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Gender-based violence and sexual and reproductive health and rights of adolescent girls in Senegal: an analysis of social control practices

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Abstract

This article problematizes gender-based violence (GBV) as a social practice and explains its role as a social mechanism for controlling bodies. Based on a mixed methodological approach (combining questionnaires, qualitative interviews, focus groups, and participant observation) targeting both adolescent girls and community actors, this study reveals forms of GBV that are little explored among the adolescent population. Social practices, such as "nëpp nëppël" or the culture of silence, frequently conceal GBV within families, hindering reporting and thus limiting adolescents' access to sexual and reproductive health and rights (SRHR) services and influencing their limited knowledge of SRHR. Shelter centres, such as Kullimaaroo, are crucially important in this context by providing holistic support to victims of GBV, but such structures are rare in Senegal. We conclude that it is necessary to adopt a holistic approach taking into account social practices to address the complex relationship between GBV and SRHR among adolescents in Senegal. *(Afr J Reprod Health 2024; 28 [8s]: 176-184).*

Keywords: : Gender-based violence; gender, sexual and reproductive health; adolescents, Senegal; social practices

Résumé

Cet article problématise les violences basées sur le genre (VBG) comme des pratiques sociales et explicite leur rôle de mécanisme social de contrôle des corps. Basé sur une approche méthodologique mixte (associant des questionnaires, des entretiens qualitatifs, des focus-group, de l'observation participante, etc.) ciblant à la fois les adolescentes et les acteurs communautaires, cette enquête révèle des formes de VBG peu explorées chez la population adolescente. Les pratiques sociales, comme le "nëpp nëppël" ou la culture du silence, dissimulent fréquemment ces VBG au sein des familles, entravant la dénonciation et limitant ainsi leur accès aux services de santé sexuelle et reproductive (SSR) et influençant leurs connaissances limitées en SSR. Les centres d'hébergement, tels que Kullimaaroo, revêtent une importance cruciale dans ce contexte en fournissant un soutien holistique aux victimes de VBG, mais ces structures restent rares au Sénégal. Il est nécessaire d'adopter une approche holistique prenant en compte les pratiques sociales pour traiter les enjeux complexes de l'articulation entre les VBG et la SSR chez les adolescentes, un domaine actuellement insuffisamment documenté. *(Afr J Reprod Health 2024; 28 [8s]: 176-184).*

Mots-clés: Violences basées sur le genre, genre, santé sexuelle et reproductive, des adolescent-e-s, Sénégal, pratiques sociales

Introduction

The Senegalese authorities have taken charge of the sexual and reproductive health of adolescents, motivated by the desire to confront the HIV/AIDS virus, to prevent early pregnancies, to promote the schooling of girls, and to respect international conventions[1-3]. Documentary research on gender based violence (GBV) in Senegal has shown that existing work mainly focuses on the forms, causes, and needs in terms of support[4,5]. Previous studies have revealed that "conservative" social norms hinder the care of adolescents[4,6]. In Senegal's social practices, Islam occupies a central place, with more than 90% of its population being of the Muslim faith. This explains, among other factors, a certain reluctance to openly address adolescent sexuality, both in public discussions and in health services. As a result, this taboo around adolescent sexuality has a significant influence on the conditions of access to medical care in matters of sexual and reproductive health, as well as on the discussion and care of gender-based violence[1,3]. By taking social practices into account, we recognize that individual behaviours are influenced by the social environment which perpetuates cultural and gendered norms[7,8].

This article is based on Elizabeth Shove's definition[7], which defines social practices as sets of actions that are deeply rooted in specific contexts (societies, cultures, social groups, etc.). They represent routine, interconnected behaviours that individuals or groups perform as part of their daily lives. These practices are influenced by various factors, such as social norms, physical infrastructure, knowledge, skills, and individual motivations[7]. It is therefore relevant to deconstruct and deepen our understanding of social practices around GBV in order to understand their systemic nature, making them capable of hindering institutional or community initiatives and rendering measures to combat GBV ineffective. This allows us to understand the mechanisms that prevent denunciation and the proposal of more adapted approaches to offer adequate support to victims/survivors.

Gender-based violence is the product of systems inherent in patriarchal contexts which are characterized by the vulnerability and subordination of women and girls. The term gender-based violence (GBV) encompasses all forms of violence experienced based on the roles socially assigned to men, women, boys and girls[9]. GBV affects women and girls more significantly than men and boys. Adolescent girls are affected by specific types of GBV such as non-consensual touching, rape, sexual violence in schools, early and/or forced marriages, excision, the ban on schooling or participation in sporting or festive activities, etc. This article investigates the links between GBV and sexual and reproductive health and rights (SRHR) of adolescent girls in Senegal, and shows how social practices affect the management of GBV.

Methods

The analysis is based on data from the HIRA action research project conducted by the Laboratory for the Analysis of Societies and Powers / Africa Diaspora (LASPAD) at Gaston Berger University in Saint-Louis since July 2021. HIRA (host, inform, resocialize and welcome): the social and political issues of caring for the health of adolescent victims/survivors of gender-based violence in Senegal was part of the cohort of projects supported by the "Improving the health of adolescents" in Senegal-ADOS project funded by the CRDI (International Development Research Center). The HIRA project aims to co-produce, with all stakeholders, a reference model focused on the care of adolescent victims/survivors of gender-based violence and the management of their sexual and reproductive health (SRH) in Senegal. In a community and participatory approach, the project also aims to document the conditions for reproducibility of the model. The research team was made up of 14 master's and doctoral level students, independent researchers as well as teacher-researchers from Gaston Berger University in Saint-Louis, specialized in social science.

This research comprised different aspects including a national mapping, a survey on the perceptions of GBV among adolescents, a survey on good practices in the management of the GBV/SSRA nexus, as well as a monograph of a shelter that accommodates adolescent victims/survivors of GBV.

A national mapping survey in the fourteen regions of Senegal was carried out by junior researchers to take stock of the reception and accommodation centres intended for victims of GBV. With a geolocation application, the different accommodation centres but also all the support services both in terms of physical and mental health, financial assistance, including professional reintegration opportunities through training were recorded.

Based on the mapping, individual interviews and focus groups were conducted with all community and institutional actors in the care chain (110 people in total). These actors were able to intervene effectively when a teenage girl is the victim of violence, in particular by requesting the intervention of the police, by facilitating access to free care, and by ensuring the protection of the child. This approach made it possible to collect information related to social practices regarding the care of victims of sexual violence in Senegal. Good practices referring to a set of protective knowledge in the context of GBV which makes it possible to prevent, resist, and protect oneself against violence.

Furthermore, the perceptions and knowledge regarding GBV and reproductive health of 1,332 adolescent girls were collected through a quantitative questionnaire. Sampling was carried out in schools, training centres, as well as by mobilizing local contacts to interview girls aged thirteen to nineteen in all regions of Senegal.

Finally, a monograph of the Kullimaaroo accommodation center in Ziguinchor was carried out by a member of the team with expertise in sociology and research on gender-based violence. A complete immersion combining individual interviews (20) and participant observation made it possible to collect the experiences of adolescent girls affected by GBV, as well as those of the center staff. Located in the Casamance region, Kullimaaroo is one of the rare establishments in Senegal to offer holistic care since its creation in 2015.

Data analysis

All data from the surveys mentioned are included in our content analysis. The analysis of the quantitative and qualitative data focused on exploring the interplay between SRH and GBV, aiming to shed light on the social practices that underpin these phenomena. The methodologies used were comprehensive and tailored to uncover both statistical trends and in-depth insights.

Ethical considerations

Researching with adolescent girls on GBV and SRH is particularly sensible, as traumatic experiences could be re-activated. Informed consent of the participants, as well as the confidentiality of the data, was respected both in the collection and in the processing and analysis. Ethical approval has been granted (00000211MSAS\CNERS\SP) on December 15th 2021 from the Comité National d'Ethique pour la Recherche en Santé (Code of Ethics for Health Research in Senegal), which ensure that all phases of the research (design, implementation, data processing, analysis, and dissemination of results) are respectful of the physical and mental integrity of participants. To this end, a member of the team was dedicated to strict compliance with the ethics protocol.

Results

In this section, the results presented will first focus on understanding GBV in Senegal through a sociological perspective of social practices, exposing themes such as forced abortion, family exclusion linked to issues of preservation of family honor, as well as the "nëpp nëppël" or the law of silence. Then, the links between GBV and SRH will be examined while emphasizing the importance of holistic accommodation structures for the care of victims/survivors of GBV. Most of the adolescent girls interviewed were adults (68.5%), Muslim (90.6%), single (93.2%), without children (97.1%). Among married adolescents, polygamy was common (58.7%). They mainly lived with their parents (68.2%), who were often in polygamous marriages (49.5%) with a minority of cases of single parenthood (10.6%).

Understanding gender-based violence in Senegal: an approach through the sociology of social practices

The investigation revealed forms of GBV that are poorly documented in scientific research in Senegal, such as forced abortion. This is the experience of H, 18 years old, who recounts:

"The first time I was pregnant, my mother gave me an abortion, I was three months old. She didn't want my boyfriend or the pregnancy…" (Excerpt from interviews with H., woman, 18 years old).

To analyze H.'s situation, it is essential to take into consideration the context of her pregnancy outside of marriage. In Senegal, sexual relations outside of marriage are strongly stigmatized and considered a sin, which leads to social disapproval and a perception of dishonour in the event of motherhood outside of marriage. The imposition of abortion reflects the desire to control women's bodies by denying them the right to choose and decide for

themselves. Furthermore, in Senegal, voluntary termination of pregnancy is prohibited and penalized, which results in limited access to appropriate medical care. Therapeutic abortion is authorized only when the pregnancy endangers the life of the mother. K's case, below, shows how having a child outside of marriage is seen as a transgression of social norms and inherent family expectations. This situation highlights the social pressures placed on women to conform to established norms, as well as the negative repercussions that such transgressions can have on their family ties:

"When my brother found out about the pregnancy, he told me to leave the house and return to the CPA where I was when I ran away two years ago. At the CPA I was told that I could no longer be accommodated there since I am now an adult. I didn't know where to go anymore. It was a lady who found me in the street (neighbourhood) crying who took me home, she called a bajenu gox and that's how I ended up in Kullimaaroo. I was relieved to see a structure like Kullimaaroo. If the centre didn't exist I would have ended up on the street. I had no one left. » (Excerpt from interviews with K., woman, 19 years old).

The two experiences shared by the participants reveal that social control over the bodies of girls and women is not exclusively exercised by men. Women are also actors in the production of sexist dynamics of control. However, their speeches and behaviors seem associated with the "protection" of their daughters and their own "reputation" as mothers. Indeed, the "bad" behaviour of girls, and of children in general, is often considered a consequence of the actions and attitudes of their mothers. It is in this context that the common use of the expression "doom ja ndey ja" (like mother, like daughter) falls, also used to designate an intergenerational transgression of social norms by girls and women of a family. This context partly explains the commitment of women, mothers, and grandmothers, to the preservation of norms which structure and ensure conformity to more socially acceptable practices.

In this same logic of the importance of the family circle, our survey confirm that sexual violence is frequently dealt with within the family (Figure 1). For example, according to the results of the survey on adolescent girls' perceptions of GBV, the majority of them (71.3%) indicate that they would first turn to a member of their family if they came to be victims of violence. They then consider turning to the police (27.9%), nurses (19.3%), or friends (15.5%). Less considered options include complete silence (2.2%), calling a toll-free number (2.6%), consulting a lawyer (5%) or discussing with a teacher (3%). On the other hand, a third of adolescent girls who declared having been victims of sexual violence consider that it would be preferable to first speak to a teacher (33.3%) or a friend (32 .7%).

These results can be interpreted by the fact that family may encourage silence and downplay or keep GBV a secret to preserve their reputations, thus pushing them to seek more open support from friends or teachers. These family constraints may therefore lead adolescent girls to seek support from their peers or teachers, thus offering an option less influenced by social norms and reputational concerns, and likely to guarantee the support and care they need.

The preferred social rules of conduct in these cases are aimed at preserving honour, family reputation, and social unity, which may lead to a desire to keep these "incidents" secret and resolve them internally. As shown in the case of M. below:

"I was raped when I was thirteen by an adult cousin. I lived with my paternal aunt in (another city). I told her about it and she took me to the hospital. The midwife did a pregnancy test which was negative. After that I returned to the village to my parents. I never told them about the rape, I don't know if my bajjen had done it" (Excerpt from interviews with M., girl, 16 years old official age).

As illustrated in the words of this adolescent, rape within the family space is surrounded by silence, so

Figure 1: Rate of adolescent girls in the sample by immediate reaction to gender-based violence

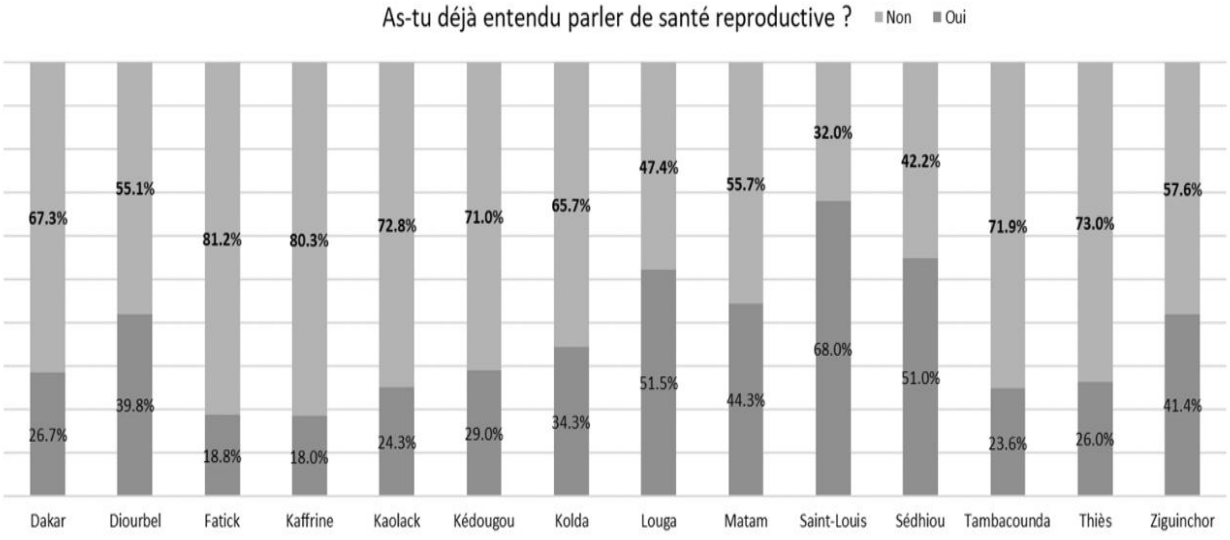

Figure 2: Percentage of adolescent girls who have ever heard of reproductive health. HIRA project, Perceptions of adolescent girls' survey, October 2022

that neither the child nor his aunt reported the incident to the midwife or to the parents of the victim. Likewise, the midwife did not appear to have questioned the pregnancy test carried out on a minor or informed the judicial authorities. The rape, perpetrated by an adult cousin known to his family, was not the subject of any legal or family denunciation. One should know that the social and religious norm of abstinence before marriage mainly stigmatizes women and complicates reporting even when pregnancies are the consequences of rape. Indeed, in these situations, the fear of the stigma linked to the loss of virginity often leads to keeping the matter quiet. It is then often pregnancies which ultimately reveal sexual violence perpetrated repeatedly.

This observation is explained, among other things, by the social practice of discretion called in Wolof "nëpp nëppël", which consists of deliberately maintaining silence on things reprehensible at the legal and social level such as attacks, rapes, divorces, etc. The concept of "nëpp nëppël" is part of a broader cultural framework, that of "sutura" or the culture of non-disclosure which encompasses practices of social discretion to both preserve one's family but also not to make people jealous and attract the evil eye. It is a concept that shapes behaviour and social interactions as one community actor explains:

"These are communities that do not denounce. Compared to the reports we receive; we can say that this is below the cases of GBV that exist. I am not able to give exact figures but out of the 20 cases of GBV among teenagers and women, 1 or 2 cases are reported. Socio-cultural constraints mean that reporting and denunciations are frowned upon. Preserving harmony in families, safeguarding family relationships and ensuring good neighborliness are some of the many reasons why the child is sacrificed and left to her own devices" (Excerpt from interviews with a community actor).

These practices fuel a self-perpetuating system of repeated violence against victims, because the aggressors are aware that they can escape the legal consequences (sometimes even the social consequences) of their actions. This situation often leads to re-victimization of those affected and limits their ability to receive adequate support. In the social contexts of this research, it is clear that "nëpp nëppël" creates an environment where victims are discouraged from speaking about their traumatic experiences and often face social and family pressure to remain silent (blackmail, threats, among others).

In M.'s case, it is clear that her aunt's primary concern was whether she was pregnant as a result of the rape, which would have compromised the "reputation" of the aunt who was her guardian at the time of the rape and "exposed" the son who committed the rape. So here the "nëpp nëppël" obeys less the great, usual logic of protecting the honor of the family in the broad sense. Rather, it is an individual strategy aimed at protecting the perpetrator of the violence suffered.

Understanding the connections between gender-based violence and the sexual and reproductive health of adolescents

Gender-based violence always has consequences on physical health (pain, trauma, gynecological problems, infections and sexually transmitted diseases, Human Immunodeficiency Virus HIV, etc.), and mental health (symptoms of post-stress disorder, traumatic symptoms, depressive symptoms, anxiety, fear, mistrust, etc.) of adolescent girls. In this regard, our data show that the stigmatization of GBV victims and the social consequences of pregnancy have an impact on the non-use of health and legal services. A teenager met at the Kullimaaroo center during the investigation reported not having consulted a health professional throughout her pregnancy in order to hide her condition.

"I had not done any prenatal consultation because I had hidden the pregnancy. When I gave birth, we called Kullimaaroo. (A Kullimaaroo team member) came and paid all the bills and prescriptions. Afterwards I was brought to the center with the baby. I stayed in accommodation for 2 months before being brought back to my parents with food for the baby, diapers, etc. I went back to school, my mother looked after the baby" (Extract from interviews with A., woman, 18 years old).

Regarding the knowledge of adolescent girls, the majority of them have never heard of reproductive health (61.9%) and more than half (58.6%) of them do not know where to obtain a means of contraception. Figure 2 is illustrative of this situation. On the other hand, a large majority of adolescent girls (77.9%) have already heard about gender-based violence through the media, school, family, friends, etc. However, we note that even if a majority of adolescent girls responded that they had already heard of gender-based violence, during the

qualitative interviews, several of them associated it with sexual assault solely linked to the use of force. This reminds us that knowing about sexual violence does not guarantee a complete understanding of its intricacies.

"Even when I refused, he forced me. To avoid this, I pretended I had a headache when he asked me to come over to his place and I didn't want to sleep. It's only now that I understood that it was rape" (Excerpt from interviews with K., woman, 19 years old).

Our survey results conclude that a lack of information and knowledge has a negative influence on behaviour and decision-making. And, conversely, educating on issues of sexual and reproductive education and GBV would allow victims to identify and deal with problematic situations, and enable young people to question their attitudes and change their behavior.

However, it is important to recognize that knowledge acquired about sexual and reproductive health and rights (SRHR) may not always reflect the reality of the context in which individuals live. Although the Senegalese judicial system officially guarantees access to sexual rights, such as contraception, even for adolescents, social and cultural realities often advocate abstinence before marriage. This creates a gap between the knowledge taught in SRHR, which emphasizes contraception and methods to prevent unwanted pregnancies, and social expectations that encourage abstinence and preservation of chastity until marriage. As a result, adolescents may find themselves confronted with a conflict between the knowledge they have acquired regarding SRHR, various pressures and influences and social expectations.

Beyond GBV and the lack of knowledge among adolescents, victims/survivors of GBV in Senegal have very few places to seek shelter. To date, as the results of the various surveys show, apart from the first reception centers (CPA), only seven public establishments are available on Senegalese territory. Accommodation remains the blind spot in the GBV support system. The Kullimaaroo accommodation centre and the holistic services offered contribute to the inventory of "protective knowledge" in the management of GBV and the consequences on sexual and reproductive health. Protective knowledge in the context of GBV aims to empower individuals by providing tools to identify the warning signs of violence, understand the mechanisms and act appropriately to protect themselves and seek help. From this perspective, the center offers services such as reception, listening, accommodation, medical care, psycho-traumatic monitoring, legal support, social and school reintegration activities, programs financial empowerment and family mediation for a possible return to family. In addition, postpartum monitoring and support for teenage mothers financially but also psychologically is guaranteed.

"Beyond the psychological and health consequences, there are social consequences which mean that these individuals may be at risk and need to be removed from their environment in order to bring them to safety. This is the case for certain adolescent girls who have been victims of rape within the family; this poses a security problem. Before Kullimaaroo was created, we relied on families for this type of welcome. With the center it is much easier to coordinate all that concerns care and follow-up" (Excerpt from interviews with Doctor K., man, no age).

Structures like Kullimaaroo remain uncommon in Senegal due to the focus there on the GBV/SSRA nexus and its capacity to accommodate adolescent girls who often give birth during their stay. By adopting a holistic approach, this center aims to provide comprehensive support to victims/survivors, addressing the immediate consequences of GBV while addressing the broader aspects of their sexual and reproductive health. This may include specialized medical care, psychological advice, support in caring for their newborn, financial support for expenses related to childbirth. With a focus on the GBV/sexual and reproductive health nexus, Kullimaaroo also recognizes the importance of combatting social and cultural norms that perpetuate GBV and hinder access to sexual and reproductive rights. This holistic approach is unique and essential

to ensure integral and complete care for victims/survivors of GBV. These situations demonstrate the relevance of accommodation structures for adolescent girls who find themselves in a situation of temporary disaffiliation favoring a certain isolation.

Discussion

In Senegal, the law relating to reproductive health institutionalized in 2005 the right to SRHR care and services for all and without discrimination. However, access to health services may be restricted due to practices of health providers, who may discriminate based on age and marital status, which may particularly affect adolescents[5]. Indeed, social norms that stigmatize premarital sex also have the effect of restricting young people's use and access to health services and effective contraception. A socio-symbolic constraint is thus added to other types of constraints in this area (economic, informational, disability, etc.)[4].

As Elizabeth Shove explains[7], social practices are influenced by social norms, knowledge and/or environmental context[7]. In the case of "nëpp nëppël" the fear of stigmatization, the protection of the family honour, as well as the fear of being rejected or excluded from the community (social isolation) prove decisive. Rooted in a sort of culture of maintaining stability in families, this practice has become an accepted behavioural norm, performed and perpetuated by populations without questioning it[7]. Gender norms also strongly influence the social practice of “nëpp nëppël”. In her work, Françoise Héritier explored the question of the perception of women's bodies and its instrumentalization in social relations of power[10]. She observes, just like our survey results, the imposition of virginity before marriage and the stigmatization of pregnancies outside of marriage. She explains, however, that these practices are put in place to determine who has the right to decide on reproduction. She emphasizes that control of women's reproduction is often exercised by individuals or groups who cannot procreate themselves, such as men, family elders or social and religious authorities. This correlates with our results which showed that the brother or mother controlled the reproduction of young women. Héritier considers that this control allows them to maintain their authority and preserve their social position by limiting the autonomy and freedom of women in their ability to decide on their own reproduction[10]. As a result, many rape victims remain silent, only revealing the assault when the resulting pregnancy forces them to do so.

Furthermore, it is interesting to note that in certain situations, the argument of reconciliation leads families to organize marriages with the dual function of hiding the aggression and preserving an appearance of “family honor”. Obviously, this type of marriage places victims/survivors at the center of the material and immaterial conditions of the sexual violence they suffered and thus exposes them to new occurrences and forms of gender-based violence. We see here that it is important to understand the socio-cultural complexities surrounding the disclosure of sexual violence. This is why, as part of their care, it is crucial to create safe and caring environments where victims can express themselves without fear of stigmatization or reprisals.

Especially since the adolescence phase is a period when adolescents are vulnerable, peer pressure, risk-taking, the feeling of maturity expose adolescents to consequences that they cannot take charging in complete autonomy[11]. It is appropriate to ask whether the acquisition of knowledge in SRH could contribute to mitigating GBV or whether better knowledge of the social dynamics of GBV in the contexts studied could have significant effects in the management of SRH among adolescents. Furthermore, survey data show that the level of knowledge of young people in terms of SRH is low in Senegal[6,12]. Raising awareness and education on sexual and reproductive health could play a positive role in the fight against gender-based violence (GBV). According to Elizabeth Shove, individual knowledge plays a crucial role in how social practices are influenced. The knowledge acquired by individuals can enable them to question existing social norms and adopt new practices.

Consequently, acquiring knowledge about sexual and reproductive health could help transform social practices in favor of greater girls' empowerment. By equipping them with the

necessary tools to recognize, prevent and act against the forms of violence they may face, it is possible to promote the empowerment of adolescent girls.

Conclusion

In conclusion, to better understand gender-based violence in Senegal, an approach based on social practices is interesting. This violence, which mainly affects women and girls, is influenced by gender norms and perpetuated by social practices such as "nëpp nëppël" or the culture of silence. These practices have the effect of dissuading victims and those around them from reporting the violence they are victims of, which aggravates the health and emotional consequences of this violence and exposes them to a risk of additional victimization. Gender-based violence acts as practices of social control (forced abortion, excision, forced marriage) having an impact on the sexual and reproductive rights as well as the overall health of survivors. Shelter centers and community stakeholders take these social practices into account by always encouraging family mediation and the return of victims to their families. They try to find a balance between the fight against GBV and respect for social norms. They encourage the denunciation of GBV and breaking taboos, which can potentially provoke changes in social practices. However, they do not go against certain gender norms, or do not always insist on the informed consent of the first concerned. It would therefore be interesting to further research on the role of community actors in the way in which they reconcile existing social norms and the developments of a Senegalese society that is increasingly egalitarian between men and women. In particular, it is appropriate to question the potential of their interventions to perpetuate pre-existing social practices or, on the contrary, to promote social changes.

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