Palacký University Olomouc
University of Clermont Auvergne
University of Pavia

MASTER THESIS

Knowledge, Attitudes, and Perceptions: The Intersection of Psychological Intimate Partner Violence and Sexual and Reproductive Health and Rights Among Young Women in Benin

Karen Adriana Castillo Ramírez

Supervisor: Lenka Dušková

GLODEP 2024

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Funded by the Erasmus+ Programme of the European Union

Declaration of Originality and Referencing

I, Karen Adriana Castillo Ramírez, hereby declare that this master thesis titled "*Knowledge, Attitudes, and Perceptions: The Intersection of Psychological Intimate Partner Violence and Sexual and Reproductive Health and Rights Among Young Women in Benin*" and the work presented in it are my own.

I confirm that: (a) This work has not been previously submitted, in whole or in part, for any other academic degree or professional qualification. (b) All sources of information, data, and literature used in the preparation of this thesis have been appropriately referenced and acknowledged in accordance with academic standards and practices. (c) Where any part of this thesis is based on work done by myself jointly with others, I have made clear what was done by others and what I have contributed myself. (d) I understand that any failure to comply with these regulations is a breach of academic integrity and may result in disciplinary action by the institutions.

Signed,

Karen A. Castillo Ramírez

27 May 2024

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Declaration of Honour on the Use of AI

During the writing of the submitted thesis, I, Karen Adriana Castillo Ramírez, used the following AI tools: *QuillBot*, *ChatGPT*, *Grammarly* and *Compilatio* to support the writing process, help with paraphrasing information, grammar correction and sentence structure, plagiarism checks, and support in the correct formatting of the references and citations.

After using this AI tool, I declare that I have reviewed and edited the text and I take full responsibility for the content of the submitted thesis.

Signed,

Karen A. Castillo Ramírez

27 May 2024

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Name and surname: **Karen Adriana CASTILLO RAMIREZ**
Personal number: **R220477**
Address: Nunspeetlaan 26, Den Haag, 2573HG Den Haag, Nizozemsko

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Supervisor: Mgr. Lenka Dušková, PhD.
Department of Development and Environmental Studies

Thesis guidelines:

According to the Council of Europe, Gender-Based Violence (GBV) refers to harmful acts perpetrated against a person's will because of their sex, gender, and/or sexual orientation (n.d.). It is rooted in the social and cultural structures, norms, and values of society and exacerbated by a system of unequal power between men and women. This study aims to investigate the impact of GBV on the attitudes and perceptions of women and girls regarding topics of Sexual and Reproductive Health and Rights (SRHR).
Health indicators in West and Central Africa pose the most significant challenges globally, especially concerning SRHR. According to the UNFPA, this region boasts the world's highest total fertility rate, averaging more than six children per woman (2015). Given its relevance and the lack of research regarding this mechanism, the region of interest for this study is West Africa—in particular, the country of Benin.
A qualitative methodology will be adopted in different communities of Benin, analyzed from an intersectional perspective. The goal is to understand why and how GBV influences women's actions and thoughts concerning their SRHR. The presence of patriarchy as an oppressing system will be assumed, together with the role of culture and religion in shaping people's perceptions.

Recommended resources:

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Supervisor's signature: Date:

Head of department signature: Date:

Internship at CARE International Bénin/Togo

In the fourth semester of my master's degree in Global Development Policy (GLODEP), I chose to do a professional internship simultaneously while conducting this research project. The internship took place with CARE International Bénin/Togo, at the Country Office of Cotonou, Bénin.

CARE International is an international NGO that works in more than 100 countries worldwide. It was established in Benin in 1999 and Togo in 1988. Since 2010, a single Country Office manages the interventions in both countries, known as CARE Bénin/Togo. CARE Bénin/Togo generally fights against poverty and social injustice, specifically focusing on the empowerment and well-being of women and girls (CARE, n.d.). It works on four program areas, including 'Maternal, Sexual and Reproductive Health', in which the organization manages more than five different projects in Bénin alone. They focus on young populations, building awareness, knowledge and skills in Sexual and Reproductive Health, as well as services in this area. Their approach is multi-sectoral and contributes to the resilience of young people, with the general aim of improving the SRHR of the less privileged girls and women in the country.

During my stay in Cotonou, the present master's thesis was carried out. The objectives of this internship were:

1. To provide a learning space for a better understanding of working in the world of international development;
2. To enable the trainee to gain practical experience in the work of international NGOs in the context of development in Benin;
3. To support the intern in carrying out a research project as part of her Erasmus Mundus Joint Master Degree (EMJMD) in Global Development Policy.

The scope of work included:

a) Support the external communication efforts of the Country Office, aimed at strengthening CARE's positioning vis-à-vis its potential donors;
b) Monitor funding opportunities for CARE programs in Benin and Togo;
c) Organize the grant tracking practice and online document archiving of the organization.

CARE Bénin/Togo played a crucial role in providing me with context, training, and the necessary tools to facilitate the exploration of this master's thesis in a West African context: i.e., the rural communities of Benin. Without their guidance, this research project would have not been possible. I express my great gratitude to the organization, for trusting me and providing me with this opportunity to grow both professionally and personally. Special thanks to Guillaume Aguettant, country director, and Modeste Anato, my supervisor throughout this journey. Special mention to Rosine Kededji and Alain Troukou. Finally, to Mélanie Assogba, for mentoring and supporting me with this research in and outside the field.

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To my GLODEP family for sharing this experience with me. I could not feel more privileged to have lived so many adventures, laughs, and mental breakdowns together. In you, I have found friends that I know will last a lifetime.

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To my thesis supervisor, Lenka Dušková, for giving me the space and freedom to work on this topic, and always guiding me on the right path, allowing me to think critically and providing me with questions instead of answers. To CARE Bénin/Togo, for the opportunity to grow professionally and for being patient with my journey. This research would have never been possible without your unconditional support both in the field and in the office.

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Abstract

This master's thesis investigates the intersection of Psychological Intimate Partner Violence (IPV) and Sexual and Reproductive Health and Rights (SRHR) among young women in rural Benin. The primary objective is to explore the Knowledge, Attitudes, and Perceptions (KAP) on SRHR among survivors/victims of Psychological IPV. Utilizing qualitative methodologies, including Focus Group Discussions (FGDs), Individual Interviews, and Key Informant Interviews (KIIs), the study reveals how Psychological IPV affected young women shape their KAP consequently influencing their SRHR behaviors. Findings indicate significant gaps in SRHR knowledge, pervasive cultural and religious stigmas, and the dominance of male partners in reproductive decision-making. Overall, a big range of experiences, opinions and interpretation levels were shared by participants and Key Informants. These insights contribute to understanding the possible impacts of Psychological IPV on SRHR, with Knowledge, Attitudes and Perceptions as a main mechanism. It offers essential data for policymakers and stakeholders to develop targeted interventions that address both IPV and SRHR, ultimately promoting gender equality and improving health outcomes for young women in Benin.

Keywords: *Psychological IPV* | *SRHR* | *Knowledge, Attitudes, and Perceptions* | *Northern Benin* | *Adolescent and Young Women*

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASRHR	Adolescent Sexual and Reproductive Health and Rights
ASRH	Adolescent Sexual and Reproductive Health
ASRR	Adolescent Sexual and Reproductive Rights
CARE	Cooperative for Assistance and Relief Everywhere
CEFMU	Child, Early and Forced Marriage and Unions
CPS	Centres de Promorion Sociale, i.e. Social Promotion Centers
ECOWAS	Economic Community of West African States
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HO	Health Officer(s)
INSAE	Institut National de la Statistique et de l'Analyse Économique, i.e. National Institute of Statistics and Economic Analysis

IOM	International Organization for Migration
IPV	Intimate Partner Violence
KAP	Knowledge, Attitudes, and Perceptions
KIIs	Key Informant Interviews
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning) +
MASM	Ministère des Affaires Sociales et de la Microfinance, i.e. Ministry of Social Affairs and Microfinance
NGO	Non-Governmental Organization
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
WHO	World Health Organization

Introduction

Gender-based Violence (GBV) is a pervasive issue with profound implications for economic, social, and human development globally. Persistent GBV not only hinders gender equality and poverty alleviation but also affects national productivity, income and perpetuates cycles of violence, making it a pressing concern at all levels (Beyene et al., 2021). In Benin, like many countries in the ECOWAS (Economic Community of West African States) region, GBV remains a critical issue, "perpetuated mainly as a result of societal failure to accept and embrace common values of equity and equality" (Samakao and Manda, 2023, p. 1). This phenomenon significantly impacts young populations, particularly adolescent and youth, who make up a 33% of the Beninese population (aged 10-24 years old) (CARE Bénin/Togo, 2021-a).

Benin currently ranks 123rd out of 156 countries in terms of gender equality (World Economic Forum, 2021), and deep-rooted discriminatory cultural practices persist, particularly in the rural and remote departments of Alibori and Borgou, where "only 22% of women of childbearing age participate in decisions concerning their own Sexual and Reproductive Health and Rights (SRHR)" (CARE Bénin/Togo, n.d.). SRHR has been reported as one of the most persistent challenges that young sub-Saharan African women face on a daily basis. The UN's Sustainable Development Goals (SDGs) recognize the importance and uniqueness that health challenges faced by adolescents have in developing countries (Manuh and Biney, 2021). Furthermore, it highlights that both "safeguarding adolescent health and well-being (SDG 3)" and "promoting gender equality (SDG 5) (…) are crucial for adolescents to reach their full socio-economic potential and for countries to harness their demographic dividend" (Ibid., 2021, p. 118). In fact, studies have found that limited access to SRHR increases the risks of unplanned pregnancies, unsafe abortions and Sexually Transmitted Infections (STIs) (Sidze et al., 2014; Nyblade et. al, 2017), which consequently can hinder women's opportunities and development. Adolescent pregnancy, for instance, can lead to (and result from) school dropouts, which in turn obstructs entry into the labor market and limits their emotional and physical growth (Bylund et al., 2020).

According to Benin's 2018 Demographic and Health Survey, a staggering 38% of girls aged 15-19 in Alibori and 28% in Borgou were already pregnant or had given birth

(CARE Bénin/Togo, n.d.). Benin's adolescent fertility rate (age 15-19) was 92.3 births per 1000 women in 2021, and scored a population growth rate of 2.7% in 2022 (The World Bank, n.d.-a; The World Bank, n.d.-b). Additionally, while the law sets the minimum legal age for marriage at 18, 30.6% of Beninese women aged 20 to 24 were married or in union before the age of 18 (CARE Bénin/Togo, n.d.). These demographics call for the need of deep understandings of Beninese contexts in order to enable transformative change, and further represent a chance for ameliorating the quality of life and well-being for adolescents and youth.

This master's thesis studies the nexus between GBV, in particular Psychological Intimate Partner Violence (IPV), and SRHR. It contributes directly to understanding the impacts of Psychological IPV on young adolescent survivors' SRHR. The primary objective is to explore the Knowledge, Attitudes, and Perceptions (KAP) on SRHR among young Beninese women who are survivors of Psychological Intimate Partner Violence (IPV). This is done by applying qualitative methodologies such as Focus Groups Discussions (FGDs), Individual Interviews and Key Informants Interviews (KIIs). Overall, it seeks to unveil how the KAP of survivors shape their behavior towards SRHR, aiming to provide a nuanced understanding that could inform future interventions and policies. This research not only fills a critical gap in the academic literature but also provides essential insights for policymakers and other stakeholders. It has the potential to guide the evolution of targeted interventions that address both IPV and SRHR, thereby improving health outcomes, empowering young women, and contributing to broader development goals such as gender equality. Thus, holding not only academic relevance but also pivotal relevance for effecting real-world change, enhancing the well-being of vulnerable populations, and fostering sustainable development in the Global South.

I begin by briefly outlining the existing literature on the GBV-SRHR nexus and identifying gaps which this study addresses. Second, the theoretical framework is constructed and three sub-questions are proposed for exploration. Third, I describe the methodology and research design used throughout the project, focusing on qualitative approaches suitable for deeply analyzing individual and contextual issues. The subsequent chapters present the results and discuss the findings from the data collected. Finally, I conclude by synthesizing the findings and outlining their implications for policy and practice. Recommendations for future research are proposed at the end.

Literature Review

1. Conceptualizing GBV and SRHR

Gender-Based Violence (GBV) and Sexual and Reproductive Health and Rights (SRHR) are intrinsically linked. As such, multiple authors recognize GBV as a common and critical unmet challenge regarding SRHR (Mingude and Dejene, 2021; Ntoimo et al., 2021; Dokkedahl et al., 2019; Rubini et al., 2023). Notwithstanding, the intersection between both concepts has rarely been studied explicitly (Manuh and Biney, 2021).

1.1. Gender-Based Violence (GBV)

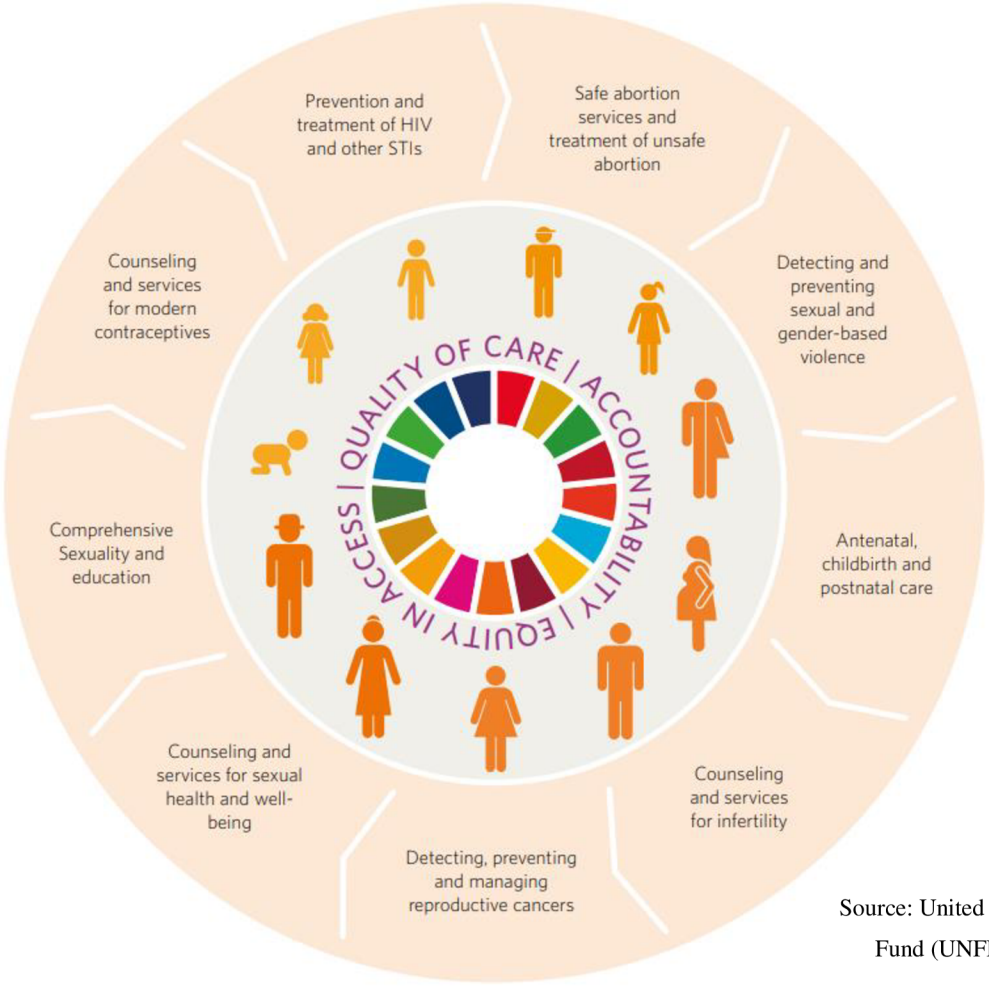
Gender-Based Violence (*GBV*) comprises "harmful acts perpetrated against a person's will because of their sex, gender, sexual orientation and/or gender identity" (Council of Europe, n.d.-a). GBV and 'violence against women' are often used interchangeably since most violence against women is gender-related and predominantly perpetrated by men (Ibid., n.d.-a). This phenomenon is often "normalized and reproduced due to structural inequalities" such as culture, social norms, values, attitudes, and stereotypes around gender and violence against women (European Institute of Gender Equality, n.d.-b). Recognizing its structural nature is crucial as it is deeply rooted in gender inequality and exacerbated by unequal power dynamics between men and women.

The Istanbul Convention by the Council of Europe identifies GBV and violence against women as "a violation of human rights and a form of discrimination against women" (European Institute for Gender Equality, n.d.-a). GBV manifests in various forms, from Intimate Partner Violence (IPV) to cyber-violence occurring online. These distinct forms are interconnected, somethings occurring simultaneously and often reinforcing each other (European Institute for Gender Equality, n.d.-b). Furthermore, GBV is not limited to physical violence as traditionally understood. It is a complex issue encompassing at least four key forms: physical, sexual, psychological and economic. This study focuses on the psychological type of Intimate Partner Violence –to be conceptualized later in this paper–, rarely researched in the literature.

1.2. Sexual and Reproductive Health and Rights (SRHR)

Sexual and Reproductive Health (SRH) is acknowledged as a human right internationally, essential for the physical and emotional health of individuals (Bylund et al., 2020). *Sexual and Reproductive Health and Rights* (*SRHR*) has emerged as an organizational framework linking issues such as family planning, maternal and child health, sexually transmitted infections, and sexual violence (Dudgeon and Inhorn, 2004). According to the United Nations Population Fund (2019), good SRHR is "a state of complete physical, mental and social wellbeing in all matters relating to sexuality and the reproductive system" (p. 8). It entails that "all individuals have a right to make decisions governing their body and to access services that support that right" (Ibid., 2019, p. 8; Starrs et al., 2018). Figure 1 shows a comprehensive definition of SRHR by the Guttmacher–Lancet Commission (Starrs et al., 2018), addressing all aspects of the concept and issues such as violence, stigma and bodily autonomy. This is the definition used for the purposes of this master's thesis.

Figure 1. A comprehensive definition of sexual and reproductive health and rights



Source: United Nations Population Fund (UNFPA), 2019, p. 9.

Prominent topics in SRHR literature include contraceptives accessibility and use, adolescent (and unwanted) pregnancies, sexual risk-taking behaviors, unsafe abortions, maternal and child health, and STIs (Manuh and Biney, 2021; Ngwena and Durojaye, 2014; Channon et al., 2010). Recent gender studies also focus on sexual orientation, gender identity, and LGBTQ+ inclusion.

1.3. The GBV-SRHR Nexus

Research highlights the importance of addressing SRHR within the scope of GBV, and vice versa. Manuh and Biney (2021) argue that examining the interrelationships between GBV and SRHR is crucial for understanding the factors driving these issues and effectively addressing the associated challenges from a holistic approach. However, the intersections between these major themes are often overlooked, with limited literature and systematic investigations. Only specific forms of GBV, such as Female Genital Mutilation (FGM) and child marriage, are consistently examined for their SRHR implications. Thus, more research is needed on the GBV-SRHR nexus, particularly regarding Adolescent SRHR in the ECOWAS region (Ibid., 2021). Rubini et al. (2023) emphasize the "importance of avoiding considering GBV and SRHR as separate domains" (p. 14), noting that GBV's consequences are intricately linked with SRHR from physical, psychological, and social perspectives. Furthermore, GBV itself constitutes a violation of human rights, including Sexual and Reproductive Rights (SRR).

Exploring these intersections regionally is crucial given the varying rates of poor SRHR outcomes among adolescents who have faced GBV. Manuh and Biney (2021) suggest that future research should prioritize identifying the role of communities, including families, parents, guardians, and partners, in addressing GBV and adolescent SRHR issues. This master's thesis focuses particularly on the influence that partners can have on adolescent and young women's SRHR.

2. Psychological IPV

2.1. Intimate Partner Violence (IPV)

Globally, one in three women experience GBV, with 30% of ever-partnered women facing *Intimate Partner Violence* (*IPV*) (Decker et al., 2014; Devries et al., 2013). The WHO defines IPV as "behavior within an intimate relationship that causes physical, sexual, economic or psychological harm" (World Health Organization, 2022), including physical aggression, sexual coercion, psychological abuse, and/or controlling behaviors by a partner or spouse (Ntoimo et al., 2021; Center for Disease Control, 2021). Between 2005 and 2019, 31% of women aged 15 and older in sub-Saharan Africa experienced IPV (Ntoimo et al., 2021). In West Africa prevalence is higher, with 44% of women reporting experiencing IPV in all forms –physical, sexual, psychological– during their lifetime, and 20% during the past year (Le Port et al., 2022; Muluneh et al., 2020). In fact, IPV is the most common type of GBV worldwide (Council of Europe, n.d.-b). Nonetheless, due to its nature, IPV is grossly under-reported, suggesting that actual cases are likely higher. Its prevalence poses a significant developmental challenge, with prevention efforts recognized as key to achieving the SDGs.

2.2. Psychological IPV

Psychological violence, when compared to physical and sexual violence, is the most prevalent form of IPV, affecting 35-49% of both men and women in the USA and Europe alone (Dokkedahl et al., 2019; European Commission, n.d.). Despite the latter, and although there is legal acknowledgment and evidence of its health impact, research on Psychological IPV is scarce compared to sexual and physical IPV, where literature is abundant. Furthermore, there is a lack of clear conceptualization on what 'Psychological IPV' entails, making results difficult to interpret and compare.

In an attempt to consolidate knowledge on the psychological subtype of IPV, Dokkedahl et al. (2019) conducted a systematic review and meta-analysis on the variable's association with mental health issues, while controlling for other types of IPV. The authors argue that there are conceptualization and methodological challenges which characterize the field and which partly explain why it is so understudied in the literature. Mason et al. (2014) agrees with the latter and call for research clearly defining psychological violence and differentiating it from other forms of IPV.

For the purposes of this study, *Psychological IPV* is defined as directly linked to other types of IPV (e.g., physical, sexual or economic), emphasizing a fundamental

psychological dimension of harm in both its perpetration and victim impact (Dokkedahl et al., 2019). This is supported by the Council of Europe (n.d.-c), stating that "all forms of violence have a psychological aspect, since the main aim of being violent or abusive is to hurt the integrity and dignity of another person". Nevertheless, there are specific forms of violence that utilize methods not fitting into other categories, thus constituting a type of "pure" psychological violence (Ibid., n.d.-c).

Psychological IPV involves "any act or behaviour which causes psychological harm to the partner or former partner", which "can take the form of, among others, coercion, defamation, a verbal insult or harassment" (European Institute of Gender Equality, 2017, p. 45). It includes belittling, constant humiliation, intimidation (e.g., destroying belongings), issuing threats of harm, isolating individuals from support networks, monitoring activities, and "limiting access to financial resources, employment, education, or medical care" (World Health Organization, 2012, p. 1; Dokkedahl et al., 2019, p. 6). This comprehensive definition will enable us to examine and differentiate Psychological IPV's specific impacts notwithstanding that, given its nature, Psychological IPV can be inherent in other forms of IPV (physical, sexual or economic), occurring simultaneously or even in conjunction.

2.3. The Impacts of IPV

The detrimental consequences of GBV and IPV are well documented. First, IPV increases women and girls' vulnerability, especially in regions where early marriage and conflicts are common (Rubini et al., 2023). Other mental health-related and economic implications such as anxiety, post-traumatic stress disorder, depression, suicide, substance abuse, cardiovascular diseases and GDP loss are also reported (World Health Organization, 2013; UNDP, 2015; King et al., 2017; Decker et al., 2014; Dokkedahl et al., 2019). Fear of social rejection, exclusion, humiliation and stigmatization of IPV victims is also documented in some studies (Scott et al., 2018).

Mingude and Dejene (2021) argue that multiple adverse health effects of GBV remain vastly underreported in the literature, the most significant and extensive ones related with SRHR. These include "adolescent pregnancy, unintended pregnancy, miscarriage, stillbirth, intrauterine hemorrhage, STIs including HIV, induced [and

unsafe] abortion, low birth weight, preterm birth", genital disturbances, sterility, among many others (Ntoimo et al., 2021, p. 1; Rubini et al., 2023, Mingude and Dejene, 2021).

3. Adolescent SRHR (ASRHR)

Poor SRHR remains a major challenge in the developing world, especially for adolescents and young women. In low- and middle-income countries, individuals aged 10-19 are "disproportionately affected in terms of access and use to SRH services" (Bylund et al., 2020, p. 1; Morris and Rushwan, 2015). The International Conference on Population and Development in 1994 recognized that SRHR underpins multiple other rights e.g., to learn, to work, to move freely, etc. necessary for advancing gender equality and women's empowerment (UNFPA, 2023, p. 2). In fact, poverty is multidimensional and impacts women more severely than men, limiting their access to SRH services, in turn increasing risks of unplanned pregnancies, unsafe abortions, health complications or childbirth mortality, STIs, among others (Bylund et al., 2020). Poor SRHR can thus limit women's opportunities and potential, further deepening their economic disadvantages and exacerbating overall poverty (UNFPA, 2023). In short, "living in poverty can hinder access to SRHR," but lack of access to SRHR can also aggravate poverty in developing countries (UNFPA, 2023, p. 9).

For *Adolescent Sexual and Reproductive Health and Rights* (*ASRHR*) this relationship is particularly relevant. One in three women in developing countries give birth before age 20 (Nsubuga et al., 2016), and "a quarter of the estimated 20 million unsafe abortions and 70,000 related deaths each year occur among women aged 15–19 years" (UNPFA, 2004). In sub-Saharan Africa, approximately 14 million unintended pregnancies occur annually, with almost half among women aged 15–24 (Hubacher et al., 2008). Adolescent pregnancy is both a cause and a consequence of school dropouts, impeding future labor market entry and diminishing opportunities for economic, emotional and physical development, including life skills acquisition and self-confidence (UNESCO, 2017; Bylund et al., 2020). As adolescence represents a period of rapid biological, emotional and psychological growth, constrained access to ASRHR profoundly impacts a nation's sustainable development and well-being.

Given ASRHS's relevance in supporting development in the Global South and the negative impacts that IPV can have on SRHR, studying the interconnection between both variables in depth, particularly considering the psychological subtype of violence, is crucial.

4. The Impacts of Psychological IPV on ASRHR

Decker et al. (2014), Rubini et al. (2023), and Beyene et al. (2021) have studied the health impacts of GBV and IPV on adolescents and young women, linking many findings to the SRHR of survivors and affirming GBV's negative influence across health domains. Decker et al. (2014) emphasize the significant association between IPV and "sexual risks" towards SRHR, including condom non-use, transactional sex, pregnancies, sterility, genital disturbances, infant loss, and STI/HIV. They argue that IPV is a risk marker, if not a predictor, of ASRHR issues in both urban and rural settings. Frequently reported psychological outcomes and social consequences include stigma associated with HIV-positive individuals and sexually-active single women, victim-blaming, various forms of rejection, and avoidance of SRH care-seeking behaviors (Rubini et al., 2023). Nyblade et al. (2017) also noted that stigma towards ASRHR is both a consequence of GBV and a barrier to young people's SRH. In essence, full-fledged stigma results in the "social, economic, and political exclusion of individuals or groups" (Ibid., 2017, p. 1093), diminishing life opportunities and heightening susceptibility to adverse health outcomes, including ASRHR.

Furthermore, "[adolescent] respondents who have not experience of free discussion about sexual and reproductive issues were almost three times more likely for gender-based violence than their counterpart", which shows a reverse association between both variables too (Mingude and Dejene, 2021, p. 7). Birkie et al. (2020) and Belay et al. (2021) also report a significant quantitative effect between GBV and ASRHR. However, more in-depth qualitative explorations of stigma and limited freedom of discussion remain lacking. Beyene et al. (2021) argue for more detailed studies digging into the factors and mechanisms associated with the health effects of domestic violence. This master's thesis aims to contribute to the latter by focusing on Psychological IPV.

5. The Institutional Nature of GBV and IPV within ASRHR

5.1. Macrosystem: Patriarchy and Structural Power Dynamics

GBV and IPV occur within a broad institutional framework. They are rooted in socio-cultural structures, norms, and values, aggravated by a system of gender inequality. This system accepts certain attitudes based on assigned sex or perceived gender, enabling power imbalances and affecting those who detach from gender norms (Rubini et al., 2023; IOM, 2021). Decker et al. (2015) consider GBV perpetuated by macro-level factors like entrenched male dominance, traditional gender roles, and societal acceptance of interpersonal violence, often reinforced by legal and customary practices. Feminists criticize these patriarchal dynamics for limiting women's autonomy and access to resources (Dudgeon and Inhorn, 2004). In fact, men play crucial roles in influencing SRHR outcomes for women and children, both positively and negatively, directly or indirectly.

Authors like Bandarage (1997), Green et al. (2001), and Dudgeon and Inhorn (2004) have studied this relationship. While macro-structural relationships between men and women's SRHR are significant, understanding these dynamics remains complex. Patriarchy, for instance, involving “men’s systematic domination” over “key structural and ideological resources and positions”, impacts SRHR but does not fully explain variations in outcomes (Dudgeon and Inhorn, 2004, p. 1380). It is crucial to also examine micro-level individual, family, and contextual (e.g., cultural) factors within this ecological framework (Decker et al., 2015; Manuh and Biney, 2021). This comprehensive approach is relevant in understanding the social determinants and global patterns of IPV and its influence on SRHR.

5.2. Microsystem: Contextual, Inter-personal and Individual Levels

5.2.1. Contextual / Cultural Level

Research over the past two decades has focused on the role of ‘culture’ in GBV perpetration and sexual education (Le Mat et al., 2019; O’Brien and Macy, 2016). Cultural barriers, often associated with tradition, can hinder the promotion of SRHR. Kedir and Admasachew (2010) demonstrate that gender experts often attribute Ethiopia’s persistent IPV to ‘culture,’ using it as a justification for not intervening on violent

behaviours. Understanding connections between culture and GBV involves recognizing patriarchy's role (Winter et al., 2002). Since men have predominantly shaped cultures in patriarchal societies, GBV and its implications for SRHR interact with these cultural notions (Le Mat et al., 2019, p. 208). Cultural and political taboos, social stigma, and traditional values and attitudes regarding adolescent sexuality, for instance, can impact legislation, ASRHR services promotion, and efforts to prevent early marriages and unintended pregnancies (Nyblade et al., 2017). Furthermore, it can predispose young people to poor knowledge, attitude and practices regarding their SRHR (Meena et al., 2015).

Studies on African women suggest they are especially susceptible to IPV due to subordination to men in sexual relationships, which common in their context (Green et al., 2001). Women's sexual choices reflect cultural values, expectations and serve as adaptive strategies for living with sexism, racism, and economic disenfranchisement (Worth, 1990). Cultural and social constraints impede women from setting personal limits with partners, e.g., when using condoms (Green et al., 2001; Ulin, 1992). In fact, in many African countries, law states that a wife must obtain her husband's approval before accessing family planning services (Cook and Maine, 1987). "Women idealize monogamy" and "see condom-less sex as a sign of trust, honesty and commitment" (Green et al., 2001, p. 586). In Uganda, women suggesting condom use risk being seen as promiscuous, unfaithful and/or as infected from a STD (de Bruyn, 1992).

In West Africa, where this study takes place, patriarchal structures see adolescents as needing control rather than autonomy. Adolescents internalize these norms, which influences their beliefs and behaviors regarding gender equality, SRH, decision-making and other social activities (Manuh and Biney, 2021). Other socio-cultural factors, including religious status, also influence ASRHR outcomes e.g., domestic violence, poor pregnancy outcomes and maternal morbidity (Zaidi et al., 2009). Various authors have studied ethical concerns about SRHR in relation to faith, including contraceptive methods, safe abortion services, and pre-marital sex (Ibid., 2009). The influence of religion as a cultural factor on GBV and ASRHR is briefly within this study's focus.

5.2.2. Inter-personal Level

On the microsystem, men also affect women's SRHR interpersonally, as intimate partners and fathers, influencing contraception, abortion, STIs, pregnancy, infertility, and childbirth, among others (Dudgeon and Inhorn, 2004). Men's effect on women's SRHR is highly complex. I argue that this influence can manifest as Psychological IPV, where women face varying degrees of pressure from male partners, ranging from mild insistence on intercourse and manipulation on the use of contraceptives to threats and even outright physical assault (Green et al., 2001). Feminist writers conceptualize all forms of male pressure within a continuum of sexual and physical IPV, which we categorized earlier as forms of Psychological IPV. They highlight men's violent behavior towards women's subordination, even in loving/caring relationships (Ibid., 2001). Such subordinate position circumscribes their SRHR options: many struggles to practice safer sex, some cannot discuss it with partners, while others face rejection and retaliation when trying (Schoepf, 1992).

5.2.3. Individual Level

The ecological framework emphasizes considering the socio-demographic characteristics of those most prone to violence, along with the sociocultural factors contributing to violence (Manuh and Biney, 2021). At the individual level, adolescents are particularly vulnerable to GBV, with limited relationship experience increasing susceptibility to physical, sexual and psychological IPV (Decker et al., 2015). They may experience relationship power imbalance, raising the risk for various future health issues and leading them onto paths enduring further abuse.

Intersectionality considers "discrimination based on the 'multiple marginalizations' experienced by people as a function of their different identities" (Manuh and Biney, 2021, p. 119; Bauer, 2014). It examines circumstances in which people live, their socio-economic status, sexual orientation, ethnicity, religion, age, etc., showing how these intersections amplify disparities employed by those in power against disadvantaged groups (Decker et al., 2015; Rubini et al., 2023). An intersectional perspective helps understand GBV and ASRHR, recognizing that adolescents face compounded vulnerabilities due to limited SRHR access and GBV susceptibility (Manuh and Biney, 2021). This master's thesis analyzes these issues qualitatively by considering these intersections.

6. The Research Gaps

The GBV-SRHR nexus is fairly big and has successfully evaluated a variety of perspectives. Only two kinds of GBV (FGM and child marriage), however, are consistently interrogated in terms of their implications for ASRHR (Manuh and Biney, 2021). Although not abundant, studies exist which examine the effects that IPV on SRHR, particularly for adolescent and young-women victims. These effects have been outlined above. The literature is replete with cases of sexual and physical IPV (Manuh and Biney, 2021), whilst for Psychological IPV research is scarce. Due to conceptual and methodological challenges, little is known about its manifestation, effects on victims, and consequences for women's SRHR. Psychological IPV itself represents a research gap in the literature, particularly regarding its impact on adolescents' SRHR.

As for ASRHR, there is substantial literature on its different aspects and external factors affecting its good practice in developing countries, both at the macro- and microsystem levels. Nevertheless, knowledge, attitudes and perceptions on ASRHR are rarely studied. The cultural and individual interpretations of SRR are crucial in shaping how individuals perceive their SRHR status, and consequently influences healthcare-seeking, preventive, and informative behaviors (Dudgeon and Inhorn, 2004). Even when protective measures are feasible, for instance, they may be perceived as unnecessary, irrelevant, or psychologically harmful by impoverished women (Sobo, 1993; Green et al., 2001). These attitudes and perceptions are specially concerning when trying to improve the SRHR of individuals, and must therefore be addressed. In order to provide adequate services, in depth exploration of the social and cultural barriers surrounding adolescents and their product understandings, thoughts, needs and expectations is needed (Agampodi et al., 2008).

There is little data regarding *Knowledge, Attitudes and Perceptions* (*KAP*) of a population towards SRHR topics. Nsubuga et al. (2016) look at contraceptive use by using the KAP framework to draw conclusions on university students' sexual behavior in Uganda. Inspired by their methodological design, Knowledge will be defined here as the state of awareness of SRHR and what it entails, while Attitudes or Perceptions will be defined as "respondents' opinion or view, whether positive or negative towards a practice or behavior" regarding SRHR (Ibid., 2016, p. 2). The authors find that misconceptions about SRHR aspects are a key determinant for poor SRHR of participants, having further negative consequences into young women's development in the Global South. Nyblade

et al. (2017) found that stigmas, as a result of KAP, are fundamental determinants of health inequity, and can keep young women down. Finally, Meena et al. (2015) found that negative KAP and nonformal, unreliable information sources on SRHR directly exposes young men in Delhi to poor SRHR outcomes.

Examining adolescents and young women's KAP on ASRHR can reveal the influence these have on youth's behaviour and healthcare-seeking practices. Furthermore, it contributes in the understanding of the mechanisms and factors associated through which GBV negatively affects ASRHR outcomes. Recognizing intersectionality, this paper examines Psychological IPV as a social process that shapes/influences the KAP of adolescents about ASRHR at the community level, potentially leading to negative outcomes in their SRH.

Interrogating these interrelationships in West Africa further addresses another gap in the literature. Not only the deeper interconnections between GBV and ASRHR are understudied, but also how these prevail in the ECOWAS region (Manuh and Biney, 2021). "Challenges of war, conflict, social, economic, and environmental fragility, poverty" and socio-cultural gender norms have hindered adolescent well-being and rights (Ibid., 2021, p. 119). With adolescents and youth making up a substantial portion of the sub-region's population, the opportunity exists for enhancing their life chances through ASRH (UNFPA, 2018). Nevertheless, research studying ASRHR and IPV in the region is scarce, with more focus on East African and South Asian countries. This paper studies the KAP on ASRHR in Benin, contributing to a West African GBV-SRHR nexus.

The conceptual framework explores the relationship between Psychological IPV and victims' KAP on their ASRHR, capturing information at the individual and interpersonal (micro) levels of GBV and its influence on health outcomes. The findings could suggest further links to macro-level structural stigma processes shaping local practices and behaviours regarding ASRHR. This research aims to achieve a holistic understanding of GBV-ASRHR interrelationships and underlying challenges, addressing both an empirical puzzle and theoretical gap through an intersectional lense. It will not attribute whether a causal relationship exists between Psychological IPV and adolescents' KAP on ASRHR, but rather explore and describe how a specific group of people (survivors of IPV) behave towards a certain topic given their condition as a possible explanation.

Inspired by the academic gaps and the importance of addressing them for future interventions, the following exploratory Research Question will be examined: *What are the Knowledge, Attitudes and Perceptions (KAP) towards Adolescent Sexual and Reproductive Health and Rights (ASRHR) among young survivors of Psychological Intimate Partner Violence (IPV) in Rural Benin?*

Theoretical Framework

1. Internship in Benin

This master thesis was carried out simultaneously while undertaking a professional internship with CARE International Bénin/Togo, as previously described in a separate section. CARE Bénin/Togo played a crucial role by providing context, training, and necessary tools for exploring the Research Question in a West African context. Benin was chosen not only because of the direct opportunity to immerse myself in the cultural framework and carry out in-person qualitative research, but also the great significance that GBV and ASRHR issues have in the country. Furthermore, no published literature was found that explore these variables in Benin, thus presenting another opportunity to contribute new knowledge in the GBV-SRHR nexus.

2. ASRHR and GBV in Benin

In Benin, the SRH of young people and adolescents continues to be a concern. This is particularly relevant as 33% of the population in the country is aged 10-24 (CARE Bénin/Togo, 2021-a). Despite years of investment in SRHR in Benin, adolescents and young people continue to be exposed to multiple challenges, including early and unwanted pregnancies, sexual harassment, unawareness of SRR, domestic violence and taboos, which remain constant in most households (Ibid., 2021; Assogba et al., 2022).

Around 13% of girls aged 15-19 have started a reproductive life with 3.3% who are pregnant with their first child (INSAE and ICF, 2019). According to the United Nations Population Fund in Benin, one in three girls gives birth before reaching the age of 18. Contraceptive prevalence among teenagers is 4% and 6% among young people aged 20-24 (UNFPA, 2017). This situation leads to unwanted pregnancies that hinder academic and professional development of adolescents and young women.

Benin's constitution enshrines gender equality, and the country has progressive legislation on GBV, SRHR, early and forced child marriage (CEFMU), sexual harassment, and FGM (CARE Bénin/Togo, n.d.). Furthermore, in 2021, Benin passed a revolutionary law legalizing abortion, one of the most progressive in Africa (Soler, 2022). The government prioritizes SRHR in its strategies and plans, and has announced huge investments in the recruitment of over 15,000 new community health workers for the coming years (CARE Bénin/Togo, n.d.). Nevertheless, despite Benin's favorable legislation and investments efforts, young women and adolescents' access to SRHR services remains limited and very little engagement has been reported.

Adolescents and young women are confronted with a lack of quality information on ASRHR, linked to the weight of socio-cultural and gender norms –framed as GBV at the macro-level– unfavorable to adequate SRH practices (Assogba et al., 2022). Currently, Benin ranks 123rd out of 156 countries in terms of gender equality (World Economic Forum, 2021) and deep-rooted discriminatory cultural practices persist, particularly in rural Northern departments of Alibori and Borgou, where only 22% of women of childbearing age participate in decisions concerning their own SRHR (CARE Bénin/Togo, 2021-b). According to the 2018 Benin Demographic and Health Survey, 14.6% of women aged 15-49 reported experiencing physical and/or sexual violence from an intimate partner in the past year (EDS, 2019). This indicates further forms of Psychological IPV have also been exercised on victims, albeit underreported. GBV is often accepted by women and girls in Benin, and the percentage of those citing IPV as justifiable doubled between 2012 and 2018 (Ibid., 2019).

Adolescents and young women are among the least well-off in terms of SRH services and rights. While the law sets the legal age for marriage at 18, 30.6% of Beninese women aged 20-24 were married or in union before 18 (CARE Bénin/Togo, n.d.). Young people often fear or experience stigmatization, discrimination and even denial of services when visiting health centers, leading to increasing unsafe abortions and 15% of maternal

deaths as a result of these practices (Ministère de la Santé, 2020). In fact, an ENABEL (2021) study carried in the southern Atlantic and Couffo departments showed that only 18.6% of adolescents and young people surveyed had good knowledge of sexual rights, 19.9% of reproductive physiology, 6.5% of STIs, and 65.2% knew about contraceptive methods, though only 42.3% had used them. 46.3% of adolescents had a sexual partner and 3.9% had experienced sexual violence. Finally, only 15.6% had a very positive attitude towards gender equality (Ibid., 2021). These findings are relevant for studying the relationship between Psychological IPV and young women's KAP on ASRHR, and can help in the formulation of sub-research questions for this paper.

3. Proposing Exploratory Questions

O'Brien and Macy (2016) found that GBV, especially IPV, has a detrimental effect on survivors' sense of agency and well-being. Additionally, rigid gender roles and expectations of female passivity, which are common in the context of Benin, can hinder young women's ability to make informed choices about their health (Heise et al., 2002). Fear of rejection or abandonment threats by partners further limits women's choices. The latter suggests that IPV, especially when perpetrated in contexts such as that of Benin, has the power of impacting individual's KAP, consequently affecting their behaviours. Adolescents and young women are particularly vulnerable. At the individual level, they "are considered uniquely impacted by GBV" (Decker et al., 2015) given their young age and inexperience in relationships, which increases their risk of being manipulated and influenced by Psychological IPV.

Studies from Ghana and Nigeria outline some ways in which male partners significantly influence the SRHR of adolescent women (Ezeh, 1993; Bankole, 1995). For example, men mediate economic resources required to access contraceptive methods, and "may either indirectly sanction or directly prohibit" their use (Dudgeon and Inhorn, 2004, p. 1383; Meena et al., 2015). In Zimbabwe, men reported being responsible for making final decisions on contraceptive use, directly influencing a women's SRHR choice (Mbizvo & Adamchack, 1991). The similar happens with abortion. In Turkey, for instance, married women are restricted from obtaining abortions without their husbands' permission, "reflecting conservative interpretations of Islamic law" (Gürsoy, 1996).

Furthermore, men can influence women's decisions by controlling and withholding economic and emotional support; or by actively or passively imposing their preferences for or against abortion on their partners (Dudgeon and Inhorn, 2004). Women also report that their partner's support is crucial when deciding not to terminate a pregnancy (Henderson, 1999). The latter are clear examples of Psychological IPV as conceptualized in this study.

A study conducted by CARE Bénin/Togo in 2022 in northern Benin found that half of interviewed women and girls needed (informal) permission from male family members to visit a SRH center and access contraception (CARE Bénin/Togo, n.d.). Additionally, most husbands and fathers make decisions on behalf of women and girls living in their households regarding marriage, family planning and overall SRHR. The theories and findings reviewed above unfold the following sub-research question to be explored:

> Sub-RQ 1: *To what extent do Psychological IPV young survivors hold negative Knowledge, Attitudes and Perceptions of ASRHR topics?*

This question explores the variety and depth of KAP that survivors hold towards ASRHR, documenting their understanding, experiences, and feelings about these topics and exploring the influences of Psychological IPV without presupposing a direct impact.

Mingude and Dejene (2021), among other authors, reported associated factors between GBV and free discussion about SRHR issues. In Zambia, psychological violence was one of the most common forms among college students (19%), leading to stigma and mental trauma (Samakao and Manda, 2023). Nyblade et al. (2017) found that perceived, anticipated and experienced stigma among young people's SRHR in Tanzania was influenced by micro-level social processes e.g., interpersonal socialization with family members and partners. Because Psychological IPV is a form in which (typically) men exercise power over women through forms of coercion, defamation, verbal insults, humiliation, intimidation, threats of harm or controlling behaviors, I argue that such violent system of socialization can create not only stigmas but misconceptions and taboos for adolescents and young women regarding their SRHR. Thus, the second sub-research question is:

> Sub-RQ 2: *In what ways might Psychological IPV contribute to the creation of stigma, misconceptions, and taboos among adolescents regarding ASRHR topics?*

This question aims to identify and describe specific types of stigmas, misconceptions, and taboos among survivors of Psychological IPV, focuses on identifying and describing these aspects rather than assuming their presence, thereby uncovering the social and psychological mechanisms that IPV might activate or exacerbate regarding SRHR.

Literature has also reported barriers that adolescents encounter when accessing ASRHR services. This is especially interesting for Benin since, as previously shown, despite consistent government and international efforts to facilitate ASRR, statistics are not very encouraging. Fears of shame, scolding, physical punishment, or social isolation due to sexual behavior by family, peers, and the community serve as obstacle encountered by young women in the seek for SRH care and services (Nyblade et al., 2017). Similarly, a multi-country study conducted in Africa found that embarrassment, fear, and other psychosocial factors shaped by an individual's environment, hindered access to care (Biddlecom et al., 2009). I argue that these fears and factors often concern Psychological IPV and can therefore be perpetrated by male partners as a form of GBV.

Finally, Agampodi et al. (2008) found that lack of self-confidence and shyness among adolescents were "the main obstacle" to seeking help and accessing ASRH services. This lack of confidence was exacerbated by insufficient privacy and confidentiality provided by family and other community actors regarding these issues (Ibid., 2008). Negative KAP about SRHR held by parents, teachers, and society influence adolescents and young women through intergenerational processes. If the above is true in contexts where violence, namely GBV was not present, the effects could also exist (and possibly be more visible) in adolescent victims of Psychological IPV. Thus, the third sub-research question is:

> Sub-RQ 3: *How do Knowledge, Attitudes, and Perceptions on ASRHR, shaped by experiences of Psychological IPV, potentially impact ASRHR outcomes for adolescents?*

This question explores the connection between survivors' KAP and their ASRHR outcomes, identifying patterns, mechanisms and insights into how their understandings, influenced by their IPV experiences, might act as barriers or facilitators to achieving positive SRHR outcomes.

Methodology, Research Design & Data Collection

1. A Qualitative Study

This research analyzes the Knowledge, Attitudes, and Perceptions (KAP) of individuals affected by Psychological IPV. To explore these aspects, a qualitative research design was employed, focusing on adolescents and young women survivors at the individual level of analysis to better learn about their KAP on ASRHR. It captures real-life data on needs, beliefs, attitudes, and values, offering insights into "real-life" perspectives rather than experimental or controlled perspectives (Agampodi et al., 2008). Despite its ability to dig into the thoughts of individuals and truly understand the mechanisms behind those thoughts, barely any qualitative studies exist which look at KAP regarding ASRHR.

Qualitative methodology allows for exploring underlying reasons, meanings, and interpretations behind behaviors and beliefs, thus focusing on the "why's" and "how's" and emphasizing understanding phenomena within the participant's social and cultural contexts. It will help uncover how the previously studied societal norms, beliefs, and power dynamics can shape each individuals' responses. Given its ability to generate detailed data, capture the complexity and diversity of human experiences, and provide a holistic view of the issues under study (i.e., the interaction of psychological, social, and cultural factors), qualitative methods are the most suited for this design.

Focus Group Discussions (FGDs) and semi-structured in-depth Individual Interviews were conducted to achieve the study objectives. These data collection methods allowed for a deep focus on the individual, intrapersonal and community levels of participants. FGDs jointly explore people's behaviors, perceptions and attitudes toward a certain issue, and have previously been used in literature to analyse common barriers to health services related to SRH (Agampodi et al., 2008; Nyblade et al., 2017; Boldero and Fallon, 1995; Flaherty et al., 2005). Semi-structured Individual Interviews allow for a flexible yet focused approach enabling participants to express their knowledge, experiences and perspectives in depth. The open-ended nature of the questions further encourages participants to share personal insights and narratives, highlighting the complex interplay between Psychological IPV and ASRHR. Furthermore, they delve

deeper into specific themes, capturing the richness and diversity of opinions within a context.

2. Sampling and Participants

Purposive sampling was used with the help of CARE Bénin/Togo to gather data from participants meeting the study's inclusion criteria: adolescent or young women aged 14-24 which were victims and/or survivors of Intimate Partner Violence. Furthermore, all participants had to belong to a rural municipality of northern Benin. The age range was established based on previous studies in the literature and CARE Bénin/Togo's work when it comes to projects regarding adolescents and young women's SRHR.

This study recognizes that young women in rural Benin face multiple layers of marginalization. By acknowledging factors like gender, age, rural location, socio-economic status and experiences with IPV, the intersectional lense aims to understand how these overlapping factors influence KAP towards ASRHR. A heterogenous sample was chosen to include individuals with different occupations, education, ages, religion, and work areas to gain diverse perceptions and experiences and consider all intersections within identities.

The NGO was crucially helpful in connecting the researcher with the participants of this study. CARE Bénin/Togo works directly with survivors and/or victims of GBV and IPV, thus, making contacting with the adolescents and young women a direct, ethical and professional process arranged through them. Survivors included in this study had all been victims of Child, Early and Forced Marriage and Unions (CEFMU). Given their background with CEFMU and IPV particularly, and based on our conceptualization of Psychological IPV and its manifestations, we assume the participants' experience with the psychological subtype of IPV, whether it was previously detected or not. This is justified by the diagnosed psychological effects from their violent past. CARE Bénin/Togo helped organizing a total of 5 FGDs and 7 Individual semi-structured Interviews in the municipalities of Nikki and N'Dali, in the department of Borgou, northern Benin. The data collection spanned a week and a half, with a total of 36

adolescents and young women studied among the two municipalities. A brief description of the participants is provided in Table 1 and Table 2.

Table 1. Description of Participants, Individual Interviews

IPV Survivor	Code	Age	Religion	Municipality	Education / Occupation	GBV
Survivor #1	S1	21	Christian	Nikki	Graduated high school, currently working in weaving sector	Child, Early and Forced Marriage and Unions (CEFMU) + Intimate Partner Violence
Survivor #2	S2	21	Christian	Nikki	Graduated high school, currently studying the Bible	
Survivor #3	S3	20	Christian	Nikki	Graduated high school, currently working as a merchant	
Survivor #4	S4	18	Muslim	Nikki	Currently studying in high school	
Survivor #5	S5	17	Muslim	N'Dali	Did not graduate high school, currently seeking to finish her studies	
Survivor #6	S6	23	Christian	N'Dali	Did not graduate high school, currently working in weaving sector	
Survivor #7	S7	16	Muslim	N'Dali	Currently studying in high school	

Table 2. Description of Participants, Focus Group Discussions (FGDs)

Focus Group Discussion	Code	Number of Participants	Age Range	Religions	Municipality	GBV
Focus Group Discussion #1	FGD1	6	14-21	Christians, Muslims	N'Dali	Child, Early and Forced Marriage and Unions (CEFMU) + Intimate Partner Violence
Focus Group Discussion #2	FGD2	5	17-23	Christians, Muslims	N'Dali	
Focus Group Discussion #3	FGD3	6	16-22	Christians	Nikki	
Focus Group Discussion #4	FGD4	7	15-20	Christians	Nikki	
Focus Group Discussion #5	FGD5	5	16-23	Christians, Muslims	Nikki	

Additionally, Key Informant Interviews (KIIs) with 2 CPS ('Centres de Promotion Sociale', i.e., Social Promotion Centers) Directors and 2 SRH professionals (Health Officers) working in cohesion with diverse CARE Bénin/Togo projects. KIIs entail a conversation with a person(s) who are knowledgeable about the issue under investigation. CPS are grassroots community support complexes ensuring government policies and strategies of the Ministry of Social Affairs and Microfinance are applied throughout municipalities, focusing on social risks incurred by vulnerable groups, including GBV survivors (MASM, n.d.). For this study, interviews were conducted with CPS Directors from Kalalé (Borgou) and Karimama (Alibori), both in northern Benin. Health Officers (HO) consisted of one gynecologist and a general practitioner who regularly assist women in their SRHR needs. KIIs aimed to gather background and contextual information on adolescents and young women's KAP regarding ASRHR in rural Benin and to complement the data gathered from the primary subjects by providing a different perspective on the issue.

3. Data Collection: FGDs, Semi-structured Interviews and KIIs

Information about confidentiality, anonymity, and the dissemination strategy was provided to the participants by CARE Bénin/Togo and verbally explained by the researcher before starting the data collection. Furthermore, a Consent Form drafted by CARE Bénin/Togo was distributed among survivors and signed before each FGD and Individual Interview. Participants were made aware of their right to withdraw consent or participation at any point. Conversations were conducted in French with most participants, and when needed, in the local language (Borgu Fullfulde) with an interpreter. All FGDs, Individual Interviews and KIIs were audio-recorded with the aim of transcription for a later stage. The main aim of FGDs and Individual Interviews was to understand adolescent and young women Psychological IPV survivors' KAP regarding ASRHR overall. To do so, different topics on ASRHR (e.g., contraceptives, STIs, etc.) were selected based on literature and drafted together with other aspects into an Interviews and FGDs Question Guide (see Appendix A).

The first section contained questions about participants' background information, including their current marital status and whether or not they had children. The second

section focused on Knowledge of SRHR, exploring familiarity of participants with the term and its scope. The third section covered Perceptions and Attitudes toward SRHR, inspired by studies from Dudgeon and Inhorn (2004) and Manuh and Biney (2021). Topics included prevalent SRHR areas e.g., Contraceptive Methods, Consulting a Gynecologist, Abortion and Unwanted Pregnancies, and STIs. Questions regarding GBV, social norms, power relations and decision-making processes related to SRHR were also included. The fourth section briefly delved into the existence of Taboos and/or Stigma regarding ASRHR within the participant's communities. Questions were open-ended and primarily focused on allowing participants to share their experiences and opinions. Probing techniques were further used to explore topics such as SRHR laws, services and stigma-related issues in depth.

For KIIs a smaller Question Guide was used containing about six questions, varying depending on the type of actor (CPS Director or Health Officer) interviewed. This guide can be found in Appendix B. The general goal was to gather data from a different perspective that could not have been generated by the survivors themselves, and to add contextual information not found in the literature. KIIs were all conducted in French and in a more casual manner.

All question protocols were previously approved by CARE Bénin/Togo and the supervisor of this master's thesis. Data collection took place in private rooms at CARE's Youth Centers in the respective municipalities. FGDs ranged from 1 to 1.5 hours, while Individual Interviews ranged from 28 minutes to 1 hour and 6 minutes in duration. KIIs were briefer, ranging from 15 to 37 minutes. Data saturation was achieved when no new data emerged in successive Individual Interviews and FGDs.

4. Method of Analysis

The tape-recorded data was fully transcribed verbatim, checked for accuracy and translated from Borgu Fullfulde to French when necessary. NVivo (version 14) was used to manage, explore, code and manually analyze the data. Thematic analysis was conducted to meet the study objectives. Each transcript was thoroughly read multiple times by the investigator individually to identify the main ideas, barriers, perceptions and

beliefs expressed by participants. Subsequently, discussions were held with the internship supervisor at CARE Bénin/Togo about the data shared by survivors, leading to substantial reflections on the most prevalent knowledge, attitudes, perceptions, stigmas and misconceptions observed in FGDs and Individual Interviews.

This study aims to comprehend the social world of adolescents and young Psychological IPV survivors by interpreting their narratives within their own context and past experiences. Intersectionality was used to identify and interpret themes, e.g., those emerging around cultural norms, influenced by the survivors' gender, age and religion. This lense helped uncover the compounded effects of various identities and categorize them on broader thematic. All themes were developed inductively while reading all transcripts generated. An inductive approach was therefore employed for data coding and analysis. The coding and categorization process was iterative, involving multiple cycles before arriving at the final themes. By focusing on recurring patterns of meanings in both FGDs and Individual Interviews, the final Coding Tree was constructed (see Appendix C). Various quotations were later selected throughout the categorized themes in order to illustrate the findings.

For the KIIs, the same inductive process was followed for data analysis, however, with different themes identified given that the questions and topics talked during the exchange differed from those discussed with the survivors. The final Coding Tree was constructed taking into account all purposes of KIIs (see Appendix D). Because KIIs were carried out with actors other than adolescents and young women survivors, the data collected from such interactions was analyzed separately from that originating from the main subjects of study, in a complementary manner. Thus, the results of the latter will be presented in a different section.

Results and Data Analysis

1. Focus Groups Discussions (FGDs) and Individual Interviews

After individually interviewing 7 young women survivors of Psychological IPV and conducting 5 FGDs with 29 participants, a wide variety of data was collected to explore and answer the research question.

1.1. Knowledge on ASRHR

The awareness and understanding of ASRHR among young survivors of Psychological IPV in rural Benin were influenced by educational programs, community beliefs, and personal experiences. Most participants had some familiarity with SRH issues, mainly due to their involvement with CARE International Bénin/Togo projects. Nevertheless, a big range of understandings and knowledge levels was found. Some participants recognized basic concepts like the importance of contraception to prevent unwanted pregnancies and were aware of STIs. S4 stated, "*lack of condom use which leads to unwanted pregnancies*". S2 added, "*I've heard that as a woman, if you want to have sex and if you're not married, you have to make planning so you don't get pregnant or get sick*". FGDs facilitated knowledge sharing, with participants jointly defining what SRH entailed. On the other hand, some individuals did not know much about the subject and made vague claims, e.g., "*sexual and reproductive health are condoms... it's about condoms, right?*" (S1).

The most commonly known aspect of SRH was contraceptives. In FGDs 3 and 5, older survivors shared their experiences with different contraceptive methods, taking the lead in explaining some of them to their groupmates: "*I know about the pill that you take daily. Mmh… there, there's also the thing that you change every three months, and the one that they put here [pointing at her arm]… I forgot the name ... but you can use that too. And the one you can put inside your private parts ... that's the one I have. Oh, and the condoms too*". However, these were rather the exceptions. In most cases, participants demonstrated rudimentary awareness and lack of comprehensive understanding, especially during Individual Interviews, where most participants could only name condoms. Furthermore, misinformation about contraceptives was prevalent, as S6 mentioned, "*One girl told us she didn't want to use family planning because it causes illness. So, I also don't want to do it either because I don't wanna risk being sick*". In FGD2 a young girl said, "*condoms are only necessary if you have had sex with more than one person or if your husband has multiple women... otherwise you won't get pregnant*".

Similarly, S7 argued, "*contraceptives are only for prostitutes or women who are unfaithful to their husbands*".

Understanding of SRH as a human right also varied. Some survivors, educated on autonomy and women's rights, recognized SRHR as such. The latter indicated how targeted educational programs can enhance awareness and understanding of ASRHR issues. Yet, overall recognition of these rights as personal entitlements remained limited. In FGD2, a participant reflected a partial understanding: "*All women have the right to be checked for sexual diseases... it's their decision. But only if she's having sex … then she can go and check it out*", showing an awareness of the right to healthcare but conditioned by sexual activity. Knowledge of available SRHR services was uneven, with some participants aware but lacking personal experience. In FGD1, a participant said, "*I know about those services but I have no experience with them (…) As we haven't been, we don't know if there's an issue with them like the people say or if they're actually okay*". This suggests that while information about SRHR services might be circulating, its reach and impact is still insufficient. In fact, only very little survivors knew someone in their community who has attended a SRH centre and/or utilize the services available.

Regarding STIs, interviewees showed general knowledge about risks and prevention methods, recognizing the link between unprotected sex and disease transmission. S3 stated, "*Many infections are caught through sexual intercourse. If now your boyfriend has the virus and you have sex without condoms… then you will get the disease too. It is contagious*". In FGD5, a participant emphasized preventing STIs with contraceptive methods. In the same FGD, another survivor added, "*a person who has AIDS must know that they will never be cured (…) they can't change it. But you can prevent it*". Overall, most participants recognized that "*sexually transmitted diseases are dangerous*" (S4). However, misconceptions emerged, such as the belief that "*all women should be warned of sex diseases... except for singles. If she's single it doesn't concern her*" (S6) or that "*STIs can only be passed once, so if your partner has already passed it to someone else you will be safe*" (FDG2). Interestingly enough, when asked about the source of her information, she replied that her former partner (from which she had been a victim of IPV) told her.

1.2. Attitudes and Perceptions on ASRHR

Attitudes and perceptions regarding ASRHR among young women in rural Benin, particularly survivors of Psychological IPV, varied but tended to be more negative. This was especially true regarding unwanted pregnancies, abortions, sex before marriage, SRH services, and contraceptive methods for unmarried women. However, some positive attitudes and perceptions were shown supportive to ASRR. IPV influence was often reflected in narratives about gender norms and power dynamics within relationships.

1.2.1. Decision-Making Regarding SRHR Choices

Young survivors' SRHR choices are heavily influenced by their partners and community. S2 expressed a desire to align her ASRHR decisions with her partner's wishes, even at the cost of her preferences: "*It's his opinion and mine that count when it comes to deciding on my SRH... unless our opinions don't match. If the opinions don't match... and if I try to explain it and he disagrees I can't disobey him... I would have to submit*". Similarly, a participant from FGD5 said, "*I have never been to a health center... my husband hasn't given me permission... and he says that without his permission I will not be attended. Although, actually I don't really want to go there either*". These statements highlight the struggle many women face in asserting their reproductive choices against their partner's opposition, reflecting manipulation and coercive control as forms of Psychological IPV. Another participant said, "*I can't decide on my own to use contraception. My husband has to agree, otherwise it won't work*" (S1). This reflects the broader cultural expectation that men hold the final say in reproductive matters.

Male partners' influence on decision-making was evident in discussions about sexual encounters. S3 stated, "*I think it's the man... It's the man who decides when to have sex... he's the one who has the need. But if the woman doesn't want to have sex, the man shouldn't force her.... that's what happened to me, it was ugly*". Most FGD participants agreed that men have the final say in sexual decisions. However, in FGD1, an older survivor said, "*Personally, I think it's important to negotiate with your husband when you want to make love. There can be a fight between you otherwise. Because if one doesn't want to, it's going to create problems, which isn't good*".

Some participants were unsure about their partner's opinion on SRHR matters but indicated it would significantly influence their decisions. S7 said, "*I don't know how my boyfriend feels about birth control... but he probably doesn't like it. A lot of men don't*

like it. I don't know... he wants to have children in the future and I want him to be happy". This implies that her decision would, regardless, be influenced by her partner's preferences and she would prioritise them. In FGD2, some girls expressed fear of discussing contraception with their partners, worried about accusations of infidelity. A participant said, "*Sometimes I'm afraid to discuss contraception with my husband, because he might think I'm trying to cheat on him (...) And in the end, no matter what, I know that his decision will be good*". Fear of conflict or accusations of infidelity deter women from initiating conversations about ASRHR, leaving them vulnerable to their partner's control over SRHR choices. This, however, is not only through survivors' partners. S5 explained, "*No... I've never been to a health center because I'm not married yet.... and my community would look down on me if I went. But, well, it's not something I want to do anyways... maybe in the future, but not now*". This fear was echoed by others in FGDs 1, 3, and 4, showing how community attitudes control actions and decision-making regarding ASRHR. More on these community attitudes will be discussed later.

1.2.2. Cultural Norms, Gender Roles and Relationships

Cultural norms and gender roles heavily shape attitudes and perceptions towards ASRHR among young women in rural Benin. These norms often place men in dominant positions, dictating SRH terms within relationships. This dynamic was evident in participants' accounts. S4 highlighted the traditional belief that men's opinions should control reproductive decisions: "*If a young woman who is already married gets pregnant and decides to have an abortion, her husband will react badly... and rightly so. It's his right to get angry and react badly... because she disrespected him*". Norms and roles unfavorable to women's autonomy were not only identified in terms of decision-making. In FGD3, one participant argued, "*If there's an unwanted pregnancy in a relationship, it's the man who's responsible. Because he conceived the pregnancy... and he's the head of the family. But the woman can help him too... if he gives permission*". Similarly, in FGD4 another girl said: "*The responsibility for an unwanted pregnancy lies with the boyfriend (...) he's the one who has to take care of the woman and the child*". Participants among both FGDs seemed to agree with these statements. These cultural expectations undermine women's agency over their SRHR and further add pressure on men as traditional providers.

Cultural norms and roles were also expressed in relation to the purpose of relationships, marriage, and pre-marital sex. Participants expressed negative attitudes about married women not wanting children. S1 said, "*Being married and not wanting to have children? Pfff… in my opinion, that's not good. I think she was put in this world for procreating. She needs to put a bit of her part too*". In the FGDs, claims like "*If she loves the husband, she can't refuse to have children*" (FGD1) and "*Maybe the woman was forced to marry this man… If she loved him, she would have no problem having children (…) If she wanted to save her marriage, she must at least have two children*" (FGD5) were common. S6 suggested that "*maybe she's unfaithful to her husband... that's why she doesn't want kids*".

Furthermore, most survivors expressed negative attitudes about sex before marriage. S7 said, "*I don't like the idea of going... I'm not married yet to attend a sexual and reproductive health center, it's not my place*" (S7), suggesting that only married women can be sexually active and thus visit a SRHR centre. S3 added, "*Why would she have an active sex life... a young girl who isn't married? It doesn't make sense. She'd better get married… because if she gets pregnant, then she won't find a good husband*". Most of these relationship norms and beliefs stemmed from religious thought, as all survivors interviewed identified as either Christian or Muslim.

1.2.3. Religious Beliefs

Religious beliefs significantly shape attitudes towards SRHR, often creating barriers for young women. Participants highlighted the conflict between faith and using contraceptives or accessing SRHR services. In FGD3, a participant shared her views about family planning: "*Me, regarding young people… it's not good. First of all because it dishonors God. That's a sin we're doing. As a young person, we've got to stay pure, we've got to abstain. After marriage, if your husband agrees, you can do the planning*". This tension between religious doctrines, which shape cultural norms, and addressing SRHR needs, inhibits women from seeking healthcare services as they fear committing a sin. S2 echoed this by expressing the community's disapproval: "*People here think that using contraception is against God's will. They say that if you believe in God, you must accept all the children he gives you*".

While discussing contraceptive methods for unmarried women, a participant in FGD5 said, "*I know people who have taken contraceptive methods, yeah... but they are all married, as they should be, as God wants them to be*". S4 shared, "*Yes... I talk about these topics with my mom. She doesn't want me to get pregnant before I get married... it's better to save myself for God*". Not a single participant supported abortion regardless the reason behind it, reflecting religious beliefs. A participant in FGD2 argued, "*I know people who have had abortions (…) in a health center, yes. But it's not right... not like that either. Abortion is not the solution, I don't agree*". Another in FGD1 added, "*It's not good because the child didn't ask for life. So, it's not a reason to end its life. God created life and it is so precious (…) If the person is unable to raise his child, she can take him to an orphanage (…) she can leave him there. But it's not right to kill children, it's a sin*". Finally, few survivors understood the reasoning behind a woman wanting abortion despite being already married: "*If a woman is already married, it's best to keep her pregnancy... there's no reason for her to have an abortion… the husband will be angry*" (S7). These religious perspectives influence individual choices and reinforce community-wide stigmas/taboos around SRH, making it challenging for IPV survivors to exercise their rights.

1.3. Stigmas, Taboos and Misconceptions Surrounding SRHR

Stigmas, taboos, and misconceptions surrounding SRHR were identified during FGDs and Individual Interviews, significantly impacting young women IPV survivors' willingness and ability to seek out and use ASRHR services. As previously hinted, many participants reported strong cultural stigmas against unmarried women accessing SRHR services, tied to religious ideas of sex after marriage. Misconceptions about who should use SRHR services further exacerbated these stigmas. A participant from FGD3 expressed, "*I don't understand why an unmarried girl would go to a health center for checking sexual diseases... she's probably a prostitute. Maybe that's why she's single*". This prejudice was counter-argued by another colleague: "*I don't agree, she doesn't have to be a prostitute... maybe that girl was raped, or maybe she's just curious*" (FGD3).

Frequent stigmas and misconceptions included that "*a married woman who adopts contraceptives might be committing adultery*" (S5) and that contraceptives can lead to infertility. S1 said, "*I've heard that adopting family planning can make us fall ill later on*

(…) Also that if I start contraceptives, I will no longer be able to conceive later, and one of my greatest dreams is to have children… so I don't want to risk it". Many survivors believed they needed their husband's official authorization before using any contraceptive method or accessing a SRHR center. It is important to note, however, that by Beninese law, any women, regardless of age or marital status, who seeks help at a Health Center or CPS will be attended and supported based on her needs.

Another misconception related to religion affiliation also emerged. S7 claimed, *"(…) Us, women of certain religions are not allowed to adopt family planning. I think that is only for Christians… or at least everyone I've heard that uses it is not Muslim*". In FGD4, when asked one of the participants her opinion, she replied: "*I don't know... I don't know as much as they do, I go to a different mosque*". These misconceptions suggest the existence of multiple SRHR taboos within certain religions, and also portray the mechanisms in which they manifest in young women and adolescents.

To learn more about the presence of SRHR taboos among IPV survivors, questions about their openness of discussion with people around them were posed. Responses such as "*Yes... I talk about sexual and reproductive health with my friends... but not much. And with my family... no, my family doesn't talk about it. They would think I am pregnant*" (S3) were received. The latter was the case for most of participants: open to discussing ASRHR with friends and educators but not with family, as "*it is sometimes hard to talk about these things with them*" (FGD1). Regarding partners, S5 noted "*I've never talked about it with him... I think it would be very embarrassing to talk about these issues with my boyfriend. We're not even married yet*". Once again, the majority of interviewees coincided by arguing, "*This is not a topic I can talk about with my husband, he would not understand*" (S2) and "*I'm not sure what his views are on SRH (...) I'm afraid to ask him and that he won't not accept to use family planning in the future, because I want to try it after we get married*" (FGD4).

Finally, gender roles and social norms also generate taboos and stigmas about SRH and morality. S6 noted, "*If a girl uses contraceptive methods… here in my community people think she's immoral. They say she doesn't respect traditions*". Claims like this demonstrate how women can turn hesitant from seeking SRH care given the fears of social ostracism and judgment. More about community attitudes towards ASRHR and their impacts on adolescent's autonomy and decision-making was found throughout the KIIs and will be presented in the upcoming sections.

1.4. Closing Remarks

The varied levels of knowledge and awareness about SRHR highlight the complex intersections between individual experiences, cultural norms, religious beliefs, and the influence of Psychological IPV. While some survivors understood contraceptive methods and STI prevention, widespread misconceptions and cultural stigmas hinder informed ASRHR decisions. Furthermore, male partner dominance in decision-making and the strong community and religious influences challenge young women's SRHR assertions. Fear of judgment and exclusion also complicate open discussions about contraception, abortion and other available services. Despite the awareness efforts by organizations like CARE International Bénin/Togo, there remains a critical gap in comprehensive education and empowerment regarding ASRHR for these survivors.

2. Key Informant Interviews (KIIs)

The Key Informant Interviews provided rich background information on the Research Question in the context of northern Beninese municipalities. This was essential for further understanding the KAPs shared by survivors, as one CPS Director interviewee noted, *"(...) when you look at Benin as a whole, that's something else. In Benin the realities in the south are different from those in the north... and when you go north, the realities of each department are different too. In terms of tradition, in terms of social perception, in terms of culture, in terms of ethnicity... in every sense*" (CPS1). Thus, understanding the specific conditions of N'Dali and Nikki, from which data is not available online, was crucial.

2.1. Role and Function of CPS / Health Officer

Informants discussed their roles in supporting adolescents and young women survivors, highlighting how CPS and Health Centre structures operate at the municipal level to effect behavioral changes related to SRHR. Strategies such as community dialogues and educational sessions were used to shift community behaviors. CPS Directors reflected a nuanced understanding of the local context and emphasized the importance of their roles and those of Health Officers in fostering positive SRH outcomes.

The CPS provides multifaceted services, including prevention, psychosocial support, and active listening for IPV and GBV survivors: "*The Centres de Promotion Sociale focus on the prevention and management of social risks incurred by its target groups, especially gender-based violence. Among these targets are adolescents and young people*" (CPS2). They actively engage with individuals and communities to address risks and promote well-being. "*In addition to the prevention aspect, there's the psychosocial support aspect… and this psychosocial support is a whole methodology, it's a strategy that goes from defining the urgent needs of the victim or survivor to defining their goals, what they want to do, their life projects*" (CPS2). Health Centres "*support activities aimed at adolescents and young people and follow up on their SRH needs and progress*". They also "*strengthen the capacities of the service providers who are responsible for adolescent care*" (HO1). Both CPS Directors and Health Officers play pivotal roles in addressing the impact of IPV on young women's KAP regarding ASRHR. Their interventions raise awareness among vulnerable victims and create safe spaces for discussing sensitive topics related to Psychological IPV and ASRHR. Key Informants empower young women victims to make informed decisions about their SRHR, considering their contexts.

Financial constraints, human resource deficits, and structural limitations were significant challenges mentioned by informants. "*The lack of adequate funding not only affects the quality of psychosocial support but also impacts our ability to conduct thorough follow-ups and sustain long-term interventions*" (CPS1). Dependence on external partners for technical support highlighted the need for greater autonomy and investment in local research and solutions. Health Officers noted the lack of engagement with ASRHR among adolescents and young women: "*There are laws. The laws are there. The laws already exist... but people don't follow through… most of them don't even know!*" (HO 2). CPS2 also mentioned internal challenges: "*Even us actors, we bicker inside. We're bickering. We're not convinced yet. Because of... the slips they could have made. We're not convinced… and that is affecting the whole process*", indicating a need for reinforcing the convictions of workers and other personnel who fight for better ASRHR.

2.2. Recognition of Psychological IPV Victims

Most actors agreed that recognizing victims of Psychological IPV involves understanding its challenges and mechanisms. Psychological "*domestic violence is everywhere, but it manifests itself in different ways (...) it's so hard to identify because it happens inside of the house*" (CPS1). Detecting IPV, especially the psychological subtype, requires nuanced observation and community vigilance, as marital problems are not immediately visible.

CPS2 highlighted the lack of a formal system for public recognition of IPV victims in Benin, noting that victims often need to seek help themselves or report their situation. This indicates a gap in proactive surveillance or detection mechanisms at the community level. HO2 acknowledged: "*the problem is that people… the women, don't denounce it. We're afraid. We don't report. Or even when they do, afterwards they say they've withdrawn the complaint... they say 'no, it's okay, we'll deal with it as a family'... it's difficult*". Community-based surveillance mechanisms were deemed essential, though challenging without victims self-reporting or seeking assistance.

The interviews highlighted signs and behavioral indicators of Psychological IPV, despite the absence of visible physical abuse. Recognizing such violence requires keen observation of behavioral cues and active listening. These cues may include "*changes in a person's demeanor, withdrawal from social interactions, or expressions of fear and anxiety*" (HO1). Similarly, CPS2 described IPV survivors as "*people who are psychologically affected, who live... despite everything we do to them, they live a little self-enclosed. In fear. They live in fear*". Common forms of psychological abuse reported include verbal insults, economic deprivation, and controlling actions by partners, aligning with the literature. The effects described by actors included significant emotional distress and a sense of powerlessness among victims, impacting their autonomy and self-perception.

2.3. Barriers and Challenges of IPV Survivors towards ASRHR

2.3.1. Community Perceptions and Stigmas on SRHR

The KIIs also revealed deep-seated taboos and misconceptions about ASRHR within the community and among adolescents. CPS1 mentioned that "*men don't agree with family planning because they believe in the popular conception that family planning,*

even in contraceptive ways, is a means of promoting adultery… oh, and also have a negative impact on women's sexual health". Furthermore, "*the woman can't ask the man to use a condom (…) if a woman asks the man to use a condom that's her adulterous logic, that's what they think*" (CPS1). These taboos create barriers to open communication, education, and awareness regarding SRHR topics, especially for vulnerable survivors of violence.

Moreover, the stigma attached to discussions around ASRHR was described as evident in women's reluctance to openly seek SRH services. Health Officers described this secrecy as highlighting societal pressures and judgments faced by adolescents and young women. "*A young girl has no access to a health center. Because a young girl who goes to the health center is considered a young girl who has become pregnant and has gone for an abortion*" (HO2). HO1 added, "*if a woman commits an abortion it is perceived as a sinful crime... a crime, a sin. And because of that, she may not find a husband. Because of that she can't return… she can't be... she will even be banished from the house for having the abortion*". The fear of social repercussions e.g., being labeled as promiscuous or facing exclusion, influences young women's decisions regarding their ASRHR.

The interviews highlighted the taboo surrounding discussions about sex itself. Cultural and societal norms make it challenging for individuals, especially adolescents, to seek information or support related to sexual health openly. This lack of dialogue contributes to misinformation, limited access to services, and perpetuates stigma and discrimination. For example, CPS2 explained, "*there is also the thought that condoms can be often used for more than one partner (…) There are men who use a condom for several partners. And they even... they wash it. And they use the condom... they wash the condom to use it several more times*".

Prevalent misconceptions and taboos hinder open discussions and acceptance of ASRHR practices. Additionally, cultural and religious beliefs significantly shape attitudes and perpetuate stigma among adolescents. "*We're in an area that's heavily Islamized. And Islam, as people practice it there, doesn't recognize contraception or family planning. Islam is against family planning… that's another problem*" (CPS1). Traditional roles assigned to women limit their decision-making power, especially concerning reproductive choices. CPS2 explained, "*marriage is the only means of security for women (…) because the woman does nothing: she's not allowed to leave the house, she's not*

allowed to engage in any income-generating activity… she cannot leave the house to work (…) So if she gets divorced, she's got nothing (…) she cannot support herself. She's going to live in extreme poverty. And so, to continue living and surviving, she's forced to marry and maintain that marriage. Because in marriage, the man is obliged to take care of her".

Actors also highlighted the stigma and social ostracization faced by young girls or unmarried women with unplanned pregnancies, which often lead to judgment, exclusion, social isolation, or pressure to marry early. They emphasized intersections between cultural norms, reproductive health, and social status. "*When she passes, she's stigmatized. When she passes, people point at her: 'that's the woman… the one who's destroying and disrupting our cultures and values'. And people take that away*" (HO2). The fear of stigma and discrimination prevents adolescents from accessing essential support services, reporting abuse, and taking care of their SRHR. "*Women and girls see themselves alone in the face of this battle, and they have no other reference point left*" (CPS1). "*Stigmatization affects their actions as, once stigmatized, they are not free to go seek help. They sometimes hide. They live clandestinely... clandestinely. They are not free, they become un-free*" (HO1).

These deeply ingrained taboos, misconceptions, and stigmatization surrounding SRHR and IPV survivors highlight the complex socio-cultural factors impacting adolescents and young women's health-seeking behaviors and autonomous decision-making processes. Understanding these community perceptions and stigmas is crucial for developing interventions and support services that address the intersectionality of IPV, SRHR, and social norms. It emphasizes the need for culturally sensitive approaches, community education, and advocacy to challenge harmful beliefs and promote women's rights to sexual and reproductive health autonomy. Engaging with religious and community leaders, promoting awareness, and fostering an environment supporting open dialogue and respectful discussions about ASRHR and IPV within cultural contexts is also essential.

2.3.2. Impact of Psychological IPV on Decision-making and Autonomy

Key Informants highlighted various ways young women's agency and autonomy are restricted through Psychological IPV. The interviews underscored the pervasive influence husbands or partners exert over SRHR decisions. CPS1 expressed, "*the woman*

herself does not have the possibility to choose... to make decisions. Regarding her body, for example". CPS2 added, "*the woman who stands up herself, who goes for a contraceptive method, for example... will be kicked out of the house by her husband. These are the consequences (...) he may send her out of the house. The woman herself can no longer make a decision*". HO2 further noted that "*boy partners aren't for contraception. And when it's like that, girls won't be able to do it either. Because the woman is submissive to the man in our community*".

Interviewees pointed to the direct relationship between Psychological IPV and adolescent girls' SRHR behaviors. Manipulation, threats, coercive control, humiliation, and exploitation of vulnerability were mentioned as tools used by women's partners. "*We [Health Officers] are the ones who often say that she's free to manage her body as she likes. But as far as husbands and partners are concerned, in our circles, it's not up to her, no, no, it's not her problem. Her body belongs to her husband*" (HO1). HO2 agreed and added, "*Women often don't have the right to go to the hospital themselves, to say: 'I want this or that'. She doesn't have the right to say: 'I want to stop the number of children'. It all depends on the man; it all depends on her husband*". Key Informants described a broader pattern where women's choices, especially regarding contraception and family planning, are subjugated to their male partners' preferences. This coercion leads to restricted access to healthcare measures, impacting women's reproductive autonomy.

Societal stigma and cultural norms previously discussed also significantly restrict both married and unmarried women's access to ASRHR services. "*Here it is thought that a young girl has absolutely nothing to do in a health center... if she goes there, it is definitely because of something bad... and if that is the case, it is very easy for the community to turn its back on her*" (CPS2). These norms contribute to gender-based violence towards adolescents at the cultural patriarchal level, perpetuating limited freedom and dependence on male figures for decision-making.

In Benin, the patriarchal society places men in dominant household positions, disempowering women from making their own choices. Statements like "*Our tradition was conceived in such a way that it's the man who has the right of veto over these women*" (CPS1) and "*In African society, and more particularly in Benin, it's the submission of the wife to the husband (...) the man is considered the master of the house… he has power over the women traditionally*" (CPS2) reflect this dynamic. The results highlight the link

between Psychological IPV, gender dynamics, and decision-making autonomy concerning ASRHR. Addressing these issues requires a multi-faceted approach that challenges tradition and culture, promotes women's empowerment, and ensures access to SRHR services free from coercion or intimidation.

2.4. Survivor's Support and Empowerment

Questions addressing the needs of adolescent survivors of IPV were discussed throughout the KIIs. Informants emphasized that understanding the impact of Psychological IPV on KAP and autonomy among women in northern Beninese communities reveals a complex landscape where survivor support and empowerment are crucial yet constrained by various factors. CPS2 highlighted the role of 'Service Écoute', a listening service providing psychological support for GBV survivors, offering a safe space for sharing experiences without fear of judgment.

Awareness campaigns aim to challenge ingrained beliefs and behaviors related to gender roles, sexuality, and violence. CPS2 noted, "*We need our townhalls to accompany, help and support them [adolescent survivors] in their journeys. And now, with that, we also need to raise awareness in the field. We can't leave it like this... because it is that awareness that touches culture, that touches religion*" (CPS2). Awareness and empathy promotion initiatives contribute to creating a more supportive environment for survivors to seek help and embrace their rights. Education is a transformative tool, equipping survivors with knowledge and skills, enhancing their self-esteem and decision-making capacity. CPS1 emphasized the need for religious leaders to promote understanding and reduce stigma: "*We need to talk more in churches, in churches as well as in mosques, so that we can show how today women no longer have big difficulties... there are no more inconveniences, and they shouldn't be stigmatized (...) It is crucial that everyone is informed, sensitized, and understands*".

Economic empowerment and self-sufficiency were also highlighted. HO2 stated, "*If we manage to promote women's empowerment, so that these women who are victims of domestic violence can do something and earn money, they will no longer be obliged to be under a man's dome*". CPS1 added, "*We need to help them reintegrate into society, by finding them income-generating activities (...) to be self-sufficient. We need to help the woman to be autonomous, to do something... to create resources*". The latter underscores

the link between economic independence and ability to break free from cycles of abuse. HO1 stressed, "*We have to remove male domination from their heads*".

2.5. Closing Remarks

KIIs provided context on the experiences of young women as IPV survivors and the efforts by CPS and Health Centres for their well-being. Significant barriers and challenges faced by adolescents regarding access to SRHR services were discovered. Gender-based power dynamics, cultural norms, and societal beliefs limit adolescents' autonomy. The dominance of men in decision-making processes related to ASRHR is evident, and manifests as a form of Psychological IPV. Young women, and especially those victims of GBV lack freedom to access healthcare services or make decisions about contraception within their relationship. "*Everything depends on the man, everything depends on her husband*" (HO2). Societal norms and cultural beliefs also play a significant role in limiting adolescents, since contraceptive methods and SRH care is often associated with negative perceptions or social stigma, deterring adolescents from using available services due to the fear of judgement, exclusion and even social penalizations. Religious beliefs, as interpreted and practiced locally, pose additional barriers to ASRHR. Informants agreed that despite existing laws and regulations, practical autonomy for young women regarding SRHR remains a challenge.

Addressing these barriers requires comprehensive awareness campaigns and advocacy efforts involving a multi-stakeholder approach with community leaders, policymakers, healthcare providers, and civil society organizations to sensitize communities, religious institutions, and women survivors themselves. The goal is to promote understanding, reduce stigma, and advocate for women's rights to make informed decisions about their health. HO1 hinted at a hopeful future: "*We'll carry on, continue. Maybe then it'll come to something (...) It'll come. Better times are coming for women*".

Discussion

This study aimed to investigate the impact of Psychological IPV on adolescent and young women's knowledge, attitudes, and perceptions (KAP) regarding ASRHR in northern Beninese communities. The findings offer important insights into the intersections of IPV, SRHR, socio-cultural norms and patriarchal influence at the individual and community levels, supporting and expanding upon the proposed sub-research questions.

1. Sub-RQ 1: *To what extent do Psychological IPV young survivors hold negative Knowledge, Attitudes and Perceptions of ASRHR topics?*

Overall, survivors of Psychological IPV displayed a diverse range of KAPs, with the majority holding little to none Knowledge and mostly negative Attitudes and Perceptions towards ASRHR topics. Many participants showed fundamental misunderstandings about SRHR and what it entails, for example, regarding the use of contraceptive methods, transmission of STIs, and availability of other services. Notably, participants often discussed family planning within a context of fear and misinformation, influenced by their partners' attitudes and opinions which were frequently based on control rather than meditated decision-making. Psychological IPV manifested in survivors through claims of manipulation, threats, and coercive control, directly impeding women's ability to access and benefit from ASRHR care.

The attitudes and perceptions towards ASRHR are particularly telling. Many survivors expressed resignation or deference to their partners' preferences, often prioritizing these over their own health needs. This behavior is indicative of the deep psychological impacts of IPV, where the victim's agency is diminished to the point that their health decisions are no longer in their own hands but are instead dictated by the abuser. This dynamic severely restricts their ability to pursue preventive measures and treatments, directly impacting their health outcomes. The latter was backed up through the KIIs, where CPS Directors and Health Officers provided further context and information on survivor's KAP, from their professional perspective. All of them agreed

that women who have suffered psychological abuse often lack the freedom to make informed decisions about their SRH. Regarding family planning and abortion, for instance, coercion was detected into avoiding any method, as survivors were fearing retaliation from their partners and community around. Health Officer 2's statement explaining that women who seek contraceptive methods may be expelled from their homes highlights the severe social repercussions that women fear. This fear and coercion result in limited knowledge and negative attitudes towards ASRHR, as women are prevented from accessing accurate information and services.

These finding aligns with the broader literature identifying IPV as a significant determinant of adverse SRHR outcomes (Decker et al., 2014; Dokkedahl et al., 2019). Our study finds that Psychological IPV, together with other intersecting identities and experiences of survivors, exacerbates these risks of detrimental effects and mental traumas that IPV can cause on women's autonomy and health-seeking behaviors. Although we cannot attribute all of the participants' KAP to their experiences with Psychological IPV (i.e., draw causation nor to assume that Psychological IPV leads directly to negative KAP on ASRHR topics), it is true that the given population group (young Beninese women who are survivors of Psychological IPV) know, view and perceives ASRHR in the exposed ways. In fact, the objective of this master's thesis was to explore rather than explain these women's' KAP on a specific health-care issue.

2. Sub-RQ 2: *In what ways might Psychological IPV contribute to the creation of stigma, misconceptions, and taboos among adolescents regarding ASRHR topics?*

We cannot affirm that Psychological IPV itself creates stigma, misconceptions and taboos for adolescents on ASRHR topics. Nevertheless, it is true that Psychological IPV survivors held and spread stigmas, misconceptions and taboos of all kinds. The data illustrates that Psychological IPV acts as a catalyst for generating and sustaining stigma, misconceptions, and taboos surrounding ASRHR, however, it is not the only source. A lot of evidence points towards the role that the community also has in shaping these attitudes and perceptions, which are later transmitted generationally to adolescents and young women. These findings align with those from Nyblade et al. (2017) and Biddlecom et al. (2009). Furthermore, partner dynamics, stigmas and attitudes were found to be

shaped by intersecting identities of survivors. The intersecting factors highlight the compounded vulnerabilities of young women who navigate IPV in their individual backgrounds. It also creates a complex web of unequal power and constrain women's autonomy over SRH decisions.

The stigma associated with accessing SRHR services was palpable among participants, who reported a significant societal backlash against women who sought these services independently. Such stigmatization not only isolates survivors but also reinforces harmful myths about sexuality and reproductive health, perpetuating a cycle of ignorance and abuse. Misconceptions propagated through IPV, such as the belief that contraceptive use is indicative of promiscuity, further complicate efforts to educate and empower women. The fear of being labeled, judged or mistreated by their partners and community based on their SRHR choices leads many survivors to forego necessary health services, thereby increasing their risk for adverse SRH outcomes like unintended pregnancies and STIs.

The findings also highlight how deeply ingrained cultural and societal norms shape attitudes towards ASRHR and IPV. All Data Collection revealed that patriarchal structures and religious beliefs profoundly affect women's autonomy and further exacerbate stigmas, misconceptions and taboos on the topic. For example, the idea that family planning is often associated with adultery and deemed inappropriate for women, or that abortion entails killing a child and is therefore against God's will. Stigmas and taboos on SRHR reinforce male dominance in decision-making. In fact, there is a lack of legislation protecting adolescent survivor's SRHR, and "where the laws do exist, religious and customary laws co-occur" and sometimes prevail (Manuh and Biney, 2021, p. 1237). Thus, cultural norms and social barriers create an environment where Psychological IPV can thrive, as women are discouraged from asserting control over their bodies, thereby perpetuating cycles of abuse and limited access to ASRHR services.

3. Sub-RQ 3: *How do Knowledge, Attitudes, and Perceptions on ASRHR, shaped by experiences of Psychological IPV, potentially impact ASRHR outcomes for adolescents?*

In fact, Psychological IPV not only impacts profoundly a victim's mental health and well-being, but can also shape their KAP on topics of SRHR, specially for adolescents and young women who are often easily influenced and/or manipulated. The findings robustly highlight how negative KAP, shaped by Psychological IPV, pose significant barriers to achieving positive ASRHR outcomes. The latter was confirmed through the KIIs, in which professionals who constantly work with survivors of Psychological IPV shared the most frequent ways in which challenges manifest themselves. Interestingly enough, most of the time it was regarding the adolescents' low engagement with their ASRHR that was the problem. This low engagement can be explained through their Knowledge, Attitudes and Perceptions as a main mechanism. Thus, the intricate relationship between knowledge deficits, influenced by IPV-induced isolation and control, and the broader societal attitudes towards women's autonomy creates a hostile environment for asserting reproductive rights.

Survivors' narratives underscore a lack of confidence and a pervasive fear of judgment or discrimination, which not only affects their psychological well-being but also limits their interaction with health services, presenting an obstacle to positive ASRH outcomes. The latter echoes findings by Mingude and Dejene (2021) on the impact of social stigma on health-seeking behaviour. This fear is also compounded by the lack of privacy and confidentiality in health service delivery within a community, which is crucial for survivors of IPV. Additionally, this fear is closely tied to broader societal norms that value female modesty and fidelity, which can be manipulated by abusive partners to control and restrict the victim's behaviors and choices.

Furthermore, misconceptions and stigmas are detrimental as they discourage the use of e.g., contraceptives, leading to higher risks of unintended adolescent pregnancies, which are a direct barrier to positive ASRHR outcomes. The lack of comprehensive knowledge extends beyond contraception to broader aspects of sexual and reproductive health, such as understanding the availability and purpose of local health services. Many participants were not aware of the range of services offered or firmly believed that these were only accessible with their partner's permission, also reflecting a significant barrier to seeking help or advice. The latter is also indicative of the broader patriarchal context that limits women's agency in rural Benin. Overall, the interrelated deficiencies in knowledge and the prevalence of negative attitude and perceptions pose by itself barriers which impair positive ASRHR outcomes.

4. Recommendations

The insights of this master's thesis underscore the urgent need for multi-faceted interventions that address the cultural, social, and structural challenges faced by IPV survivors. Efforts to combat these issues should include comprehensive awareness campaigns among the community and advocacy for women's rights to SRH autonomy. Furthermore, targeted, context-specific educational programs are essential to dismantle the deep-rooted cultural and religious barriers. Empowering young women with accurate information and fostering supportive community attitudes towards ASRHR can enhance their autonomy and ability to make informed choices. Additionally, addressing the specific dynamics of Psychological IPV is crucial in enabling these survivors to exercise their rights and access necessary health services without fear or coercion. Ultimately, this research hints towards the need for integrated and intersectional approaches that engage with religious institutions, community leaders, and legal frameworks to challenge harmful beliefs and promote supportive environments for discussing ASRHR in rural Benin. Finally, enhancing the capacity and resources of CPS and Health Centres to provide sustained and discrete support and follow-up for IPV survivors is essential to normalize and encourage sexual and reproductive healthcare free from judgment or stigma. I.e., healthcare facilities, especially those serving young people, need to be equipped for and proactive in treating survivors, implementing trauma-informed care practices and trained professionals for cases of violence. By doing so, we can move closer to ensuring that all individuals, regardless of their background, circumstances, or violent experiences, can make autonomous and informed decisions about their SRH.

Conclusion

This master's thesis has explored the intricate relationship between Psychological Intimate Partner Violence (IPV) and Adolescent Sexual and Reproductive Health and Rights (ASRHR) among young survivors in rural Benin. Through qualitative analysis, the study delved deep into the Knowledge, Attitudes, and Perceptions (KAP) of these

survivors, offering diverse understandings of how Psychological IPV is able to shape these women's views and experiences regarding ASRHR. A qualitative methodology was followed, engaging participants through Focus Group Discussions and in-depth Individual Interviews to gather rich, subjective insights into the survivors' experiences. Furthermore, Key Informant Interviews were held with CPS Directors and Health Officers with the purpose of gaining contextual information and expanding the findings from a different, professional perspective. This approach facilitated an exploration of the personal and societal dynamics influencing young survivors' SRHR, uncovering how Psychological IPV and patriarchal social norms can impact their ability to make autonomous health decisions.

The research project did not intend to draw causation i.e., to assume that Psychological IPV leads directly to certain KAP of adolescents and young women. Instead, it seeked to understand and dig deeply into how a given population group (young Beninese survivors of Psychological IPV) view, perceive, and act towards ASRHR. That is, to explore rather than explain the women's KAP. Rich narratives were captured, which revealed the primary findings of this study: (a) Despite awareness of some SRHR aspects, there remains a big gap in comprehensive understanding among survivors; (b) Young Psychological IPV survivors held mainly negative attitudes and perceptions to ASRHR, especially on sex-before marriage, abortion, and contraceptive topics; (c) Participants demonstrated varying degrees of agency in making health decisions, influenced by the psychological control exerted by intimate partners and prevailing socio-cultural norms within their communities. The influence of survivor's intersecting identities was further reflected in their KAP and SRHR behaviours; (d) A wide range of stigmas, misconceptions and taboos exist among Psychological IPV survivors regarding ASRHR, which suppose a barrier and restricts survivors' ability to seek and utilize available services effectively.

Scholarly, this study contributes to the GBV-SRHR nexus, highlighting the critical need to further address Psychological IPV within the discourse of adolescent health rights. On a broad scope, it re-states the importance of not considering GBV and SRHR as completely separate domains (Rubini et al., 2023), since Psychological IPV is intricately linked with SRH across physical, psychological, and social dimensions. In fact, Psychological IPV constitute a violation of human rights, including SRH rights. As such, manipulation, coercion and threats against a women's SRH is by itself a type of

Psychological IPV which needs to be addressed particularly. Practically, the findings show the importance of challenging socio-cultural and gender norms unfavorable to ASRHR and lifting out taboos, stigmas and negative attitudes and perceptions on the topic. They also call for integrated health and social interventions that recognize survivor's intersectionality and the complex interplay between psychological abuse and SRHR. Programs aimed at enhancing SRHR in settings afflicted by IPV should incorporate elements of psychological support and education that empower women to make informed health decisions free from coercion.

Three main limitations were found along the way. First, the inherent challenge it supposed to engage with the targeted young women –survivors of Psychological IPV–, who often found it difficult to discuss their experiences due to trauma, insecurity, and other psychological barriers. The sensitive nature of the topics explored in both FGDs and Individual Interviews sometimes led to reluctance in sharing detailed personal stories. Additionally, being an outsider researcher may have exacerbated these challenges, potentially affecting the depth and openness of the responses received. Alternative approaches could have better enhanced participant engagement and data richness. For instance, involving local researchers who could easier establish trust and comfort among participants or employing trauma-informed research methods that prioritize the emotional safety of participants. Second, this study's scope is limited to a specific subset of survivors and demo-geographical area in northern Benin (municipalities of Nikki and N'Dali), which may not represent broader experiences of other Beninese young women facing Psychological IPV. Third, the reliance on self-reported data could have introduced bias related to personal interpretation and recall of events. Furthermore, the use of a Borgu Fullfulde interpreter when needed could have introduced errors or subtle shifts in meaning, potentially altering the nuance, accuracy and depth of participants' responses.

Addressing Psychological IPV is crucial not only for the health of individuals but for the broader realization of human rights. Future research should further explore the KAP barriers and effective ways to enforce the existing laws and policies on GBV and ASRHR. A special focus could be set on the dissonance between national legislation and local customs. Additionally, studies should further dig on the intersectional identities of Psychological IPV survivors vis a vis their SRHR, analyzing deeply how each of these reinforces the other resulting in vulnerability and marginalization. Research could also examine the potential contributions of male partners in combatting psychological abuse

and supporting SRHR initiatives. Furthermore, assess the quality and effectiveness of comprehensive sexuality education programs on psychologically affected individuals in comparison to non-affected ones, to explore the possible discrepancy in access and efficacy of current methods. Quantitative studies which evaluate the economic costs of Psychological IPV and poor ASRHR at multiple levels (individual, household, community, and state) could be also powerful in providing a comprehensive view of their socio-economic burden. Finally, it is encouraged to carry out cross-country studies in the ECOWAS region to address the limited scope of single demo-geographical area research.

As we look to the future, let us carry forward the message that change is not only possible but necessary. Let the findings of this research serve as a call to stakeholders – policymakers, practitioners, communities, and survivors themselves– to envision and create spaces where every young woman can navigate her adolescence free from violence and full of health and autonomy. Let us hold firmly to the vision that constructs allowing for Psychological IPV and impacting ASRHR "have been shaped in social and historical processes" and as such, "they can be re-imagined and re-defined" (Le Mat et al., 2019, p. 208). Let this be our collective aspiration for a re-defined reality.

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Appendices

Appendix A : FGDs and Individual Interviews Question Guide

Individual Interviews Protocol

1) **Introduction:**
   - Introduction of the researcher
     - Who am I?
     - What am I doing in Benin?
   - Explanation of the purpose of the interview
     - Master's thesis: carrying out research regarding perspectives and attitudes on SRHR.
   - Confidentiality and voluntary participation
     - I assure complete confidentiality and anonymity of the participants.
     - Do I have your consent to record this conversation? If so, please say "yes".

Good morning/afternoon. I would like to start by thanking you for being part of this interview and for your valuable time. My name is Karen Adriana Castillo Ramirez, I am originally from Spain and currently studying a Master Programme in Global Development. I came to Benin so I could discover your country and do a professional Internship with CARE International Bénin/Togo. I am here to do some research for my Master's Thesis regarding Perceptions and Attitudes towards Sexual and Reproductive Health and Rights. I have asked you for this interview as you fit perfectly the profile for my research, which are young women between 14 and 24 years old from Beninese communities.

I want to do a semi-structured interview, which means that I have prepared some open-ended questions that you can answer as you wish, and based on the path your answers take, I will formulate new questions. I want to ask you to speak freely, the most important thing for me is to understand your experiences, opinions, thoughts and feeling towards Sexual and Reproductive Health and Rights. I understand that some of the topics we are going to touch on may be sensitive, so if there is something you do not want to share or a question you would prefer not to answer, please let me know and we will move on to the next question. Your anonymity is guaranteed in this interview – all personal information will be anonymized and is confidential. I agree to delete the recording after transcribing and/or analyzing it and I give you my word that no one will be able to recognize you in the final work. Likewise, I will not share your information with anyone.

Finally, I would like you to confirm that I have permission to record the conversation and take notes during the interview by saying "I agree". Thank you very much, I will now proceed with the questions.

2) **Background Information:**

   - Demographic information (age, marital status, religion, education, occupation?)
   - Can you tell me a little bit about your family?
   - Relationship status: Do you currently have a partner?
     - Can you tell me a little bit about him? (How long you've been together? How is your relationship like?)

- Do you have any children?
  - If yes:
    - Do you want to have more children in the future?
    - Was any of your pregnancies undesired?
  - If no:
    - Would you like to have children in the future?

Knowledge on SRH

3) **Sexual and Reproductive Health:**

- What is your understanding of Sexual and Reproductive Health (SRH)? Are you familiarized with the term?
- Can you describe your experiences with SRH services (if any)?
  - Have you attended a medical appointment regarding your SRH?
- How important is your partner's opinion for you when it comes to your sexual and reproductive health choices?
  - Whose opinion has a greater weight / is important for you?
  - Do you need your partner's consent to access SRH services / assist a medical consult?
- Have you faced any challenges accessing SRH services? Which?

Perceptions and Attitudes towards SRHR

4) **About the use of Sexual and Reproductive Health Services:**

Adoption of Contraceptive Methods

- What are your thoughts on family planning methods?
- Which methods are you familiarized with (if any)? Do you use them?
  - If not: why? Would you like to implement family planning methods in your relationship?
- What does your partner think about using family planning methods?
  - Is your partner's opinion crucial in your decisions regarding family planning methods?
  - Do you need your partner's authorization /permission for requesting contraceptives?
- How important is it for young women to use and have access to contraceptives? Why?
  - Do you think family planning methods could bring any benefits to young women?
- What do you think about other young women in your community who currently adopt contraceptive methods? Do you agree with their decision?

Consulting a Gynecologist

- Have you ever consulted a gynecologist (SRH professional)?
  - If not: why / why not?
- Why do you think young women would decide to visit a gynecologist?
  - What if the gynecologist that such woman visits is a male doctor?

Abortion and Unwanted Pregnancies

- What do you think are the main reasons why unwanted pregnancies happen?
- Do you know anyone in your community who has interrupted an unwanted pregnancy (abortion)?

- What do you think of a married woman who aborts an unwanted pregnancy? What if she's not married?
- How do you think the partner of a women who is willing to carry out an abortion should react?

Sexually Transmitted Infections and Diseases

- What is your understanding of Sexually Transmitted Infections (STI) /AIDS?
  - How can we prevent STI / AIDS?
- Who do you think should be the women checking up for and making use of STI/AIDS prevention methods?
- What do you think about the women who are single and make use of STI/AIDS prevention services? Why do they do so?

5) **About GBV, Social Norms, Power Relations and Decision-making:**
- Who in the relationship do you think should be the one deciding when to have sexual intercourse?
  - Do you communicate it with your partner when you do not feel like having sex?
    - If yes: how does he reacts?
    - If no: why?
- Who's fault in the relationship do you think it is when an unwanted pregnancy comes to place?
- In case an unwanted pregnancy is not interrupted, who should bear with the responsibility of the children? Why?
- What do you think of a married women who does not want to have children? What could be the reason behind?
- What is your perception about a women who is not married but enjoys of a sexually active life?

Taboos / Stigma

6) **Perceptions and Attitudes towards SRHR Indicating Stigma:**
- Do you talk about SRHR with your family and/or friends?
- What does your family members/ friends / classmates think about visiting a SHR center? Have they even been in one?

Focus Group Discussions (FGDs) Protocol

1) **Introduction:**
- Introduction of the moderator and interpreter, researcher and participants
- Explanation of the purpose and format of the focus group
  - Who am I? What am I doing in Benin?
  - Purpose of the focus group → Master's thesis: carrying out research regarding young women's perspectives and attitudes on SRHR.
- Establishment of ground rules (respect, confidentiality, etc.)
  - Do I have all your consents to record this conversation? If so, please say "yes".

Good morning/afternoon. I would like to start by thanking you for being part of this focus group discussion and for your valuable time. My name is Karen Adriana Castillo Ramirez, I am originally from Spain and currently studying a Master Programme in Global Development. I came to Benin so I could discover your country and do a professional Internship with CARE International Bénin/Togo. I am here to do some research for my Master's Thesis regarding Perceptions and Attitudes towards Sexual and Reproductive Health and Rights. I have asked you to be part of this focus group discussion as you all fit perfectly the profile for my research, which are young women between 14 and 24 years old from Beninese communities.

I want to do a semi-structured focus group discussion, which means that I have prepared some open-ended questions that you can answer and discuss as you wish, and based on the path your answers take, I will formulate new questions. I want to ask you to speak freely, the most important thing for me is to understand your experiences, opinions, thoughts and feeling towards Sexual and Reproductive Health and Rights. It is completely okay if you don't agree on the same things said by another person: there's no right or wrong opinion /answer. I understand that some of the topics we are going to touch on may be sensitive, so if there is something you do not want to share, please let me know and we will move on to the next question. Your anonymity is guaranteed in this focus group – all personal information will be anonymized and is confidential. I agree to delete the recording after transcribing and/or analyzing it and I give you my word that no one will be able to recognize you in the final work. Likewise, I will not share your information with anyone.

Finally, I would like you to confirm that I have permission to record the conversation and take notes during the focus group by saying "I agree". Thank you very much, I will now proceed with the questions.

2) **Ice-breaker / Background Information:**

- Brief round of introductions: Demographic information (age, marital status, religion, what's your favorite thing to do with your family?)
- Do you have any children?

Knowledge on SRH

3) **Sexual and Reproductive Health:**

- Could you all help me define together what sexual and reproductive health (SRH) is? Are you all familiarized with the term?
- Has anybody in this group have experiences with SRH services? Could you tell us a little bit about it?
- What challenges / main barriers do young women face in accessing sexual and reproductive health services in your community?

Perceptions and Attitudes towards SRHR

4) **About the use of Sexual and Reproductive Health Services:**

Adoption of Contraceptive Methods

- What do you all think about a young woman who decides to use contraception? What if she is married?
- What do you all think about a woman whose husband is absent but still decides to use contraception?

Consulting a Gynecologist

- Have you ever visited a gynecologist (SRH professional)?
  - If yes: did your partner agree with this decision? What was his opinion?
  - If not: would you ever visit a gynecologist? Why/ why not?
- Why do you think young women would decide to visit a gynecologist?
- What if the gynecologist that such woman visits is a male doctor?

Abortion and Unwanted Pregnancies

- What do you think about a young woman who is pregnant before marrying?
- According to you, what are the main causes of unwanted pregnancies?
- How does your community (and you) perceive those women who had an unwanted pregnancy?
  - What is the significance of such a pregnancy? Why?
- What alternative would people in your community take if they had an unwanted pregnancy and didn't want to have the baby?
- Are there cases of abortion in in your community? Is it commonly discussed?
  - If yes: what are the causes and consequences of an abortion?
- How are young women who have had abortions (either spontaneously or provoked) seen in your community?

Sexually Transmitted Infections and Diseases

- What do you all think about a young woman aged between 14 and 24 who uses the STI/AIDS prevention and care services? What about a young man?
- Who do you think should be the women checking up for and making use of STI/AIDS prevention methods?

5) **About GBV, Social Norms, Power Relations and Decision-making:**
   - Do you all agree with the following quotes? Why / why not?
     (a) "Each of the two spouses has a share of responsibility in the occurrence of marital violence".
     (b) "Marital violence leads women to respect their husbands".
   - In which cases do you think it is acceptable for a young woman to suffer from violence from her partner?
   - What are the main causes why a women would suffer violence from her partner?
   - Who's fault in the relationship is it when an unwanted pregnancy comes to place?
   - What do you think of a married women who does not want to have children? What could be the reason behind?

Taboos / Stigma

6) **Perceptions and Attitudes towards SRHR Indicating Stigma:**
   - Do you talk about SRHR with your family and/or friends?
   - What does your family members/ friends / classmates think about visiting a SHR center? Would they agree with such wish?

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7) **To Conclude…**
   - Summary of key points discussed.
   - Thank participants for their contributions.
   - Ask: any final thoughts, comments, or requests from participants?

Appendix B : Key Informant Interviews (KIIs) Question Guide

Key Informant Interviews (KIIs)

1) **Introduction:**
   - Introduction of the researcher
     - Who am I?
     - What am I doing in Benin?
   - Explanation of the purpose of the interview
     - Master's thesis: carrying out research regarding perspectives and attitudes on SRHR.
   - Confidentiality and voluntary participation
     - I assure complete confidentiality and anonymity of the interviewees.
     - Do I have your consent to record this conversation? If so, please say "yes".

Good morning/afternoon. I would like to start by thanking you for being part of this interview and for your valuable time. My name is Karen Adriana Castillo Ramirez, I am originally from Spain and currently studying a Master Programme in Global Development. I came to Benin so I could discover your country and do a professional Internship with CARE International Bénin/Togo. I am here to do some research for my Master's Thesis regarding Perceptions and Attitudes towards Sexual and Reproductive Health and Rights. I have asked you for this interview since you are an important actor in what concerns my research question and you work directly with my subjects of interest, which are young women between 14 and 24 years old that have suffered from IPV and belong to Beninese communities.

I want to do a semi-structured interview, which means that I have prepared some open-ended questions that you can answer as you wish, and based on the path your answers take, I will formulate new questions. I want to ask you to speak freely and take your time to think about each question. The most important thing for me is to understand your perspective on adolescent IPV survivors' situation regarding Sexual and Reproductive Health and Rights. I understand that some of the topics we are going to touch may be sensitive, so if there is some information you do not want to share, please let me know and we will move on to the next question. Your anonymity is guaranteed in this interview – all personal information will be anonymized and is confidential. I agree to delete the recording after transcribing and/or analyzing it. Likewise, I will not share your information with anyone.

Finally, I would like you to confirm that I have permission to record the conversation and take notes during the interview by saying "I agree". Thank you very much, I will now proceed with the questions.

2) **For CPS Directors…**
   - Could you please tell me a little bit about your job as CPS Director?
     - What is done at the Centres de Promotion Sociale level?
   - How do you recognize a victim of Gender-based Violence (GBV)? What about a victim of Intimate Partner Violence (IPV)?
   - How do you think partners (i.e., husbands/ boyfriends) of IPV victims psychologically affect a young women's way of thinking?
   - How do you think Psychological Intimate Partner Violence (IPV) can affect the Sexual and Reproductive Health and Rights (SRHR) of young victims?

- What are some of the most prevalent stigmas or taboos that people in your community hold regarding SRHR?
- What are some of the most common misconceptions that people in your community hold regarding SRHR?
  - According to you, where do these stigmas/taboos/misconceptions stem from?
- How do you think taboos and/or stigmas about SRHR affect the actions and decision-making of young women survivors of IPV regarding their own SRHR?
- How do you think support services (such as CPS) can better address the SRHR needs of survivors of Psychological IPV?

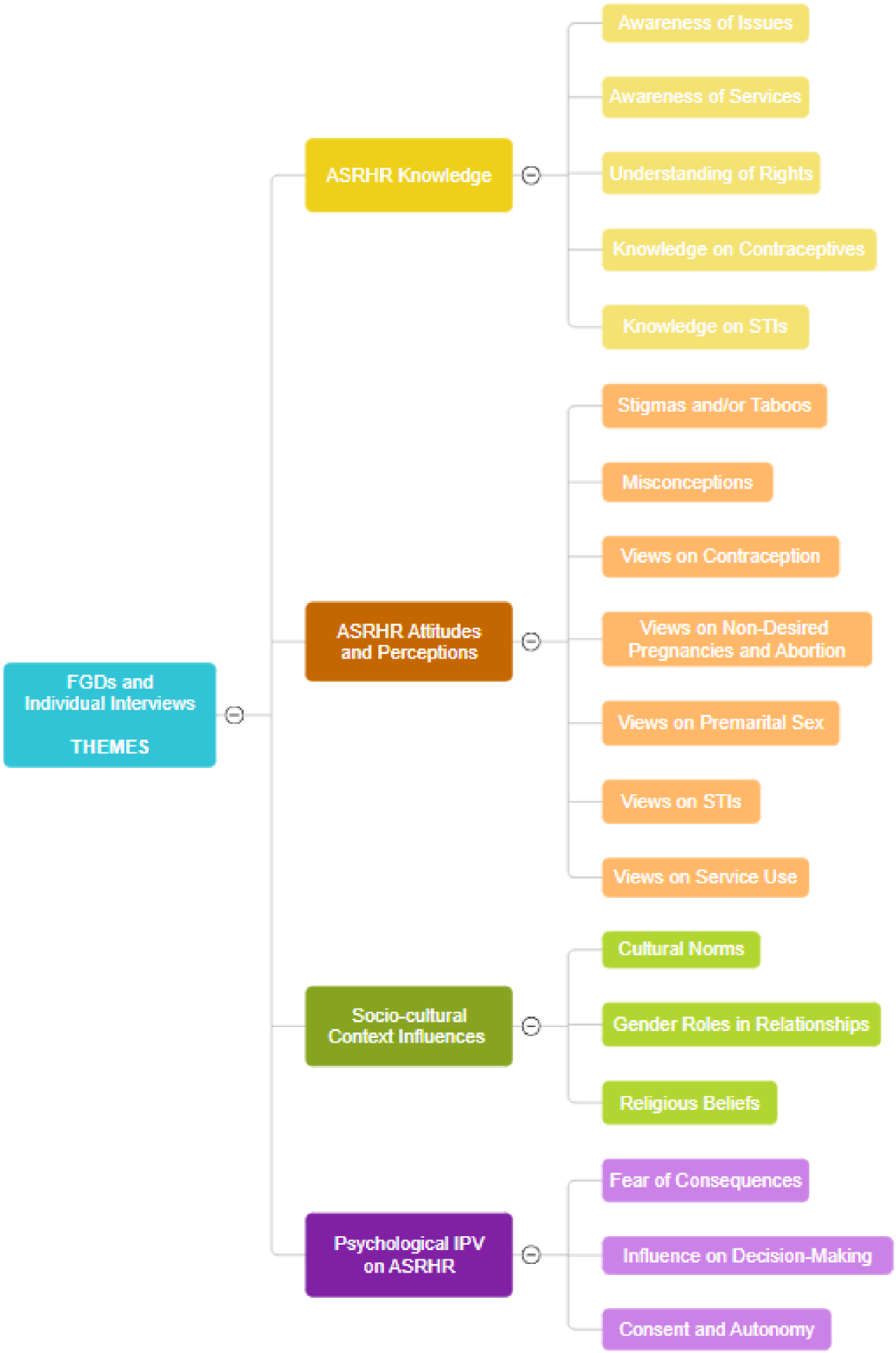
For Health Officers…

- Could you please tell me a little bit about your job as a Health Officer?
  - What type of care is provided at the Health Centre in your community?
- How do you recognize a victim of Gender-based Violence (GBV)? What about a victim of Intimate Partner Violence (IPV)?
- How do you think partners (i.e., husbands/ boyfriends) of IPV victims psychologically affect a young women's way of thinking?
- How do you think Psychological Intimate Partner Violence (IPV) can affect the Sexual and Reproductive Health and Rights (SRHR) of young victims?
- What are some of the most prevalent stigmas or taboos that people in your community hold regarding SRHR?
- What are some of the most common misconceptions that people in your community hold regarding SRHR?
  - According to you, where do these stigmas/taboos/misconceptions stem from?
- How do you think taboos and/or stigmas about SRHR affect the actions and decision-making of young women survivors of IPV regarding their own SRHR?
- What do you think are some of the consequences from poor SRH of young women?
- How do you think support services (such as Health Centres) can better address the SRHR needs of survivors of Psychological IPV?

3) To Conclude:

- Is there any other thoughts, reflections, or pieces of information that you would like to add that could be relevant for the relationship between IPV and SRHR of adolescents and young women?
  - If no: thank you very much for all the insights shared, this is the end of our interview.

Appendix C : FGDs and Individual Interviews Coding Tree (Inductively Developed)



Appendix D : Key Informant Interviews (KIIs) Coding Tree (Inductively Developed)