ORIGINAL RESEARCH ARTICLE

Analysis of care for adolescent victims of gender-based violence in Senegal: a qualitative study

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Abstract

In Senegal, many adolescent victims of gender-based violence (GBV) do not receive care. The aim of this study was to analyse the care circuit for adolescent victims of GBV, taking gender differences into account. This was a qualitative case study. A thematic analysis of the data was carried out using Nvivo 12 software. The study showed that society attached less importance to the rape of boys. The study also showed that the main attitude of adolescents to GBV was silence, encouraged by under-reporting. The structural barriers to providing care were the insensitivity of health and judicial structures towards adolescents, as well as geographical and financial obstacles. In conclusion, it is important for policies to tackle these structural barriers in order to promote a system of care suited to cases of GBV among adolescents. *(Afr J Reprod Health 2024; 28 [8s]: 99-106).*

Keywords: GBV, adolescents, care circuit, Senegal

Résumé

Au Sénégal, de nombreux adolescents victimes de violences basées sur le genre ne sont pas pris en charge. L'objectif de cette étude est d'analyser le circuit de prise en charge des adolescent(es) victimes de VBG en tenant compte des différences de genre. Il s'agissait d'une étude qualitative de type étude de cas. Une analyse thématique des données avait été faite avec le logiciel Nvivo 12. L'étude a montré que la société accordait peu d'importance aux viols des garçons. L'étude a également montré que la principale attitude des adolescents face aux VBG était le silence, favorisant la sous-dénonciation. Les barrières structurelles à la prise en charge étaient l'insensibilité des structures sanitaires et judiciaires envers les adolescents, ainsi que les obstacles géographiques et financières. En conclusion, il est important que les politiques s'attaquent à ces barrières structurelles pour promouvoir un système de prise en charge adapté aux cas de VBG chez les adolescents. *(Afr J Reprod Health 2024; 28 [68s]: 99-106).*

Mots-clés: VBG, adolescent(es), circuit prise en charge, Sénégal

Introduction

In sub-Saharan Africa, gender-based violence (GBV) remains a public health priority[1]. Several factors contribute to the high prevalence of GBV in sub-Saharan Africa. Adolescence is a period when exposure to violence is more frequent, with gender-related disparities. Girls are particularly vulnerable to physical violence, while boys are more vulnerable to psychological violence[2,3]. Tolerant community attitudes toward violence, as well as a history of childhood and family abuse, increase victims' vulnerability to these forms of violence. Yet experiences of violence during adolescence or childhood can have devastating effects on adolescent health and development[4]. In Senegal, there is a legislation condemning violence, including that of a sexual nature, with protection for minors, especially those less than 18 years.

However, there is no precise, defined, and validated flowchart that describes the process of caring for adolescent victims of GBV. In addition, few studies have been carried out to understand the pathway that leads to the care of adolescent victims of GBV in many sub-Saharan African countries, including in Senegal. Previous studies mainly focused on the factors of perpetration and victimization of sexual violence[6]. It therefore becomes imperative to conduct studies analyzing the treatment of adolescent victims of GBV.

The main objective is to describe the care circuit for adolescent victims of GBV, taking into account gender differences. It aims to evaluate the organizational model proposed by the police on the one hand and that proposed by the healthcare system in the care of rape victims on the other. Specifically, the study was designed to highlight and describe the different stages of care and the organizational processes in the circuit of law enforcement and that of care services for adolescents experiencing GBV.

Theoretical framework

The study is based on the theory of planned behavior of Ajzen, 1988, 1991[7]. This theory explains decisions preceding a given behaviour by identifying direct and indirect influences. It makes it possible to connect different variables such as cognitive information, intention, and internal and external coercive factors to explain the motivations for behavior. This theory was supplemented by Lewin's 1997[8] theory of organizational change, which explains changes in attitudes and makes it possible to make an institutional diagnosis of the organization of care at the level of law enforcement but also at the level of the health care system. Lewin's model proposes three stages in organizational change in the face of environmental realities. These are the "unfreezing" stage (the identification of levers and barriers for positive change in organizations), "moving" stage (allowing the identification of recommendations and innovations for change in said organizations), and the "refreezing" stage. which consists of examining the adoption of new behaviors within the organizations, which in this case includes law enforcement and healthcare services.

Methods

Data source

This study mainly used a qualitative approach. The study used data from 201 in-depth individual interviews and 24 group discussions conducted in Dakar, Kaolack and Kolda in April 2022. Table 1 describes the sample characteristics.

A total of 92 adolescents, 30 parents of adolescent victims of GBV, 45 teachers, 18 law enforcement officers involved in the management of victims of violence and 16 health providers in the various aforementioned localities participated in the interviews and the provision of in-depth individual information. In addition, three (3) focus groups consisting of 8 people each were organized in the 3 regions mentioned above (one focus group per region). These focus groups allowed the collection of data from 24 community health promotion and care agents. During the data collection, saturation criteria were used. The interviews were conducted in French and the local language "Wolof". First recorded using a Dictaphone, the interviews were then directly transcribed into French, including those conducted in the local language.

Data analysis

Data analysis was carried out by operationalising the completed transcriptions of the interviews. The interviews were transcribed as data was collected from the digital recording. We used thematic analysis to conduct an objective and systematic analysis of the content expressed in the oral discourse[10]. Inductive analysis was conducted to explore the research elements[11]. After transcription, the data was grouped into evocative themes related to the interviews.

The analysis of the coded data followed the following steps: (1) extraction of the different units of analysis of the participants' speech using the NVivo 12 software; (2) horizontal analysis of the theoretical corpus in relation to the research objectives; (3) creation of theory from analysis of coded data; and (4) validation of the meaning of statements by triangulation of sources and methods.

Ethics

The study obtained approval from the National Ethics Committee for Health Research (CNERS), bearing the reference number SEN21/48. Participation in this study was free. Free and informed consent was obtained from all participants aged 18 and over. For adolescents aged under 18, consent from their legal guardian was obtained before their own assent.

Results

Cognitive information on GBV

In general, GBV mentioned by those interviewed mainly concerned physical, verbal and sexual

Table 1: Distribution of people interviewed

Interviewees	Locality			Total
	Dakar	Kaolack	Kolda	
In-depth individual interview				
Adolescents (es)				
Girls	15	15	15	45
Boys	17	15	15	47
Teachers				
Women	7	8	7	22
Men	8	7	8	23
Parents				
Men	5	5	5	15
Women	5	5	5	15
Law enforcement officers	6	6	6	18
Health providers	4	6	6	16
Total	67	67	67	201
Group focus (1 per region)				
Community promotion and health agents	8	8	8	24

violence (rape), as well as forced marriage, early marriage, harassment, mistreatment, early pregnancies, psychological violence and female genital mutilation (FGM).

Most adolescents were aware of the various GBV that are rampant in the Senegalese society. This observation is explained by the fact that many of them have either witnessed these acts or have friends who have been victims. Adolescents aged 12 to 14 found it difficult to address these issues and were able to identify only a few forms of GBV, including rape, forced marriage, physical violence particularly at home and at school such as punishment bodily harm inflicted on children.

Adolescents say that they are well informed about GBV, mainly through social networks and adolescent counseling centres (ACC) which constitute their main sources of information. Unlike social networks and CCAs, family is not a preferred source of information. Indeed, according to the parents interviewed, discussing the issue of sexuality with children remains a taboo subject.

Gender differences regarding cognitive information were noted. Thus, for female adolescent, concerns were more about female genital mutilation (FGM), rape, and early marriage.

> *"We can say that there is a lot of violence, we can cite cases of rape of girls in homes, early marriage. Excision is not a good practice. I have seen girls who have undergone excision and they are currently having problems, frankly it is not a good practice. ...I know a lot of them. »* (Adolescent girl, 15 years old, Dakar)

The rape of boys is often omitted or hidden because it does not seem to be a concern for society because in popular representation boys are not affected by rape. So, for some parents, there is a difference between girl and boy. A raped girl is seen as a weak victim, while a raped boy will be mocked because the community has a gendered perception of rape.

> *"...it's unfortunate that people think that it's girls who are victims when there are boys, for example I was raped. .."* 42-year-old teacher, Kaolack

Adolescent boys, for their part, seem more concerned about domestic and school violence.

> *"...I can cite as violence, parents who violently beat their children and this must stop. There are children who are mistreated, who are excluded from their homes after the death of their mother, for example, and that is not good"* Adolescent, 16 years old, Kaolack

Domestic and school violence, generally physical, manifests itself in different forms. They include a form of violence justified for repressive and educational reasons, according to adults interviewed such as parents, law enforcement and teachers. For example, a police officer interviewed mentioned the case of a mother who burnt the palm

of her child's hand as punishment for stealing money. These adults believe that this act will dissuade the child from repeating this misdeed, since the scar he will remind him and prevent him from repeating the act.

The health providers and professionals interviewed emphasised the fact that some parents justify the violence inflicted on their children. According to them, this physical, moral and symbolic violence plays a crucial role in the education of the child. For example, some parents may resort to physical violence when they notice that their child expresses different sexual orientations.

> *"I had to receive a boy who was homosexual but when his father found out, they beat him up. It was their way to tell the boy that we don't agree with the direction he was taking because we think it's normal. »* (Health provider, Dakar)

Adolescents' healthcare-seeking attitude towards GBV

Most of the adolescents interviewed maintain that silence is the first attitude in cases of gender-based violence. However, for cases of physical violence, silence is not appropriate. The attitude of silence mainly concerns cases of rape. According to the testimonies collected, this reluctance to denounce these acts is often explained by the threats made by the attackers, whether with knives, violent words, or other sharp objects. These threats dissuade victims from speaking out. This phenomenon is particularly marked in cases of rape, especially when the perpetrator is a family member. In general, denunciations occur more frequently when the author is an external individual, not linked to the family circle.

Under-reporting linked to an attitude of silence is also linked to a phenomenon of preservation of the family unit, when the adolescent victim and the executioner belong to the same family unit. Thus in cases of rape, even if the parents are informed and the rapist is a relative, the law of silence is observed in order to preserve family unity. On the contrary, if it is an external rapist, they resign themselves to bringing the matter to justice. These extracts are revealing:

> *"There is a term "diokhéré indame" which means the preservation of the family unit, the girl is raped by her uncle and if we file a complaint, the image of the family will be tarnished. It was in order not to tarnish the image of the family that they preferred to remain silent. By remaining silent, the girl suffers because something precious has been taken from her. »* (Adolescent girl, 16 years old, Kolda)

When adolescents are supported by parents, the violence is denounced. From then on, the parents with the adolescent can initiate the care process.

Support circuit for adolescent victims of GBV

Often, there is a lack of understanding of the path to follow or the attitude to adopt towards GBV. This is why some interviewees ask that the victims and their parents be assisted during the procedures.

> *"The parent must go to the people who can accompany him and show him the route to take, and until the case is at the level of justice, that the parents be patient and trust the latter and also accept all the decisions taken by this justice. But you should never give up. »* (Parent of a victim, Kaolack)

Generally, there are two main entry points into the care circuit for adolescent victims of GBV.

Point of entry: defense and security forces

According to the law enforcement officers interviewed, victims of GBV have the option of going to the police or gendarmerie to file a complaint. After an initial interrogation, the police or gendarmes direct the victims to health facilities for medical examinations and to obtain a medical certificate, making it possible to corroborate or refute the victim's allegations. It is at the end of this procedure that the file is transmitted to the courts.

In the case of a minor victim (child), the declaration is generally made first by their guardian/parent. However, the minor victim will still be interviewed by the police.

Point of entry: health facility

According to the health providers interviewed, if the victim first presents himself to the health services, the latter direct him, after consultation and with supporting papers (such as a medical certificate), to the security forces. In the event of

proven rape or violence, the police will take over. They carry out an investigation before sending the file to the court. However, it may happen that the victim does not wish to file a complaint. In this case, she will only benefit from a medical consultation as well as guidance to obtain psychological care.

In certain cases, victims are referred to the health district where counselors can support them and recommend legal support. It should also be noted that there are no specific structures dedicated to the management of Gender-Based Violence (GBV) within health structures.

Other support circuit

In rare cases, victims can contact the community leader (the neighborhood imam or village chief). Mediations are then undertaken by the latter. In these specific cases, law enforcement and healthcare providers may not be involved. These strategies are part of the management of silence surrounding cases of GBV.

Barriers to the care of adolescent victims

Several types of barriers were mentioned. These are barriers linked to the perception of violence in communities, the socio-cultural policy of non-denunciation of rape and violence, but also barriers linked to structures for dealing with violence among children and adolescents.

Barriers linked to the perception of violence

It is about the social representations that communities have of violence. This is the case with domestic violence which is legitimised as being "educational" according to some interviewees, even if it can be violent, it may not be the subject of treatment.

Socio-cultural policy of non-denunciation of cases of rape and violence

These barriers refer to cases of silence in situations surrounding rape and violence. This often prevents these crimes from being reported, and therefore properly dealt with.

Barriers linked to GBV support structures

At the level of judicial support structures (law enforcement), a lack of adequate equipment is noted to accommodate children and adolescents in cases of GBV. According to the law enforcement officers interviewed, the premises are not suitable for caring for children and adolescents. There is no specific place that promotes the trust and intimacy necessary for these young people experiencing GBV.

> *"The obstacles in our structure are the means. Because we had to equip this room for children. And our offices are not suitable for receiving children and adolescents, because to audition a child, we must have everything necessary. For example, toys and everything... And you see that in our offices, we don't even have toys, we don't even have candy for the children. And even to give the child a drink…"* (Law enforcement, Kolda)

The problem of accessibility of care services was a major subject. In addition to geographic inaccessibility in isolated areas, the parents interviewed also highlighted financial difficulties. For most healthcare providers and law enforcement officers, the costs associated with obtaining the medical certificate represent a barrier to care. Indeed, people struggle to raise the funds necessary to cover the costs of the medical certificate, particularly the most disadvantaged families, where cases of gender-based violence occur most often, according to those interviewed.

Among the obstacles associated with care in institutions, specific barriers stand out in the management of adolescents. Adolescents highlight a lack of confidentiality and compassion in their follow-up, resulting in an insufficient quality of reception within health establishments and legal institutions for most of the adolescents interviewed.

> *".. I have a friend who was raped, the midwife asked her what did you do there until you were raped"* (Adolescent girl, 15 years old, Kaolack)

"I'm afraid to go to the police because they won't welcome you. It's the same as when you go to the hospital." (Adolescent, 17 years old, Dakar).

Discussion

The main objective of this study was to describe the care pathway for adolescent victims of GBV,

taking into account gender differences (sex). The analysis also aimed to identify the support process most used by adolescent victims of GBV depending on whether first aid is sought from a health facility, a police station, or a community leader.

The reports showed that the GBV reported mainly included physical violence, particularly that of domestic origin, verbal violence, sexual violence (rape), forced and/or early marriage, harassment, early pregnancies, psychological violence and female genital mutilation (FGM). These results corroborate those observed among in-school and out-of-school adolescents in other African countries, including the Central African Republic[12] and Mali[13].

This study also highlights the variation in the types of violence according to the sex of the participants, as well as the influence of the differentiated socialization of boys and girls on the perpetration of GBV (Gender-Based Violence). This is similar to results obtained in other African countries [10,6.] Although gender-based violence does not spare young boys either, a raped girl is often perceived as a weak victim, while a boy victim of rape may be subjected to ridicule due to the gendered perception that the society has rape[14].

This study highlights that boys are more frequently confronted with domestic violence, while girls are more concerned about sexual violence. Cultural norms help normalize domestic violence by sometimes justifying it as a corrective measure, particularly in low-income countries where it can be seen as a means of discipline. In serious cases, such as burns, service providers tend to focus on the seriousness of the situation rather than condemning the nature of the act, reflecting a broader acceptance of violence against children, sometimes considering it as a normal, even desirable, form of education. These findings highlight cultural differences in the perception of violence[15,16]. This explains why many adolescents choose to remain silent in the face of violence, often out of fear of threats from abusers and in order to preserve family unity, particularly when the abuser is a family member[17, 18].

Parental support is essential to create an environment favourable to the management of vulnerable adolescents[19]. This result corroborates the theory of planned behavior which explains decisions preceding a given behavior, by identifying the direct and indirect influences which motivate them. These influences include factors in the family and social environment that may partially predict reporting or non-reporting behaviors. Among these factors, we find the executioner's membership in the family circle and the support of parents.

On the other hand, the nature of the violence also has an impact on care-seeking behavior. Our results show that denunciation mainly concerns cases of sexual violence, while physical violence is often perceived as legitimate or even educational. The choice of therapeutic route (first aid point) depends on these considerations.

However, many adolescents do not know the path to follow or the attitude to adopt in the face of GBV. Because of this lack of knowledge, access to the support circuit may be affected. This study identified three main entry points into the care circuit for adolescent victims of violence: the health facility, the judicial structure, and the community leader.

However, some victims of gender-based violence (GBV) do not receive adequate help due to accessibility barriers, particularly linked to care systems that are insensitive towards adolescent and child victims[19].

Conclusion

This study analyzes adolescent gender-based violence as a public health problem, highlighting the impact of social norms on its perception. It highlights the differences in treatment between young girl and boy victims. The study identifies gaps in support systems (health, justice, community) for young people, highlighting the absence of a standardized framework. The deficiencies are attributed to a lack of consideration of gender by health and justice organizations. Specialized services are lacking in support structures, compromising the treatment and support of young victims. Thus, if child victims of sexual abuse must be examined in hospital emergency departments, a protocol must be developed to guarantee an evaluation that is not only rapid, complete, uniform, but above all caring. This goodwill must also include better geographical and financial accessibility of services, including the financial accessibility of the medical certificate. For policies, care must be taken to put in place care

structures that take into account the specificities of adolescents.

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Contribution of the authors

The conceptualization of the project was carried out by Adama Faye, Ndèye M Sougou, Oumar M Samb, Sokhna Ndiaye and Serigne M Mbaye. The methodology was developed by Ndèye M Sougou, Adama Faye, Oumar M Samb, Amadou I Diallo, Fatoumata B Diongue, Adams Diedhiou, Sokhna Ndiaye and Serigne M Mbaye. The investigation was led by Adams Diedhiou and Ndèye M Sougou. Data coding and analysis were carried out by Ndèye M Sougou and Adams Diédhiou. The first version of the manuscript was written by Ndèye M Sougou.
The manuscript was reviewed and corrected by all authors. All authors have approved the manuscript.

References

1. Beyene AS, Chojenta C, Roba HS, Melka AS, Loxton D. Gender-based violence among female youths in educational institutions of Sub-Saharan Africa: a systematic review and meta-analysis. System Rev. 2019;8(1):59.
2. Muluneh MD, Francis L, Agho K, Stulz V. A Systematic Review and Meta-Analysis of Associated Factors of Gender-Based Violence against Women in Sub-Saharan Africa. Int J Environ Res Public Health. 2021;18(9):4407.
3. Musizvingoza R, Tirivayi N, Otchere F, Viola F. Risk factors of adolescent exposure to violence in Burkina Faso. BMC Public Health. 2022;22(1):2405.
4. Exner-Cortens D, Eckenrode J, Rothman E. Longitudinal associations between teen dating violence victimization and adverse health outcomes. Pediatrics. 2013;131(1):71-8.
5. Leye MMMb, Seck I, Faye A, Diongue M, Ka O, Ndeye MS, et al. Epidemiological and Clinical Aspects of Domestic Violence in Senegal. Health. 2017;9(10):1404-15.
6. Koker PD, Mathews C, Zuch M, Bastien S, Mason-Jones AJ. A Systematic Review of Interventions for Preventing Adolescent Intimate Partner Violence. Journal of Adolescent Health. 2014;54(1):3-13.
7. Armitage CJ and Conner M. Efficacy of the Theory of Planned Behaviour: a meta-analytic review. *Br J Soc Psychol*. 2001;40(Pt 4):471-99. doi: 10.1348/014466601164939
8. Hussain ST, Lei S, Akram T, Haider MJ, Hussain SH, Ali M. Kurt Lewin's change model: A critical review of the role of leadership and employee involvement in organizational change. Journal of Innovation & Knowledge. 2018;3(3):123-7.
9. Yin RK. Case Study Research: Design and Methods. Sage Publications, Inc. Thousand Oaks; 2008.
10. Gauthier B. Social research: From the problem to data collection. 5th edition. Press of the University of Quebec. 2009 isbn 978-2-7605-1600-7.
11. Blais M, Martineau S. General inductive analysis: description of an approach aimed at giving meaning to raw data. Qualitative research. 2006; 26(2):1.
12. Mimche H, Tanang P. Gender-based violence at school in the Central African Republic. Research & education. 2013;(8):49-63.
13. Sidibé K. Gender-based sexual violence at the "One Stop Center" unit at the Reference Health Center of Commune V of Bamako/Mali [Internet] [Thesis]. USTTB; 2021 [cited May 24, 2023]. Available at: https://www.bibliosante.ml/handle/123456789/5047
14. Hofmann E. Gender violence in schools in French-speaking Africa: definitional issues behind the instigation to fight against commonplace harmful practices. Somewhere else. 2018;87(3):35-52.
15. Collibee C, Fox K, Folk J, Rizzo C, Kemp K, Tolou-Shams M. Dating Aggression among Court-Involved Adolescents: Prevalence, Offense Type, and Gender. J Interpers Violence. 2022;37(13-14):NP12695-705.
16. Grzejszczak J, Gabryelska A, Gmitrowicz A, Kotlicka-Antczak M, Strzelecki D. Are Children Harmed by Being Locked up at Home? The Impact of Isolation during the COVID-19 Pandemic on the Phenomenon of Domestic Violence. International Journal of Environmental Research and Public Health. 2022;19(21):13958.
17. Namy S, Carlson C, Norcini Pala A, Faris D, Knight L, Allen E, et al. Gender, violence and resilience among Ugandan adolescents. Child Abuse Negl. 2017;70:303-14.
18. Mwanukuzi C, Nyamhanga T. "It is painful and unpleasant": experiences of sexual violence among married adolescent girls in Shinyanga, Tanzania. Reprod Health. 2021;18(1):1.
19. Usonwu I, Ahmad R, Curtis-Tyler K. Parent-adolescent communication on adolescent sexual and reproductive health in sub-Saharan Africa: a qualitative review and thematic synthesis. Reprod Health. 2021;18(1):202.
20. Koudou O, Crizoa H, Serifou MD. Determinants of obstacles to the care of women victims of rape in Abidjan. Social sciences and actions [Internet]. 2019 [cited May 25, 2023];(11). Available at: https://journals.openedition.org/sas/993
21. Adams JA, Kaplan RA, Starling SP, Mehta NH, Finkel MA, Botash AS, et al. Guidelines for Medical Care of Children Who May Have Been Sexually Abused.

Journal of Pediatric and Adolescent Gynecology. 2007;20(3):163-72.
22. Ricci LR. Child sexual abuse: the emergency department response. Ann Emerg Med. 1986;15(6):711-6.
23. Mignot S, Fritel X, Loreal M, Binder P, Roux MT, Gicquel L, et al. Identifying teenage sexual abuse victims by questions on their daily lives. Child Abuse Negl. 2018;85:127-36.
24. Janighorban M, Boroumandfar Z, Pourkazemi R, Mostafavi F. Barriers to vulnerable adolescent girls' access to sexual and reproductive health. BMC Public Health. 2022;22(1):2212.
25. Pourkazemi R, Janighorban M, Boroumandfar Z, Mostafavi F. A comprehensive reproductive health program for vulnerable adolescent girls. Reprod Health. 2020;17(1):13.