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Exploring intersections between gender-based violence and adolescent sexual and reproductive health and rights in West Africa: A review of the literature produced in the sub-region

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Abstract

This review, commissioned by the Canadian International Development Research Centre (IDRC), explores the intersection between gender-based violence (GBV) and adolescent sexual and reproductive health and rights (ASRHR) in the Economic Community of West African States. It is imperative to understand this intersection for research, policy, and practice purposes in a sub-region characterized by high youthful populations with significant reproductive health challenges. A mapping exercise, literature review, and gap analysis were conducted. Findings indicate that several stakeholders and organizations exist, though few are youth-led or centred. Legislation and policies are not comprehensive or necessarily enforced in a context of legal pluralism where institutions and infrastructure in place for providing services are weak. There was minimal knowledge production from the region on the GBV-ASRHR intersections, uneven attention to the issues among countries, and intersections mainly focused on female genital mutilation and child marriage. Opportunities for addressing gaps and implications for research, policy, and practice, arising from the findings are discussed. *(Afr J Reprod Health 2021; 25[4]: 118-134).*

Keywords: Regional mapping; knowledge synthesis; gap analysis; legislation and policies; institutions and capacities; GBV-ASRHR intersection

Résumé

Cette revue, commandée par le Centre canadien de recherches pour le développement international (CRDI), explore l'intersection entre la violence sexiste (VBG) et la santé et les droits sexuels et reproductifs des adolescents (ASRHR) dans la Communauté économique des États de l'Afrique de l'Ouest. Il est impératif de comprendre cette intersection à des fins de recherche, de politique et de pratique dans une sous-région caractérisée par des populations très jeunes avec des défis importants en matière de santé reproductive. Un exercice de cartographie, une revue de la littérature et une analyse des lacunes ont été menés. Les résultats indiquent qu'il existe plusieurs intervenants et organisations, bien que peu soient dirigés ou centrés sur les jeunes. La législation et les politiques ne sont pas complètes ou nécessairement appliquées dans un contexte de pluralisme juridique où les institutions et les infrastructures en place pour fournir des services sont faibles. Il y avait une production minimale de connaissances de la région sur les intersections GBV-ASRHR, une attention inégale aux problèmes entre les pays et des intersections principalement axées sur les mutilations génitales féminines et le mariage des enfants. Les opportunités de combler les lacunes et les implications pour la recherche, les politiques et la pratique, découlant des résultats sont discutées. *(Afr J Reprod Health 2021; 25[4]: 118-134).*

Mots-clés: Cartographie régionale ; synthèse de connaissances; analyse des écarts; législation et politiques; institutions et capacités; carrefour GBV-ASRHR

Introduction

The United Nations' Sustainable Development Goals (SDGs) acknowledge the importance and the uniqueness of the health challenges facing adolescents and youth, and underscore that safeguarding adolescent health and well-being (SDG 3), promoting gender equality (SDG 5), reducing inequalities (SDG 10), and ensuring justice and building strong institutions (SDG 16), among others, are crucial for adolescents to reach their full socio-economic potential and for countries to harness their demographic dividend[1]. Key among these challenges is gender-based violence (GBV), and poor adolescent sexual and reproductive health and rights (ASRHR), which have repercussions for

the development of adolescents and youth and the societies in which they live. GBV comprises sexual or non-sexual acts "perpetrated against a person's will and is based on gender norms and unequal power relationships…and is a severe violation of several human rights"[2]. GBV is intrinsically linked to ASRHR which connotes an adolescent's "state of complete physical, mental and social wellbeing" in relation to sexuality and the reproductive system and includes an awareness of his or her rights to a fulfilling sexual and reproductive life[2–4,5].

Globally, we know that GBV exists throughout the life course in different forms for girls and women, with the most common being intimate partner violence (IPV)[6–8]. It is a global phenomenon but differs "only in scope from one society to the next"[9]. Other forms of GBV denoted in the literature include harmful traditional practices (by harmful traditional practices, we refer mostly to female genital mutilation/cutting (FGM/C) and child marriage), school-related gender-based violence, sexual violence, and child trafficking in conflict/post-conflict countries[2,10–12]. The literature is replete with cases of sexual and physical violence among intimate and dating partners, while the literature from low and middle income countries also emphasize those related to harmful cultural practices such as child/forced marriage[13]. Key topics emerging from the global and regional literature on ASRHR include contraceptive access and use, adolescent pregnancy and childbearing, sexual risk-taking behaviour, maternal and child health, unsafe abortion, STIs and HIV/AIDS, and issues concerning sexual orientation and gender identity[10,12,14–16]. Exploring the interrelationships between GBV and ASRHR is imperative to enable a holistic understanding of the drivers of these challenges, and consequently, effectively confront the challenges associated with GBV and/or ASRHR[10,17]. Ultimately, resources set aside to address GBV and ASRHR issues can be maximized since solving one challenge (for example, early marriage) would address the effects of others (for instance, obstetric fistula, complications due to childbirth, and other morbid conditions associated with adolescent pregnancy, prevalence of STIs, etc..)[18]. That notwithstanding, this intersection has rarely been studied explicitly. Along with the benefits of studying the GBV-ASRHR nexus, we acknowledge potential risks that may arise, such as reduced budgets and redundant personnel, which will make it difficult to interrogate the important themes separately.

Intersectionality, a theory used to better understand discrimination based on the "multiple marginalizations" experienced by people as a function of their different identities, can aid in a deeper understanding of health issues, including GBV and ASRHR[19]. Since intersectionality presumes that it is the "intersection" of varying identities that intensify discrimination, we imply in this paper that among adolescents compounded vulnerabilities exist, due to their lack of sexual and reproductive health and rights, and susceptibility to gender-based violence. Ultimately, adolescents encountering these multiple vulnerabilities are worse off than their older counterparts. The denial of their rights as a function of their different identities results in harsher violations that can impede their health and well-being. These rights such as access to reproductive health information and services, basic education, and marriage at lawful age- as stated in the various global conventions ratified by countries and national legislations- may not be enforced in contexts where GBV-ASRHR inequalities persist[20]. Further, interrogating these interrelationships in the context of West Africa adds to the challenges in these ways. First, in the 15 countries of the Economic Community of West African States (ECOWAS), challenges of war, conflict, social, economic, and environmental fragility, poverty, and slow changes in socio-cultural and gender norms that enhance adolescent well-being and rights, have retarded development. Particularly in situations of war and conflict, the bodies of girls and boys become sites for perpetuating and enacting violence, through their use as child soldiers, and in the acts of rape and other forms of sexual violence that are perpetrated on them[2,9,21,22]. We acknowledge that women are also targets, but choose to highlight the youth due to the focus of the study. Second, adolescents and youth constitute a significant proportion of the nearly 450 million population of the ECOWAS sub-region, where more than a fifth of the total population is aged 10-19 years[23]. With a projected annual population growth rate of 2.7%, West Africa is expected to have a youth population of 200 million by 2050[24]. These demographics represent an opportunity for enhancing the life chances and well-being, particularly of adolescents and youth, and for harnessing the demographic

dividend. Third, current indicators of development and progress are disappointing. Fertility is high in the sub-region; it is estimated that Africa will contribute 14 out of the 15 countries globally, which will have the highest fertility rates in 2025-2030[25], and out of these 14, five (Niger, Mali, The Gambia, Nigeria, and Burkina Faso) are in the ECOWAS region. Maternal and infant mortality are also high in the sub-region[26,27]. Other challenges include low literacy and political representation of females and youth. Globally, 11 of the 20 countries with adult literacy rates below 50% are found in the sub-region, with girls being disproportionately represented[2]. In addition, the low representation of women in political positions has implications for their rights and interests on national agendas[28]. Finally, a rights-based approach to health, including sexual and reproductive health, is advocated but rarely practiced in this context. Policies promoting rights to health are lacking and opportunities to seek redress once rights have been violated are underutilized[29]. The pluralistic nature of the legal system where there is a co-existence of customary, religious, and statutory laws and policies, further impinge on structures and mechanisms intended to promote rights, especially those of adolescents[2]. All these underscore the urgency of understanding the context to enable transformative change to occur. However, these issues have not been interrogated thoroughly.

Against this backdrop, Canada's International Development Research Centre (IDRC), commissioned a desk study consisting of a mapping exercise, a review of literature produced in the region, and a gap analysis, on GBV, ASRHR, and the intersections between them, in the ECOWAS sub-region. The objective was to support the generation of a body of knowledge and application of evidence to contribute to combatting GBV and to improving ASRHR across ECOWAS member states. This paper is derived from the reports that ensued from the study and mainly incorporate findings from the regional mapping, knowledge synthesis, and gap analysis of knowledge, policies, and practices on the intersections between GBV and ASRHR in the ECOWAS sub-region. The review focuses on answering three research questions:

1. Who are the stakeholders and what legislation, policies, and institutions inform action on the GBV-ASRHR linkages?
2. What are the main ways GBV and ASRHR intersect in the literature in the ECOWAS sub-region?
3. What gaps and opportunities can be identified to further understand and provide evidence for policies and practices on the interrelationships between GBV and ASRHR?

Theoretical-conceptual framework

Adolescence is a period of rapid biological, emotional and psychological growth, and like other periods in the life course, is culturally constructed[2,30]. West African settings with their gerontocratic and patriarchal structures, typically do not view adolescents as full human beings with their own views, preferences, and rights, but as persons needing control, whose "excesses" should be contained[31]. Practices abound to curb sexual desire in girls and to enforce the subservience of the young to adults in society, the obedience of girls to males, and the natural inferiority of females to males[18]. Puberty and initiation rites, for example, perpetuate some of these gendered norms that on the one hand celebrate their entry into adulthood, but on the other hand impinges on their physical integrity and their rights to privacy, among others[32,33]. In turn, adolescents internalize many of these norms in their collective consciousness, which can affect their beliefs and practices about gender equality, developing healthy sexualities, and confidence in their ability to participate in decision making processes and other activities in their societies.

Such views on the capabilities and rights of adolescents are reinforced in policy narratives and practice and in decision-making structures at national and regional levels that largely marginalize them[31]. Much of the narrative about adolescents in policies developed in the sub-region frame them in negative terms and disempowers them. Adolescents also tend to be homogenized, with their different and unique needs as male/female; differently/abled; and with different sexual orientations and gender identities not being recognized, resulting in a denial of their rights with consequences for their health and well-being.

The theoretical-conceptual framework underpinning the study is an integrated framework consisting of two ecological models – the World Health Organization's ecosystem framework on adolescent health and well-being[34] and Heise's

integrated ecological framework on violence and abuse[35]. The WHO's framework integrates individual, interpersonal, community, organizational and institutional, environmental, and structural factors that are interconnected and often reinforcing, not only to understand the determinants of health and well-being but also serve as the means for addressing the challenges. Such a framework is particularly salient in the ECOWAS context of fragility and weak economic and human development that has been presented above. This framework has also been adopted by the pre-eminent regional institution on health, the West Africa Health Organization[24]. We incorporate this alongside the violence against women (and girls) ecological framework which emphasizes the importance of paying attention to the socio-demographic characteristics of those most likely to experience violence as well as the sociocultural factors that explain the occurrence of violence[35]. In this framework, violence is conceptualized as "a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors"[35].

Using this framework allowed for a more holistic approach to conceptualizing violence occurring in situations of both conflict and non-conflict, and in places where adolescents are likely to find themselves, including at home and in school. (See Figure 1 for a model of this integrated framework). The framework guided the knowledge synthesis and provided a foundation to understand the GBV-ASRHR nexus in the literature.

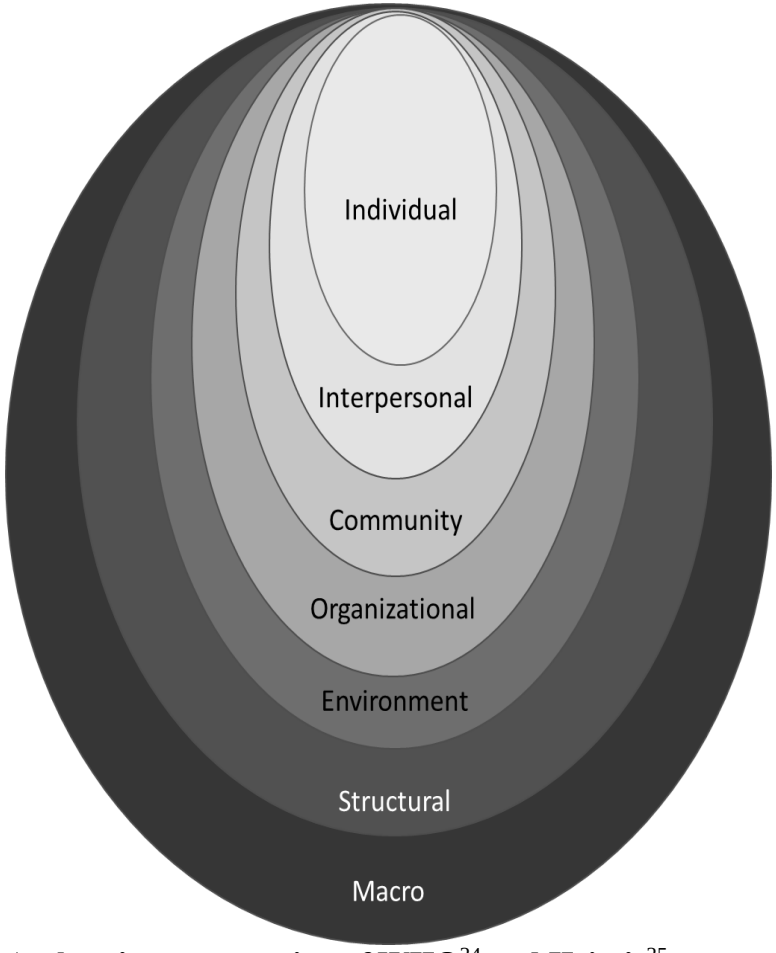
Methods

Literature/document search strategy

The review highlights findings from the following data: 1) mapping exercise to identify organizations and key actors undertaking research, implementation, and advocacy in the region, jointly on the two themes of GBV and ASRHR, particularly highlighting any examples of the intersections between them. This included a review of national and regional policies, strategies, legislation, and programmes for addressing GBV and ASRH and their interrelations; and identification of relevant donors investing in these domains and themes (related to research, programme implementation, and advocacy); 2) a literature review and synthesis of research findings in the region relevant to the two themes and their intersections; and 3) production of a gap analysis and opportunities for research, policy, and practice in the literature. The findings on the intersections for all three products were the focus of this review.

To explore issues of GBV, ASRHR, and the nexus between them in a systematic way, the research team gathered, reviewed, and synthesized literature including from journal articles, book chapters, and grey literature from different sources such as multilateral agencies, international non-governmental organizations (INGOs), non-governmental organizations (NGOs) and media resources. Academic literature for the knowledge synthesis was gathered online using variations of the following search terms: "sexual violence", "gender-based violence", "sexual and gender-based violence", "adolescent sexual health", "adolescent reproductive health", "adolescent sexual and reproductive health", "adolescent sexual and reproductive health and rights" in the entire sub-region, as well as the fifteen individual member states. Databases contacted included Google Scholar, EBSCO host (which provided the database Academic Search Complete), and JSTOR, for journal articles, books, and book chapters. The search engine, Google, was used to identify the grey literature from organizations, agencies, and the media. Published documents between 2000 and 2018 that highlighted ASRHR and GBV issues focusing on adolescents in the ECOWAS member states were included in the study. A few studies that comprised a sample of women or men in the reproductive age group were also included, especially when they disaggregated 15 to 19-year olds from the older sample. If not, these studies were not considered. The information search for the mapping involved mainly online sources for the various countries, in addition to searches within policy documents and reports. The information was collated onto an Excel Spreadsheet for the mapping activity. The supplementary Excel file (available from the authors upon request) shows all stakeholders, legislation and policies, and institutions included in this study.

The data collection process was iterative, with a continual process of searching for documents to review between August and October 2018. The period for gathering and analyzing the data was short, further adding to the limitations of the study. We acknowledge that there are limitations to relying on online databases and websites of organisations for academic and grey literature.



Authors' reconstruction of WHO[34] and Heise's[35] Frameworks

1. **Individual (Personal history)**: age, gender, education, knowledge, self-efficacy and mindsets combined with experiences of witnessing or facing abuse, and absent or rejecting fathers/mothers may promote or suppress health, wellbeing and violence.

2. **Inter-personal (Microsystem)**: family, friends, peers, teachers, conflict, social networks, expectations, financial and social capital along with male dominance in the family, male control of wealth in the family, alcohol use, marital/verbal conflict may promote or suppress adolescent health, wellbeing and violence.

3. **Community (Exosystem)**: community values and norms, networks, support and social cohesion, community and religious leadership, low socio-economic status/unemployment as well as isolation of woman and family, delinquent peer associations may promote or suppress health, wellbeing and violence.

4. **Organizations**: infrastructure such as roads, schools, community halls, health facilities, opportunities for work and pay may be places that promote or suppress adolescent health, wellbeing and violence.

5. **Environment**: physical environment (water, sanitation, pollution), socio-cultural environment (media), biological environment (epidemics) promote or suppress adolescent health and wellbeing, with the socio-cultural environment promoting or suppressing violence.

6. **Structural**: policies, laws, gender attitudes, racial equality, equity, male entitlement/ownership of women, masculinity linked to aggression and dominance, rigid gender roles, acceptance of interpersonal violence, and acceptance of physical chastisement may promote or suppress adolescent health, wellbeing and violence.

7. **Macrosystem** - national wealth, wealth distribution, war/social unrest, impact of globalization may promote or suppress adolescent health, wellbeing and violence.

Figure 1: Integrated framework highlighting factors related to violence and spheres for addressing adolescent health and wellbeing

Apart from this medium, we also reached out to colleagues for literature, (but we only received responses for literature and documents from Cape Verde on the topic). As mentioned earlier, the literature reviewed was from 2000 to 2018, except when there was a unique study by West African authors prior to that. The review focused as much as possible on literature produced by scholars in the sub-region to bring out the knowledge production generated internally. This focus contrasts markedly with the useful Situation Analysis commissioned by WAHO (2016) that relies heavily on the literature on the sub-region, produced mostly by Western scholars, and mainly on DHS data. However, to the extent that this was not possible, we prioritized West African authors writing from outside the sub-region to demonstrate how scholars in the region were engaging on the issues and identifying priorities, gaps, what was not being prioritized, and the reasons for this. We then drew from African authors in general, writing from within or outside the continent. Due to the lack of an online database for postgraduate theses written in the sub-region, this source is missing from the literature review. This resulted in a total of 425 documents. One hundred and eighty were non-academic (reports, web articles, etc) and 245 were academic (peer-reviewed journal articles and books/book chapters). Out of the 245 academic documents, 45 were systematic or literature reviews with 16 books/book chapters. Also, 121 studies used quantitative methodologies, 42 used qualitative methodologies and 21 were mixed methods studies. [The supplementary Word file with the full bibliography list is available from the authors upon request] The study is not a systematic review but a literature review.

Texts consulted were primarily in English although texts in French that provided unique insights into the phenomenon under discussion were also consulted. The lead author and a colleague who consulted on the initial project leading to this paper are proficient in French. Although the majority of searches for literature from all 15 countries were conducted in English, there was also an attempt to search for documents in French from the 9 Francophone countries. The lead author and the consultant also called on colleagues for documents related to GBV and ASRHR. However, the limited number of documents from Francophone and Lusophone countries, in their respective languages, is a major limitation as was the short duration to gather the data. As far as possible, country data for each of the 15 countries in the sub-region were incorporated into the review. To some extent, the Lusophone countries are under-represented in this report, although a lot of effort has been put into ensuring that the little written about Cape Verde and Guinea-Bissau in English and French have been incorporated in the review. The literature reviewed included scholarly literature on socio-cultural factors impacting on the incidence of GBV and ASRHR and their nexus where they exist, as well as assessments of laws, policies, and programmes designed to address these issues, and studies and reports on the phenomenon of both GBV and ASRHR. Given the importance of inter/multi-disciplinary perspectives for understanding the social determinants of health and well-being, attempts were made to draw on literature from a broad range of disciplines including medicine and public health, demography, sociology, law, anthropology, and human geography, and the intersections among them. Predominantly, however, much of the literature reviewed tended to be discipline-bound and did not engage teams from different backgrounds.

Assessing literature quality

As a quality check, we adopted an appraisal guide adapted by Dixon-Woods and colleagues that was developed to assess empirical literature[36]. Thus, it is not applicable for assessing systematic reviews, policy documents, reports, newspaper articles, and other grey literature that are not academic resources but contain important information and data. To assess the quality of the non-empirical literature and documents, we investigated their sources and assured ourselves that they emanated from credible sources, such as various ministries and governmental agencies, NGOs, and other recognized national and international academic and non-academic agencies and institutions. We also examined the authenticity of data used within certain documents by identifying whether the data were from known institutions or agencies in that country. In assessing the quality of the academic literature used in the review, we applied the criteria indicated in Dixon-Woods and collegues[36] on "fatally flawed" literature but did not find any that fit the "fatally flawed" criteria.

Analysis

Online website and document searches resulted in the compilation of GBV and ASRHR organizations, legislation, policies, strategies, action plans, and programmes and funders to fulfil the first study objective, which was to identify stakeholders and the legislation, policies, and institutions that informed action on the GBV-ASRHR linkages. The academic and non-academic documents were also gathered and read for review by the two authors and another lead consultant on the project. This review indicated the main ways GBV and ASRHR intersected in the literature from the ECOWAS sub-region. During the literature review, gaps and opportunities across the various themes that were generated were noted which informed the findings for the gap analysis. The mapping was summarized on an Excel spreadsheet while the literature review was expanded on a Word document.

Results

Findings from the three tasks pertaining to intersections between GBV and ASRHR are summarized in this section to bring out the research, policy, and practice interfaces. The mapping exercise of identifying stakeholders, and the legislation, policies, and institutions that inform action on the GBV-ASRHR linkages, enabled us to contribute to policy and practice. The second task of identifying how GBV and ASRHR intersect in the literature enabled us to highlight findings to inform research activities. Lastly, the gaps and opportunities from the literature review demonstrate the outstanding work that needs to be done in policy, research and practice. All three tasks aim to show the existing documentation on the nexus between GBV and ASRHR and what more needs to be done.

Mapping exercise - national and regional stakeholders, legislation and policies, and institutions and infrastructure on the intersection between GBV and ASRHR

Results from the mapping exercise on stakeholders working to combat GBV and promote ASRHR resulted in a total of 404 organizations (governmental institutions, NGOs, INGOs, coalitions, and networks) across the 15 countries. Eight of these organizations were in multiple countries – DKT International, Intrahealth International, Ouagadougou Partnership Youth Think Tank, Population Services International, Marie Stopes International, Pathfinder International, Plan International, and Care. Out of the 404 organizations listed, 23 across only eight of the 15 countries focused on the nexus, while 243 were solely GBV-related organizations, and 138 were solely ASRHR-related (see Table 1). The organizations working on the intersections included Association Maïa, and Fondation Rama d'Aide Aux Femmes Victimes de Fistule Obstétricale/Prolapsus (Burkina Faso), Renel Ghana Foundation (Ghana), Youth Bridge – Liberia (Liberia), Active Voices and African Girls Empowerment Network (Nigeria), Grandmother Project (Senegal), and National Cooperative of Students for Self-Reliance (Sierra Leone). They comprised mostly of NGOs and networks whose core functions were mostly in advocacy and implementation.

Meanwhile, a summary of the legislative and policy documents used across the ECOWAS member countries indicates a total of 61 laws on GBV, with 32 policies, 18 strategies, 27 action plans, and one programme; and 18 laws on ASRHR, with 49 policies, 40 strategies, 25 action plans, and 13 programmes (see Table 1). However, on their interrelations, there were only eight laws, 18 policies, four strategies, 10 action plans, and one programme. These policies on the intersections particularly relate to the FP2020 commitments by ECOWAS member states where the goal is to eliminate child marriage while promoting various forms of ASRHR. The following 12 out of the 15 countries made commitments at the FP2020 summit – Benin, Burkina Faso, Cote d'Ivoire, Ghana, Guinea, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. The eight laws on the nexus are found across five countries- Benin, The Gambia, Guinea, Guinea-Bissau, and Togo. Four of these laws are Acts or Articles on Reproductive Health, while the others comprise a Code on Persons and Family, Women's and Legal Aid Acts, and a Law on Nationality. These acts, codes, and laws, touch on freedoms from sexual abuse and rights to physical integrity, including preventing FGM and child marriage, while promoting reproductive health. The action plans, strategies, and programmes indicating the nexus are also centred on furthering positive behaviours such as female education, contraceptive use, as well as improving maternal and child health, while impeding problematic outcomes such as teenage pregnancy, child marriage, FGM and sexual abuse.

Table 1: A breakdown of mapping results on organizations, legislation, and policies for GBV, ASRHR, and their intersections

	Organizations			**Laws**			**Policies**			**Strategies**			**Action Plans**			**Programmes**		
Country	**GBV**	**ASRHR**	**Both**	**GBV**	**ASRHR**	**Both**	**GBV**	**ASRHR**	**Both**	**GBV**	**ASRHR**	**Both**	**GBV**	**ASRHR**	**Both**	**GBV**	**ASRHR**	**Both**
Benin	11	7	0	3	3	1	0	2	2	0	1	0	0	3	0	0	1	1
Burkina Faso	16	11	4	1	1	0	6	4	2	3	3	2	1	6	0	0	2	0
Cape Verde	7	1	0	6	1	0	0	1	0	0	2	0	2	0	0	0	0	0
Cote d'Ivoire	11	11	2	4	1	0	0	1	1	1	1	0	1	0	0	0	0	0
The Gambia	12	7	0	3	1	2	4	4	0	0	1	1	1	0	0	0	1	0
Ghana	28	24	2	4	1	0	2	11	2	1	8	0	1	1	0	0	0	0
Guinea	9	5	0	1	1	1	4	2	1	2	4	0	2	2	0	0	1	0
Guinea-Bissau	8	4	0	5	1	3	0	0	0	0	1	0	5	3	9	0	0	0
Liberia	18	5	2	4	0	0	3	4	3	0	1	0	1	0	0	0	0	0
Mali	12	9	2	6	1	0	1	1	0	1	2	0	3	0	0	1	1	0
Niger	7	9	0	7	2	0	3	1	3	1	2	0	1	3	0	0	2	0
Nigeria	57	22	7	4	0	0	2	10	2	1	4	0	1	1	1	0	2	0
Senegal	8	7	2	5	2	0	0	0	1	6	2	1	6	3	0	0	1	0
Sierra Leone	27	8	2	6	2	0	6	6	0	1	8	0	0	0	0	0	1	0
Togo	12	8	0	2	1	1	1	2	1	1	0	0	2	3	0	0	1	0
Country Total	**243**	**138**	**23**	**61**	**18**	**8**	**32**	**49**	**18**	**18**	**40**	**4**	**27**	**25**	**10**	**1**	**13**	**1**
Final Total	**404**			**87**			**99**			**62**			**62**			**15**		

Table 2: Key legal and policy indicators of gender-based violence against women in ECOWAS member states

Country	Legislation on domestic violence	Criminalization of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Benin	Yes	Yes	Yes	Yes	No
Burkina Faso	Yes	Yes	Yes	Yes	Yes
Cape Verde	PC	Yes	Yes	Yes	No
Cote d'Ivoire	No	No	Yes	Yes	Yes
The Gambia	Yes	Yes	Yes	Yes	Yes
Ghana	Yes	Yes	WP	Yes	Yes
Guinea	PC	No	Yes	Yes	Yes
Guinea-Bissau	Yes	-	No	Yes	Yes
Liberia	Yes	-	No	Yes	Yes
Mali	No	No	No	Yes	Yes
Niger	Yes	No	No	Yes	Yes
Nigeria	No	No	Yes	Yes	Yes
Senegal	PC	No	Yes	Yes	Yes
Sierra Leone	Yes	Yes	Yes	Yes	Yes
Togo	No	No	Yes	Yes	Yes

*NAP=National Action Plan 1325; Y=Yes, legislation exists/violence is criminalized; N=no legal provision/law/legislation; PC=legal provisions in penal/criminal code; WP=legal provisions specific to legislation on the workplace; '-'=missing data

Table 3: Research addressing GBV and intersection issues in ECOWAS countries

Country	Topics addressed
Benin	Female Genital Mutilation (FGM), child marriage, school-related and gender-based violence (physical, sexual, sexually transmitted grades), domestic workers, child trafficking (commercial sex work), child beggars
Burkina Faso	FGM, child marriage, **intersections between FGM and ASRHR**, child marriage, school-related gender-based violence (sexually transmitted grades), child beggars
Cape Verde	Child marriage, domestic workers, child trafficking (for commercial sex work), **intersections between child trafficking and ASHR**
Cote d'Ivoire	FGM, child marriage, sexual violence during and post-conflict, school-related gender-based violence, domestic workers, child trafficking (for work on plantations),
The Gambia	FGM, child marriage, **intersections between FGM and ASRHR**, child trafficking (commercial sex work), **intersections between child trafficking and ASHR**
Ghana	FGM, child marriage, **intersections between FGM and ASRHR**, school-related gender-based violence (physical, sexual, bullying, sexually transmitted grades), **intersections between school-related gender-based violence and ASRHR**, ritual bondage and marriage (*trokosi)*, child trafficking (for commercial sex work), child witchcraft accusations
Guinea	FGM, child marriage, domestic workers, child trafficking (for commercial sex work),
Guinea-Bissau	FGM, child marriage, child beggars
Liberia	FGM, child marriage, **intersections between child marriage and ASRHR**, sexual violence during and post-conflict, school-related gender-based violence (sexually transmitted grades), child trafficking (for commercial sex work), child witchcraft accusations
Mali	FGM, child marriage, **intersections between FGM and ASRHR, intersections between child marriage and ASRHR**, child trafficking (for commercial sex work)
Niger	FGM, child marriage, school-related gender-based violence
Nigeria	FGM, child marriage, **intersections between FGM and ASRHR**, **intersections between child marriage and ASRHR**, sexual violence during conflict, school-related gender-based violence (sexually transmitted grades), child trafficking (for domestic work, and commercial sex work), child beggars, child witchcraft accusation,
Senegal	FGM, child marriage, school-related gender-based violence (sexually transmitted grades), child trafficking (for commercial sex work**)**, **intersections between child trafficking and ASHR**, child beggars
Sierra Leone	FGM, child marriage, violence, sexual violence during and post-conflict, school-related gender-based violence (physical, sexual), child trafficking (commercial sex work), child witchcraft accusation
Togo	FGM, child marriage, **intersections between child marriage and ASRHR**, school-related gender-based violence (sexually transmitted grades, physical, sexual), child trafficking (for domestic work, and commercial sex work)

The *State of African Women Report* (2018) further documents that the constitutions of some countries provide legislation on GBV; about 11 countries have legislation on FGM[2]. The countries with legislation on FGM are Benin, Burkina Faso, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Niger, Nigeria, Senegal, and Togo. In Sierra Leone and Mali which have high prevalence rates[37],

only a programmatic response or action plans to address the issue exist. But in The Gambia where legal and constitutional provisions and a programmatic response exist, prevalence is still high[37]. All countries in the region have passed legislation in the last two decades prohibiting child marriage, and 10 countries criminalize the practice (the countries with an outright ban or criminalization of child marriage are Burkina Faso, Cape Verde, The Gambia, Ghana, Liberia, Mali, Nigeria, Sierra Leone, Senegal, and Togo). But high rates persist across the sub-region, with adolescent girls at greater risk than boys. In addition, all countries have passed laws on human trafficking, but rates of child trafficking are higher in the region than across other regions in Africa (see Eerdewijk and collegues[2], OHCHR[38], and Table 2 which expand on child trafficking rates further). Legislation on ASRHR is much more uneven. Five ECOWAS member states have specific legislation on reproductive health (Benin, Burkina Faso, Guinea, Mali, and Togo), and four other countries have frameworks on adolescent sexual and reproductive health and rights (Ghana, Niger, Nigeria, and Sierra Leone)[2]. These legal instruments discuss young people's rights to access reproductive health information and services. In essence, legislation needed to protect adolescents' reproductive health and rights does not exist in all settings, and where the laws do exist, religious and customary laws co-occur, leading to weak or uneven enforcement of the laws.

In terms of institutions and infrastructure, a plethora of national and international organizations mainly engaged in service delivery and advocacy on GBV and ASRHR in ECOWAS member states exist, supported mainly by foreign funders, but few organizations focus exclusively on adolescents or are led by youth. International organizations such as the International Planned Parenthood Federation (IPPF), Plan International, and the Marie Stopes Foundation also have a regional presence. Other regional advocacy networks exist that also address gender equality and reproductive health issues. However, findings suggest GBV, as well as ASRHR, are not prioritized, while the intersections between them are not explored. [A supplementary Excel file listing several organizations and legislative and policy documents is available from the authors upon request].

Literature review – Key insights on the intersection between GBV and ASRHR

The review of the literature brought out the minimal knowledge production from the region on the two themes and their nexus, the uneven attention among countries, as well as the lack of multi-disciplinary perspectives in the research that is conducted. Few studies were also designed to span several countries. Tables 3 and 4 summarize the state of research on the themes and their intersections in ECOWAS member states. Much more scholarly attention has been paid to countries such as Nigeria, Liberia, and Ghana in Anglophone Africa, and Burkina Faso, Senegal, and Benin in Francophone Africa, than to countries such as Guinea, Guinea-Bissau, or Niger. This is reflected also in the relative attention paid to the various countries in this review. However, the coverage of themes across the countries does not necessarily connote progress in countries that have more research themes. For example, while Cape Verde has fewer research themes, it shows good progress on many themes, including legislation on safe abortion, the lowest adolescent fertility rate, and more permissive laws that safeguard sexual orientation and gender identity rights in West Africa.

Four main themes on FGM, child marriage, child trafficking, and school-related gender-based violence, are covered widely in the literature across the sub-region (see Table 3). The studies on FGM and child marriage discuss negative health implications and legal issues pertaining to the practices, while the school-related gender-based violence studies highlight the impact of GBV on girls' school attendance and performance. Child trafficking research reports overworked and poorly paid children engaged in various forms of labour, including farm, domestic, and commercial sex work[11]. The sexual violence and other rights violations inflicted on the bodies of adolescents in conflict and post-conflict situations in Sierra Leone, Liberia, Cote d'Ivoire, and recently in Northern Nigeria, have also been well documented. Studies highlight its gendered nature with girls being more susceptible, although there are reports of male victims of sexual violence[18,39,40]. But themes such as the ritual bondage of girls and child witchcraft accusations, levelled mostly against females, have been covered in only a few countries.

Table 4: Research addressing ASRHR and intersection issues in ECOWAS countries

Country	Topics addressed
Benin	Contraceptive use; fertility; abortion; HIV
Burkina Faso	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; abortion; Sexually Transmitted Infections (STI); HIV
Cape Verde	Contraceptive use; fertility; Sexual Orientation and Gender Identity (SOGI) issues
Cote d'Ivoire	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; unsafe abortion; HIV; SOGI issues; **intersections between conflict and ASRHR**
The Gambia	Contraceptive use; access to information and education on sexual and reproductive health and rights; maternal morbidity/mortality; STI; HIV; SOGI issues
Ghana	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; abortion; STI; HIV; SOGI issues
Guinea	Contraceptive use; fertility; sexual risk-taking; HIV
Guinea-Bissau	Sexual risk-taking; HIV
Liberia	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; abortion; HIV, **intersections between conflict and ASRHR**
Mali	Contraceptive use; fertility; sexual risk-taking; STIs; HIV
Niger	Contraceptive use; fertility; maternal morbidity/ mortality, abortion*
Nigeria	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; maternal morbidity/mortality; abortion; STI; HIV; SOGI issues, **intersections between conflict and ASRHR**
Senegal	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; abortion; HIV; SOGI issues;
Sierra Leone	Contraceptive use; fertility; access to information and education on sexual and reproductive health and rights; HIV, **intersections between conflict and ASRHR**
Togo	Contraceptive use; fertility; sexual risk-taking; access to information and education on sexual and reproductive health and rights; abortion; HIV

*It appears that the Laboratoire d'étude et de recherches sur les dynamiques sociales et le développement local (LASDEL) in Niger is in the process of preparing a book on abortion, mainly in Francophone countries, based on socio-anthropological studies.

However, there is ample reference to these and other rights violations in the reports issued by the CEDAW and the Convention on the Rights of the Child (CRC) for several ECOWAS countries. We reviewed several countries' reports from the UN Treaty Bodies on the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee. These forms of violence expose adolescents to neglect, physical and sexual violence, early childbearing, and other negative reproductive health outcomes.

Compared with GBV, the literature on ASRHR, usually from a demographic and health perspective, is fairly comprehensive across the sub-region, as a consequence of several rounds of Demographic and Health Surveys (DHS) in most ECOWAS countries. The main themes generated from the survey data identify poor reproductive health indicators, low contraceptive use including condom use, among sexually active adolescents, sexual risk-taking sexual behaviours, adolescent childbearing, as well as worse pregnancy and child health outcomes, compared to their older counterparts. However, research on the components of ASRHR across countries varies, as shown in Table 4. Demographic, social, economic, cultural, and institutional factors affecting contraceptive use are fairly well discussed in the literature across all the countries in the sub-region, except for Guinea Bissau. Fertility was the second most discussed issue across several countries. Studies emphasized the high adolescent fertility and premarital births in this setting. Mortality and morbidity rates are high across the region, but this is not one that is meticulously discussed in the various countries with respect to adolescents. A notable absence in research and coverage is on issues around sexuality, including comprehensive sexuality education, and on sexual orientation and gender identity. A plausible reason could be because these topics are recent in the global SRHR discourse, and also because of social and academic conservatism around these issues in the sub-region.

Notwithstanding its importance, the intersections between the two major thematic areas appear not to be a priority area of focus, while what exists of literature on the intersections is fairly narrow, with few systematic investigations. Only two kinds of GBV (FGM and child marriage) were more likely to be consistently interrogated in terms of their implications for ASRHR, as shown in

Table 4. The literature has identified a relationship between child marriage and age at first birth, where women who marry early have first births as teenagers and are prone to maternal morbidity and mortality. Married adolescents are likely also to be in intergenerational and perhaps polygynous relationships; power dynamics tend to be unequal, and married adolescents can experience intimate partner violence and be susceptible to STI/HIV infection. In the case of trafficked children, they lack the ability to exercise their rights and are likely to suffer poor sexual and reproductive health, with little access to services and information about their health and rights. Cultural understandings that may normalize such a practice include notions of females as passive sexual beings[41], the prevalence of child marriage, and the wide age difference between married or cohabiting women and men[42]. Child marriage is more prevalent among girls than boys, with girls being married off to older (sometimes married men) compared to being betrothed to similarly aged children[43]. The inherent inequalities in such relationships impact negatively on their sexual and reproductive health and rights. While children from poorer socio-economic backgrounds are more susceptible to engaging in commercial sex work or sexual tourism, trafficked children are particularly vulnerable to this industry. Much like other children in unfortunate situations, trafficked children are also prone to STI/HIV infection, unintended pregnancies, and other negative health outcomes. Lifestyles of alcohol and drug abuse may deteriorate these children's overall health, but all these have not been systematically explored in the literature. A study in Ghana has depicted statistically the impact of school-related gender-based violence on adolescent fertility[40], but work on the intersections among other kinds of GBV and ASRHR does not appear to exist or may not be done systematically. In this instance, the few existing comprehensive sexuality education (CSE) curricula have components that seek to promote quality sexual health knowledge and protective sexually autonomous behaviours. Young people are given the information and skills to make informed decisions about their sexual lives. However, there are cultural and religious reservations about various components of CSE guidelines with a major fear that it promotes promiscuity among adolescents[44]. DHS data suggest that adolescents who had given birth were more likely to have permissive attitudes toward wife-beating, but more studies, particularly qualitative, are needed to establish links. Finally, intersections between conflict and ASRHR were identified in four countries- Cote d'Ivoire, Liberia, Nigeria, and Sierra Leone. Regions of these countries have been embroiled in long periods of conflict, while others have had an episodic conflict. In periods of large-scale conflict, many girls experience sexual violence and trauma, culminating in poor ASRHR outcomes such as unintended pregnancies and STI/HIV.

It is likely though that some of the intersections have been explored in grey literature and in theses and dissertations produced in university departments, but these were not readily available in online databases through open access. In summary, an assessment of the literature points to the slow change in gender norms that perpetuate the existence of SGBV among girls and women while failing to improve the sexual and reproductive health and rights of girls and boys.

Gaps and opportunities for research, policy, and practice on the intersections between GBV and ASRHR

Key gaps and opportunities for research, policy and practice based on the literature review comprise the following:

1. ***Minimal knowledge production:*** Existing knowledge production is generally limited to single-country studies, with the health sciences and medicine dominating the studies. There is also limited regional and national funds for knowledge production which encourage single focus country studies and donor determinations of relevant research themes. The mapping of organizations revealed a focus on service provision and advocacy, with limited attention to research. The limited research that organizations conducted tended to focus on the areas and issues that they had prioritised, with little evidence of collaborations across different sectors and disciplines. Thus, significant opportunities for collaboration and learning have not occurred, both at the national and regional level, limiting the scope and effectiveness of findings and recommendations. Limited regional knowledge production also diminishes the influence of local researchers on policy making and institutional capacity building.

2. ***Lack of disaggregated data and focus on young adolescents, boys, the disabled, mental health issues, and the rural-urban divide:*** The review of the literature shows a lack of disaggregated data and focus on adolescents, particularly young adolescents aged 10-14 years, who have been found to be the most vulnerable[45]. In addition, little work on adolescents with disabilities has been conducted, although data suggest a linkage between poverty, disability, and well-being, especially in sub-Saharan Africa[46]. Much attention is also not paid to boys and their gendered experience of violence and their sexual and reproductive health and rights, reinforcing notions of dominant masculinities and unequal gender relations. As well, studies on the mental health and psychological well-being of adolescents and their links to GBV and ASRHR are limited. Finally, there is a paucity of research on the rural-urban divide, despite the diverse GBV and ASRHR-related issues impacting adolescents in both settings. This divide underscores the gendered and spatial inequalities and experiences confronting boys and girls as they come of age in these settings. The identification of these gaps suggests areas for research opportunities to focus on.
3. ***Conceptualization of adolescence and youth:*** Adolescence is both biologically determined and culturally constructed[30]. Although international conventions and frameworks recommend biological means of categorizing these groups[47], there are generally gaps in legislation concerning the conceptualization of adolescence and youth. Africans have varying meanings and experiences ascribed to that period[32,33]. As such, adolescents' views, perspectives, and ideas about this phase may be subdued, while their sexual and reproductive health and rights are violated. Clear and legally defined conceptualizations of adolescence in this context will preserve their rights.
4. ***Legislation and policies in a context of legal pluralism:*** Although some GBV and ASRHR legislation exists, we find that it is not comprehensive or may lack enforcement[2,33]. These challenges create research opportunities to understand barriers to the enforcement of legislation, and to its adoption and acceptance in communities, as some laws may not have resonance to the lived realities of people. Further, research is required on the disjuncture between national legislation and policies, and the acceptance and prevalence of actions violating those laws. In the ECOWAS context of legal pluralism, issues centred on GBV and ASRHR legislation and policies abound and require an in-depth understanding through scientific inquiry.
5. ***Comprehensive sexuality education:*** Regarding comprehensive sexuality education for adolescents, few assessments exist of their quality, including the quality of information young people receive on sexuality education and from whom they receive this education, or of the uses in the sub-region of the tools developed by UNFPA and UNESCO for assessing comprehensive sexuality education[48]. Further, gender differentials with regard to access to sex education are rarely acknowledged.
6. ***Youth-friendly reproductive health services:*** In a similar fashion, few research assessments exist of youth-friendly services and whose needs are served, including those of adolescents with a disability, and male and female youth residing in impoverished circumstances, their accessibility in economic and social terms, and the training and capacities of the service providers.
7. ***Silence on expressions of sexuality:*** There continues to be heteronormative biases in the literature on sexuality in the sub-region made evident in the complete silence/dis-interest in identifying and studying groups of people who do not fit the heteronormative standard. The only exception in this regard is the limited literature available on men who have sex with men.
8. ***Changing gender norms empowering adolescents and girls:*** The extant literature fails to highlight research suggesting changing gender norms that work to empower adolescents and girls in the ECOWAS sub-region, although such studies exist in other contexts[49]. Organizations such as UNICEF and Girls, not Brides, among others, are spearheading change by advocating against child marriage and FGM, promoting girl child education, and married adolescents' use of contraception, but the processes need to be understood in depth with all their subtleties[50]. More research is needed that brings out these

slow and positive changes that can aid transformation in the sub-region.

9. ***The role of the media:*** Few studies identify the media's role in deterring GBV or promoting ASRHR specifically[51], while other studies discuss its use as providing access to pornographic material to impede their sexual health[52,53]. Thus, opportunities exist for media organizations to raise awareness about issues of GBV and ASRHR while serving as advocates for change. Radio and television shows have been successful in promoting social norm change, especially on GBV issues, in other low-middle income regions[49]. In addition, social media along with other forms may reach adolescents with health information in an innovative manner. The poor, rural, urban and underserved, require access to different forms of media in diverse modes and languages to impact positively on GBV and ASRHR.
10. ***Costs of GBV and poor ASRHR:*** Minimal information exists on the economic impact of GBV, poor ASRHR, and their intersection. A study conducted in Ghana discusses this gap and computes the economic costs of violence against women and girls (VAWG) occurring not only at the individual and household level (through loss of income, medical costs, and police reporting expenses) but also to businesses, communities, and the state[54].

Discussion

The mapping activity, literature review, and gap analysis produced three distinct outputs to generate an understanding of the intersections between GBV and ASRHR. Essentially, adolescent health intersects with violence at various levels. The findings from each activity discuss underlying themes that address the need for more research on the GBV-ASRHR interrelations, the disjuncture between national legislation and policies, and the acceptance and prevalence of practices violating those laws. The findings also infer the existence of slow changing socio-cultural and gender norms in communities. These have implications for research, policy, and practice as well as the ability of countries to meet national, regional, and international commitments. Overall, some progress has been made on several fronts in terms of institutions, legislation, and research on the GBV-ASRHR nexus. However, suitable apposite stakeholders need to create conditions for more research in the region, including strengthening the capacity for research through various means.

First, additional research is required on topics that are silent in the literature, along with increased avenues for disseminating their findings. These topics include ASRHR-related school curricula (which have implications for reducing GBV), as well as research on out-of-school youth, along with younger adolescents, the disabled, and other marginalized groups who despite the lack of recognition, are often sexually active, and are prone to sexual risk-taking behaviour that can jeopardize their rights and wellbeing[45,55]. We acknowledge work done by Raising Voices in Uganda[62,63], IPPF/WHR in Mexico[64], and UNICEF/UNGEI[50] that have shown reductions in school-based violence due to school-based interventions in the curriculum and whole school approaches to prevent GBV. Related to this are the few organizations focusing on research; most of the organizations we mapped worked on implementation and advocacy. Therefore, a research agenda must focus on the under-researched GBV and ASRHR topics and their interrelations among the side-lined and yet at-risk adolescents in the ECOWAS. In addition, we recommend that work carried out uses clear definitions of age groups of youth, in line with our findings that data need to be disaggregated for it to be effective. Opportunities for collaboration and learning at the regional level with donors will ensure more relevant themes are considered.

Second, findings from the mapping showed the various legislation and policies that exist, but with few on the GBV-ASRHR interrelations. In addition, there is an obvious disjuncture between the existence of legislation and policy and the wide prevalence of GBV and weak ASRHR. While several countries have laws and policies and have ratified regional and international conventions, they have often failed to implement them, because of weak institutions and pressure from religious and traditional authorities and communities. For example, legislation on age at marriage and FGM are violated by several countries[2]. Given the strong influence and use of traditional and religious institutions in the ECOWAS sub-region[2,56], effective engagements between them and state institutions and agencies, as well as with organizations working on GBV and ASRHR, are required.

The importance of exploring intersectionality, in this case, the GBV-ASRHR intersections among adolescents in ECOWAS member states, is evidenced by various rates of poor reproductive health outcomes from adolescents who have experienced gender-based violence. Interventions targeting the GBV-ASRHR nexus, such as adolescent marital unwanted fertility in these settings, will help combat subsequent consequences. Overall, the findings indicate a lack of rights-based approaches to adolescent sexual and reproductive health behaviours and care which must be strengthened.

Finally, slow changing socio-cultural and gender norms in favour of girls, and adolescents in general, have implications for their health and wellbeing. Limited improvements in contraceptive use in West Africa have occurred, with socio-cultural factors acting as a major barrier to use, despite financial and geographic accessibility over the decades[57,58]. Child marriage is another subject where slow progress has been achieved in the sub-region[59–61]. Evidence of the slow change is also evident in an assessment of attitudes to wife-beating in 13 ECOWAS member states among men and women in age groups spanning five decades. The results indicate higher proportions of younger boys (15 to 19-year olds) exhibiting views that endorse wife-beating, compared to their older counterparts. While attitudes justifying wife-beating are expressed by younger cohorts in most of the ECOWAS countries, higher proportions of women compared to men approved of wife-beating in all 13 countries suggesting a disturbing trend where those who are marginalized adopt or sustain favourable attitudes toward practices that disenfranchise them. The analysis involved an assessment of attitudes to wife-beating among men and women from the most recent DHS datasets for 13 ECOWAS member states (data for Cape Verde and Guinea-Bissau were not available). These data were analyzed using the STATcompiler feature from the DHS program website at https://www.statcompiler.com/en/. Evaluations from mass media interventions conducted in Nepal indicate that social norms in relation to IPV can change to improve futures of adolescents[49]. Essentially, future research must focus on identifying the role of communities, including families, parents and guardians, in addressing the myriad of issues in order to promote rapid change on GBV and ASRHR related issues. Additional research needs must entail improved methods, definitions, and ethical guidance.

Contribution of authors

TM conceptualised and supervised the study. TM and AAEB searched for the literature, carried out the analysis, drafted the manuscript, revised all versions of the manuscript, and approved the final version submitted.

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