3.2 PNDS, PDIS and Other Government Policies

(1) National plan for health and social development

The constitution of Senegal states in chapter 14 that "the government and local authorities have the social responsibility of taking care of the family's physical, moral and mental health". Following the Declaration of the Health and Social Action in 1989, and the consequent efforts by the government to realize the strategy to solve various health related problems, the Ministry of Health and Prevention elaborated *Plan National de Développement Sanitaire et Social* (PNDS: the National Plan for Health and Social Development) for 1998-2007. Furthermore, as the first phase of PNDS, a 5-year's action plan called *Programme de Développement Intégré de la Santé et de l'Action Sociale*, (PDIS: Integrated Development Program for Health and Social Action) for 1998-2002 was launched, with the focus on the priority areas in PNDS. Although PDIS has officially finished in 2002, the activities of this program are still ongoing to be completed. PNDS Phase II 2004 – 2008, which is temporary named for the second phase after PDIS, is in preparation.

In PNDS, eleven strategic objectives are identified and emphasized to improve the health sector, which extend over several domains such as institutional reform, improvement in service performance, and care and prevention;

1) To reform the legal and statutory framework of the health sector
2) To improve the accessibility to the service
3) To improve of the quality of health care
4) To develop the human resources
5) To strengthen the performance of reproductive health program
6) To reinforce the control of epidemic diseases and the epidemiological surveillance
7) To promote the individual and collective protection measures through hygiene and sanitation
8) To support the private sector and traditional medicine
9) To develop the operational research
10) To improve the living standard of impoverished families and vulnerable social groups
11) To support the institutions at the central, regional and district level

Among the above objectives, the following areas are prioritized and incorporated in the PDIS;

- Reduction of the child mortality by eliminating diarrhea diseases, malnutrition, the vaccine preventable diseases by Expanded Program on Immunization (EPI), and other local endemic diseases,
- Reduction of the maternal mortality rate by establishing the surveillance system for the pregnant women.
- Reduction of the fertility rates by reinforcing family planning, female literacy rate, and girls' school enrolment rate,
- Improving livelihood of impoverished families by securing their access to basic social services.

As far as health policy is concerned, efforts will be focused on ensuring greater equity in the health care provision, improving the availability of essential drugs, and the access to health services. Improved health services, such as primary care, prenatal care, vaccination coverage, emergency obstetrical care, emergency surgery and STD and HIV/AIDS prevention, should eventually contribute to reduce infant and maternal mortality rates.

Likewise, in terms of institutional issue to implement PNDS, the roles and contribution of NGOs and training facilities at all levels are emphasized. For financial needs, it is envisaged that sources from central government, self-finance by the local government, and the external aids are fully integrated. For the purpose of the overall management of the progress of PNDS and PDIS, Supporting Unit for the Monitoring of PNDS/PDIS (*la Cellule d'Appui et de Suivi du PNDS/PDIS*) was established.

(2) Plan national de formation (PNF; National plan for training)

In parallel with PDIS, the government implemented *Plan National de Formation* (PNF; National Plan for Training) for the year 1997 to 2002. In the plan, based on the demand projection of health personnel, nurses and primary health care personnel are being trained in government institutions. The main fields for training are: health mapping, information techniques such as Information Management System, urgent obstetrical care, drug inspection, community health, and hospital management.

Likewise, in 2000, the government concluded to assist private nurse training institutions so as to fill the absolute lack of human resources. The priorities identified for the year 2002 are as follows:

- Construction and rehabilitation of regional hospitals; Fatick, Kolda, and Ziguinchor
- Improvement in hospital management
- Urgent obstetrical care
- Creation of specific indicators to monitor the activities and expected outcome
- Commencement and evaluation of retraining at region level
- Formulation of human resource development plan by region

Likewise PDIS activities, the activities of this plan are also under going, and the second phase for this Plan is also in the process of Planning.

(3) Poverty reduction strategy paper

In addition, the government has elaborated the Poverty Reduction Strategy Paper (PRSP) issued in October 2001, in which the mid and long term objectives are specified as the promotion of social health services for the poor: 1) improvement in access to the health services of the poor; 2) health service development at the grassroots level; and 3) improvement in hygiene conditions in rural and peri-urban area.

Furthermore, the followings are identified as the prioritized objectives;

1) improvement in health service offers in the area where health situation and poverty status are alarming,
2) promotion of access to medicine for vulnerable groups,
3) development of attitude and behavior for the prevention of certain diseases.

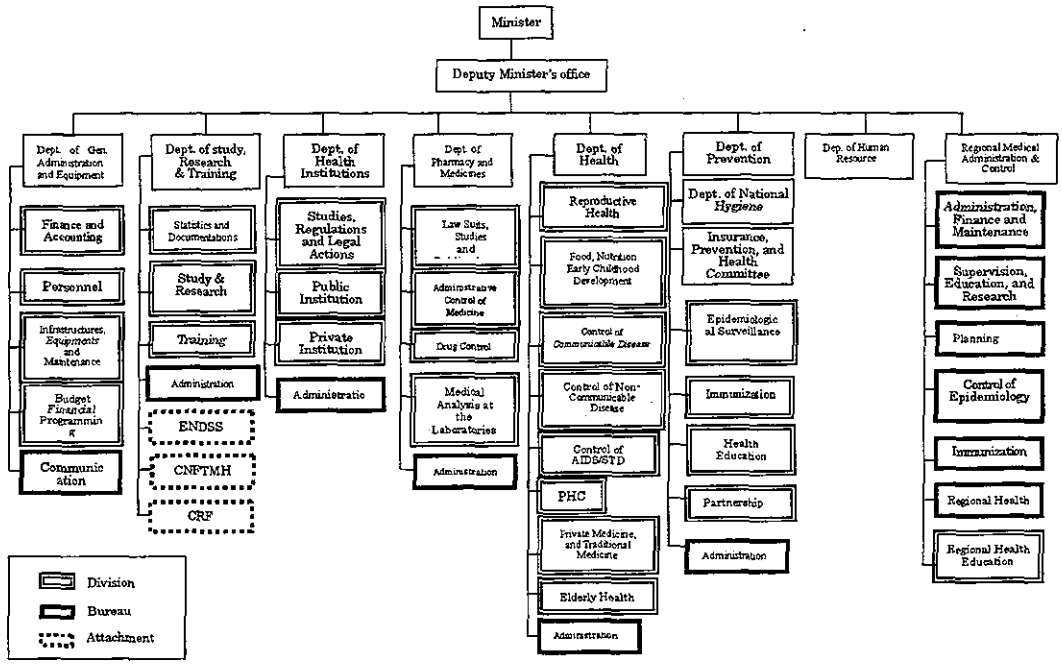
3.3 Institutions and Organizations Related to Child Health and Nutrition

3.3.1 Organizational Structure of the Ministry of Health and Prevention

In Senegal, the health care and nutrition are being administered mainly by the Ministry of Health and Prevention (MHP) until April 2004. The MHP was organized as Ministry of Health, Hygiene and Prevention in 2001 and the Department of Prevention was incorporated to the Ministry at that time and reorganized as Ministry of Health and Prevention in September 2003. However, this is separated into two Ministries: Ministry of Health and Ministry of Prevention, Public Hygiene and Sanitation, separating the Department of Prevention[9]. The organization of MHP before the reorganization in April 2004 is shown in the figure below.

[9] The finalization on the personnel and demarcation between two ministries are still under way in Early May 2004.

Figure1.3.3 Organizational Chart of Ministry of Health and Prevention



1) Department of the General Administration and Equipment has four divisions with one bureau, and is in charge of budget preparation and execution. They design the policy for facility and equipment acquisition, realization and maintenance. The department also assured personnel administration and management. Although the Personnel Division was planned to move to the Department of Human Resources, it has not yet been completed.

2) Department of Study, Research and Training has three divisions with one bureau, and is in charge of promotion and coordination of operational research on the social medicine, as well as initial and continuous training; and the collection of health statistics. It is closely connected to universities and other institutions working on health related research and training. *Ecole Nationale de Developpement Sanitaire et Sociale* (ENDSS; National School of Sanitation and Social Development), *Centre Nationale de Formation Technique de la Maintenance Hospitaliere* (CNFTMH; National Center of Technical Training for Hospital Maintenance) and *Centre Regionale de Formation* (CRF; Regional Center for Maintenance).

3) Department of Health Institutions has three divisions with one bureau, and is in charge of designing and following up the policy, concerning to the hospitals and other health facilities. The Department also promotes the private health institutions to contribute in public health services.

4) Department of Pharmacy and Medicines has four divisions with one bureau and is in charge of designing and following up the policy and program implementation related to pharmacy and medicines. The Department is also responsible for; a) enforcing the laws and regulations related to pharmacy, medicines, medical analysis laboratory reagents, poisonous substances, alcohol and medical devices; b) regulating pharmaceutical professions and controlling private medical laboratories; c) regulating and promoting traditional pharmacopoeia.

5) Department of Health has eight divisions with two bureaus, and is in charge of designing the health policy and programs implementation focusing on the maternal and child health and the control of the communicable and non-communicable diseases. The Department is also responsible for the regulation of the medical and paramedical professions, the control of the medical and paramedical services, as well as the regulation and promotion of traditional medicine. It promotes the co-ordination of all programs under its competence.

6) Department of Prevention has four divisions with one bureau, and is in charge of designing and follow-up the prevention policy. The main responsibility is the immunization and epidemiological surveillance; information, awareness raising and communication in the field of health, as well as developing external partnerships. It is also responsible for border sanitary control, as well as elaborating and controlling the enforcement of hygiene regulations. *Service National de l'Education pour la Sante* (SNES; National Service for Health Education), under Division of Health Education, is working on the advocacy and campaigning regarding every aspects of health; e.g. malaria control, vaccination, nutrition including breastfeeding promotion, family planning etc. It has good resources for the health education, including about 2000 video/films (all are in French, but some are dubbed in local language). Since April 2004, this Department is independent Ministry. However, the function of this Department is not yet clear at this moment.

7) Department of Human Resource is officially established under the Minister's order in 2003, combining the Personnel Division in Department of General Administration and Equipment and Education Division in Department of Study, Research and Training. However, this is not yet carried out practically

8) *Regions Medicales*, namely, Regional Medical Administration and Control is in charge of promoting the inspection and control of public and private health structures at a regional level, promoting the technical co-ordination of all

regional health structures, supporting regional health structures in their administrative, management and planning tasks, organizing continuous training for health staff in the region, including community staff, providing the statistic processing of the region health data and providing the surveillance of local endemics.

3.3.2 Training Institutions

In Senegal, *Universite Cheikh Anta Diop* (UCAD) and *Ecole Nationale de Developpement Sanitaire et Sociale* (ENDSS) are the major national schools for the medical professionals' training. The UCAD has the courses for medical doctor, dentists and pharmacists. ENDSS was established in 1992 and now has 14 courses under three Departments. The Department of Basic Health Science has the courses for nurse, midwife, dental technician, hygiene technician, assistant pharmacist. The Department of Social Science has the courses for social workers and social assistant. The Department of Advanced Health Science has the re-training courses of anesthesiology, biology, education and administration, X-ray technology, kinetic therapy, dentistry and ophthalmology, for those who have acquired more than four years' work experience. The Department of Study, Research and Training, Ministry of Health and Prevention, also have the re-training programmes for the health professionals, including nurses and midwives. There are several private school too, of which *Institut Services Sante* in Dakar (for nurse and midwife), and *Monseigneur Ndione de Thies* (for nurse) are well recognized.

As for the nutritionist, UCAD has the postgraduate course to train the nutrition specialists. *Ecole Nationale de Formation d'Economie Familiale et Sociale* (ENFEFS) has two-years undergraduate course to train dieticians, who will work for the diet therapy at the hospital and the related institutions.

As for the *Agents Sanitaire Communautaires* (ASC), the Division of Primary Health Care, Department of Health, Ministry of Health and Preventions is in charge of the trainings. Currently, the Project for the Development of Human Resource in Health is underway since 2002 by JICA in order to strengthen the capacity of ASC at the community level. Besides, several international organizations (e.g. BASICS/USAID and Africare) have organized the training programmes for ASC.

3.3.3 Budget for Health Care and Nutrition

The percentage of the governmental budget allocated to the Ministry of Health and

Prevention has been around 8% of the total during last decade, with the increase rate of 0.5% per year. Total budget for PNDS (1997-2008) is estimated at FCFA 336 billion (except personnel), of which 40% is allocated for the capital investment, 57% for the recurrent cost, and 3% for the training. More than half of the resource allocated for each structure is designated to the primary and secondary care, focusing on the pharmaceutical reform to improve the access to health care for the poor.

Table below shows the allocation of budget for PDIS, into each of personal, programme operation and capital investment. The proportion of the budget allocated for personal, programme operation and capital investment is 31.2%, 42.6% and 26.2%, respectively. Health committee is the local unit that implements the Bamako Initiative, whom the population pays for the medicines and treatment at the hospital or other health facilities.

Table 1.3.12 Budget for PDIS (1998-2002)

Unit: million FCFA

	Personal	Programme operation	Capital investment	Total	(%)
Government	63,672	49,131	10,677	123,480	(53.9)
Health committee	2,210	22,655	0	24,865	(10.9)
Local government	4,697	6,410	1,832	12,939	(5.6)
External partners	1,000	19,326	47,505	67,831	(29.6)
Total	71,579	97,522	60,014	229,115	(100.0)

Source: Ministére de la Santé 2001[10]

Table below shows the budget for PDIS by year from 1998 to 2002, according to the type of the revenue source and expenditure allocation. As indicated, about FCFA 40-50 billions are being allocated for health care during 1998-2002. In the Evaluation report, it was reported that the budget initially planned was insufficient; therefore, it had been augmented each year and it increased 39% in total.

Table 1.3.13 Estimated Amounts of Revenue and Expenditure for Each Year and Financial Execution of PDIS 1998-2002

Unit: million FCFA

	1998	1999	2000	2001	2002	Total
Sources						
Government	21,196	22,786	24,793	26441	28,264	123,480
Health committees	4,500	4,725	4,961	5,209	5,470	24,865
Local governments	2,200	2,378	2,571	2,781	3,009	12,939
External partners	12,429	16,515	13,967	12,473	12,447	67,831
Total revenues	40,325	46,404	46,292	46,904	49,190	229,115
Allocation	1998	1999	2000	2001	2002	Total
Personal	13,193	13,747	14,308	14,878	15,453	71,579
Programme operation	17,210	18,237	19,106	20,629	22,340	97,522
Capital investment	9,922	14,420	12,878	11,397	11,397	60,014
Total expenditures	40,325	46,404	46,292	46,904	49,177	229,115
Actual Expenditure*	37,157	51,946	61,995	75,456	92,205	318,759

Source : Ministère de la Santé 2001, *Evaluation Finale du PDIS 29-02 (Novembre 2003)

[10] Ministére de la Santé. *Programme de Development Integre de la Sante. Rapport Financier PDIS au 30/06/2000.* 2001

3.4 Facilities, Staff and Services Available

3.4.1 General Structure

The Health System of Senegal can be divided largely into three levels;

A) Peripheral level, corresponding to health district (*District Sanitaire*)

B) Regional level, corresponding to *Région Médicale*

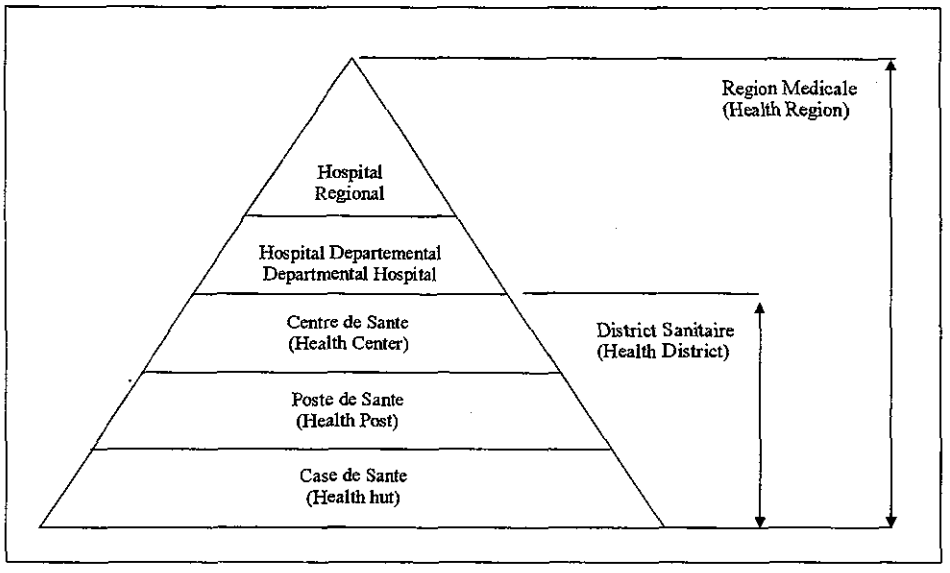
C) Central level, corresponding to the Ministry of Health and Prevention

A) There are 50 health districts in the country. Each health district has at least one health center (*centre de santé*) and health post (*poste de santé*) network, covering population on average between 100,000 and 150,000. Basically, the health districts correspond to the administrative department (*département*), although there are some exceptions where an administrative department is divided into two or more health districts. The health post is usually located in Communauté Rurale or sometimes in relatively highly populated villages so that the population in the responsible zone could be defined approximately 10,000 and that each village could have access to a health post in less than 15 km. Under the health posts, there are *cases de sante* (health hut) managed at the village level, and *maternité rurales* (rural maternity), although it is reported that many of them are not functioning properly nowadays. There are also private health services such as medical and dental clinics, especially in Dakar. The referral system from the community level to the regional hospital is illustrated below.

B) *Région Médicale* is corresponding to administrative unit of region and it assures the management, operation, and management of regional hospitals and department hospitals. The following services and offices are linked together at the regional level; Regional endemic disease service, Regional team for hygiene, Regional office for health education, Regional office for foods and nutrition, Regional maternal and child health protection center, Statistics office for primary health care, Regional pharmaceutical supply.

C) At the central level, the Division of Public Institution, Department of Health Institution, Ministry of Health and Prevention is responsible to the overall coordination and management of the regional hospital and other health facilities in the country.

Figure1.3.4 Health Pyramid in Senegal



3.4.2 Infrastructure, Facilities and Staff

(1) Hospitals

There are eleven regions and every region is supposed to have a regional hospital. However, in two regions, the hospitals are not functioning because of shortage of human resource and in the newly established region, namely in Matam, a hospital is in the preparation stage for construction in 2004. Under PNDS, the regional hospital is entrusted to the autonomy status for operation and management. There is a regional chief doctor at each hospital while the number of staff vary by region. In addition, there are seven teaching hospitals (*Centre Hospitalo-Universitaire*: CHU), which are all in Dakar; Dantec, Fann, Albert Royer, Abass Ndao Hospital, Psychiatric hospital in Thiaroye, General hospital at Grand Yoff and Hopital Principal which has a special status.

(2) Health centers (*Centre de Santé*)

As was mentioned in the previous section, each of 50 health districts has at least one health center, and currently there are 52 health centers (as of 1999). The numbers vary by region, and while Dakar has ten centers and Thies has nine, there are only three in Kolda and Ziguinchor, respectively. In each health district, there is a district chief doctor.

(3) Health post (*Post de Santé*) and health hut (Case de *Santé*)

The Communauté Rurale assures the management, construction, equipment, operation, and management of health posts, health huts, and rural maternity in rural area. The number of the health posts has been increasing during the past decade, from 733 in 1994

to 1,206 in 1999. Furthermore, the government declared in PDIS that 231 health posts would be newly constructed, and 166 existing health posts would be renovated. Each health post has several nurses and midwives, but no doctor. There are 1,694 health huts (1999), each of which has the traditional birth attendants (*matrone*) and community health worker (*ASC*). Table below shows the coverage of the health posts and health huts, presenting that the health personnel in the country is far below the WHO standards.

Table 1.3.14 Coverage of Infrastructure and Health Personnel

Unit: person

	Coverage Rate in Senegal	WHO Standards
Infrastructure		
1 health post for	11,500	10,000
1 health center for	175,000	50,000
1 hospital for	545,800	150,000
Health Personnel		
1 medical doctor for	17,000	5,000 to 10,000
1 nurse for	8,700	300
1 midwife for	4,600*	300*

* women at reproductive age
Source: ESIS 2000

In addition to the inadequate health facilities, another problem to be noted is an unequal distribution of the infrastructure and personnel between urban areas (especially Dakar) and rural areas.

3.5 Ongoing Programs with regard to Health and Nutrition

(1) Government's Programs

In accordance with PNDS and PDIS, each Department of the Ministry of Health and Prevention employs their own programs. There are ten main programs recognized for its importance: 1) *Le Programme National de Lute contre le Paludisme* (PNLP: National Program for fight against Malaria), 2) *Le Programme National de Lute contre SIDA* (PNLS), 3) *Le Program National de Sante de la Reproduction* (PNSR: National Program for Reproductive Health), 4) *Le Program National Elargi de Vaccination* (PEV), 5) *Le Program National de Nutrition et Alimentation*, 6) *Le Programme National de Lute contre Bilharziose*, 7) *Le Programme National de Lute contre la Ceite*, 8) *Le Programme National de Lute contre la Lepre*, 9) *Le Programme National de Lute contre l'Onchocercose*, and 10) *Le Programme National de Lute contre la Tuberculose*. The Programs most closely related to Children's health include more programs as well as these main programs.

1) Programs for a Child Survival

The Department of Health is in charge of coordinating the programs for the a Child Survival, which are: PEV, *Lutte contre les Maladies Diarrheiques* (LMD; Program of Controlling Diarrhoeal Diseases), Program of Nutrition and Food, PNLP, and Infections Respiratoires Aigues (IRA). These programs are implemented at the level of Health District through the coordination of the related divisions in the central Ministry.

The strategies employed to carry out PDIS through the programs are mainly *Prise en Charge Integree des Maladies de l'Enfant* (PCIME; Integrated Management of Childhood Illness) and Paquet d'Activities Integrees de Nutrition (PAIN; Package of Integrated Nutrition Activities). These strategies are particularly effective in a Child Survival.

In 1998, a Package of Integrated Nutrition Activities (PAIN), as the main nutritional strategy for these programs, was incorporated. The package includes the following seven components, and the agents community relays (*Agents Relais Communautaires*: ARC) are expected to undertake these activities for the target populations.

1. Promotion of the exclusive breastfeeding for 4-6 months
2. Promotion of the appropriate complementary feeding from 4-6 months of age, together with the breastfeeding up to 24 months
3. Prevention of Vitamin A deficiency among women, infants and young children
4. Control of iron deficiency among pregnant women
5. Growth monitoring of children aged 0-36 months
6. Promotion of the regular consumption of iodized salt
7. Appropriate nutritional care for the infants after the illness

Another strategy, *Prise en Charge in Integree des Maladies de l'Enfant* (*PCIME:* Integrated Management of Childhood Illness), makes it possible to synthesize the various programmes. In many cases, children are suffering from more than one symptom, making a single diagnosis impossible. PCIME is an integrated strategy, which takes into account the variety of factors that put children at serious risk. It ensures the combined treatment of the major childhood illnesses (e.g. acute lower respiratory tract infections, diarrhoeal diseases including dehydration, measles, malaria and malnutrition),

emphasizing prevention of disease through immunization and improved nutrition. IMCI was developed by UNICEF and WHO, which have been incorporated into the strategies of the Ministries of Health in more than 60 countries. IMCI works at three levels: Ministry of Health (policy), health facility (staff performance); and community (caretaker behaviors).

2) P*rogramme de la Nutrition Communitaire* (PNC: Community Nutrition Programme) and *Programme de Renforcement de la Nutrition* (PRN: Reinforced Nutrition Programme)

PNC started in 1996 as a five-years programme, with the aim to halt further deterioration in the nutritional status of the most vulnerable groups in the poor peri-urban districts. The programme was funded by the World Bank and KfW, and the supplementation food was provided by World Food Programme (WFP). The project was managed by AGETIP (*the Agence d'Execution des Travaux d'Interet Public*), a private agency which was launched to implement the project and signed a Convention with the government to execute the project. The inter-ministerial National Commission against Malnutrition located at the Presidency of the Republic closely monitored the project. During 1996-2000, about 400 Community Nutrition Centers (CNC) were built. Each CNC recruited 460-600 beneficiaries composed of women at six months of pregnancy, lactating mothers of children under 6 months, and children aged 6-35 months. They were entitled to stay in the project for a limited term only (6 months), and during that period, the following services were provided: a) monthly growth monitoring of the children; b) food supplementation, a flour mix made of local ingredients, to malnourished children; c) referral to health services for unvaccinated children and pregnant women, for severely malnourished children; d) Weekly nutrition and health education sessions to women. In most of the cases, day nursery rooms are attached to the centers. A unique characteristic of the CNP was the involvement of youth associations, women groups, and *Groupement d'Interet Economique* (GIE) that consisted of four young people previously unemployed, as the service providers of this project. For whom, training were provided by the local training institutions beforehand. After the completion of the CNP in 2001, and the operating costs for the CNCs have been managed by the government, together with the continuous support from KfW. Yet, it is reported that, due to the financial constraints, some of the CNCs no longer function. The National commission against Malnutrition has moved from the Presidency to the Prime Minister's cabinet, where the CNP is replaced by the new programme, *Programme de Renforcement de la Nutrition* (PRN: Reinforced Nutrition Programme) which

is being implemented for 2002-2011, with the financial supports from the World Bank.

3) The National Program of Reproductive Health (PNSR)

The main activity of SNSR is to extend the reproductive health care services, including family planning, through local health facilities such as health centers and health posts. SNSR is located at the Division of Reproductive Health, Department of Health, Ministry of Health and Prevention.

(2) International cooperation

The PNDS and PDIS of the Ministry of Health and Prevention have been partly supported by the various international organizations; e.g. World Bank, African Development Bank and EU etc. Besides, there are several interventions regarding health and nutrition, carried out by governmental institutions, NGOs, and development partners.

The World Bank supports the DANSE (*Division de l'Alimentation et de la Nutrition Service*) for implementing PAIN in Dakar, Thies, Diourbel, Kolda and Tambacounda. Previously, World Bank also contributed to the Community Nutrition Programme (CNP) by the government for 1996-2000. CNP has been supported also by KfW: financially, and by WFP through the provisions of the supplementary food.

After CNP ended, the World Bank has been financing PRN, of which first phase has a period between 2002 and 2005. Within the line of the support to PRN, the World Bank is supporting *Projet Amelioration de l'Etat Sanitaire et Nutritionnel du Couple Mere – Enfant a travers la Case des Tout-Petit* (Improvement of Sanitary and Nutritional Status of Mother and Child through CTP), using CTP as a focal point for the intervention in the communities. This project aims: 1) to promote exclusive breastfeeding during 6 months, 2) to promote the appropriate baby food practice through the preparation and utilization of improved cereal baby food, 3) to fight against the micronutrient deficiencies in the houses of vulnerable groups, and 4) to realize micro-gardens to improve the food and nutrition security of children. The activities of the project are as follows:

- diagnostic study,
- training of *Animateur Polyvalent* (instructor), *Relais* (relays) and assistant mother on hygiene and Sanitation, food and nutrition, prevention of certain disease, implementation of micro-project, and technique of animation and communication,

- Information Education and Communication (IEC) activities such as chat, quiz, sketch, and games to collect funds,
- Parental Education on IEC/CC (Information, Education and Communication for change of attitude, improving preparation technique of baby food,
- Activities of vegetable gardens and chicken farming, and
- Monitoring and evaluation.

In Accordance with their Country Program 2002 to 2006, WFP is providing the snacks from March to June 2004 in 17 CTPs in 5 regions: Dakar, Kaolack, Fatick Tambacounda and Kolda. This is the first pilot phase and the JICA's four CTPs are included in the target. This project aims mainly to: 1) reduce the population who suffer from hunger, 2) reduce the U5MR in the targeted area, and 3) fight against HIV/AIDS, malaria and other diseases. The snacks which a child receives are 20g of sugar and 100g of mixed cereal powder per day, which provide 484 kcal in total. After the first phase, the target will be expanded up to around 60 CTPs from July 2004.

The UNICEF and WHO also support the DANSE, focusing on the control of micronutrient deficiencies (Vitamin A, Iodine). The UNICEF set the specific goals for 2002-2006, of which, those related to child health and nutrition are; a) To reduce mortality, under 5 mortality and maternal mortality rate by 20%; b) To reduce child *malnutrition by 25%; c) To develop an integrated community approach for early* childhood development, to reach 35% (3 to 6 years). Under this circumstance, about 34% of total UNICEF budget for the 2002-2006 country programme is allocated for the ones in the field of health and nutrition.

BASICS II (1999-2004), *Basic Support for Institutionalizing Child Survival*, is a flagship project funded by the Office of Health and Nutrition, the US Agency for International Development (USAID). The precedent project, BASICS I (1994-1999), was primarily designed to strengthen the nutrition and control of diarrhoeal diseases programmes implemented by DANSE (former SNAN), with the priority given to upgrading the skills needed to plan and manage those programmes. Now, BASIC II focuses on achieving the following strategic objectives: 1) increased use of oral dehydration therapy (ORT); 2) appropriate care seeking for ARI, 3) appropriate care seeking and treatment for febrile illness; 4) increased use of insecticide treated materials; 5) appropriate breastfeeding; 6) appropriate child feeding; 7) increased consumption of vitamin A; 8) increased immunization coverage; 9) increased measles vaccination coverage; 10) introduction of new or under-utilized vaccines. The project is congruent with the priorities of the Ministry of Health and Prevention as laid out in PDIS. The interventions in Senegal cover six regions of Louga, Kaolack, Fatick, Dakar,

Thies and Ziguinchor, 29 of the country's 52 district, and 237 rural communities in total. This project is now in the final stage and will end in September 2004. Instead, BASICS III will take a place with continuation of BASICS II concept in some areas. However, the Framework of the BASICS III is in the final planning stage and not yet confirmed in May 2004.

With respect to family planning, since 1988, the UNFPA and USAID are the leading donors, who have been working under the collaboration with the Ministry of Health and Preventions and other NGOs, including a well-acknowledged local NGO called *Association Senegalese pour le Bien Etre Familial*, under the National Program of Family Planning launched in 1974. In Senegal, the Female Genital Mutilation (FGM) was officially banned in 1999, yet the efforts are still needed to abandon the customs, for which the WHO is actively involved.

There are several projects implemented by JICA, in the field of polio vaccination, malaria control and maternal and child health (under the collaboration with UNFPA). JICA also supported the renovation of the regional hospital in Thies. As was described in3.3.3, there is a project on the human resource development project in health for 2001-2006

(3) Activities of NGOs

1) Plan International

Plan International is an international humanitarian NGO working on the long-lasting improvement of the quality of life among the disadvantaged children in developing countries. In Senegal, Plan International works on the child survival programmes in Kaolack, Louga, Thies, Dakar and Saint-Louis. One important aspect in the child survival project is the control of malnutrition, aiming at reducing the morbidity and mortality of infants aged 0-5 years. The principal ongoing activities include the growth monitoring, Information, Education and Communication (IEC)/Social mobilization, and the training. An innovative health project in Senegal uses a traditional game to help reduce the maternal and infant mortality rate. The project covers various health issues, like immunization against diseases, train medical staff or build the health center. Of which, the most notable is the invention of game, "*Wure, Were, Werle* (in Wolof)" to raise awareness of the risks of pregnancy and childbirth among the expectant mothers. The game explains the medical causes of pregnancy complications and helps to promote safer, more conventional forms of medical treatment among Senegalese women.

2) AFRICARE

AFRICARE has been working in Senegal since 1974, and more than 100 water, environmental, agricultural and health care projects have been implemented in rural villages of the country. The ongoing major projects are Kaolack Community-Based Health Project in Kaolack and micro credit programme in Tambacounda. The former project collaborates with the Ministry of Health and Prevention, and eight agricultural-based enterprise (ABEs) groups to establish eight small *cases des sante* in five villages that do not have access to health care.

3) World Vision

World Vision is an international NGO, and has been working several nutrition interventions. Of which, the major programme is "Micronutrients and Health (MICAH)", that focuses on control of micronutrient deficiencies (iron, iodine and vitamin A). World Vision employs the strategy of PAIN, targeting the under five children, pregnant women and breastfeeding women. The main activities are nutrition education, grow monitoring, supplementation of iron and vitamin A, and promotion of iodized salt consumption.

4) *Christian Children's Fund*

Christian Children's Fund has been working in Senegal since 1985. CANAH (*Projet d'Action Communautaire pour la Nutrition et la Sante*), a child survival programmes, was launched in 1996, and was funded by USAID (1998-2002). The main activities are growth monitoring for under five children, micronutrient interventions, promotion of breastfeeding, vaccination, control of diarrhoeal diseases, malaria and ARI. These activities are still ongoing partly receiving fund from USAID (2002-2006).

5) Management Science for Health (MSH)

MSH has been working on the Senegal Maternal Health/Family Planning (MH/FP) Programme (2000-2005), together with Johns Hopkins University/Center for Communication Programmes and Future Group International, with the financial supports by USAID. The programme aims to achieve sustainable use of high-quality MH/FP services throughout the country. MSH also aims to help the Government of Senegal to achieve the long-term goal of reducing maternal mortality and morbidity through the improvement and increased use of reproductive health services, by strengthening the health

management and service delivery and encouraging behavior changes among the population through the education and communication campaigns.

3.6 Present Situation and Analysis of Kaolack and Tambacounda Regions

3.6.1 Existing Facilities and Services Available

Both regions have one regional hospital each in the regional capital. A health center exists in every health district: Kaolack, Kaffrine, Koungheul and Nioro in Kaolack region and Tambacounda, Goudiry, Bakel and Kedougou in Tambacounda region.

Table below shows the existing condition of health post and *case de sante* in two regions. About 89% of the community rural owns one active health post at least in Kaolack, while 83% in Tambacounda. However, 11% of the rural community has no health post or non-active in Kaolack, while 17% in Tambacounda.

A *case de sante* is operated by a local community, each of which has a traditional midwife and health workers. At least one *case* exists in 69% of total community rurals, but 15% of that is not active in Kaolack. On the other hand, the *case* exists in 85% of total community rurals, but 3% of that is not active in Tambacounda.

Table 1.3.15 Number of Community Rural with Health Facility

Region	Total Number of Community Rural	Health Post			Case de Sante*		
		More than one active health post	Exist, but no active health post	Not exist	More than one active health post	Exist, but no active health post	Not exist
Kaolack	42	39	1	2	14	4	8
Tambacounda	36	30	2	4	22	1	4

Note: As concerns case de sante, total number of community rural is 26 in Kaolack and 27 in Tambacounda
Source: JICA Study Team

Data and information related to health facility including health personnel in two regions are presented in detail in the separate report on the Survey on Facility Mapping in Kaolack and Tambacounda.

3.6.2 Results of Children's Survey

GERAD, of which this section summarizes the finding on the components relevant to the health conditions among the pregnant women and children in Kaolack and Tambacounda regions. Two sites were chosen from each region, one in the urban and the other in the rural; Touba Kaolack and Sagna in Kaolack and Camp Navetane and Sinthiou Maleme in Tambacounda. The study sample consists of 60 mothers and 60

children from each site. The details of the survey are provided in the separate report.

Besides, another short-termed survey was conducted in the same sites by JICA Study Team together with her C/P. The findings of this survey also are presented here. Questionnaire was prepared, focusing on the information on the breastfeeding, infant feeding and dietary practices, the intake of vitamin A/iron intake by the pregnant women and food security. Anthropometric measurements were also made for the children aged 0-6 years, so as to assess their nutritional status. In total, 155 children from 44 households were studied.

(1) Food availability

Touba Kaolack: Most of the inhabitants work in the informal sector, being involved in trade and craft industry, and less so in agriculture. Millet, groundnuts and maize are cultivated in the area, though the production is insignificant. Most of the foodstuffs used by the populations can be bought from the small market in the district, though the central market in the downtown is generally preferred, due to more food supplies at the lower prices. Typical diets are bread for breakfast, rice with fish for lunch, and couscous with *mafe* for dinner.

Sagna: Pluvial agriculture is the populations' main activity, and the major crops are the groundnuts, millet and maize. Beans, sorrel, marrow and watermelon are the vegetables/fruits grown locally. These foods would characterise the diets in Sagna; rice with *mafe* for lunch, and couscous with sauce made of green leaves for dinner, and the leftover of which comes as the breakfast on the following morning. It is reported that the crops would last only for 2 or 3 months after harvesting, hence the consistent food shortage, especially during rainy season.

Camp Navetane: Fruits (papayas, mangoes, oranges) are quite available locally, but most of other foodstuffs are obtained from the nearest market located 30 minutes' walk away from the district. Like in other sites, millet, groundnuts and rice are the major foods consumed. Most of the foods in the market come from outside Tambacounda, like Dakar, Kolda, Kaolack and the Gambia. The transport difficulties, in addition to the seasonal scarcity, would exacerbate the food insecurity during the rainy seasons.

Sinthiou Maléme: Food production is only limited to groundnuts and millet. Okra, beans, sorrel and mango are the locally grown vegetable/fruit. Typical dietary pattern in this area is porridge for the breakfast, rice with *mafe*, and couscous with *mafe* for dinner. Fish is hardly available, and few households can afford to buy the meat, resulting in the insufficient protein intake especially among the children, the pregnant and lactating women. In addition to the small market inside the village, there is also a big weekly

market held every Saturday.

In addition to the serious food insecurity especially during the rainy seasons, another problem commonly observed in all the sites is that; the women would prefer to allocate their limited resources to purchase the staple foods, such as rice and millet, which could easily fill their hungry stomach, rather than the fruits and vegetables. Consequently, the children and women in these areas are at risk of the micronutrient deficiencies.

(2) Intake of iodized salt

Significantly more households in Tambacounda than in Kaolack always use the iodized salts (84.6% vs. 22.2%). In fact, most of the studied mothers in Kaolack could not make difference between iodized salts and non-iodized salts.

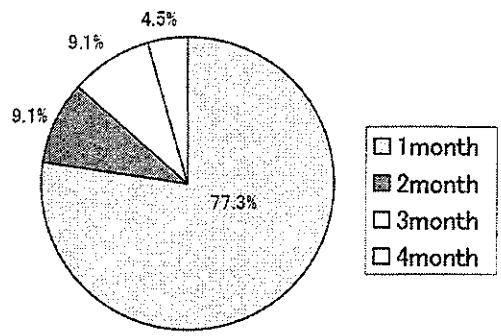
This study also revealed that even those who actually use the iodized salts at home do not know why the iodized one is recommended. About 20% of the mothers mentioned the prevention of goiter, but most of the others answered that they would prefer the iodized salts than normal one, because of better color, taste and availability only.

(3) Breast feeding and weaning foods for infants

Like in other areas of the country, the breastfeeding is widely practiced in the study areas, on average up to 1-2 years of age, though in Touba Kaolack the mothers tend to breastfeed longer for more than 2-years (52%). Among the study sample, the proportion of the mothers who gave the colostrums was higher in the rural sites (89%) than in the urban ones (61%).

This study confirmed the inadequacy of the exclusive breastfeeding. The recommended duration of the exclusive breastfeeding is at least for 4 month, and if possible for 6 months. In the study sites, however, 95.5% of the mothers start feeding the foods before the babies reach 4 months of age, and 77.3% of them would start at as early as 1 month of age (Figure 1.3.5).

Figure 1.3.5 Duration of the Exclusive Breastfeeding



Source : JICA Study Team

Millet porridge is the most common weaning food with low caloric density. A child being weaned has small capacity of stomach an thus, can not eat more than 200ml of the porridge per meal, which is insufficient in terms of both calories and protein, especially when a child has only 2-3 meals a day. Another problem is the mothers' practices to feed the family meals that often contain too much oil for the young infants to digest, leading to the diarrhea.

(4) Nutritional Status of the Study Children

Overall, except in Sagna, the prevalence of stunting and underweight was higher than national average in the study sites. Looking at the disadvantaged living environments in Sagna, especially with respect to the availability of health facilities, the low prevalence was surprising. Stunting, a proxy of chronic malnutrition, was more prevalent in Tambacounda than in Kaolack (Table1.3.16). Since this survey was undertaken in the middle of the dry season, the wasting was less common. Regardless of the study sites, the infants under 2 year were very small and thin for their age, whereas those aged 5-6 years were better-off.

Table 1.3.16 Prevalence of Malnutrition among the Children Aged 0-6 Years, by the Study Site

	n	Stunting		Underweight		Wasting	
		n	%	N	%	n	%
Touba Kaolack	17	5	29.4	4	23.5	2	11.8
Sagna	60	10	16.7	8	13.3	3	5.0
Camp Navetane	27	9	33.3	6	22.2	1	3.7
Sinthiou Maleme	51	20	39.2	17	33.3	2	3.9
Senegal		19.0%		18.4%		8.3	

Source: JICA study team

(5) Maternal health

Early marriage is common in all the study sites. Apparently, the situation was more serious in the rural than urban areas, and the proportions of the mothers who had experienced the first birth before they reached 20 years old was 77% in Sagna (of which, 17% was before 15 years old) and 75% in Sinthiou Maleme.

The regional average fertility rate is as high as 6.5 in Kaolack and 7.1 in Tambacounda[11]. More than 90% of the mothers in the urban areas stated that they had heard of family planning, mostly through radio, though in Sagna, only 68.3% of them knew it. It was difficult to grasp the actual contraceptive use, since many mothers were reluctant to answer. Likewise, only a few of them responded to the question on the constraints to pursue the family planning, most of which was to obtain the consents from their husbands.

More than 70% of the mothers stated that they had consulted with the nurses or midwives during the pregnancy, though it is unlikely that they did so more than once/twice times. Further information is required so as to assess the quality of prenatal care services.

Only 50-65% of the mothers had taken the two doses of anti-tetanus injections during the last pregnancy. In Sagna, 30% of the mothers had not taken it at all.

It is recommended that women should receive high doses (200000IU) of vitamin A capsules within 42 days after the delivery. Yet, the coverage is still very low in the study sites; 57% in Touba Kaolack and 25-32% in other sites. Interestingly, the iron intake during the pregnancy was found quite common (89%), though not all of them knew why they had to take it, as was observed in Sagna. Very often, food taboo during the pregnancy would affect the maternal nutritional status. In the study sites, millet porridge, couscous and salt were reported as the food forbidden during the pregnancy.

Inadequate facilities at the childbirths would accompany great risk not only for the mothers, but also for the new-born babies. In the urban sites, the hospital is the most common place (42-43%) followed by the *poste de sante*. On the other hand, in Sagna and Sinthiou Maleme, 76.7% of the mothers gave birth to their babies at home, mainly with the supports of the traditional birth attendance or midwives (though there is *poste de sante* in Sinthiou Maleme).

[11] Sante Familiale et Population, Ministere de l'Economie, des Finances et du Plan. 1997

(6) Vaccination

According to UNCEF and WHO guidelines, a child should receive a BCG vaccination, three doses of DPT, three doses of polio vaccine and a measles vaccination by the age of 12 months. It is now well acknowledged that the National Immunization Days (NIDs) programme has been effective to expand the coverage all over the country. In this study, the vaccination coverage was found very high in Tambacounda (98%), but less so in Kaolack (88% in Touba Kaolack and 93.3% in Sagna). The proportion of the children who were fully vaccinated is unknown this time. When looked at the data according to the type of vaccine, the coverage was high for polio and BCG, though relatively low for DTP3 and measles.

Since the year of 2000, the vitamin A supplementation programme has been incorporated in the NIDs. Out of 44 mothers in the study sites, 33 (91.7%) answered that their children had taken the vitamin A capsules.

(7) Child Morbidity

With respect to the morbidity among the study children, significant difference was observed in both regions, with the proportions of the children who had suffered from diarrhea during the past 2 months, with the higher values in the rural than urban areas (50% v.s. 27% in Kaolack, 43% v.s. 28% in Tambacounda). In Tambacounda, the urban-rural difference was obvious also in terms of the fever (65% vs. 37%), though it was as high as 63-65% in both sites of Kaolack. The main cause of the fever is known to be malaria. Yet, the coverage of mosquito net, especially impregnated one, is very low.

CHAPTER 4 CHILDREN'S RIGHTS

4.1 General Situation of Children in Senegal

4.1.1 Review on Children's Rights[1]

Only 44% of all Senegalese households have ever heard of the rights of the child. This percentage varies widely from urban (55.4%) to rural areas (36.1%). Best-known rights are those related to the family, name and nationality (30.1%), education and leisure (21.9%), survival and development (17.9%), and protection (16.2%). Peace (8.8%) and health (5.5%) are less known rights. It is important to note that non-discrimination, freedom of expression and the right to a healthy environment are among the rights not mentioned by any household[2].

The Senegalese Poverty Reduction Strategy Paper (PRSP) includes among the most vulnerable groups: women, children (particularly, early childhood, mendicant *talibés*, working children, and children in conflict with the law), handicapped people (all ages), the elder, and the unemployed or underemployed[3].

According to the Senegalese government, the current number of children at risk is estimated to be between 2.5% and 4% of total population[4], i.e. between 240,000 and 380,000 children. The characteristics of children at risk are low school enrolment rates, unemployment or shaky employment (unpredictable revenues, informal sector, low-paying and low-skilled jobs, labour exploitation), large –generally broken– families, malnutrition, precarious health care, lack of capital, and coping strategies (drugs, prostitution, delinquency, etc.). Indeed, the United Nations estimates that 50% of the approximately 400,000 Senegalese children at risk, are involved in any of the worst forms of child labour, 25% have broken their family ties, and the remaining 25% are victims of commercial sexual exploitation[5].

(1) Birth registration

Article 7 of the United Nations Convention on the Rights of the Child (CRC) states that "*the child shall be registered immediately after birth and shall have the right to a name and a nationality*". The Senegalese Code de la Famille also establishes this obligation.

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1 This point reviews the country's compliance with the United Nations Convention on the Rights of the Child (CRC), ratified by Senegal on July 31st, 1990. The analysis does not cover all children's rights, but those more relevant to early childhood or to the purpose of the study.

2 Rep. of Senegal / UNICEF. *Rapport de l'enquête sur les objectives de la fin de décennie*. MICS, 2000.

3 *Rapport de synthèse du Séminaire National de Lancement de l'Elaboration du DSRP*. July 2001.

4 Primature. *Programme National de prise en charge des enfants en situation de risque*. January 2000.

5 United Nations. Economic and Social Council / UNICEF. Senegal Country Note. 14 November 2000.

In spite of the binding effect of the law, 40.0% of all Senegalese under-6 year-old children are not registered. Non-registration is a much more frequent phenomenon in the countryside (53.6%) than in urban areas (25.0%)[6]. Thus, the lowest registration rates are observed in Kaolack (44.4%) and Tambacounda (46.2%), whereas Dakar records the country's highest child registration rate (82.6%)[7].

The non-registration of children thwarts any effort to make a correct estimation of the child population, as well as their distribution and characteristics. This phenomenon has, among others, a pervasive effect in the planning of educational and health programmes, and in the allocation of budgetary resources for children-related needs. A non-registered child is also more vulnerable; for instance, he or she may encounter difficulties to prove his identity, to be recognized by his or her father or mother, or to claim an inheritance.

(2) Non-discrimination

Article 2 of the CRC stipulates that the States parties shall respect and ensure the rights of the child "(...) to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status (...)". Furthermore, it urges States parties to take "(...) all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members (...)".

1) Ethnic, linguistic and religious minority children

Senegal is a diverse country in terms of ethnic and linguistic groups. Besides French –the official language–, there are six "national" languages by Presidential decree, Wolof, Sérère, Diola, Malinké, Soninké and Puular. Wolof is the predominant ethnic group (43%) and their language –together with French– is the most widely spoken. Article 1 of the new Constitution recognizes the right of each group to use their own language. Nevertheless, some minority languages such as Ashamia, Mancagne and Balante do not enjoy "national" status and are not used in education.

From a religious point of view, Senegal is a much more homogeneous country. Indeed, 95% of the population are Muslim –the other 5% being predominantly Catholic Christians. In contrast with some other African countries such as Sudan or Nigeria, there not seem to be tensions between both religious

[6] *Rapport National sur le Suivi du Sommet Mondial pour les Enfants*. December 2000.
[7] Rep. of Senegal / UNICEF. *Rapport de l'enquête sur les objectives de la fin de décennie*. MICS II, 2000.

confessions.

2) Disabled children

Concerning mentally or physically disable children, article 23 of the CRC states that such a "(...) child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community (...)".

Most of the 60,000 disable Senegalese children[8] live in the rural areas and encounter major obstacles to insert themselves into school and social life[9]. Senegalese schools and community facilities are generally thought for "normal" children and, except for sporadic humanitarian activities, there are no specific disable-oriented programs[10]. Indeed, only a handful of them have ever pursued University studies and got qualified jobs. In addition, disable children also suffer from social discrimination, lack of protection and difficult access to credit.

(3) Child exploitation

1) Child labour exploitation

Article 32 of the CRC recognizes "(...) the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development (...)". Moreover, "States parties shall in particular: (...) Provide for a minimum age or minimum ages for admission to employment: (...) Provide for appropriate regulation of the hours and conditions of employment (...)". Senegal has also ratified relevant ILO Conventions on Minimum Age (138/1973) and on the Eradication of the Worst Forms of Child Labour (182/1999).

In addition to international law instruments, Senegalese children are also protected from labour exploitation by the national Constitution and the Code du Travail, which fixes the minimum working age at 15 years, limits working hours, regulates apprenticeships, etc.

In spite of the abundant legislation, both the Government and UNICEF recognize that child labour exploitation is one of the main problems faced by Senegalese children from 5 to 14 years[11]. An official survey in 1993

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8 Latest available figure from 1998.

9 *Bulletin du Système des Nations Unies au Sénégal n°7*. August 2001

10 Not surprisingly, there are only three specialised institutions in the whole country: The National Education and Training Institute for the Blind at Thiès, the Centre Talibou Dabo in the Grand Yoff, and the Verbo-tonal Centre of Colobane.

11 *Bulletin du Système des Nations Unies au Sénégal n°7*. August 2001

considered 293,783 children from 6 to 15 years as active population: 78% working in a family business, 6% employed as apprentices, and 5% as independent workers. A more recent survey confirms that 37.6% of all children aged 5 to 14 are working, i.e. around 1,100,000 children; the percentage being much higher in the rural (43.5%) than in the urban areas (27.7%), and boys (39.4%) being slightly more affected than girls (35.7%)[12]. In addition, 12% of all children devote more than four hours a day to domestic work, which exceeds maximum recommended time and has a negative impact on school attendance.

Child labour exploitation begins early. Indeed, children from 6 to 9 years account for 47% of all child workers, mainly employed in agriculture, cattle breeding, and urban craftsmanship, whereas children from 10 to 14 represent 53% of all child workers. Significantly, most child workers are totally or partially orphans, earn a lower salary than adults, have no social protection, do not enjoy benefits such as paid holidays, and are not affiliated to any trade union[13].

In spite of a more active stand by the authorities against child labour exploitation[14], the phenomenon seems to be growing, alarmingly in some of its worst forms such as garbage recycling[15] (*boudiouman* in Wolof) or domestic work[16] (*mbindaan* in Wolof). Generally, employers neither respect the Social Security rights of child workers nor their working conditions as established by the *Code du Travail*. Furthermore, there seems to be an abuse of apprenticeships that often hides exploitation[17]. There are not specialised inspectors to combat this phenomenon and resources are clearly insufficient.

2) Commercial sexual exploitation of children (CSEC)

Article 34 of the CRC protects the child from "(...) all forms of sexual exploitation (...) the inducement or coercion of a child to engage in any unlawful sexual activity; (...) the exploitative use of children in prostitution or other unlawful sexual practices; (...) the exploitative use of children in pornographic performances and materials (...)". In addition, Article 35

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12 Ministry of the Public Service, the Employment, and Labour / ILO. *Rapport d'exécution*. January 2001.

13 Cf. Sadio, A. *Le travail des enfants au Sénégal*. Paris, 1994.

14 8,710 child workers were attended in 1999 and 20,620 in 2000.

15 In the dump of Mbeubeuss, 15 kms away from Dakar, 120 "workers" out of 400 are children under 15 years of age (ILO-IPEC, 2000).

16 41% of all domestic workers are girls, of which 12,000 are aged from 6 to 14 years (World Bank. Senegal. An Assessment of Living Conditions. May 1995).

17 One of the effects of the formal sector contraction has been a growth in the number and duration of apprenticeships, which may be taking on a more important role as a coping strategy against general economic deterioration and lack of employment opportunity.

prevents "(...) the abduction of, the sale of or traffic in children for any purpose or in any form (...)".

In addition to the CRC, there is a specific optional protocol on the Sale of Children, Child Prostitution and Child Pornography, signed by Senegal in 2000[18], which has recently, came into force. The protocol bounds States parties to typify as criminal offences subjected to punishment any violation of the rights and obligations derived from the treaty. Besides, it establishes the principle of the extraterritorial prosecution of such offences.

Officially, 20% of all prostituted women in Senegal are underage[19]. According to the NGO ENDA, the most affected sex and age segment is girls from 7 to 15 years, and most vulnerable girls are those who accompany beggars, daughters of mentally disable persons, run-away girls with no family links, and girls who live in a family where prostitution is a source of income[20].

According to UNICEF, child sex tourism –one of the forms of CSEC– has emerged as a new phenomenon and is on the increase. CSEC is particularly evident in the tourist resort of M'bour Sally and in other tourist areas such as Gorée, Ziguinchor, Kaolack and Saint-Louis.

Excepting some repressive measures at the legal level, little has been done to prevent and eradicate this phenomenon, and even less to rehabilitate the victims of CSEC. Reasons have been attributed largely to the lack of awareness and expertise on the issue, cultural taboos, lack of resources and lack of interest or political will. In March 2002, in compliance with the Stockholm Declaration and Agenda for Action (1996), Senegal finally adopted a National Action Plan against CSEC[21].

A report by ILO-IPEC on the trafficking of children in West and Central Africa states that children are being trafficked to and from Senegal to neighbouring countries to work as domestics. The report specifically states that children, particularly girls, from the Casamance, go to work as domestics in neighbouring Gambia where they are very vulnerable to CSEC. According to the Gambia office of UNICEF, young girls from Senegal go to Gambia for sex work during the peak tourist season.

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[18] Pending ratification.

[19] *Rapport de synthèse du Séminaire National de Lancement de l'Elaboration du DSRP*. July 2001.

[20] Rep. of Senegal/UNICEF. *Analyse de situation de l'enfant et de la femme au Senegal 2000*. June 2001.

[21] Senegal is the second Sub-Sahara country to adopt such a plan, the first being The Gambia Republic.

4.1.2 Specific Circumstances of Street Children and *Talibés*

According to the WHO, "street children" are both those who literally live in the street and generally have no other place to stay, and those who spend most of their time in the streets, although usually go home to sleep.

Since the worst effects crisis began to be felt, the number of street children has skyrocketed from 88,000 in 1994 to more than 310,000[22] in 2000, of which 40% are from 6 to 9 years of age, 36% from 10 to 14 years, and 24% from 15 to 18[23]. Most street children are nationals (91%), mainly from Diourbel, Thiés and Saint-Louis, although some of them (9%) come from neighbouring countries (Guinea, The Gambia, Mauritania, and Mali). The majority come from poor families and broken homes. Indeed, 34.4% have no family ties, 30.6% go to their parents' home to sleep, and 32.9% go to sleep to someone else's home[24].

Contemptuously called *faqmaan*[25], street children have no access to social amenities like shelter, educational and health facilities. This is what forces them to start precarious work in the informal sector as apprentices or hawkers, or to fall into coping strategies such as prostitution, drugs or delinquency, coming in conflict with the law and at risk of sexual abuse, AIDS, STDs, drug dependency, social violence, etc. Very often, they organise in groups to protect themselves.

Talibés are boys who study –and generally live– in a Koranic school (*daara*) under the guidance of a religious teacher (*marabout*). They are usually required to beg for food and money as a part of their religious education, in order to pay the *marabout* for the tuition and the lodging at the *daara*. The religious theory is that begging teaches both humility and independence. The final objective is to prepare them for any situation that life may bring in the future.

Very often, particularly since the beginning of the economic crisis, the begging goes beyond a moral or religious education and *talibés* spend most of time in the streets trying to collect the amount required by the *marabout* (in order to avoid a severe punishment) and not receiving the religious education they were expected to get[26]. In this case, *talibés* are both victims of economic exploitation and of mistreatment. That is when the authentic *daara* (*sëriñ daara*) becomes an abusive *daara* (*sëriñ xaalis*).

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[22] 30,000 of them in Dakar.

[23] Rep. of Senegal / UNICEF. *Analyse de situation de l'enfant et de la femme au Sénégal 2000*. June 2001.

[24] Primature. *Programme national de prise en charge des enfants en situation de risque*. January 2000.

[25] "Street children" in Wolof.

[26] According to studies conducted by the Islamic Institute in Dakar, in a 15-hour day *talibés* spend an average of 10 hours begging.

The current number of *talibés* is unknown. Nevertheless, in 1993 UNICEF estimated the number of *talibés* between 50,000 and 100,000. If the number of street children has multiplied by four since 1994, the number of *talibés* may have probably followed a very similar trend over the last decade, i.e., there could be now around 400,000. In any case, most of them are from rural areas: Thiés (24%), Louga (20%), Saint-Louis (12%) and Diourbel (12%)[27].

It is not easy to distinguish a mendicant *talibé* from a "standard" street child[28], given that both of them beg in the street for money[29]. Actually many street children were once *talibés* who could not tolerate anymore the strict discipline of a *daara* and/or the violence of a *marabout* and ran away. This does not mean that all *talibés* become street children –the decision to take the street is not only due to the rigidity of the *daara*, but more crucially to the lack of any form of family support. In any case, both street children and mendicant *talibés* "*(...) constitute the bulk of children at risk and are the expression of a deep socio-economic crisis. They are both the cause and the consequence of poverty, social exclusion, demographic pressure, rural exodus, urban explosion, and family breakdown (...)*"[30].

For centuries, *daaras* have played a crucial role in the education of Senegalese boys. Indeed, they were the only educational institutions for children in pre-colonial times. Unfortunately, lack of resources and a certain abandonment by their communities –more accentuated since the beginning of the economic crisis–, have contributed to a progressive deterioration of the living conditions and educational standards[31] in most *daaras*.

Certainly, living conditions at *daaras* are generally inadequate in terms of facilities, hygiene, food, sanitation, water, electricity, etc. Nevertheless, the exemplary *daara* of Malika[32] proves that it does not necessarily have to be like that. From an educational point of view, *daaras* that combine religious teaching with a basic education curriculum, including languages, are more likely to increase *talibés*' opportunities to find better jobs –and, therefore, to overcome poverty. It may be argued that most *marabouts* are not adequately prepared to teach a basic education curriculum and that they do not even provide *talibés* with basic educational materials (students are often given just a wooden

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[27] World Bank. Senegal. An Assessment of Living Conditions. May 1995.

[28] The Country Office of UNESCO considers both situations as the same phenomenon.

[29] Interestingly enough, the *Code Penal* outlaws mendicity except in the cases foreseen by religion.

[30] *Diagnostique de la pauvreté au Sénégal*. Document de travail n° 3. March 2001.

[31] 80% of *talibés* are illiterate (World Bank. Senegal. An Assessment of Living Conditions. May, 1995)

[32] Established in 1980, it has 124 *talibés* (66 boarders) from low-income families who receive Koranic and academic education as well as vocational training. The living conditions of *talibés* are adequate; they neither beg nor work, enjoy free medical care, and are properly fed.

plank). Surely, but with a committed will and the necessary involvement of all stakeholders, solutions could also be found to solve these problems –In this sense, some positive signs are already coming from both the government[33] and the *daaras*[34].

The first donor programs targeting *talibés* and street children began in 1992 and 1998, respectively[35], but the lack of continuity with similar Senegalese programs[36] and their assistance-oriented approach, have produced a duplication of efforts and diminished their impact. The phenomenon was seen as a social emergency that required immediate action, but without putting into place preventive measures and not dealing with the structural causes of the problem.

Another issue that gets our attention is the unanimous consideration of exploited mendicant *talibés* as "innocent victims", whereas street children are generally perceived as "riffraff", "pickpockets" or "delinquents". Needless to say that in both cases we are talking of children, whose most basic rights, are brutally violated and who require equal protection.

4.2 Senegalese Policies and Approaches to Children's Rights and Welfare

4.2.1 Legal Framework

(1) Relevant international laws

All major international and regional human rights instruments such as the Universal Declaration of Human Rights of 1949, the International Covenant on Civil and Political Rights of 1966, the International Covenant on Economic, Social and Cultural Rights of 1966, the UN Convention against Torture of 1984, and the African Chart of Human and Peoples' Rights of 1984, have been ratified by Senegal.

Senegal is also a State party of specific instruments against racial and gender discrimination such as the ILO Convention on Equal Remuneration (100/1951), the ILO Convention concerning Discrimination in Respect of Employment and Occupation (111/1958), the UN Convention on the Elimination of All Forms of Racial Discrimination of 1965, and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979.

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[33] See point 3.2.2 (3) below.

[34] See point 3.4.1 (3), letter "a", §3 below.

[35] UNICEF *"Projet de réhabilitation des droits des talibés"* (1992-1996) / *"Programme d'appui aux enfants travailleurs et aux enfants de la rue"* (1998).

[36] For instance, the *"Fonds d'aide à l'enfance déshéritée et aux actions d'éducation non conventionnelle"* of the Ministry of Social Development and National Solidarity.

Concerning children's rights, Senegal has also ratified major relevant international and regional instruments, in particular:

1) General

   UN Convention on the Rights of the Child (CRC) of 1989, ratified in 1990.

   African Chart on Children's Rights and Welfare of 1990, ratified in 1998.

2) Child protection and international adoptions

   Hague Convention on the Protection of Children and Co-operation in Respect of Inter-country Adoption, ratified in 1999.

3) Abolition of child labour

   ILO Convention on Minimum Age for Admission to Work (138/1973), ratified in 1999.

   ILO Convention on Worst Forms of Child Labour (182/1999), ratified in 2000.

4) Commercial Sexual Exploitation of Children

   Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography, signed in 2000 (pending ratification)

5) Children Victims of Armed Conflict

   Optional Protocol to the CRC on the Involvement of Children in Armed Conflict, signed in 2000 (pending ratification)

6) Children in Conflict with the Law

   UN Rules for the Administration of Juvenile Justice (Beijing Rules) of 1985

   UN Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines) of 1990

   UN Rules for the Protection of Juveniles Deprived of their Liberty of 1990

As can be seen above, Senegal is an exemplary country in terms of participation in major international and regional human rights, non-discrimination and children rights instruments. Unfortunately, ratifying an instrument of international law does not guarantee the effective protection of the rights that it consecrates. It is also required a committed political will, adequate means and resources, the active participation and involvement of all stakeholders, and, of course, the technical capacity and expertise to translate treaties into realities.

A clear example of this "dissonance" is the CRC, the basic and most important instrument for the protection of children's rights. Immediately after its ratification and entry into force in 1990, Senegal established a working group in charge of adapting the

dispositions contained in the CRC to the national context[37]. Twelve years later, the national *Code de l'Enfance* is still a proposal, although the Ministry of the Family and Early Childhood has a draft "terms of reference". Nevertheless, following a treaty obligation, in 1994 Senegal submitted an Initial Report on the Application of the CRC[38], and a Progress Report in 1999[39].

(2) Relevant national laws, rules and regulations

Senegal has also been prolific enacting national laws, rules and regulations related to human rights, and more particularly to women and children's rights. Obviously, the most important is the new Constitution of January 2001, which makes explicit references to both the CRC and the CEDAW, and pays particular attention to most vulnerable groups.

In the field of criminal law, the most relevant pieces of legislation are the *Code Penal*, which punish most violations of children's rights[40], and the *Code de Procedure Penal*, which establishes a specific juvenile justice administration for delinquent children[41]. More recently, Law 05-1999 modifies some dispositions of the *Code Penal* and specifically punishes all forms of FGM, sexual harassment, paedophilia, sexual aggression, violence against children and the incitement of a minor to debauchery, although, as we have seen, this law is not properly enforced.

The *Code de la Famille* of 1972, which provides the legal basis for most women and children's rights, contains some dispositions that are in clear contradiction with the CRC and the CEDAW such as the impossibility for a child to claim parental recognition in a Court of Justice, the discrimination in succession rules of women and of children born outside marriage, the parental authority, which is only granted to the father; and the election of the marital status –an exclusive privilege of the husband.

The majority of rules, however, are in the field of labour law. The most relevant are the *Code du Travail* of 1997, which establishes a minimum age for admission to employment[42], conditions and modalities of apprenticeships, and the right to labour breaks; and the Social Security Code of 1973, which regulates the right to social security, the protection of apprentices, and the right to receive family subsidies up to 18

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37 MSDNS / UNICEF. *Etude comparative CDE et environnement législatif, social et institutionnel sénégalais*, 1996.

38 The Committee warned Senegal against the alarming increase in child workers and complained about the non-compulsory character of primary education.

39 Senegal informed of special measures taken on children in conflict with the law, child labour and CSEC, fight against drug addiction among children, child mistreatment, and street children.

40 It does not contain, however, any disposition punishing the sale of a child or trafficking on children

41 Although a child's testimony in a Court of Justice is not valid in any case

42 15 years (18 for hazardous or unhealthy jobs).

years of age. Two other minor laws regulate domestic work (Ministerial Decree 72-3006) and child labour in agriculture (Decree 61-347).

As can be seen above, the legal framework at national level is abundant, although quite disperse and sometimes incoherent with international treaties subscribed by Senegal. In any case, the problem lies more in the non-enforcement of the law than in its juridical weaknesses. Once again, the political will must be accompanied with adequate means and resources, stakeholder involvement, and technical assistance to effectively guarantee the rights granted by the law.

4.2.2 Institutional Set-up and Policies

First governmental activities in favour of children at risk were carried out in the framework of the *Plan d'Action Nationale pour l'Enfance 1991-2000* (PANE). In that context, Senegal launched in 1997 a *Plan de Lutte contre la Pauvreté* (PLP), aimed at halving the level of poverty by 2015[43]. A Programme for the Elimination of Child Labour followed this plan in 1998 and an Attention Programme for Children at Risk, with emphasis on equal opportunities, in 1999.

(1) Ministry of the Family and Early Childhood (MFEC)

Early Childhood Development (ECD) has been a political priority since the new Government got to power in 2000. Thus, in March 2001 a specific Early Childhood and Children's Rights Division was created within the MFEC. Almost simultaneously, a new ECD initiative –the *Case des Tout-Petits*– was launched[44].

Afterward, the MFEC was restructured into Delegated Ministry of Early Childhood and CTP in December 2003 and then transferred to under the Presidential Office in April 2004.

(2) Ministry of Family, Social Development and National Solidarity (MFSDNS)

Through 32 *Centres de Promotion et de Réinsertion Sociale* (CPRS) scattered throughout the country, the *Division of Social Action* carries out child protection and vocational training activities. Initially thought to care for the destitute (*talibés*, orphans, disable children, victims of sexual exploitation, etc.), many of them serve today as social centres, places for child weighting and nutrition.

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[43] Unfortunately, the poverty trend since the launching of the plan has been rather negative, as we have seen above. (Cf. *Rapport national sur le suivi du Sommet Mondial pour les Enfants*. December 2000)

[44] The Case des Tout-Petits Initiative is discussed in Chapter 2.

In 1992, in association with UNICEF and in the framework of the *Projet de réhabilitation des droits des talibés*, the Division of Social Action created 41 *Classes Communautaires*. This kind of modern *daaras*, which combine primary and Koranic education, have proved very useful in preventing the exodus of *talibés* to the cities and in facilitating their future insertion into the labour market. Since the end of the project in 1998, their support to *talibés* has consisted of 40 million FCFA a year in food (basically rice) for 180 *daaras*, and a national awareness day in April (*Talibés'* National Day). If according to the Division's estimations there are around 400,000 *talibés* and between 2,500 and 3,000 *daaras*, this support is clearly insufficient.

With regard to street children, the Division has cooperated with UNICEF since 1992. Initially, through a series of studies and research activities (1992-1996) and later within the framework of the project *Appui aux enfants travailleurs et aux enfants de la rue* (1997-1998), involving around 60 national institutions, mainly attention centres and NGOs. Since 1998, however, the Division does not carry out any specific activity for street children, although following Presidential indications, they have recently designed a proposal with three objectives: reintegration into their families of origin, promotion of adoptions, and enrolment in non-formal education schools. Unfortunately, the program lacks funding and there is not synergy with the actions of other Divisions and Ministries.

(3) Delegated Ministry of Technical Education and Vocational Training & Delegated Ministry of Literacy Promotion, National Languages and French-speaking World under the Ministry of Education

The alarming situation of *talibés*[45], has forced the *Division of Arab Language* to have a look for the first time at the non-formal education provided in the *daaras*[46]. In association with UNICEF, they have launched a pilot project (2002-2006) that combines religious with trilingual education (Arabic, French and the national language of the area) and vocational training. The project has selected 80 test-*daaras* in four different regions of the country[47]. In order to ensure the sustainability of the action and to avoid *talibés* mendacity, the project foresees income-generating activities and the set-up of steering committees in each community.

(4) Ministry of Justice

Created in 1965, the *Division of Education and Social Protection* is responsible for adopted children, children in conflict with the law, and children in moral danger (abandoned, sexually exploited, street children, etc.). It works at three different levels

[45] See point 3.1.3 on street children and *talibés* above.
[46] Note that religion at the *daaras* is taught in Arabic, the language of the Koran.
[47] 25 in Diourbel, 15 in Thiès, 20 in Kaolack and 20 in Dakar.

(State, society and family) and in five realms: legislative, criminal, civil, economic and cultural. It is in charge of the following centres:

AEMO[48] Centres. Created in 1974, they are oriented towards protection. There are currently 14 such centres, four of them in the Dakar area.

Social Adaptation Centres. Exclusively for males (up to 21 years), these centres are oriented towards social reinsertion through treatment and vocational training. There are only two in the country (Nianning and Sébikotane).

Polyvalent Centres. Created in 1996, they offer primary and secondary education to children at risk and children expelled from the formal education system. There are three in the country, two of them in Dakar.

Juvenile Detention Centres. There is just one, and it is only for boys. Detained girls are kept in a special module at the women's prison, most of them condemned for "prostitution"[49]

Safeguard Centres: Open institutions, they give refuge to children in moral danger. There are four in the country (Pikine, Cambèrene, Thiés and Ziguinchor).

Despite having numerous centres with different modalities of attention, the Division faces cumbersome problems: budget is scarce, most centres are in the Dakar area, there are no reliable statistics, and there is almost no coordination with other Divisions at the different Ministries[50].

(5) Ministry of Civil Service, Labour and Employment

This Ministry has been very active in the fight against child labour. They included this problem in the first PANE (1991-2000), recommending further research for a better understanding of the phenomenon. In 1994 took part in the elaboration of the *Plan d'action pour l'amelioration de la condition des enfants qui travaillent*; have ratified major international child labour protection instruments (such as ILO Conventions 138 and 182[51]), and have taken other important legislative initiatives at the national level (such as the revision in 1997 of the *Code du Travail*, raising the minimum age for

[48] *Action Educative en Milieu Ouvert.*

[49] This is probably the most outrageous violation of the CRC, which considers girls sexually exploited as victims, and never as criminals.

[50] According to the person responsible, coordination should be closer with the MFEC, the Ministry of Home Affairs, and the National Police.

[51] See point 3.2.1 (1) above.

admission to work at 15 years, or the draft decree identifying the worst forms of child labour[52]). Since 1997, this Ministry chairs the Steering Committee in charge of the National Programme to Eradicate Child Labour Exploitation, sponsored by ILO-IPEC.

Unfortunately, the Ministry has neither a Child Worker Protection Unit nor specialised inspectors in child labour issues; and some other legislative problems at the national level have not been solved yet such as the existing gap between the primary school graduating age (12 years) and the minimum age for admission to work (15 years). Most child workers are unaware of their rights, indicating that much needs still to be done in terms of information.

4.2.3 Activities of Selected Civil Society Organizations

(1) ECOPOLE

As the Senegalese section of ENDA Tiers Monde, ECOPOLE works with street children, child workers and in the field of CSEC[53]. In particular, the organisation provides shelter, medical care, formal and non-formal education, as well as counselling to street children. Since 1985, they carry out activities to prevent child labour exploitation, mainly promoting the organisation of self-employed child workers and domestic girl workers. Gender-sensitive, they actively promote girls' organisation and participation as well as awareness-raising campaigns on girls' rights such as the "Week of the Girl".

Active mainly in the marginal, urban areas of Dakar[54], ECOPOLE bases its fruitful strategy in partnerships with the local communities, which have resulted in the creation of 240 local organisations and 6 autonomous centres. Among its most successful experiences, the *Formations de Coin de Rue* (FCR), addressed to non-enrolled children from 3 to 7 years[55], and the *Journées aérées*, socio-educative happenings for children from 9 to 14 years[56], have stood out.

Besides the revenue provided by income-generating activities, they also get funding from several governmental bilateral donors (Switzerland, The Netherlands, Austria,

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[52] According to Article 4.1 of ILO Convention 182, Senegal must submit to the ILO a list of the worst forms of child labour in the country. The draft list includes: mendicity on someone else's account, bound or slave labour, arduous jobs, hazardous activities, public transportation of goods or persons, garbage recycling, and animal slaughtering.

[53] They are the focal point of ECPAT in Senegal.

[54] In Tambacounda they carry out with "*ENDA-Jeunesse action*" actions in favour of child workers.

[55] Due to an intensive awareness-raising activity and to the active involvement of the beneficiaries, the initiative has grown from 3 schools in 1992 to more than 57 in 2001, with more than 10,000 enrolled children and 240 teachers.

[56] Since 1997, more than 20,000 children have participated.

Luxembourg and Japan) and multilateral organisations (World Bank, UNESCO, and ILO-IPEC).

(2) Espoir sans Frontièrs

Founded in 1988, "*Espoir sans frontières*" used to publish the journal *Les enfants martyrs*. They have carried out medicine recycling activities and awareness raising campaigns on the situation of children at risk –similar activities to those carried out in Cameroon, Haiti and Brazil.

Since 1994, they manage the *Keur Sokhna Soukeyma* a preschool centre in the middle-income neighbourhood of *Sacré Coeur* in Dakar. With 28 children enrolled, distributed in three sections according to their age, its peculiarity is that it allows the enrolment of 12 poor children free thanks to the monthly fee paid by the other 16 children (10,000 FCFA). Besides, they take in every years around 15 children referred by the Paediatric Psychology Unit of the University Hospital of Fann. Finally, they offer free medical consultations and social counselling to anyone in need, thanks to the voluntary support of five doctors, two social workers and one pharmacist[57]. Their main problem is their precarious financial situation.

4.3 International Cooperation in Children's Right and Welfare

4.3.1 Multilateral Organizations

(1) UNICEF

Soon after the World Summit for Children in 1990, and coinciding with the first *Plan d'Action Nationale pour l'Enfance* (PANE), UNICEF launched the first phase of the *Programme des enfants en situation difficile* (1992-1996), focusing on *talibés* (*Projet de réhabilitation des droits des talibés*) as well as on street and working children (*Études et recherches*).

The second phase of this program, the *Program des enfants à risque* (1997-2001), developed further activities in favor of children at risk[58]. Since 1998, *talibés* were included in the *Projet de lutte contre les pires formes de travail.*

The third phase of the program, the Children's Rights Promotion and Protection of Children at Risk Program (2002-2006), includes a "children's rights" dimension and is also divided into two projects: The Elimination of the Worst Forms of Child Labour

[57] From 1998 a 2001, more than 5,500 persons in extreme need have benefited from their services.
[58] It benefited 15,000 girl domestic workers, 15,000 apprentices and 10,000 street children.

Project[59] (including sexual exploitation), focusing on mendicant children, *talibés*, domestic workers, victims of CSEC, and victims of the Casamance conflict; and the Strengthening Protection of and Combating Violence against Children Project, focusing on awareness-raising campaigns on children's rights and on legislative harmonization.

(2) UNESCO

The main activity of the Dakar Regional Office (BREDA)[60] is the implementation of the Basic Education for All Program (2000-2016)[61]. The peculiarity of the Senegal Office is a specific support to ECD activities. In line with this commitment, they have already financed the construction of three *Case des Tout-Petits*[62], are collaborating with the Ministry of Education in both the training of the technical personnel and the elaboration of the educational materials, and will cooperate with parents in the framework of the upcoming *Projet de pré-alphabétisation des jeunes enfants à la maison* (2002-2004).

Budgetary constraints have forced the Office to limit the Senegal Programme (2002-2004), focusing on vulnerable children, to the support of other institution's ongoing actions. Thus, they will cooperate with the Ministry of Justice in the strengthening of the educational aspects of the two Polyvalent Centres that the Division of Education and Social Protection has in Dakar[63].

(3) ILO-IPEC

Thanks to the technical and financial support of the ILO-IPEC, the National Programme to Eradicate Child Labour Exploitation[64] began its activities in 1998, concentrating in Dakar, Saint-Louis, Kaolack, Fatick and Ziguinchor. During the first two years, targeted children were girl domestic workers, rural child workers, and ragman children. Since 2000, it also includes victims of CSEC and of extreme forms of labour exploitation. By June 2001, 28,000 children had directly benefited from the program and 47,800 indirectly.

Their strategy is mainly based in prevention policies and programmes through the active involvement of the Government and social institutions in the improvement of living

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59 In collaboration with the Italian Co-operation.

60 Responsible for Senegal, Cape Verde, Guinea-Bissau, The Gambia, Sierra Leone and Liberia

61 The Basic Education for All Programme comes under the PANE, the Jom Tien Declaration on Education for All, the Dakar Declaration of the World Forum on Education, and the vision of children-friendly schools. It will also use other non-conventional approaches such as recourse to basic community schools and *daaras*.

62 Although UNESCO theoretically advocates for the integration of disable and mentally handicapped children in regular schools, their *Case des Tout-Petits* are not disable-friendly and they have no plans for introducing a disable-oriented approach.

63 Cf. Point 3.2.2. (4) above.

64 The Steering Committee, chaired by the Ministry of Labour, includes several other Ministries, relevant NGOs, Trade Unions, UNDP, Municipalities, the Royal Embassy of The Netherlands, and UNICEF.

conditions for working children and their families, research activities, social awareness, and the priority eradication of the worst forms of child labour. They do not carry out any specific support programme for *talibés*, given that the ILO (in conformity with article 32 of the CRC[65] and with article 3.d. of ILO Convention 182[66]) considers that begging – particularly, on someone else's account– is harmful to the child's development[67].

The most remarkable achievements of ILO-IPEC in Senegal have been a more protective legislation[68], several educational and training projects[69], the involvement of trade unions[70], the inclusion of child labour issues in statistical surveys and research[71], the promotion of social partnership strategies, support to child workers' organisations, and effective awareness-raising campaigns[72]. They are currently preparing a Time-Bound Programme (TBP) aimed at obtaining concrete results in the eradication of the worst forms of child labour within a limited timeframe.

(4) World Bank

The involvement of the World Bank in the fight against poverty consisted in two specific projects: The Human Resources Development Project, which lasted until 1997, and the Social Development Fund. These projects, concentrating mainly in Saint-Louis, Kaolack, Ziguinchor, Fatick and Louga, supported actions for the improvement of women's labour status such as construction/rehabilitation of houses, credit systems similar to the traditional *tontines*, functional alphabetisation activities, and training/empowerment in income-generating activities.

The Quality Education for All Programme (QEFA), which comes in support of the first phase of the *Programme Décennal de l'Education et de la Formation* 2000-2010 (PDEF), has specific children-at-risk components that aim at increasing access to education through support to ECD initiatives (mainly, construction of centres) and to the integration of children with special needs into regular school programmes.

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65 Cf. Point 3.1.2. (7), letter "a" above.

66 Article 3.d. of ILO Convention 182/1999 includes among the worst forms of child labour "*(...) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children (...)*".

67 The draft list drawn by Senegal (cf. point 3.2.2 (5) above) of the worst forms of child labour includes "begging on someone else's account". If the list is finally approved, Senegal will have to abolish this practice.

68 Although the informal sector, which employs large numbers of children, is not covered yet.

69 Such as the Support Programme to the School Enrolment of Girl Domestic Workers or an awareness-raising campaign through a mass media programme, both in Kaolack.

70 The two major Senegalese trade unions (the *Confédération Nationale des Travailleurs du Sénégal* and the *Union Nationale des Syndicats Autonomes du Sénégal*) have both signed a declaration against child labour.

71 Such as the *Recensement National sur la Population et l'Habitat*, the *MICS II*, and the *Recensement agricole*.

72 Organisations such as Amnesty International and the African Human Rights Network have recently included child labour exploitation in their action programmes.

(5) African Development Bank

In association with the Ministry of Social Development and National Solidarity and with funding provided by Nordic Development Fund, the ADB also participated in the fight against poverty, through the *Projet d'Appui aux Groupements de Promotion Féminine* (PAGPF). Among some other women's economic empowerment activities, the project created 152 kindergartens (for children from 2 to 7 years of age) in Diourbel, Kolda, Tambacounda and Thiés, which received more than 19,000 children. Their approach was based in community responsibility and in the respect of the child's environment. A new phase was launched in 2000, with the name *Projet de lutte contra la pauvreté*.

4.3.2 Bilateral Donors

(1) Luxembourg

Luxembourg's official development aid to Senegal amounted to 1,300 million FCFA in 2000 and is concentrated in Dakar, Saint-Louis, Thiés and Louga. Their main objective is the alleviation of poverty and their areas of cooperation are the strengthening of civil society, water supply in rural areas, health, and education.

Within education, technical vocational training and early childhood education were declared priority areas in 2000. Soon after, they have carried out a comprehensive study on the national preschool education policy. If they finally decide to support the *Case de Tout-Petits* initiative, their model will be similar to that of JICA, i.e. infrastructure and local participation, prioritising teacher training and the pedagogical aspects of the curricula.

(2) Other donors

Bilateral aid is mainly channelled through international organizations and international NGOs. Thus, The Netherlands funds the IPEC Program in Senegal since 1998 and Italy supports the UNICEF Project to Eliminate the Worst Forms of Child Labour (2002-2006).

Some other bilateral donors may opt for direct financial and technical support to governmental programs and institutions. For instance, Canada has funded the Community-based Schools of the Ministry of Education[73], whereas Japan and Taiwan are supporting the *Case de Tout-Petits* initiative of the MFEC –and this Study, which is funded by JICA.

[73] A new phase is about to be launched.

Finally, bilateral aid may also be channelled through local or international NGOs. This is the case of Switzerland, which regularly funds ECOPOLE activities, and of the United States, which supports the actions of Plan International in the country (since 1996).

Over the last decade, most bilateral aid to children-related needs has been devoted to children in general, paying little attention to early childhood or children at risk issues.

4.3.3 Selected International NGOs

(1) Defence for Children International (DCI)

Officially recognised in 1991, their objectives are to increase the awareness on children's rights; to foster, evaluate and monitor the implementation of children's rights as set out in international law; and to encourage cooperation to improve the mechanisms of protecting children's rights. They also offer legal aid to children, especially those in conflict with the law.

With the assistance of UNICEF (1996-1997), they conducted training workshops on children in conflict with the law for social workers, police, judges, teachers, parents, prison officers and community leaders. In 1998 –also with UNICEF-, they carried out an investigation on the same issue and implemented an awareness-raising program on children who work as apprentices. In 1999, they persuaded the presidential candidates to have a special children's programme as part of their presidential campaign manifesto. In 2000, with the help of ECPAT International and the Ministry of Family, Social Action and National Solidarity, they organized the West African Regional Consultation on Networking for the implementation of the Stockholm Declaration.

(2) Plan International

Their presence in Senegal dates back to 1982, since when they have been working in the regions of Dakar, Thiés, Saint-Louis, Louga and Kaolack. Their main goal is the improvement of children's living conditions, and their first source of finance is the international sponsoring of children –up to date, 35,000 children.

Their actions in favour of early childhood include the creation of 13 *Centres d'éveil*. These preschool institutions divide the responsibility of their functioning between the local community (provides the infrastructure, and is also in charge of selecting –and paying– the mother-educators[74]) and the Ministry of the Family and Early Childhood

[74] Alternate of the teacher, she must fulfil two conditions: being literate (either in French or in the national language of the area) and have a proved inclination to work with children. She is responsible for elaborating educational

(trains the mother-educators[75], monitors the pedagogic performance of the centres, and evaluates the experience with the participation of all stakeholders), supported by Plan International, which also supplies the equipment. As in the case of the *Case des Tout-Petits*, these centres also incorporate health and nutrition components. In order to ensure the sustainability of their actions, they have launched a series of micro-projects and a representative Steering Committee is responsible for the management.

The first children-at-risk programme of Plan International in Senegal was launched last year, when they began to cooperate with ILO-IPEC in the framework of the Programme for the Prevention of Child Labour in Rural Areas. The first phase (from March 2001 to January 2002) has consisted of a qualitative research study on the phenomenon, and they plan to continue this cooperation in an upcoming second phase.

4.4 Study at the Regional Level: Kaolack and Tambacounda

4.4.1 Children's Rights, Institutional Set-up and Civil Society Organizations

(1) Brief review on children's rights and welfare in Kaolack and Tambacounda[76]

Almost two thirds (63.9%) of all rural Senegalese households have never heard of the rights of the child, compared to "only" 44.6% in urban areas. Tambacounda has one of the country's highest rates of non-knowledge (65.7%), whereas Kaolack –slightly less rural– ranks in the middle (57.6%), both far away from Dakar's rate (42,7%)[77].

There seems to be a correlation between poverty and unawareness of children's rights. Indeed, Tambacounda and Kaolack register two of the country's highest poverty rates, 45.6% and 45.4% respectively[78]. Remoteness of Tambacounda and significantly lower adult literacy rate (24%, compared to 36% in Kaolack), may also explain its even greater ignorance of children's rights.

Concerning birth registration, Kaolack (44,4%), Tambacounda (46,2%) and Louga (46,3%) are the three regions with the country's lowest rates, well below the national average (60.9%). Most common reasons argued for the non-registration of children are "long distance to the closest registration office" (21.7% in Tambacounda),

materials and toys. Since 1999, 39 mother-educators have been trained.

[75] Plan International is planning the introduction of a new training module in special education.

[76] With regard to Early Childhood Education and Early Childhood Health & Nutrition in these regions, please see chapters 4th and 5th of this report, respectively.

[77] Rep. of Senegal / UNICEF. *Rapport de l'enquête sur les objectives de la fin de décennie*. MICS, 2000

[78] *Plan régional de Développement Intégré de Kaolack 2000-2005*. Janvier, 2000

"unawareness of the obligation" (16.8% in Kaolack and 11.8% in Tambacounda), and "cost of the registration" (11.2% in Tambacounda)[79].

Gender discrimination is also more accentuated in rural than in urban areas, not just in terms of primary school enrolment, but also in early marriage and early pregnancy rates, particularly in Tambacounda. Indeed, average marriage age for girls in this region is only 15.8 years, i.e. the country's lowest rate and even below the minimum legal age to marry, which is set at 16 years. Child mothers (15-18 years) also account for 20.6% of all mothers in Kaolack and 25.3% in Tambacounda, the national average being 21.0%[80].

With regard to children at risk, Kaolack has the country's highest rate of child labour (46.8%), mainly in the groundnut industry[81] and in the domestic work sector. Latest surveys indicate that around 330,000 children (from 5 to 15 years of age) are working in Kaolack, and 160,000 in Tambacounda[82]. As in the rest of the country, there are no reliable data for *talibés*, but current estimations indicate that the number of *daaras* in the region of Kaolack is around 500, compared to only 50 in the Department of Tambacounda.

(2) Institutional Set-up

By virtue of Law 03/1996[83], regional services are theoretically responsible for administering all programs in favour of the early childhood in their respective regions, whereas central services are in charge of the coordination of actions at the national level. Unfortunately, the transmission of this responsibility to the local communities has not been accompanied with a simultaneous transmission of adequate financial[84] and human[85] resources to implement it. Thus, preventing local communities from effectively take over the administration of the different program.

The Division of Social Action of the MFSDNS encounters similar problems in both regions. Their office in Kaolack participated in the *Project de rehabilitation des droits des talibés* de UNICEF (1992-1996), supporting three *daaras* in the region. A succession of problems (delays in food delivery, resistance from some *marabouts*, lacks of sustainability of most micro-projects) condemned the initiative to failure. In Tambacounda, although there are no specific projects targeting *talibés*, the Division has

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79 Rep. of Senegal / UNICEF. *Rapport de l'enquête sur les objectives de la fin de décennie*. MICS, 2000

80 Ministry of Economy. *Santé Familiale et Population. Région de Kaolack, 1998.*

81 Seeding, fertilising, fumigating, harvesting, processing, packing, transporting, transforming, distributing…

82 Rep. of Senegal / UNICEF. *Rapport de l'enquête sur les objectives de la fin de décennie*. MICS, 2000

83 Law 03/1996 establishes the decentralisation of government services to the local communities.

84 Current budget does not cover operational costs.

85 Most Regional Offices have less than three persons and most Divisions just one.

proposed the creation of a new vocational training centre oriented towards all categories of children at risk.

The regional offices of the *Division of Arab Language* of the MTEVTLLL have not supervised the non-formal education provided in the *daaras* until very recently. Indeed, since this year 20 *daaras* of Kaolack will participate in a UNICEF-sponsored pilot project[86] coordinated by this Division. In the case of Tambacounda, the Governor has also expressed his interest in supervising said centres, although he regrets not having the budget for an attention project.

With regard to the Division of Education and Social Protection of the Ministry of Justice, they have one AEMO Centre[87] in each region. Their main problem, besides scarce budget, is not having separated sections and programmes for "children in conflict with the law" and "children in moral danger"[88].

(3) Activities of civil society organizations

1) Kaolack

Since 1989, "Plan International" is present in the rural areas of the region, where they have established three Centres d'Éveil[89]. They are also involved in the Children's Rights Education Project, sponsored by the Red Cross and coordinated by the *Inspection de l'Éducation Nationale* (IDEN); in the USAID-funded *Programme de survie de l'enfant*, and in the creation of eight Community-based schools (for children 9 to 14 years) financed by the Canada International Development Agency (CIDA). In cooperation with ILO-IPEC, they are participating in the Programme for the Prevention of Child Labour in Rural Areas, improving living conditions in several *daaras*.

The *"Centre Emmanuel"* provides 30 street boys (from 6 to 17 yeas) with lodging –not food – in two houses[90], free medical care[91], and education, with objective of reintegrating them into their families. They receive funding from "Aimer" and "CEDO", two French NGOs. Since 1999, they have served 325 children, most of them from other regions, who had generally run-away from the violence of either their families or their *daaras*.

The *"Union des Maîtres des Ecoles Coraniques"* is a recent initiative

[86] See point 3.3.2 (3)
[87] See point 3.3.2 (4)
[88] The centre in Kaolack hosts 54 minors (20 of them in open regime), and the centre in Tambacounda 20. In this last town there are also 15 boys in a special module of the Detention and Correction House (MAC).
[89] See also point 3.3.3 (2) above.
[90] One family-type home with capacity for 12 children, and an "open centre" for 25 children.
[91] Provided by the Catholic Sisters of Cahone.

launched in 2000 by a group of *marabouts*, whose objective is the improvement of living and educational conditions in the *daaras*. Their first tangible achievements have been the granting of discounts in the acquisition of medicines.

2) Tambacounda

Since 1999, the association *"La Lumiére"* serves children at risk through a series of poverty alleviation activities and actions against social exclusion. They have also pursued some research activities on street children and *talibés*. Their main source of funding is a preschool centre that offers education to young children in need in exchange of a very low monthly fee (1,000 FCFA)[92]. Their most ambitious idea, for which they are currently looking for funding, is the creation of a multifunctional centre that would allow them to provide an integral assistance to children at risk of the area.

4.4.2 Analysis of the Results of the Surveys on Street Children, *Talibés*, and *Daaras*

The inexistence of reliable data on the actual situation of street children, *talibés* and *daaras* in these regions and the need to have a clear understanding of the problem, took the JICA study team to design a series of questionnaires on the issue and to subcontract a Senegalese consulting firm to conduct surveys in the field. Four surveys were thus conducted in January-February 2002, one in Tambacounda (on *talibés*), and three in Kaolack (on *talibés*, *daaras* and street children). Samples included 21 street children, 66 *talibés* (42 in Kaolack and 24 in Tambacounda) and 30 *daaras*.

In the next paragraphs, an analytical summary of the main findings of these surveys is provided. The detailed results –including graphs and specific comments on each question– as well as the background and the methodology of the investigation can be found in a separated report, together with the technical data of the surveys and copies of the questionnaires.

(1) Street children

The large majority (81%) of interviewed street children in Kaolack are boys between 10 and 15 years old, the rest (19%) being also boys, but between 15 and 18 years of age. This does not mean that there are neither younger nor girl street children in Kaolack[93], but simply that they were not found the day of the survey.

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[92] The number of children has grown from 40 in 1999 to 105 in 2001.

[93] Actually, even children of less than 6 years of age can be seen in the streets of Kaolack, although they are generally accompanied by their "street mothers", generally begging. On contrast, girl street children are very rare.

Very few of them come from Kaolack City (less than 5%), but rather from Dakar (38.1%), rural Kaolack (14.3%) or neighbouring regions. Three elements must be considered to explain why so many of them come from Dakar. Firstly, because many parents in Dakar, particularly those immigrated from rural Senegal, who cannot satisfy the basic needs of their children in the city often send them away either to their villages of origin (mostly girls) or to a *daara* at the care of a *marabout* (boys only). Secondly, because Kaolack is a traditional place for religious education, counting more *daaras* than many other regions of the country[94]. And finally, because the great majority of these children (95.2%) took the street running away from either a repressive *daara* (47.6%) or a violent family environment (47.6%).

With regard to their family situation, practically all of these street children are alone in the street, where they have usually been for less than five years (95%). They generally come from large families (more than four siblings), whose fathers are craftsmen, traders or work in the primary sector (agriculture, fishing, cattle breeding), although very few of them (less than 15%) have any contact with their parents, either regular or sporadic. Sadly enough, for two thirds of them (66.7%) their best memory ever is the lost "life with their parents". Even if most street children (85%) consider the school a "good thing", only one out of three have ever entered a classroom.

Less than one quarter (23.8%) of street children in Kaolack have regular meals, although only the same proportion of them admit being usually hungry. They normally spend the morning "working" (57%) or "wandering about" (38%), the afternoon also "wandering about" (43%) or "begging" (33%), and the evenings "going to the movies" (43%) or again "wandering about" (33%). Most of them (75%) spend the night generally in the same place, usually in "the street" (29%) or in a public place (29%) such as "the train station" or "the bus terminal", although over one third of them (37%) go to sleep to the *Centre Emmanuel*, a charity[95]. They commonly "do their business" in the street.

Almost half of them (48%) affirm having had a "bad experience" during the night, mainly robbery (60%) or aggression (20%). On contrast, less than one fifth of them (19%) admit having had "problems with the police", in general also for robbery (75%). More than half (57%) of the street children of Kaolack are somehow organised, the

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[94] This is because in Kaolack there are two religious places (Prokhane and Medina Baye), of particular importance for the two Islamic brotherhoods of the country, the *Mouriddiya* and *Tidianiyya*, respectively. A branch of this last brotherhood called *Niasséne* is also very active in Kaolack, which also helps to explain the large number of *daaras* in the region (over 500 out of 2,500 in the country).

[95] See point 3.4.1 (3), letter "a" §2 above.

majority with the purpose of mutual care and support (77.8%), although some of them confess being organised for robbery (11.1%).

Practically all of them know what a *daara* is. Among the disadvantages of not being in a *daara*, they mention with the same frequency "not having a place to stay", "having problems to feed myself" and "lacking religious education". On contrast, they consider that not being in a *daara* has some advantages too, notably "lack of restrictions" (57%) and "not being beaten" (14%)

(2) Talibés

As in the case of street children, most *talibés* are boys between 5 and 10 years old, the proportion being higher in Kaolack (62%) than in Tambacounda (54%), and the rest being older (up to 20 years maximum). However, unlike street children *talibés* in both places come generally from their respective or neighbouring regions, and less than 8% of them from Dakar.

They generally live in the *daaras* (100% in Tambacounda and 88% in Kaolack), but some of them with their families (12% in Kaolack). Almost two thirds (64.3%) of *talibés* in Kaolack have regular or sporadic contact with their parents, a much higher figure than *talibés* in Tambacounda (38%). Poorer parents and greater distances in Tambacounda may explain this gap. Over 55% of *talibés* in both regions affirm to be in a *daara* since more than one year, but less than five.

In general, *talibés* also come from large families (more than four siblings) and their parents work in the primary sector (agriculture, fishing, cattle breeding), or are traders or unemployed –the proportion of peasants and unemployed being greater in Tambacounda, and traders being more numerous in –less rural– Kaolack. In contrast with street children, the proportion of peasants is higher among *talibés*' fathers and few of them are craftsmen (only 7.1% in Kaolack). This suggests that fathers with more liberal professions do not send their children to *daaras* as much as peasants do, although we do not know if that is due to economic (craftsmen are better off and can afford paying schools) or to ideological (peasants are more traditionalists) reasons.

The majority of *talibés*, particularly in Tambacounda (70.83%), affirm being in a *daara* in order to "learn the religion", although the percentage of those who admit "economic reasons" or being "obliged by my parents" is not negligible, especially in Kaolack (48.69%). The spectacular proliferation of *daaras* and of the number of *talibés* since the early nineties, when the worst effects of the economic crisis began to be felt, leads us to think that the last two reasons have played a more important role that they should have. Indeed, all *talibés* interviewed in Tambacounda affirm that their families do not have to

pay anything for having them in the *daara*, whereas in –slightly less poor– Kaolack, only 28.6% of parents pay something for their children's education.

With regard to their education, most *talibés* have regular study time every day, which normally last 6-8 hours in Tambacounda, and 8-10 in Kaolack –outlying cases being a minimum of 4 and a maximum of 11 hours. The great majority of them only receive religious education (100% in Tambacounda and 95.2% in Kaolack), which means that less than 5% of the *talibés* of Kaolack are also taught a primary education curriculum at the *daara*[96]. Moreover, very few *talibés* –and only from Kaolack– have ever gone to school (2%), although surprisingly around 17-19% of them in both regions consider that primary education is "as important" or "more important" than the education provided at the *daaras*, reflecting certain frustration.

Kaolack *talibés* affirm spending the morning "working" (54%) or "begging" (38%), and the afternoon and the evening "learning" (56%-53%) or "begging" (42%-40%). This would mean that they spend an average of roughly 40% of the day "begging", 30% "learning" and 30% "working". On contrast, Tambacounda *talibés* affirm spending the morning and the afternoon either "learning" (50%) or "begging" (50%), and the evenings "learning" (91.7%). If that is the case, many of them –particularly, in Kaolack– could not be saying the truth when they said they spend a daily average of 8-10 hours "learning" and 4-6 hours "begging" (83% in Tambacounda and 50% in Kaolack). In any case, unlike the *talibés* and street children of Kaolack, the *talibés* of Tambacounda do not work, whereas the main differences in the daily activities of street children (Kaolack) and *talibés* (both regions) is that the first do not spend any time "learning" and that the latter spend much more time "begging".

Educational materials at the *daaras* are scarce and often *talibés* have to share them, the proportion being much higher in Kaolack (81%) than in Tambacounda (46%). Indeed, "didactic materials" –together with "infrastructure" and "curriculum"– are among the things that would need improvement most frequently mentioned by the *talibés*. With regard to infrastructures, *talibés* in both regions say they would need "toilets" (32-39%) and "classrooms" (29-32%). In addition, roughly one third of them (37.5% in Tambacounda and 29% in Kaolack) consider that their bedrooms are "not clean"[97].

Most *talibés* (57% in Kaolack and 87% in Tambacounda) have to provide their *marabouts* with a daily amount of money that may vary between FCFA 150-250 in

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[96] *Talibés* receiving also primary education at the *daara* are largely Arabs.

[97] Ironically, only one *talibé* said he missed a "playing room" in the *daara*. Needless to remember that children also have the right to play, although when life is not easy even they forget. Fortunately, not all!

Kaolack (90%) and 100-175 in Tambacounda (71%) –outlying cases being a maximum of 400-500. But only 12-12.5% of them affirm to be punished by the *marabout* if they do not collect this amount. Punishment is generally physical (80% in Kaolack, 33% in Tambacounda[98]), although sometimes children may instead be asked to get twice the required amount next day.

In addition to the daily economic contribution, *talibés* are also expected to do some work at the *daara*, generally "cleaning" (42-44%) –In Tambacounda, some *talibés* are also asked to "look for firewood" (22.5%) for cooking or lighting as there is normally no electricity. Some of them (16.7-19%)[99] affirm to be punished by the *marabout* if they do not do their work. As in the previous case, punishment is usually physical.

The great majority of *talibés* affirm having to look for their own food (92% in Tambacounda and 71.4% in Kaolack) and most of them admit not having regular meals (50% in Tambacounda and 38.1% in Kaolack), although very few of them –and only in Kaolack (11.9%)– confess eating "insufficiently" or "being always hungry".

Among the advantages of being in a *daara*, *talibés* of both regions mention, in exactly the same order, having "friends" (45-46.3%), getting "religious education" (22.2-23%) and sleeping in a "bedroom" (18.5-19%). The "hardship of living conditions" and the "strict rules" are by far the most frequently mentioned disadvantages (79%-81%), followed –well below– by "not being able to go to school" (6%-7.1%).

Around half of the *talibés* (46-52%) in both regions are somehow organised. When they get sick, however, it is normally the *marabout* that takes care of them (86-92%). Only if the *marabout* is not there, other *talibés* (sometimes the elder) take care of the sick child. In less than in 5% of all cases in both regions, it is a doctor who takes care of the sick *talibé*.

It is important to note that both groups of *talibés* expressed little criticism in their answers and that generally they did it indirectly, i.e. praising what they do not have, but not denigrating what they have. Although living and educational conditions in the *daaras* of Tambacounda are similar to those of Kaolack, the *talibés* of the first region were particularly non-critic, what leads us to think that either they are more "conformist" than their colleagues of Kaolack or that they felt less comfortable to say their pieces freely during the interviews.

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[98] Significantly, 67% of *talibés* in Tambacounda did not answer this question.

[99] Note that it is a higher proportion than in the case of not bringing money in.

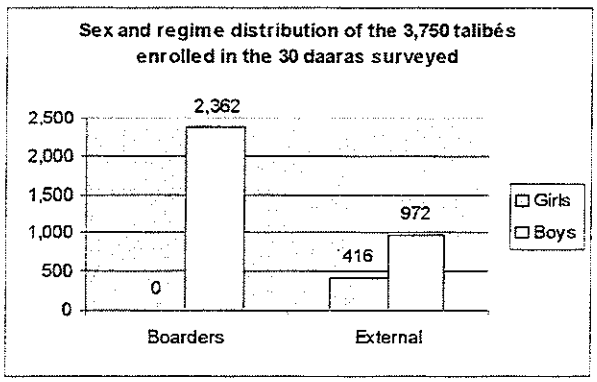
(3) Daaras

For this survey, the *marabouts* of thirty 30 *daaras* in Kaolack were interviewed. The total number of *talibés* enrolled in these *daaras* amount to 3,750, of which 3,334 are boys (89%) and 416 girls (11%).

As can be seen in the graph (right), all visited *daaras* take in students principally in boarding regime (63%), although some of them also accept external students (37%)[100].

It is important to point out that girls can only enrol in *daaras* as external students[101].

Figure 1.4.1 Sex and Regime Distribution of Talibé in Daara

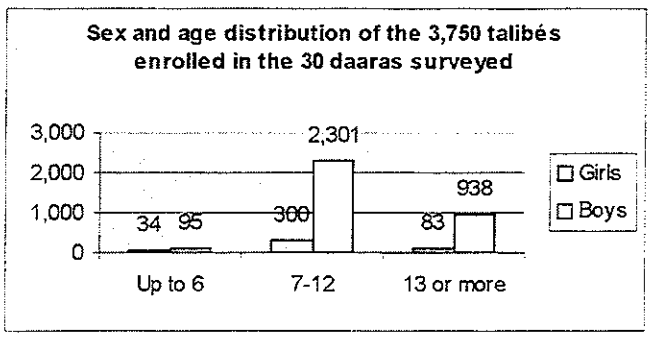


Source: JICA Study Team

The largest sex and age group among *talibés* is boys between 7 and 12 years of age (61.4%)[102], followed by older boys (25%).

On contrast, the largest female group (girls from 7 to 12 years of age) accounts for only 8% of all *talibés*.

Figure 1.4.2 Sex and Age Distribution of Tablibe in Daara



Source: JICA Study Team

[100] This figure roughly coincides with the data obtained in the survey on *talibés* (See point 3.4.2. (2) §2 above)
[101] And they cannot become *marabouts* either.
[102] This figure also confirms the data obtained in the survey on *talibés* (See point 3.4.2. (2) §1 above)

The large majority of these talibés (86.71%) belong to the Wolof ethnic group, a rather shocking figure taking into the account the proximity of the Sérère area. This phenomenon can however be easily explained. Firstly, because –as we have seen– numerous *talibés* (41%) come from other regions. And, secondly, because many Sérère are not Muslims, but Christian Catholics.

Most *marabouts* (61%) in Kaolack are over 40 years of age, which is a quite old age in a country where current life expectancy at birth is 53 years. More impressive is the fact that 92.9% of them have been *marabouts* for more than five years, which means that those who chose to become *marabouts* generally commit themselves for the rest of their professional lives, and that the *marabout* of a *daara* does not change everyday, not even every five years.

Not surprisingly, the majority of *marabouts* (64%) confer a certain (non-formal) authority to the elder among them, and not so much to those who are objectively better prepared or have more years of experience. This explains why, upon his death or retirement, the *marabout* is often (53.6%) replaced by his eldest assistant, who becomes thus *marabout*[103]. Indeed, three out of four *marabouts* have teaching assistants, a real necessity considering that 78% of daaras have more than 60 *talibés*, the average of the sample being 125. The number of *talibés* per teacher, thus, is predominantly (57%) less than 30, being greater in the rest of cases (43%).

Half of the *marabouts* (50%) consider that parents place their children in a *daara* "to learn the religion", but –unlike *talibés*– the second reason given is not "economic need" (3.6%), but "socialisation purposes" (35.7%). Indeed, children are not generally aware of the importance that studying and living with other children, under the teaching and guidance of an adult, has in terms of socialisation. It is also true, however, that parents in need tend to hide their economic situation and that *marabouts* –particularly, those who are also in need– do not generally inquire too much. In any case, whatever the reason is, *marabouts* overwhelmingly agree (82%) with *talibés* that the most important thing that children get in the *daara* is religious education.

Even in *daaras* that do not provide children with a basic education curriculum –the large majority, as we have seen[104]–, children often learn something else besides religious education. For instance, farming or cultivating the land. They generally learn this agricultural techniques taking care of the *marabou*'s animals or vegetable garden

[103] Interestingly, most *marabouts* (55.34%) would like their *talibés* to become also *marabouts* in the future.
[104] See point 3.4.2. (2) §5 above

during the years they spend in the *daara*. Indeed, according to the *marabouts*, 8% of the *talibés* of Kaolack end up in the agricultural sector, although many more (21%) become traders or small businessmen[105].

Slightly over one third of the *daaras* (35%) are solidly built, although most of these buildings are in precarious conditions and many have roofs made of reed or zinc. *Daaras* "under construction" account for 26% of them, not too many considering that the construction may last many years (given the shaky financial situation of most *daaras*). Daaras made of reed represent 23% and, finally, 13% are "open-air" *daaras*. As the *talibés* pointed out, the *marabouts* also think that the toilets (26%), the dining rooms (19%), the classrooms (17%), and the bedrooms (14%) need rehabilitation. In addition, they also mention problems with water and electric supply as well as with getting medicines.

Educational materials are scarce, generally (89%) just a wooden plank to write in. Only 11% of *daaras* have (very few) books –besides the Koran, of course. Not surprisingly, *marabouts* agree with *talibés* that "educational materials" is the most urgent need they have (56%), followed by the need to increase financial resources (7%), the need to upgrade the infrastructures of the *daara* (4%), and the need to review the curriculum (also 4%). The didactic system is basically the same in all *daaras*, memorising the different chapters of the Koran –or of the Islamic rules–, by means of daily systematic recitation. Normally (71%), children are not divided in sections according to their academic level, a customary practice that corresponds to the tradition of not making distinctions among *talibés*. Obviously, the majority of *marabouts* (57%) consider that the education provided at the *daaras* is the most important, although –amazingly– 43% of them affirm that the education provided at the elementary school is "as important" as the one given at the *daaras*[106]; doubtless, a remarkable evolution.

The *daaras* of Kaolack have six basic sources of funding: the alms collected by the *talibés* (37%), the contribution of –some of– the parents (21.5%), the gifts of third persons (15.2%), the donations of the alumni (11%), the "*Mothers of Daaras*" (4.6%), and the *Association des Maîtres et Eleves d'Ecole Coranique* (1.5%). Nevertheless, most *marabouts* admit that the financial situation of their *daaras* is "hard" (64%) or at least "not good" (25%). Only 4% of them affirm that it is "very good". Considering that most *marabouts* are ashamed to confess having financial troubles, it may be rightly guessed that in many cases the situation is indeed dramatic.

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[105] This is mainly due to the economic structure of Kaolack, a trading fluvial port in a border region (by The Gambia) that is at the crossroad of many routes (Mali, Guinea...) and that has an international railway station.

[106] Note that this percentage is much higher than in the case of *talibés* (see point 3.4.2. (2) §5, last sentence, above)

When asked for the nutritional or health state of the *talibés* in their care, 82-78% of them answer: "no problem, we take care of them". Difficult to believe when 89% of them have also admitted that the financial situation of their *daaras* is "not good" and even "hard". How can they provide the *talibés* with adequate food and medical care if they do not have the means to afford it? Besides, a quick glimpse at the boys is enough to verify that their nutritional and health state is precarious, what leads us to think that when their responsibility is questioned not all *marabouts* are entirely honest. Some of them (11-21%), however, openly admit that the nutritional and health state of the *talibés* in their care is "anguishing, due to financial hardship".

Furthermore, when asked for the division of labour among *talibés* within the *daara*, almost two thirds (64%) of *marabouts* do not answer the question, whereas those who do answer affirm that "the older do the tougher jobs", reflecting again a certain embarrassment to admit that they make children work.

According to the interviewed *marabouts*, 57% of *talibés*' parents visit their children "regularly", 21% "occasionally", 7% "rarely" and the rest "never". In most *daaras* (61%), children may visit their parents freely, for the rest (39%) some conditions must first be met to allow *talibés* to visit their families. Most visits take place in religious holidays of traditional family reunification such as the *Tabaski*.

An last but not least, exactly half (50%) of the *marabouts* affirm that *talibés* never run away from their *daaras*, compared to 46% who admit that *talibés* do "sometimes" run away, and to 4% who have no problem to confess that the children in their care run away "often".