth-friendly SRHR and HIV/AIDS services, these are reported in result area 1C but a link to the other result areas is mentioned.

In addition, as the Jeune S3 programme is implemented in fragile areas its activities also contribute to 3D to promote SRHR, including HIV and AIDS, in humanitarian aid and fragile contexts, but the results presented here have not been explicitly linked to these.

Furthermore, additional quantitative results have been included in *Annex 1* which is also referred to regularly in the table below.

For the **result framework**, please consult the following pages 11 to 15.



1. BETTER INFORMATION AND GREATER FREEDOM OF CHOICE FOR YOUNG PEOPLE ABOUT THEIR SEXUALITY

OBJECTIVES

A. Promote active and meaningful involvement of young people in policy- and decision-making
B. Promote comprehensive sexuality education that reaches all young people and adolescents (in- and out-of-school)
C. Boost access to and use of youth-friendly SRHR and HIV/AIDS services
D. Prevent and halt all forms of harmful practices against children and adolescents, including child marriage and FGM/C
E. Encourage healthy and safe sexual behaviours in youth

INDICATORS (CONTEXT – PROGRAMME)

A. # of youth who participate in policy and decision-making bodies and perceive their participation as meaningful
B. % of young people reached with comprehensive, correct information on sexuality, HIV/AIDS, STIs, pregnancy and contraception
C. # of health facilities that adopt and implement youth-friendly SRHR and HIV/AIDS services
D. 1. % of women (20-24yr) who were married or in union before ages 15 and 18
   2. % of girls and women (15-49yr) who have undergone FGM/C
E. Condom use by young people at last high-risk sex

Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

1A. Jeune S3 results Meaningful Youth Participation

Pathway 1 Youth participation and youth voice

In all countries youth organizations are active and action plans have been developed. Representatives of youth participate in Jeune S3 country coordination mechanisms in the form of youth councils. This ensures young people are involved meaningfully in decision making within the programme, besides participating in trainings and being involved in numerous activities.

- In total 64 youth ambassadors (equal numbers of boys and girls) participate in meetings with external stakeholders. They have participated in various trainings: Advocacy, SRHR, CSE and organisational management aspects. In CAR, additional youth organizations have been identified to support the activities that will start in Bouar in 2018 (earlier identified as JS3 intervention zone).
- In Benin, implementation of activities started in July 2017, with the selection of 7 youth organisations, trainings and engaging in sensitization activities and exchange with religious leaders on SRHR issues.
- In total 138 young people were trained in radio and journalism techniques and/or radio programming in relation to SRHR. In CAR and DRC, 48 radio programs were broadcast by 11 radio stations. These broadcasts included regular monthly programs, 6 special editions and 3 'Best of'. In Cameroon Radio 100% Jeune continued in the Far North Region and set up and started broadcasting in the Eastern Region during 2017 resulting in 88 broadcasts in Cameroon. A telephone hotline received calls with reactions during day time. To increase accessibility during evening hours WhatsApp services are being introduced. Listeners' groups have been introduced to increase active participation, feedback and interventions of young people.
- YWCA Cameroon and DRC have trained young people in leadership skills, created safe spaces and held various SRHR information sessions to increase capacity of young people.

Youth involvement in advocacy

- In total, 222 young people were actively engaged in the implementation of advocacy activities, mostly with religious and traditional leaders, parents and other community members.
- The capacity of young people continues to be strengthened to allow them to keep the government accountable. If and when necessary, other partners within the program will support them in this.

1B. Jeune S3 results Comprehensive Sexuality Education

Pathway 2 Access to sexuality education and information for informed decision making on SRHR

In DRC, Cameroon and CAR, large numbers of teachers and other professionals have been trained in CSE. Benin is not active in this intervention area.
A complete set of CSE manuals and tools is available and most of them were validated in 2017 for all countries. The tools and manuals on CSE have contributed to the quality of interventions; however, finalisation and validation was delayed which has affected implementation of activities. Final validation by the Ministries of Education is important to ensure meaningful involvement and sustainability in the longer run for the implementation of CSE. A specific booklet for parents, "*Papa, maman, d'ou viennent les bébés?*" has been adapted from the Burundi version and has been validated and printed in DRC. It will be used in 2018 with the parent-teacher associations.

In DRC, the CSE/ IEC package based on the "*Programme national d'éducation à la vie familiale* "(approved in 2013 at national level) was elaborated. This curriculum has been integrated in the schools in North and South Kivu, except for the catholic schools in South Kivu. Youth leaders of local youth organisations were trained as well. CSE classes started in 104 schools. Implementation of CSE in 40 schools in the health zones Beni and Mutwanga (in the north of North Kivu) will follow in 2018 as the start was delayed because of insecurity in that region.
In Cameroon, CSE manuals were validated, teachers and leaders of youth organisations and peer educators were trained. The CSE will be taught by teachers in schools, but outside regular classes since the official curriculum cannot be changed at this point of time. Peer educators will provide CSE to youth groups in their communities. In CAR, there was nothing available at country level, hence the development of the CSE curriculum had to start from scratch. A reference manual and guidelines on CSE in-and –out of school were developed and validated and implementation of the programme will follow in 2018.

CSE in-school and out-of-school

- In total, 364 teachers were trained in CSE (242 in DRC, 107 in Cameroon and 15 in CAR).
- DRC started with CSE in 104 schools in September 2017, so far including 13,622 pupils between the ages of 10-24 years. The CSE curriculum of the school years will be finished in 2018, resulting in increased knowledge and changed attitudes on SRHR. Cameroon and CAR will start early 2018 with providing CSE in-school.
- 82 other adult educators (youth leaders, personnel of youth associations) were trained to provide CSE (76 in DRC and 6 in Cameroon).
- In total 212 peer educators were trained to deliver CSE out-of-school, CSE to groups of youth out-of-school will start in communities in 2018 as well.

Sensitization of youth on SRHR

- In 2017, 131,549 young people between 10-24 years old were reached with various SRHR activities, mostly sensitisation on various themes or elements of SRHR. Disaggregated data by age and sex can be found in the Annexe. Activities have been implemented in various locations and for various groups, but it is possible that the same young people have been present at several activities. Therefore, the actual number of individuals reached is overestimated in this number. However, receiving information on SRHR in multiple settings will lead to better understanding and uptake of the information by those individuals, resulting in a greater increase in knowledge.
- In all activities together, 3082 young people aged 10-24 years old were involved in providing SRHR activities (out-of-school activities). Disaggregation by age and sex can be found in the Annexe. Many young girls and boys were involved in the implementation of various activities, so this number includes double counting of the same individuals.
- With the introduction of the educational materials for 10-14-year-olds (Like Sarah, Miriam and Joe), more young people of that age group are being reached in first instance out-of-school, but the manual is also recognized by teachers as an effective tool for in-school.

1C. Jeune S3 results Youth Friendly Health Services

Pathway 3 Access to youth friendly sexual and reproductive health services

In youth friendly SRH services, activities involved further training of health staff, assessments of quality of services, cooperation between health staff, supervising authorities and Jeune S3 to improve the quality of the services and access to the services for young people, etc. Also training and education materials and need for additional education material (for instance leaflet on contraceptives specifically addressing /attractive for youth) have been (further) developed, multiplied and shared. Benin is not active in this intervention area.

- In total 153 health care providers were trained in YFHS (in DRC 80, Cameroon 43 and in Central African Republic 30). Workshops on value clarification continued for various levels of personnel.
- 40 health centres in DRC and 4 in CAR are providing YFHS as part of the Jeune S3 programme.

- Through a quality score card methodology, an assessment of the quality of YFHS in the 40 health centres in DRC was carried out in April-May 2017. Based on the information gained from this assessment, several actions were rolled out by the Jeune S3 team in and with the health centres and the supervising teams from the health zones (local health authorities). The assessment was repeated with all 40 health centres in Feb-Mar 2018 and showed that the overall quality score had increased from 40.9 to 63.1%. This shows that the actions undertaken in 2017 have effectively increased the quality of the YFHS. Scores per province can be found in the Annexe.
- An example of concrete action undertaken is that youth corners in the health centres have been equipped with educational materials to attract young people to the health centres and facilitate information of good quality and adjusted to the needs of young people is provided by the educators in the health centres.
- In Cameroon a research, called Human Centred Design (HCD) was undertaken to identify how young people can be attracted to visit a health centre. This approach made it possible to capture the expectations of the target group and confirmed some activities that were already taking place but that need some refinement. It identified additional effective interventions which will be introduced in the programme. The HDC approach guarantees MYP in design, implementation and monitoring of YFHS.
- Jeune S3 sensitization campaigns on SRHR by ACMS and local partners in Cameroon are often complemented by the "Test and Treat" strategy implemented by the Cameroonian Ministry of Public Health. Through combining these initiatives, young people attracted by the events are also encouraged to be tested for HIV. Follow-up with enrolment in treatment programmes in case of HIV-positive results is ensured and they are also encouraged to join peer support groups to increase their quality of life.

These activities contribute directly to the achievement of the objectives of result areas 2B and 2C.

- In DRC, I+Solutions trained 130 health personnel in Supply Chain Management (SCM) and use of tools for SCM, such as Informed Push Model (IPM) for distribution of products and the Electronic Management Information System (e-LMIS) to improve the quality of logistic data in real time about stock movements.
- In 2017, 94% of the health centres in South Kivu and 59% in North Kivu had at least three modern contraceptive methods available at the day of visit (done at least quarterly at each health centre). Furthermore, the 40 health centres in DRC provided a total of 249,074 condoms to clients. (More detailed results on supply of contraceptives in the health centres are provided in the Annexe).
- As part of operational research on YFHS, young people will be involved as mystery clients which will provide an accountability mechanism vis-à- vis service providers and other actors. This activity was supposed to take place in 2017 but will be executed during the first semester of 2018 (including preparation of the youth).
- The YES pilot provides the opportunity to directly check with the young people whether they appreciated the services and adjust strategies as required.
- The involvement of IPlusSolutions in C3 with UNFPA ensures close collaboration with UNFPA concerning the supply of contraceptives for the Jeune S3 program. The baseline study revealed that the health facilities in the northern part of North Kivu (Beni and Mutwanga health zones) had no contraceptives in stock at all. It is still a challenge to address this issue due to the lack of security in these zones and subsequent difficulty of distribution, but solutions are being sought.
- In Cameroon and CAR, collaboration is also established with UNFPA directly to improve supply of contraceptives in the intervention zones of Jeune S3. Especially in CAR this is still a challenge.

This activity directly contributes to the achievement of the objectives of result areas 3A and 3C.

- HE has been active with an entrepreneurial approach to SRH education and services in Jeune S3 in 2016 and 2017. The entrepreneurs delivered out-of-school sexuality education by use of tablets and provision of condoms, sanitary products and a limited range of medicines. The entrepreneurs reached a total of 9447 youth in 2017.
- Youth Eco-system (YES) pilot: 535 youth, aged between 15 -24 years old were sensitised and referred to health centres for contraceptive methods. 44% of these opted for a contraceptive method at one of the 3 selected health centres in Katana. The introduction of a peer-to-peer referral strategy in 2017 contributed to the increase of demand as 22% of total enrolments and referrals was done through peer referrals. A general improvement in the numbers throughout the 4 quarters of the year showed greater understanding of the JS3 programme and its components. The first evaluation early 2017 showed that more awareness raising was needed, value of the Tiko (incentive) to be increased, a digital card to be introduced for those not having a cell phone and connection technology to be improved. The second evaluation revealed several improvements had been achieved and the above-mentioned results had been obtained.

1D. *Not applicable*
1E. See Jeune S3 result under 1A, B, C: they all contribute to encouraging healthy and safe sexual behaviour in youth.

4. MORE RESPECT FOR THE SEXUAL AND REPRODUCTIVE RIGHTS OF GROUPS WHO ARE CURRENTLY DENIED THESE RIGHTS

OBJECTIVES

A. Strengthen and promote use of global and (inter)national human rights frameworks for SRHR and HIV/AIDS
B. Improve the enabling environment for sexual and reproductive health and rights for all
C. Strengthen accountability mechanisms vis-à-vis governments, service providers, and other actors
D. Help to end violence and discrimination against key populations, women and girls in relation to SRHR
E. Strengthen communities and advocacy networks to promote SRH rights for key populations

INDICATORS (CONTEXT - PROGRAMME)

A. Whether and how SRHR frameworks have been adopted and incorporated into national policies (current and observable changes)
B. 1. Changes in laws, guidelines, and (health) policies and practices leading to decrease of barriers to SRH and HIV/AIDS services
2. Satisfaction with degree to which SRHR barriers facing discriminated and vulnerable groups have been reduced
C. Description of types and evidence of effective usage of accountability mechanisms to address violation of rights
D. 1. Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex
2. # of recorded cases of discrimination and violence against key populations, women and girls in relation to SRHR issues
E. 1. # of key populations reached by communities and advocacy networks with SRHR and HIV/AIDS information
2. # of key populations having received SRHR and HIV/AIDS services

• % of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

4 Jeune S3 results on more respect for sexual and reproductive rights
Pathway 4 Enabling environment

4a Strengthen and promote use of global and (inter)national human rights frameworks for SRHR and HIV/AIDS
At the UN High Level Political forum on Sustainable Development (UNHLPF) organised in July in New York, JS3 organised a side event on Engaging Youth on SRHR in Fragile Settings.
The three objectives of the event were to: raise awareness of the specific Sexual and Reproductive Health Rights (SRHR) issues for young people in fragile setting; share recommendations and best practices on creating an enabling environment for youth in this setting and, issue a call for action and commitment of resources to youth SRHR in fragility.
Recommendations for actions to be taken by the government, youth and the international community (see report) were formulated and can be monitored and progress addressed during a next meeting. Key recommendations were; a. Accept, promote and protect the SRHR of young people as a pre-requisite for sustainable development (actions by government); b. keep demanding space for young people to engage in inter-governmental processes (actions by youth); c. legitimize youth participation and voice by opening up access spaces and addressing other barriers including language related that hinder their participation (actions by international community).
The ICASA conference was one of the most important engagements for the Jeune S3 youth delegates. There were 20 young people and they supported each other. They practised their messages and their advocacy engagement. They also made follow up plans for when they go back to their countries and a WhatsApp group was maintained that really helped in supporting each other, sharing information and just getting to know each other. The following recommendations that were communicated:

- Create spaces for Youth to participate and meaningfully engage in discussions on SRHR: It is critical that Youth are recognized as important stakeholders in their communities, that they are heard and consulted in processes and can promote their SRHR and to ensure their sexual reproductive health and rights are respected.
- Youth rights should be acknowledged, upheld and protected. Youth are critical actors in the future of their countries; therefore, it is essential to articulate their rights. We call upon Member States to develop or review youth policy frameworks, to ensure the inclusion of sexual reproductive health and rights, right to education, and employment.
- Invest in Youth and Youth-led Organizations: Adequate resources should be made available to strengthen the capacity of youth and youth organizations to ensure their

4B . Improve the enabling environment for sexual and reproductive health and rights for all
4B1.

An advocacy framework was developed per country (DRC, Cameroon, CAR) describing barriers, statistics, key stakeholders and the priorities for Jeune S3. Based on the frameworks, factsheets with key messages validated by young people were prepared. Furthermore, an advocacy toolkit and a facilitators guide were developed. This will be follow up by a ToT and cascade trainings for youth leaders early 2018 and the development of advocacy strategies with key messages and action plans at local, national and international level. These plans aim to change laws, guidelines and (health) policies and practices leading to a decrease in barriers to SHR and HIV/AIDS services. Gaps in policy implementation and failure to respect regional and global commitments on SRHR will be identified.

4B2.

A ToT of religious leaders was held based on the leaders' manual which was finalized in 2017. After that, religious leaders were trained at country level and action plans were formulated. These action plans are being implemented and guided by the JS3 country staff.

In DRC and Cameroon, YWCA & ACMS organised inter-generational dialogues including youth, parents, local leaders and religious leaders, which led to increased mutual understanding. In all countries, parents were also actively approached, both to specifically to inform them about the programme and that there is a need for information around sexuality among the youth, and to ask their permission for their teenage children to participate in youth groups that are provided with sexuality education. In all countries, partner organizations ensure that the objectives are well-explained to the parents. Parents may have some resistance at first, but most of them acknowledge the fact that this is information their children need and they are allowed to participate. The youth that participate stories later share how they discuss (part of) what they learn with their parents, siblings and friends; the fact that the facilitated groups support them in talking about sensitive subjects openly, gives them the courage to also do so with the people around them.

- In total 296 religious leaders were reached with advocacy activities, 2464 parents (or other family members), 43 traditional leaders, 102 people from educational authorities and 110 people from health authorities.
- An example of how the activities of the programme are appreciated and the need of youth acknowledged is the promise of a traditional leader (chef de communauté) at the end of a community dialogue in Cameroon: "I will do everything in my power to continue this initiative [of having a community dialogue on youth and sexuality issues] in my community and extend it to other communities in my area".
- In Benin the « Cadre Coexister de Religieux de l'Alibori/ Vivre Ensemble »has been established. It envisages a religious co- habitation and tolerance of Christian, Muslim and traditional religions.

4C. Strengthen accountability mechanisms vis-à-vis governments, service providers, and other actors

In DRC, Cameroon and CAR, health and education authorities are involved in the programme. Ministries agree to the programme elements and are often involved in the set-up or validation of materials, supervising bodies are involved in actual supervision of health staff and teachers and take up specific programme elements in their supervisory visits. Authorities are involved both as participants and/or trainers in many parts of the programme. Although the programme is implemented in specific schools and health centres, through this structural embedding within authorities, in the longer term, the effect can be multiplied.

In DRC, CSE in public schools has been established in close cooperation with the national and provincial education Ministries. The faith-based schools had their own curriculum around sexuality education. However, under the leadership of the Ministry of Education, the faith-based schools in North Kivu have adapted the national CSE curriculum. In South Kivu, talks with the catholic schools are still ongoing. Multiple provincial authorities, several religious leaders and Jeune S3 work together to convince the catholic community to also harmonise their sexuality education in schools with the national curriculum.

The Comité Technique Multisectoriel pour la Planification familiale) (CTMP) in DRC is a health sector body active at national level, with provincial committees in North and South Kivu having sub-committees. This has resulted in more financial resources for contraceptives and more attention for the needs of young people. Religious leaders also participate in the CTMP.

Health development committees (codesa) are in place with health centres in DRC. Those committees consist of members from communities that are in the catchment area of the health centres and are involved in ensuring the community voice is heard at health centre management level. Through active linkage with these committees some of them have also included young people as members and the committees have been involved in the set-up of youth corners in the health centres. The Jeune S3 team actively seeks this cooperation with these committees with all the other health centres in the programme.

4D. Help to end violence and discrimination against key populations, women and girls in relation to SRHR

4E. Strengthen communities and advocacy networks to promote SRH rights for key populations

Value clarification workshops continued to be held with all key stakeholders with specific attention and exercises to discuss human rights and dignity including the position of key populations and attention to SGBV. Part of this training will now be used by the teams to train health providers and include the issue of access to services for key populations.

These workshops link directly to result area 1B and 1C of the result chain. The target group of Jeune S3 is young people 10-24 years old (F&M). Specific attention is given to the age group 10-14 years old, especially girls. LGBT groups are among the selected youth organizations in CAR.

Critical reflection

In 2017, activities in all 4 pathways were implemented. Continued capacity building is needed to reach all relevant actors and levels in the programme to increase ownership, an essential factor for subsequent sustainability. The capacity building process has several phases such as introduction, awareness creation, in-depth knowledge and skill trainings, refresher trainings and follow up. Refresher trainings are needed to follow up on interventions, to monitor quality and to include new personnel. Turnover of personnel (health, education) and trained young people is high in these fragile areas.

The progress on activities in pathway 1 and 4 in DRC and Cameroon and on international level has lagged behind because of insufficient capacity and an absence of agreement on intervention strategies. W YWCA and the YWCAs at country level were responsible for these pathways. On top of the issues mentioned, structural organizational and operational issues on international and national level of W YWCA hampered the smooth implementation of activities. This was partly solved during the year by the fact that other partners (Cordaid HO, Cordaid DRC, ACMS and SwissTPH) took over activities to catch up with the backlog. The situation finally culminated in the withdrawal of W YWCA as of 2018 and activities were taken over by the other Alliance partners. A consultant assessed the situation and the recommendations he proposed have been implemented. (This report has already been shared and can be sent upon request).

In 2107, agreement with the different Ministries of Education was reached on (additional) educational materials to be used in the countries. These educational materials were pre-tested, validated and printed. Additional materials were needed to ensure that all specific groups were reached, for instance to ensure that specific materials for 10-14 years and parents were available. Each country has now a complete set of materials but it did take time and some documents still need to be translated into local languages.

TRAINING OF RELIGIOUS LEADERS WITH THE PARTICIPATION OF YOUTH REPRESENTATIVES

A privileged moment to confront their points of view and learn from each other. In many African countries, religious leaders are custodians of culture and social norms. In recognition of their important role, Cordaid has developed an interfaith tool to sensitize and equip them with the information and skills needed to understand and support young people in their sexuality. Together, they aim to convey good messages to young people without prejudices and limitations. Thanks to Jeune S3, the tool is spread and used in all four countries. To find out more about the practical guide, click here. Photos of the workshops on Twitter.

Jeune S3 ambassador advocating for youth rights during a religious leaders SRHR training, DRC, February 2018.

4. ANALYSIS OF THE PARTNERSHIP

A) Analysis of the cooperation between your alliance and the local organizations: in what way do local organizations participate in the programmes and the partnership (ownership) and what is their view on the partnership?

All countries report that involving partners and stakeholders, informing them, creating awareness at all levels is an intensive process and the key to successful program implementation. Participation of all local partners in all activities in all countries is essential and has been ensured. Local partners (NGOs and youth associations) have received training and the means to carry out their activities (laptops, equipment). Basic information and equipment such as this are required for meaningful participation in the programme.

The innovative approach of Triggerise (YES pilot) in DRC was welcomed, however also here comprehensive awareness raising and coordination were needed to inform all relevant stakeholders at all levels (within the Alliance, with local leaders, health care providers, teachers) and to ensure the involvement of all in a meaningful way (see also first paragraph).

B) Assessment of the additional value of your organization/ alliance to the programmes implemented by the local organizations.

The finalisation of the manuals and tools on CSE by the JS3 Expert group was a key element in the start of implementation of activities. Joint training courses by Cordaid and Swiss TPH on SRHR, CSE, YFHS, MYP, Advocacy and continued value clarification to all level of partners (governmental bodies, alliance members, youth organisations, local partners, community leaders, radio reporters, HE, health centres, schools) to build knowledge, skills and capacity are appreciated and relevant for a successful implementation of activities.

All local partners are trained and have started to implement their activities. The next step is to facilitate the further strengthening of the partnership between the different actors at the local and community levels (schools, health centres, youth associations, community leaders, parents). This partnership relationship is necessary to ensure synergy between the services including CSE education, YFHS services, MYP and Advocacy, and will enable the local partners to together achieve the best possible results for young people in their communities.
Local partners have been trained in the understanding and use of the monitoring tools, whereby each partner has been trained on the use of the tools which are relevant for them. Their suggestions for improvement of the tools, based on their experience in the field, have been used to further finetune the tools to local needs and context. During monitoring visits both activities and results reported are discussed and constructive feedback is provided to the partners on how to improve the quality of their work and the results reported.

C) Assessment of the partnership with the Ministry of Foreign Affairs, whereby the central and decentral level (embassies) are considered.

A representative of the Dutch MoFA participates in the steering committee meetings of Jeune S3 and informs Cordaid and partners on international developments such as SRHR in fragile settings and humanitarian aid. During 2017, collaboration with the Dutch MoFA was intensified after the change of contact persons in July 2016. A lesson learned was that it is necessary to provide a full presentation of the programme after a change of personnel to enhance smooth communication and mutual understanding of ongoing issues during the implementation of the programme.

The Jeune S3 Alliance in DRC cooperates closely with RNE Rwanda, which coordinates the Great Lakes Regional Program and monitors several projects in DRC, North- and South Kivu. The Dutch MoFA has delegated the monitoring of centrally funded programmes to RNE Rwanda to a certain extent, because of their location in the region. Jeune S3 actively participates in the (informal) SRHR platform of Dutch funded projects created by RNE Rwanda in North and South Kivu. Regular communication between RNE Rwanda, t MoFA and the Jeune S3 program team at national and international level is important to keep track of progress and challenges and to engage in dialogues about various approaches and eventual problems that might occur.

In Benin the collaboration with the RNE is strong. The period that Jeune S3 started in Benin with the inception phase (September 2016) coincided with the shift of the focus of RNE Benin to the Alibori region, and this provided a good opportunity to team up. Furthermore, the RNE supports ABMS and ABPF financially and technically and these organisations are also active in the Jeune S3 programme. Communication is regular and well-tuned and all parties are committed to continue this practice with the arrival (end of March/ April) of the new SRHR Expert at RNE Benin.
The mandate of RNE Benin covers Cameroon and the program maintains a relationship with the Embassy, although SRHR is not a thematic priority in that country for the RNE. CAR is covered by the RNE in Sudan based in Khartoum, and a visit to CAR including Jeune S3 was made in 2017 and was appreciated. Since SRHR is not a priority theme for that Embassy, a continuous partnership relation is not maintained.

D: Analysis of the coordination, communication of the Alliance on national and international level and suggestions for strengthening.

With the phasing out of W YWCA as of 2018, Cordaid HO has taken the lead for Advocacy in the programme. This in fact already started in 2016 and was gradually increased in 2017 by the Cordaid HO advocacy advisor when it became clear that W YWCA did not have the capacity to steer and manage the activities at international and national level efficiently . Youth advocacy advisers will be recruited in 2018 in DRC by Cordaid and in Cameroon by ACMS. In DRC, Swiss TPH will take on the out-of-school education and in Cameroon ACMS, which was already doing that to a certain extent , will take over. The safe space method, as introduced by W YWCA will be evaluated and strengthened, based on the lessons learnt in 2017.

Steering committees on national levels including governmental authorities ensure the integration of activities in their programmes. In DRC, there is a joint Jeune S3, Mawe Tatu (Care Alliance) and C3 (UNFPA, I+ Alliance steering committee is) to ensure efficient management of the Dutch funded programs. The CTMP (coordination committee on FP) is active in North and South Kivu and Cordaid and I+ participate in this forum (Cordaid chairing CTMP in South Kivu).

A monthly newsletter *(Cf. Annexe 3)* was produced to share and updates news and activities among Alliance partners, stakeholders, local partners and interested colleagues.

5. GENDER AND INCLUSIVENESS

A Human rights-based approach, gender equality, dignity for key populations and empowerment of women/ young people has been included in all aspects of the Jeune S3 program and integrated in all CSE materials used by the program.

The contents of the score cards developed for schools/ youth spaces has considered gender aspects such as the prevention of GBV, access to safe latrines for girls and boys and access to school for young pregnant girls.

Health care providers are trained and monitored to be youth and key population friendly and the discussion of values was a continuous activity throughout the programme period.

Equal numbers of male and female youth ambassadors are selected and gender sensitive training courses are identified to strengthen their meaningful participation.

The program prioritizes the recruitment of an equal number of female and male staff. This is a challenge as the job market is still male dominated at country level and fewer females of equal quality present themselves for vacancies in remote areas. Travelling to remote areas is required and it carries additional risks for female employees. In DRC, the large majority of teachers trained in CSE by the Jeune S3 program is male, which is a challenge in relation to reaching out to girls in schools since male teachers do not automatically inspire trust in girls.

The group of 10-14-year-olds, especially girls has been identified as a key population in the Jeune S3 program. The integration of the manual *"Like Sarah, Miriam and Joe",* developed by Cordaid, as a pilot in some of the schools has confirmed the necessity to include the age group of 10-14 years in CSE.

In Cameroon, youth peer support groups for HIV+ youth have been formed following HIV/STI testing during SRHR campaigns in the intervention zones. A mapping to identify possible inclusion of young professional sex workers as a target group will be carried out in 2018.

In CAR and DRC, FPU has guaranteed that radio trainers and producers are an equal mix of 50% male and 50 % female. FPU has also developed a *"Charte éthique"* for the Jeune S3 participative radio makers based on the value clarification workshops held and universal ethical journalism values.

ASSABE, 18 YEARS, SEX WORKER AND MUSLIM

Like 122,580 other women in Cameroon (Source: World Bank, 2016), Assabe, 18, is a sex worker. And that since the age of 14, when she lost her parents. Living in Bertoua, 350 km from the capital Yaoundé, she is in charge of her five brothers and sisters. She tries as best she can to hide her professional situation to avoid inquisitive eyes. Thanks to the support of Jeune S3, she is helped by "Aunt Michelle" from the association ASAD. Together, they explain their path and their daily lives. Read more here

Assabe (on the left) with Aunt Michelle, Bertoua, Cameroon, September 2017.

6. REFLECTION ON THE TOC

Overall ToC

The overall key assumptions of the TOC are still valid and applicable for the Jeune S3 program. However, we see that in the most fragile areas, some additional efforts are needed to meet the same results. *See page 10 for the TOC scheme.*

Assumptions pathway 1

The general assumptions are correct. There is great enthusiasm among the youth about participating in the JeuneS3 activities. In all countries, structures and mechanisms for young people to be involved at all levels of the program have been established. For instance, a *"Conseil des Jeunes"* is active, and in DRC, young people even have a desk in the office of the local organisation. Youth organisations and associations involved have different levels of capacity. In addition, the mobility of young people is a challenge so continuous training is necessary.
In CAR, there are positive experiences with a mixed group of youth that includes individuals who openly represent associations of key populations (CSW, MSM) which also actively promote the SRHR rights of all young people.

Assumptions pathway 2

Most of the assumptions under pathway 2 still hold. Progress has been made on the assumptions for the intermediate results. Teachers and educators have been trained and are willing to provide CSE. Different educational methods in- and out-of-school, radio is used to reach the young people. Different tailor-made educational materials have been developed.
The need to ensure the motivation of teachers (and educators) has been highlighted in the assumptions. Different methods such as coaching and recognition ceremonies are foreseen as motivation remains a challenge within the program.
A start has been made, but, in 2018, much more attention will be given to the inter-generational dialogue in 2018 through parents' committees.

Assumptions pathway 3

The assumptions are correct although there are certain challenges. Health centers have become more attractive and do attract more youth in DRC and CAR. Different methods have been utilized to make services more accessible in the YES pilot, assessing what attracts young people through *Human Centered Design*. Scorecard analyses has shown that youth friendliness improved in health centers. Availability of commodities has been highlighted as a necessity. In all countries, collaboration has been sought with relevant stakeholders, especially UNFPA, but availability and affordability for young people remains a challenge.

Assumptions pathway 4

The assumptions still hold but more and specific attention is placed at the local community level. Creating an enabling environment is a long-term process. At community level this is currently addressed with a mix of advocacy and capacity building activities. The capacity building activities specifically target religious leaders and parents. Youth SRHR advocacy briefs *(See Annexe 2)* per country have been made and they are currently used for the advocacy plans of the youth organisations.

7. LESSONS LEARNED

The involvement of young people in the elaboration of action plans and validation of educational materials makes their problems and priorities clear. This has been reported in all countries.
The *Human Centred Design* (HCD) approach as applied in Cameroon by ACMS to identify appealing strategies for young people to visit health centres confirmed this statement.

A Code of Conduct was developed in Cameroon to have operational guidelines available on SRHR values for the youth ambassadors. In DRC and CAR, a *"charte éthique"* was prepared for the Jeune S3 participative radio based on the workshops on value clarification and the universal ethical journalism values at the request of FPU's local partners. More broadcasts with listeners' clubs will be made to receive more and direct feedback from and interventions by young people.

YWCA Cameroon learned that for mobilisation of young people, building on positive constructive concepts and practices at the community level is a useful strategy. Equally, communication in the local language builds confidence between the target group and partner organisation. This was shared with ACMS, that has acknowledged the approach and will continue using it in their activities.

Capacity building on all levels, starting with the Alliance partners, local partners and governmental level, has led to a better understanding by all of SRHR and young people. The investment has been worth the effort and the refresher training that is always needed can now build on the basic knowledge of all partners and stakeholders.

Lessons were learned in the YES pilot executed by Triggerise and HE. The first evaluation revealed that information and communication to create awareness for all relevant stakeholders on all aspects of the interventions is a key element for success. This has been done and the second evaluation showed that understanding and commitment has increased. In these rural areas, fewer young people than expected had a cell phone. To ensure involvement in the YES pilot, a chip card is being introduced that can replace a cell phone to register the Tiko points (the incentive) when an activity is completed. In 2018, the pilot will be extended to an urban area (Goma town) where more young people have a cell phone. Because of the limited technology available in the region, it was necessary to optimize the technical connections and this caused some delays in implementation.

Initially, the value of the Tiko was kept low, but this value turned out to be too low and resulted in the use made by the actors (young people, health care providers, HE) being too low to make the system work. After the value of the Tiko was increased and a mass mobilisation campaign conducted, all actors became more enthusiastic. Issues of sustainability of incentives will be further addressed during 2018.

8. CHALLENGES AND OPPORTUNITIES FOR NEXT YEAR

The major challenge and opportunity for next year is the strengthening of partnerships between all actors at local level (schools, communities, health centres, youth associations, youth) in the project areas to create synergy between all interventions.

Measures include a network to respond to the SRHR demands created by the CSE in- and out-of-school, which involves, among others, putting in place a referral system between the schools, target groups and the health centres in order to facilitate access by young people.to services .

The Mid-Term Review will specifically assess the current situation in relation to strengthening the partnerships between the actors and identify critical success factors for achieving this long-term goal of the Jeune S3 programme.
In general, it is expected that the outcomes of the Mid-Term Review will optimize the intervention strategies to achieve the objectives of the Jeune S3 program on project and on partnership level.

In CAR, the availability of contraceptives and the affordability of services for young people remains a challenge. In Cameroon, young people often don't have the means to pay for services and products. Free testing campaigns and the YES pilot will improve access by young people to services but advocacy towards the government also needs to be undertaken. In addition, parents need to be included to create more support for the SRHR needs of young people.

A challenge mentioned in DRC for CSE in-school is the motivation of teachers for quality teaching. Part of the solution could be improving the basic conditions in schools (e.g. improving the availability of teaching materials and providing decent safe toilets).
For CSE out-of-school, the challenge is the quality and the monitoring of the education in the safe spaces for young people.

Cordaid and Triggerise have been invited to submit an additional proposal to extend the YES pilot in Goma to young pregnant women to ensure safe pregnancies, deliveries and motherhood.
At the same time, the YES pilot will be extended to Goma, an urban area, where more young people have cell phones, while the technology has been optimized and the value of the Tiko (incentive) increased. In Cameroon, a YES pilot will start in 2018 which will take the lessons learnt in DRC into account.

A forensic audit of the Cordaid Bukavu office will be carried out during the first half of 2018, following anonymous allegations about the management of the Cordaid Bukavu office in respect of the CISPE project. It has been decided to include the Jeune S3 program in the forensic audit as the programme is managed by the same administration. The results of the audit are expected during the second quarter of 2018 and if required, appropriate action will be taken.
Ongoing operations research and the use of scorecards will create opportunities to further improve the quality of services. An example of innovation is the use of reports by mystery clients to provide ideas on how to improve the quality of youth friendly services in DRC.

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ANNEXES

Annexe 1 :Jeune S3 quantitative results 2017

PATHWAY	INDICATORS	RESULTS 2017				
		DR CONGO	CAMEROON	CENTRAL AFRICAN REPUBLIC	BÉNIN	JEUNE S3
1	Number of youth representatives trained in advocacy and sensitization	16	5	18	25	**64**
	Number of youth trained on radio programming or journalism	85	2	51	0	**138**
2	Number of teachers trained to provide CSE in school	242	107	15	0	**364**
	Number of educators trained to provide CSE out-of-school	76	6	0	0	**82**
	Number of peer educators trained to-provide CSE out-of-school	84	53	50	25	**212**
	Number of schools that have started providing CSE	104	0	0	0	**104**
3	Number health staff trained on youth friendly services	80	43	30	0	**153**
	Number of health centres involved in the programme	40	0	4	0	**44**
4	Number of people reached with advocacy activities					
	Religious leaders	135	81	4	76	**296**
	Parents / other family members	48	1149	0	1267	**2464**
	Community / traditional leaders	0	14	18	11	**43**
	Education authorities	17	10	70	5	**102**
	Health authorities	45	5	55	5	**110**

PATHWAY	INDICATORS AND DISAGGREGATION		RESULTS 2017				
			DR CONGO	CAMEROON	CENTRAL AFRICAN REPUBLIC	BÉNIN	JEUNE S3
1	**Number of young people involved in SRHR activities (by age and sex)[1]**						**3082**
	Girls	10-14 yrs	83	11	31	0	125
		15-19 yrs	404	34	33	2	473
		20-24 yrs	651	58	56	3	768
	Boys	10-14 yrs	73	7	33	0	113
		15-19 yrs	545	19	47	2	613
		20-24 yrs	893	31	59	7	990
2	**Number of young people reached with SRHR activities (by age and sex)[2]**						**131549**
	Girls	10-14 yrs	4306	525	8390	829	14050
		15-19 yrs	11171	723	11495	1274	24663
		20-24 yrs	15335	499	11468	1350	28652
	Boys	10-14 yrs	4831	304	8016	764	13915
		15-19 yrs	11649	1351	8810	1041	22851
		20-24 yrs	16896	1416	8042	1064	27418
2	**Number of young people that have started receiving CSE in school (by age and sex)**						**13622**
	Girls	10-14 yrs	2877	-	-	-	
		15-19 yrs	3301				
		20-24 yrs	426				
	Boys	10-14 yrs	3039				
		15-19 yrs	3380				
		20-24 yrs	599				
3	**Number of young people tested for HIV (by age and sex)**						**25898**
	Girls	10-14 yrs	738	58	319	-	1115
		15-19 yrs	4111	257	1698		6066
		20-24 yrs	6405	58	2163		8626
	Boys	10-14 yrs	734	32	259		1025
		15-19 yrs	2112	262	1411		3785
		20-24 yrs	3008	126	2147		5281

[1] These young people have had a role in the activities, either at the development phase or at implementation
[2] The young people reached are all young people that have participated in any activity aimed at informing them about elements of SRHR. As youth can participate at multiple activities that may be organized in their neighbourhood, it cannot be excluded that some youth have been counted double, as we do not register names etc at those kind of activities.

PATHWAY	INDICATORS AND DISAGGREGATION		RESULTS 2017				
			DR CONGO	CAMEROON	CENTRAL AFRICAN REPUBLIC	BÉNIN	JEUNE S3
3	**Number of young people that received family planning consultation (by age and sex)**						**21904**
	Girls	10-14 yrs	292	-	337	-	629
		15-19 yrs	3630		1229		4859
		20-24 yrs	8334		2140		10747
	Boys	10-14 yrs	252		230		482
		15-19 yrs	1813		588		2401
		20-24 yrs	2409		650		3059
3	**Number of young girls receiving the contraceptive pill**						**3913**
	Girls	10-14 yrs	3	-	0	-	3
		15-19 yrs	731		600		1331
		20-24 yrs	1966		613		2579
3	**Number of young victims of GBV receiving care**						**241**
	Girls	10-14 yrs	42	-	2	-	44
		15-19 yrs	96		15		111
		20-24 yrs	59		11		70
	Boys	10-14 yrs	0		0		0
		15-19 yrs	3		3		6
		20-24 yrs	9		1		10
4	**Number of young people involved in advocacy activities (by age and sex)[3]**						**222**
	Girls	10-14 yrs	0	11	3	1	15
		15-19 yrs	0	38	10	3	51
		20-24 yrs	13	45	7	4	69
	Boys	10-14 yrs	0	7	4	0	11
		15-19 yrs	0	13	9	3	25
		20-24 yrs	20	14	9	8	51

[3] These young people have had a role in the advocacy activities, either at the development phase or at implementation

INDICATORS		DRC ADDITIONAL RESULTS 2017			
		NORTH KIVU	SOUTH KIVU	TOTAL	COMMENTS
QUALITY CSE	Number of schools where QSC has been applied	20	40	60	Schools in the northern zones of Beni and Mutwanga of North Kivu have not been included due to security.
	Average score from QSC on ESC	54,0%	32,2%	39.5%	
QUALITY YFS	Number of health centres involved (for YFS and supply chain)	20	20	40	
	Average score from QSC on YFHS, 2017	34.2%	47.6%	40.9%	Measured in April-May 2017
	Average score from QSC on YFHS, 2018	59.6%	66.9%	63.1%	Measured in Feb 2018
	Average change (% points)	+25.4%	+19.3%	+22.2%	
SUPPLY CHAIN	No. condoms provided by the health centres	105 740	143 334	249 074	Male condoms only. Total no. female condoms: 6496
	No. contraceptive pills provided by the health centres	1917	15 458	17 375	No. packages of contraceptive pills
	Average no. days stockout of condoms per quarter	6	0	3	
	Average no. days stockout of (morning after) pill	20	14	17	
	% of health centres with at least 3 modern contraceptive methods available at time of visit	59%	94%	76%	

Annexe 2

ADVOCAY TOOL CAMEROON

FICHE D'INFORMATION PLAIDOYER

SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE AU CAMEROUN

Jeune S3 Santé, Sexualité, Sécurité

Les jeunes Camerounais sont confrontés à des obstacles substantiels et persistants pour faire valoir leurs Droits à la Santé Sexuelle et Reproductive (DSSR). Pour faire en sorte que les jeunes puissent faire valoir leurs droits, la première étape consiste à leur permettre d'accéder à des informations et à des services de santé reproductive. Les tabous sociaux et le manque de mise en œuvre des politiques et des lois qui permettent aux jeunes d'avoir accès à une éducation sexuelle complète (ESC) et à des services de santé sexuelle et reproductive spécifiquement adaptés pour eux entraînent des taux très élevés de grossesses non planifiées, de mortalité maternelle, de VIH/SIDA et de mariages d'enfants.

STATISTIQUES SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE AU CAMEROUN[1]

Les Droits à la Santé Sexuelle et Reproductive des jeunes au Cameroun varient selon les lieux, mais les résultats les plus faibles en matière de santé ont été mesurés dans le nord et l'est du Cameroun.

Relations sexuelles
- 16 % des jeunes femmes et 9,3 % des jeunes hommes âgés de 15 à 24 ans ont eu leurs premières relations sexuelles avant l'âge de 15 ans. L'est du Cameroun est la région qui présente le taux le plus élevé.
- 21 % des jeunes femmes âgées de 15 à 19 ans qui ont déjà eu un enfant.

VIH/SIDA
- Le taux de prévalence du VIH est élevé chez les jeunes et chez les adolescents par rapport au taux national qui est de 4,3 %.
- L'est du Cameroun affiche un taux de prévalence du VIH/SIDA d e 6,3 %.
- Pour les jeunes de 15 à 19 ans, le taux atteint 1,2 %, avec un ratio jeunes filles/femmes de 5:1.
- Seuls 41,2 % des jeunes de 15 à 24 ans sont conscients de l'existence du VIH et savent s'ils sont infectés ou non.

Mariage des enfants
- 20,1 % des jeunes filles sont mariées avant l'âge de 18 ans et 11,4 % avant l'âge de 15 ans.
- 33 % de ces mariages se produisent dans l'extrême nord et 30 % dans l'est.

Accès à des services axés sur les jeunes
- Seules 12,1 % des filles de 15 à 19 ans et 22 % des jeunes femmes de 20 à 24 ans utilisent des contraceptifs.
- 38,9 % des jeunes de 15 à 19 ans mentionnent des problèmes d'accès aux soins pour l'une des raisons suivantes :
  - Absence d'autorisation de la part des parents/soignants (16,6 %)
  - Obstacles financiers (34,4 %)
  - Obstacles géographiques (distance) (16,6 %)

POLITIQUES ET STRATÉGIES SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE POUR LES JEUNES AU CAMEROUN

Le Cameroun dispose d'un environnement juridique, politique et stratégique plus avancé en faveur de la santé des adolescents. De nombreuses lois promeuvent et protègent les Droits à la Santé Sexuelle et Reproductive des jeunes, mais la connaissance et l'application de ces lois, politiques et stratégies restent limitées.

Aperçu des lois[2]
- Le mariage des enfants et les mutilations génitales féminines (MGF) sont interdits.
- L'éducation est un droit qui est garanti. Les parents ne sont pas autorisés à empêcher leur enfant d'aller à l'école.
- L'âge légal pour pouvoir faire un dépistage du VIH sans consentement parental est de 16 ans.

[1] 2014. MICS 5, http://dmip-550-104.dc.world.cr.net/~slot54/downloads/2015/MICSResultatsclesp.pdf

[2] 2016. Code pénal camerounais, https://www.prc.cm/fr/multimedia/documents/4722-loi-2016-007-du-12-juillet-2016-portant-code-penal-fr

Aperçu des plans de santé du Cameroun[3]
- *Plan stratégique national de lutte contre le VIH, le Sida et les IST 2014-2017*
  - 80 % des jeunes âgés de 15 à 24 ans bénéficient d'excellents programmes de prévention ciblés, destinés à leur offrir des connaissances complètes sur le VIH
  - Portée géographique et coordination des initiatives intégrées d'éducation sexuelle pour les jeunes en dehors des écoles
- *Plan stratégique national de la santé de la reproduction, maternelle, néonatale et infantile 2014-2020 (PSN/SRMNI) :*
  - Couverture d'au moins 80 % d'interventions SRMNI de qualité
  - Hausse de la prévalence des contraceptifs (méthodes modernes) chez les femmes en âge de porter des enfants (15-44 ans) de 16 % à 30 % d'ici à 2020
  - Réduction de 50 % de la prévalence des grossesses précoces et des MST/VIH chez les adolescents et les jeunes d'ici à 2020

MESSAGES CLÉS DES JEUNES EN MATIÈRE DE DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE
- Éducation garantie pour les filles : L'éducation et le droit à l'éducation ont une place importante au regard des lois. Ce n'est pas le cas pour tous notamment les jeunes filles enceintes c'est pourquoi pour promouvoir l'égalité des chances, les lois doivent être revues
- Dépistage du VIH/SIDA garanti : La première entrave au dépistage du VIH/SIDA est l'obtention obligatoire de l'approbation des parents avant l'âge de 16 ans. Étant donné les taux de prévalence élevés du VIH/SIDA chez les jeunes, les jeunes demandent de faire eux même les choix sur leur santé sexuelle et reproductive et d'éliminer l'obstacle de l'autorisation
- Protection et mesure des Droits à la Santé Sexuelle et Reproductive du groupe des 10-14 ans : Les jeunes demandent au gouvernement de prendre en compte la tranche d'âge des 10-14 ans dans les politiques, les lois et la prise en compte des données nationales. Ils demandent notamment au gouvernement d'inclure ce groupe d'âge dans le prochain Plan Jeunesse et dans les systèmes de données des enquêtes démographiques et de santé (DHS).
- Gratuité des soins et de l'accès à des services axés sur les jeunes pour les jeunes de moins de 18 ans, avec une mention spéciale pour les jeunes de 10 à 14 ans, dans l'est et dans le nord du Cameroun : Le manque de moyens financiers est un obstacle à l'accès des jeunes aux services de santé, notamment à l'Est et à l'Extrême Nord du Cameroun d'où la nécessité de la gratuité des soins pour les moins de 18 ans en particulier et les jeunes en général
- Fin de la pratique du mariage des enfants : même si cette pratique est interdite au Cameroun, elle reste très courante dans l'est et dans le nord du pays. Les jeunes Camerounais demandent à leurs parents et aux leaders communautaires/traditionnels/religieux d'agir pour mettre fin au mariage des enfants et de respecter les droits des filles.
- Exploitation du dividende démographique au Cameroun : mortalité maternelle et infantile élevée, prévalence du VIH/SIDA et pratiques socioculturelles qui limitent l'accès à la santé (mariage des enfants, MGF, taux d'abandon scolaire dû aux grossesses non prévues, etc.) font partie des principaux éléments qui empêchent le Cameroun d'exploiter son dividende démographique. Nous demandons donc au gouvernement du Cameroun, au niveau national et régional, à nos communautés, à nos parents, à nos leaders traditionnels/religieux de travailler ensemble pour faire en sorte que les jeunes disposent de meilleurs résultats en matière de santé, particulièrement via l'accès à l'éducation et à des services axés sur les jeunes. Il est grand temps d'agir.

[3] Plan stratégique national de lutte contre le VIH, le Sida et les IST 2014-2017/Plan stratégique national de la santé de la reproduction, maternelle, néonatale et infantile 2014-2020 (PSN/SRMNI)

Jeune S3 Santé, Sexualité, Sécurité

PROGRAMME JEUNE S3

Le programme Jeune S3 estime que l'accès à des informations et des services sur les Droits à la Santé Sexuelle et Reproductive (DSSR) est un droit fondamental pour permettre à chaque jeune de vivre une vie saine et de faire des choix libres et sûrs pour son avenir.

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SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE EN REPUBLIQUE DEMOCRATIQUE DU CONGO

Jeune S3 Santé, Sexualité, Sécurité

Les jeunes de la République Démocratique du Congo (RDC) sont confrontés à des obstacles substantiels et persistants pour faire valoir leurs Droits à la Santé Sexuelle et Reproductive (DSSR). L'accès à des services de santé sexuelle et reproductive axés sur les jeunes ainsi qu'à une Éducation Sexuelle Complète (ESC) reste néanmoins très difficile pour les jeunes en RDC. Les tabous sociaux et le manque de soutien au niveau des politiques et des lois pour permettre aux jeunes d'avoir accès à des services de santé sexuelle et reproductive et à une ESC axés sur les jeunes entraînent des taux très élevés de grossesses non planifiées, de mortalité maternelle, de VIH/SIDA et de mariages d'enfants.

STATISTIQUES SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE EN RÉPUBLIQUE DÉMOCRATIQUE DU CONGO

À l'heure actuelle, en RDC, les taux de prévalence élevés sont indicatifs d'une éducation sexuelle inadéquate et de besoins non satisfaits en matière de contraception[1].
- Le taux de prévalence des grossesses non prévues chez les adolescentes est de 30 %.
- 27 % de toutes les grossesses sont le fait d'adolescentes de 15 à 19 ans qui ont déjà eu un enfant.
- La prévalence du VIH chez les jeunes de 15 à 23 ans atteint 0,7 %, avec 1 % pour les jeunes femmes et 0,4 % pour les jeunes hommes.

Mariage des enfants et violences sexuelles
- 37 % des jeunes femmes sont mariées avant l'âge de 18 ans[2].
- 50 % des femmes âgées de 20 à 24 ans qui ont suivi une scolarité primaire ont été mariées avant l'âge de 18 ans.
- 36 % des adolescents de 15 à 19 ans ont été confrontés à une forme de violence sexuelle[3].
- 31 % des jeunes de 20 à 24 ans ont été confrontés à une forme de violence sexuelle.

LOIS/POLITIQUES/STRATÉGIES SUR LES LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE POUR LES JEUNES EN RÉPUBLIQUE DÉMOCRATIQUE DU CONGO

Aperçu des lois[4]
- La loi stipule que l'accès aux services de Santé Sexuelle et Reproductive (SSR) est soumis à l'autorisation parentale pour les jeunes de moins de 18 ans et au consentement de l'époux pour les femmes de tous âges.
- Le droit de la famille congolais stipule que les deux parties doivent accepter personnellement d'être mariées et que l'âge légal du mariage est de 18 ans pour les hommes et de 18 ans pour les femmes.

Aperçu des politiques/plans nationaux
- Le « *Plan stratégique national de la santé et du bien-être des adolescents et des jeunes* » (2016-2020)[5] a pour but de :
  - Améliorer les connaissances et les compétences des adolescents et des jeunes sur les problèmes de santé qui les concernent et sur leurs droits.
  - Conduire au moins 50 % des adolescents et des jeunes à être capables de défendre leurs droits dans 258 zones de santé.
  - Définir les critères des services de santé sexuelle et reproductive axés sur les jeunes.
  - Fournir des produits contraceptifs dans au moins 3 870 établissements des zones ciblées, notamment des préservatifs pour les adolescents et les jeunes.
- Le « *Plan Stratégique national à vision multisectorielle pour la planification familiale* » (2014-2020) réclame :
  - Une loi sur la planification familiale pour protéger les mineurs et les adolescents et promouvoir l'égalité de genre.
  - L'élargissement des services intégrés axés sur les jeunes dans toutes les zones de santé.
- Les « *Standards de services de santé adaptés aux adolescents et jeunes, 2014* » :
  - Reconnaissent le droit des adolescents à avoir accès à des services de santé confidentiels et de qualité.
  - Décrivent les services minimums qui doivent être mis en œuvre pour les jeunes à chaque niveau du système de santé, y compris au niveau communautaire.
  - Mettent l'accent sur l'accès à des informations de santé reproductive.
- La *Politique nationale sur la santé des adolescents et des jeunes* de 2013 reconnaît l'importance de l'éducation sexuelle et met l'accent sur la participation des jeunes, des parents, des écoles et des communautés.

MESSAGES CLÉS DES JEUNES EN MATIÈRE DE DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE
- Présence de produits et de services gratuits/subventionnés de SSR axés sur les jeunes, avec notamment une large gamme de méthodes contraceptives : un des principaux obstacles à l'accès aux services de santé pour les jeunes et les adolescents en RDC est la barrière financière. Les fournitures et les services axés sur les jeunes doivent donc être gratuits et/ou subventionnés et à la disposition de tous les jeunes, quel que soit leur âge, leur genre, leur orientation sexuelle ou autre caractéristique.

  Messages-clés des jeunes :
  - *Kiona, na likinga na magenjua ya ukumui, na wa imizo wangine ku ji kinga pia.*
  - *Être informé sur l'utilisation des contraceptifs, c'est mon droit et informer les autres jeunes c'est mon devoir, agissez maintenant !*
- Amélioration de l'accès aux informations sur les Droits à la Santé Sexuelle et Reproductive : le faible niveau de connaissance des Droits à la Santé Sexuelle et Reproductive a entraîné de mauvais résultats en matière de santé. Il est donc demandé au gouvernement de la RDC de garantir de manière systématique la mise en œuvre dans tout le pays des cursus d'ESC existants et de leur apporter un soutien financier, en mettant l'accent sur les zones les plus marginalisées.

  Messages-clés des jeunes :
  - *Plus jamais comme hier ; j'ai droit aux informations sur ma santé sexuelle et reproductives car ma vie en dépend.*
  - *Les informations sont de notre droit, les droits à la santé sexuelle et reproductive sont importants pour notre survie, un peuple sans informations c'est tout un avenir à perdre.*
- Mise en place d'un environnement favorable : les jeunes réclament la création d'espace surs de sécurité auprès des parents, des leaders religieux, des professionnels de santé, afin de les sensibiliser à l'importance des Droits à la Santé Sexuelle et Reproductive des jeunes.

  Messages-clés des jeunes :
  - *Chers parents, autorités et leaders religieux ; nos enfants ont droit aux informations fiables et précises sur la sexualité*
  - *Nous jeunes avons besoin d'une bonne santé sexuelle, la communauté, le gouvernement, nos parents et nous-mêmes devons sérieusement lutter pour notre vie.*
- Fin de la pratique du mariage des enfants : les jeunes de la RDC demande une modification du cadre juridique qui encourage le mariage des enfants. Ils demandent notamment au gouvernement de relever l'âge légal du mariage des jeunes femmes à 18 ans et aux parents et aux leaders communautaires/traditionnels/religieux de prendre des mesures plus efficaces pour mettre fin au mariage des jeunes et pour appliquer les droits des filles.

  Messages-clés des jeunes :
  - *Chers parents, je suis encore trop jeune, je dis non au mariage précoce.*
  - *Désormais, nous la communauté nous engageons à mettre fin au mariage précoce.*
- Exploitation du dividende démographique en RDC : mortalité maternelle et infantile élevée, prévalence du VIH/SIDA et pratiques socioculturelles qui limitent l'accès à la santé font partie des principaux éléments qui empêchent la RDC d'exploiter son dividende démographique. Nous demandons donc au gouvernement de la RDC, au niveau national et provincial, à nos communautés, à nos parents, à nos leaders traditionnels/religieux de travailler ensemble pour faire en sorte que les jeunes disposent de meilleurs résultats en matière de santé, particulièrement via l'accès à l'éducation et à des services axés sur les jeunes. Il est grand temps d'agir.

  Messages-clés des jeunes :
  - *La main d'œuvre d'une nation c'est sa population ; ensemble avec notre gouvernement faisons en sorte que notre pays se développe en fonction des travaux de son peuple. C'est encore possible ; il suffit tout simplement que nous nous décidions à agir positivement.*

[1] EDS-RDC-2013, †UNICEF, La Situation des enfants dans le monde, 2016
[2] †UNICEF, La Situation des enfants dans le monde, 2016, † EDS-RDC-2013
[3] Les Codes Lancier de la République Démocratique du Congo, Tome I Droit Civil et Judiciaire, 1967
[4] Plan Stratégique National de la Santé et du Bien-Être des Adolescents et des Jeunes, 2016-2020

Jeune S3 Santé, Sexualité, Sécurité

PROGRAMME JEUNE S3

Le programme Jeune S3 estime que l'accès à des informations et des services sur les Droits à la Santé Sexuelle et Reproductive (DSSR) est un droit fondamental pour permettre à chaque jeune de vivre une vie saine et de faire des choix libres et sûrs pour son avenir.

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SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE EN REPUBLIQUE CENTRAFRICAINE

Jeune S3 Santé, Sexualité, Sécurité

En République Centrafricaine (RCA), les jeunes sont confrontés à des obstacles substantiels et persistants pour faire valoir leurs Droits à la Santé Sexuelle et Reproductive (DSSR). Pour que les jeunes puissent jouir et faire valoir leurs droits, la première étape consiste à leurs faciliter l'accès aux informations et services de santé sexuelle et reproductive. Les tabous sociaux, le manque d'implication des jeunes dans la prise des décisions politiques et la non application des lois permettant aux jeunes d'avoir accès à une éducation sexuelle complète (ESC) et à des services de santé sexuelle et reproductive spécifiquement adaptés pour eux, entraînent des taux très élevés de grossesses non désirées, d'avortements, de mortalité maternelle, de VIH/SIDA et de mariages précoces.

STATISTIQUES SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE EN RÉPUBLIQUE CENTRAFRICAINE

En RCA, les statistiques montrent combien il est urgent de répondre aux besoins des jeunes en matière de DSSR.

Relations sexuelles et grossesse[1]

- 36 % des jeunes filles âgées de 15 à 24 ans sont enceintes
- 9,3 % des jeunes filles âgées de 15 à 19 ans utilisent des contraceptifs modernes
- 49,8 % des jeunes ont leurs premières relations sexuelles avant l'âge de 15 ans

Le taux de prévalence du VIH chez les adolescents de 15-24 ans est de 2,8 % avec[2] :

- 4,2 % pour les jeunes femmes
- 0,7 % pour les jeunes hommes

Mariage des enfants et mutilations génitales féminines

- 6 % des jeunes femmes âgées de 10 à 14 ans ont subi des mutilations génitales féminines/circoncision féminine[3]
- 18 % des jeunes femmes âgées de 15 à 19 ans ont subi des mutilations génitales féminines/circoncision féminine
- 29 % des jeunes femmes sont mariées avant l'âge de 15 ans[4]
- 68 % des jeunes femmes sont mariées avant l'âge de 18 ans

[1] STATISTIQUES DE L'UNICEF SUR LA RÉPUBLIQUE CENTRAFRICAINE : https://www.unicef.org/infobycountry/car_statistics.html
[2] STATISTIQUES DE L'UNICEF SUR LA RÉPUBLIQUE CENTRAFRICAINE : https://www.unicef.org/infobycountry/car_statistics.html
[3] STATISTIQUES DE L'UNICEF SUR LA RÉPUBLIQUE CENTRAFRICAINE : https://www.unicef.org/infobycountry/car_statistics.html
[4] STATISTIQUES DE L'UNICEF SUR LA RÉPUBLIQUE CENTRAFRICAINE : https://www.unicef.org/infobycountry/car_statistics.html

LOIS, POLITIQUES ET STRATÉGIES SUR LES DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE POUR LES JEUNES EN RÉPUBLIQUE CENTRAFRICAINE

Aperçu des lois[5]

- L'âge minimum légal du mariage civil est de 18 ans, mais le mariage à 13 ans peut être autorisé s'il est approuvé par un tribunal et/ou si la jeune fille est enceinte. Le mariage précoce est également légal avec le consentement des parents.
- Loi n° 06.005 Bangayassi :
  - Article 1er : « Par santé en matière de reproduction, on entend le bien-être général, tant physique que mental et social de la personne humaine, pour tout ce qui concerne l'appareil génital, ses fonctions et son fonctionnement et non pas seulement l'absence de maladie ou d'infirmités. »
  - Article 16 : « Toute personne a le droit de ne pas être soumise à la torture, à des peines ou traitements cruels, inhumains ou dégradants sur ses organes en général et en particulier ceux de la reproduction. »
  - Article 29 : caractérise les actes ci-dessous cités comme portant atteinte aux droits de la santé sexuelle et reproductive : mutilations génitales féminines, pédophilie, transmission volontaire du VIH/SIDA, exploitation sous toutes ses formes de la prostitution forcée des femmes et des enfants.

[5] Loi BANGAYASSI n° 06.005 du 20 juin 2006 relative à la santé de reproduction/ Ordonnance n° 64/16 du 22 Mars 1996 portant sur l'émancipation de la jeune fille/ Décret n° 000/61 du 9 juin 2009 instituant la charte de la jeunesse en RCA.

- Charte des jeunes du gouvernement de RCA : tout jeune Centrafricain a le droit de bénéficier d'un meilleur état de santé physique, mental et social.
  - Il relève de la responsabilité de l'État de :
    - Renforcer et développer des programmes spécifiquement ciblés sur les jeunes pour lutter contre les maladies sexuellement transmissibles, le VIH, le SIDA et autres pandémies.
    - Renforcer et développer des programmes pour la prévention des grossesses non désirées et de l'avortement illégal par le biais de mesures législatives destinées à améliorer la santé reproductive des jeunes.

Aperçu des politiques du gouvernement de la RCA[6]

- Politique nationale sur la santé reproductive (2015) :
  - Promouvoir le bien-être physique, mental et social des jeunes à l'école, à l'université et hors du système scolaire. Elle met également l'accent sur le fait que chaque jeune a droit à une éducation sexuelle, à une vie familiale et à une éducation parentale.

MESSAGES CLÉS DES JEUNES EN MATIÈRE DE DROITS À LA SANTE SEXUELLE ET REPRODUCTIVE

- Protection des jeunes contre les mutilations génitales féminines (MGF) et le mariage des enfants : En effet, l'article 16 de la loi Bangayassi stipule que toute personne a le droit de ne pas être soumise à la torture, à des peines ou traitements cruels, inhumains ou dégradants sur ses organes en général et en particulier ceux de la reproduction.
- Protection et mesure des DSSR du groupe des 10-14 ans : D'après l'article 29 de la loi BANGAYASSI les jeunes demandent au gouvernement de tenir compte du groupe des 10-14 ans dans les lois et politiques. Ils demandent notamment au gouvernement d'inclure ce groupe d'âge dans le prochain Programme National sur la Santé des Jeunes et des Adolescents.

[6] Programme national de santé des adolescents et des jeunes (2008-2012)

- Renforcement des systèmes de santé existants afin qu'ils intègrent et répondent davantage aux besoins et aux droits des jeunes : Il suffit juste de voir le taux élevé de 2,8% de prévalence du VIH/SIDA et le nombre des jeunes filles âgées de 15 à 16ans 9,3% qui utilisent des contraceptifs modernes pour dire qu'il y a un manque d'information et manque d'accès à des services médicaux qualifiés. En effet, selon la loi BANGAYASSI l'article 1er CF, d'où nécessité de renforcer les systèmes de santé existant davantage aux besoins et aux droits des jeunes. Des prestations d'éducation sexuelle et des services axés sur les jeunes devraient être à la disposition de tous les jeunes quel que soit leur âge, leur genre, leur orientation sexuelle, leur religion ou tout autre critère de différence.
- Mise en place d'un environnement favorable : les jeunes réclament la création d'espaces de sécurité avec les parents, les leaders religieux, les professionnels de santé pour qu'ils puissent promouvoir et défendre les droits des jeunes en matière de santé sexuelle et reproductive afin de réduire le taux élevé des grossesses non désirées et le mariage des enfants.
- Exploitation du dividende démographique en RCA : mortalité maternelle et infantile élevée, prévalence du VIH/SIDA et pratiques socioculturelles qui limitent l'accès à la santé (mariage des enfants, MGF, taux d'abandon scolaire dû aux grossesses non désirées, non désirées etc.) font partie des principaux éléments qui empêchent la RCA d'exploiter son dividende démographique. Nous demandons donc au gouvernement de la RCA, au niveau national et provincial, à nos communautés, à nos parents, à nos leaders traditionnels/religieux de travailler ensemble pour faire en sorte que les jeunes disposent de meilleurs résultats en matière de santé, particulièrement vis l'accès à l'éducation et à des services de santé axés sur les jeunes. Il est grand temps d'agir.

Jeune S3 Santé, Sexualité, Sécurité

PROGRAMME JEUNE S3

Le programme Jeune S3 estime que l'accès à des informations et des services sur les Droits à la Santé Sexuelle et Reproductive (DSSR) est un droit fondamental pour permettre à chaque jeune de vivre une vie saine et de faire des choix libres et sûrs pour son avenir.

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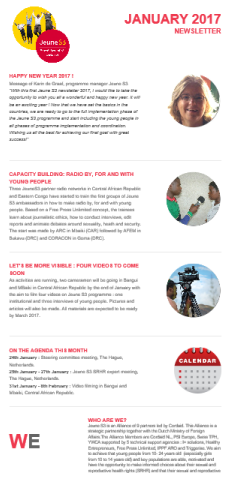
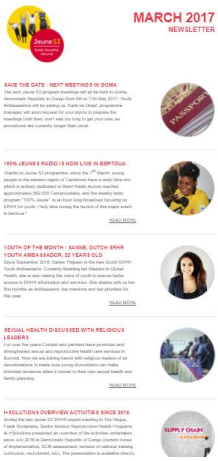
Annexe 3 : Newsletter Jeune S3 in 2017



January 2017

February 2017



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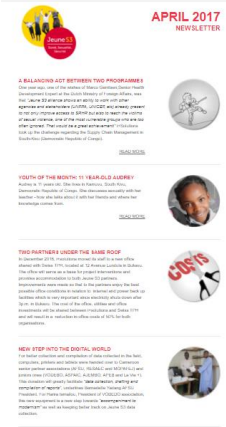
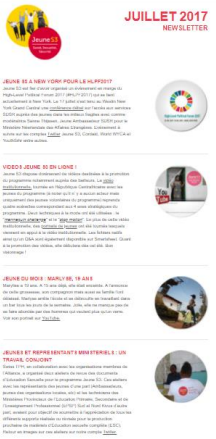


April 2017

June 2017



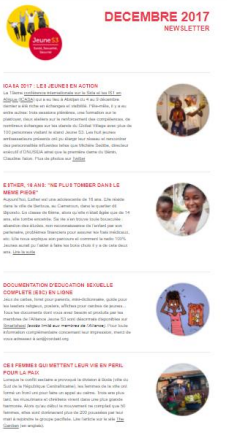
July 2017

August 2017

September 2017

October 2017

November 2017



December 2017

Through our newsletter we share:
1) Actual information on progress of Jeune S3 activities by all Alliance members
2) Interesting and relevant reports, articles and documents by all Alliance members and third party
3) Dates of visits of Alliance members to the countries and dates of meetings/ workshops of the Alliance
4) Agenda of relevant events (inter)nationally

The subscribers can be Alliance Partners, stakeholders, local partners and interested colleagues.

Santé Sexualité Sécurité

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