Unplanned pregnancy among unmarried adolescents in Urban Gambia

Kumba Khan

Supervisor: Professor Johanne Sundby

Co-supervisors:

Dr Viva Combs Thorsen

Benedikte Victoria Lindskog

Local supervisor: Dr Abdou Jammeh

University of Oslo Faculty of Medicine

Institute of Health and Society

Department of Community Medicine

Section for International community Health

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Abstract

In many developing countries, including the Gambia, unplanned and unwanted pregnancy among unmarried adolescents is a problem. In general their reproductive health needs are not being met due in part to the fact that accessing sexual and reproductive health information and services by unmarried adolescents is considered taboo and remains a controversial issue. Currently there is no comprehensive programme that addresses their reproductive health needs. As a result, they sometimes lack accurate and appropriate sexual information that would protect them from unplanned pregnancies.

The issue of adolescent pregnancies in the Gambia is a cause for concern. Even though there are no statistics on the prevalence of adolescent pregnancies and unsafe abortions in the Gambia, the Department of Social Welfare registered 19 cases of abandoned babies in 2011 and these figures increased to 20 in 2012 and 25 in 2013. The department also registered 91 paternity dispute cases during these three years. Some of the consequences of adolescents' pregnancy include unsafe abortions, instrumental deliveries, complications from pregnancy and childbirth, school dropout, expulsion from home, abandonment by and violence.

The aim of this study was to explore factors contributing to unplanned pregnancy among unmarried adolescents in urban Gambia using qualitative design. In-depth interviews with 15 unmarried adolescents who were pregnant or had delivered within two months up to one year and one focus group were conducted.

The findings show that the culture of silence, low access to reproductive health services, unmet economic needs, and power of external forces, curiosity and failed preventive measures were perceived by participants as factors contributing to unplanned pregnancies. Participants perceived pregnancy outside marriage, abortion and baby dumping negatively. In addition, participants experienced challenges both during pregnancy and as adolescent mothers. Some of the challenges were expulsion from home, physical and verbal assaults, being abandoned by family and partner and financial constraints.

The circumstances surrounding adolescent pregnancies need to be addressed collectively as they are interconnected and affect not only the adolescents themselves but also the family and the society at large. This study provides insights that will inform the development or revision of policies that would adequately address the sexual and reproductive health and rights of adolescents.

Dedication

This thesis is dedicated to Dad (May you continue to Rest in Peace); my Mother, to my children Muhammed and Alpha Omar; to my sister and her family; to my brothers and their families and to all my participants and their babies.

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List of acronyms

AP – Adolescence Pregnancy

GDHS- Gambia Demographic and Health Survey

GFPA- Gambia Family Planning Association

IASC- Inter-Agency Standing Committee

IPT- Intermittent Preventive Therapy

IWC- Infant Welfare Clinic/ Card

MCH/FP- Maternal and Child Health / Family Planning

PEGEP- President Empowerment for Girls Education Project

POP/FLE- Population and Family Life Education

RCH- Reproductive and Child Health

RH- Reproductive Health

RVF- Recto- Vaginal Fistulae

SRHR- Sexual and Reproductive Health Rights

STIs- Sexually Transmitted Infections

TBA- Traditional Birth Attendants

UNFPA- United Nations Populations Fund

UNICEF- United Nation Children's Fund

VHW- Village Health Worker

VVF- Vasico Vaginal Fistulae

WHO- World Health Organization

Structure of the thesis

This thesis consists of six chapters. In Chapter One, background information on the burden of unplanned pregnancies on adolescents' reproductive health is provided. It also provides background information about The Gambia and the situation of adolescents' sexual and reproductive health. This chapter also provides a statement of the problem, the justification of the study and concluded with the study objectives and questions. In Chapter Two a brief review of literature is presented. Chapter Three provides the theoretical perspectives, research design and detailed description of the methodology. The trustworthiness, reflexivity and ethical consideration are also discussed in this chapter. In Chapter Four the findings of the study are presented. The findings of the study are discussed in Chapter Five and in Chapter Six the implications of the study, the limitations, recommendations and the conclusion are presented.

Chapter 1: Introduction

1.1: Introduction

Adolescents are at a greater risk of having an unplanned and unwanted pregnancy and they are less likely to access safe abortion services. As a result, 15% of the global unsafe abortions are performed on adolescents aged 15-19years. Adolescence pregnancy is a major public health problem because it does not only increase their risk of instrumental delivery and obstetric complications like obstructed labour and obstetric fistulae but it also increases their risk of having a poor pregnancy outcome for both the mother and the baby (Vogel et al, 2015). Despite the global reduction in maternal deaths, pregnancy related mortality remains the second leading cause of death among adolescent girls age 15-19 years (Vogel et al, 2015). It was also found out that adolescents don't have access to information about their sexuality and reproductive health and as a result, they are less likely to seek for or utilize reproductive health services. Adolescent also have a higher risk of dying from pregnancy related causes when compared to older women because their pelvis and reproductive organs are not fully developed to begin reproduction.

The proportion of adolescents who become pregnant or mothers each year is estimated to be highest in Sub Saharan Africa (20-40%) and as a result of their under developed reproductive systems, lack of access to safe abortion services and other reproductive health services, the complications from pregnancy, unsafe abortion, and childbearing are the leading cause of death among girls age 15-19 in low and middle income countries (Atuyambe, 2008). It has also been realized that while the global proportion of adolescent pregnancies has reduced over time, in Sub- Saharan Africa it has increased. It is estimated that 11% of the global birth occur in adolescent mother, however, 95% of these births occur in developing countries and a significant proportion of these pregnancies are neither planned for nor wanted (Vogel et al, 2015).

"Unplanned/ unintended pregnancies are pregnancies that are reported to have been either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired)" (Santelli et al, 2003). Unplanned pregnancy includes both mistimed and unwanted pregnancies. Unplanned pregnancy is very common among adolescence and they have a higher risk than any other age group. In most developed countries as well as in Latin America, the Caribbean and some parts of sub-

Saharan Africa the majority of pregnancies in adolescents occurs outside of marriage and are often unplanned and unwanted (WHO, 2012).

Globally, about 16 million adolescent girls between 15 and 19 years give birth each year, which is approximately 1 in every 5. In the poorest regions of the world this figure rises to one in three girls and a further million become mothers before the age of 15 years, some as young as 12 years (Nove et al, 2014). In West and Middle Asia the percentage of adolescents giving birth before 18 years continues to exceed 30% (WHO, 2012).

It is estimated that globally three million adolescent girls undergo unsafe abortions every year and thousands of them die from complications due to unplanned pregnancy (WHO, 2012). It is also stated that globally unsafe abortion is the fourth leading cause of maternal mortality (Vogel et al, 2015).The major contributing factors of these deaths are complications from unsafe abortion and childbirth. Adolescents are less likely than adults to access legal and safe abortions, skilled prenatal, childbirth and postnatal care (WHO, 2012).

It is also estimated that approximately 25% of unsafe abortions in Africa are performed on teenagers aged 15-19 years, half occur in 15-24 years with disastrous effects for those girls and young women (WHO, 2012). This is because access to safe abortion is restricted by laws and policies in many countries. Furthermore, reproductive health services are often hindered by healthcare workers who subscribe to cultural norms that disapprove of the provision of contraceptives to unmarried adolescents, and are strongly opposed to safe abortion on demand (Temmerman, 2012).

In The Gambia adolescents constitute 23% of the population, approximately 386 thousand (UNICEF, 2011), and like their peers in other developing countries, they are faced with early physical maturation. As a result, many of them venture into early unprotected sexual activities which predisposed them to unintended and often unwanted pregnancies (UNFPA, 2000). The consequences of unwanted pregnancy include, unsafe abortion practices which exposes them to pelvic inflammatory diseases, ectopic pregnancy, and secondary infertility, baby-dumping, sexually transmitted infections, including HIV/AIDS, and involvement in drug use and abuse (UNFPA, 2000). However, even though there are no data on the prevalence of adolescence pregnancies and abortions, in 2011, 19 cases of abandoned babies were registered by the Department of Social Welfare and these figures increased to 20 in 2012 and 25 in 2013 (Department of social welfare, 2013). Their annual reports also

indicated that in 2011, 7 paternity dispute cases were registered with the unit and this figure increased to 52 in 2012 but then declined to 32 in 2013.

In addition to the complications which might possibly lead to death, other severe consequences for an unmarried adolescent with an unplanned pregnancy include: expulsion from home and school, loss of a job, dishonour for her family and herself and child neglect and abuse. And because they are afraid, ashamed or desperate, many of these adolescents are willing to risk their lives to end an unplanned pregnancy (UNFPA, 2000). Early motherhood also compounds disadvantages by limiting future livelihood opportunities for adolescents because the birth of a child to an adolescent mother does not only affect the girl, but also have implication on their families as they would have to care for both the adolescent mother and her child physically, socially and financially.

The underlying causes of unplanned pregnancies among unmarried adolescents are associated with socio-economic, cultural, political, and health system factors. These factors include poverty; lack of timely and appropriate information from parents on issues of sexual and reproductive health; denial of adolescents' access to sexual and reproductive health information and services, inadequate laws and policies; and also ill- equipped health systems which lack confidentiality, convenient opening hours and unfriendly attitudes of staff towards unmarried adolescent girls (United Nation, 2011).

Young people's sexual rights are denied by both religious and traditional forces in the Gambia which promotes early marriage and stigmatizes premarital sex and pregnancy outside marriage. Misinformation about sex and lack of youth friendly sexual and reproductive health services also poses challenges to the sexual and reproductive health of young girls (UNFPA, 2000).

Unplanned pregnancy among adolescents has been the focus of numerous studies and has been linked to marginality, family disintegration, poverty, illiteracy and sexual promiscuity. However, knowledge about the phenomena surrounding adolescent pregnancy differs from culture to culture, and still needs to be explored further (Spear and Lock, 2003, Bonell 2004).

1.2: Back ground

1.2.1: Country profile

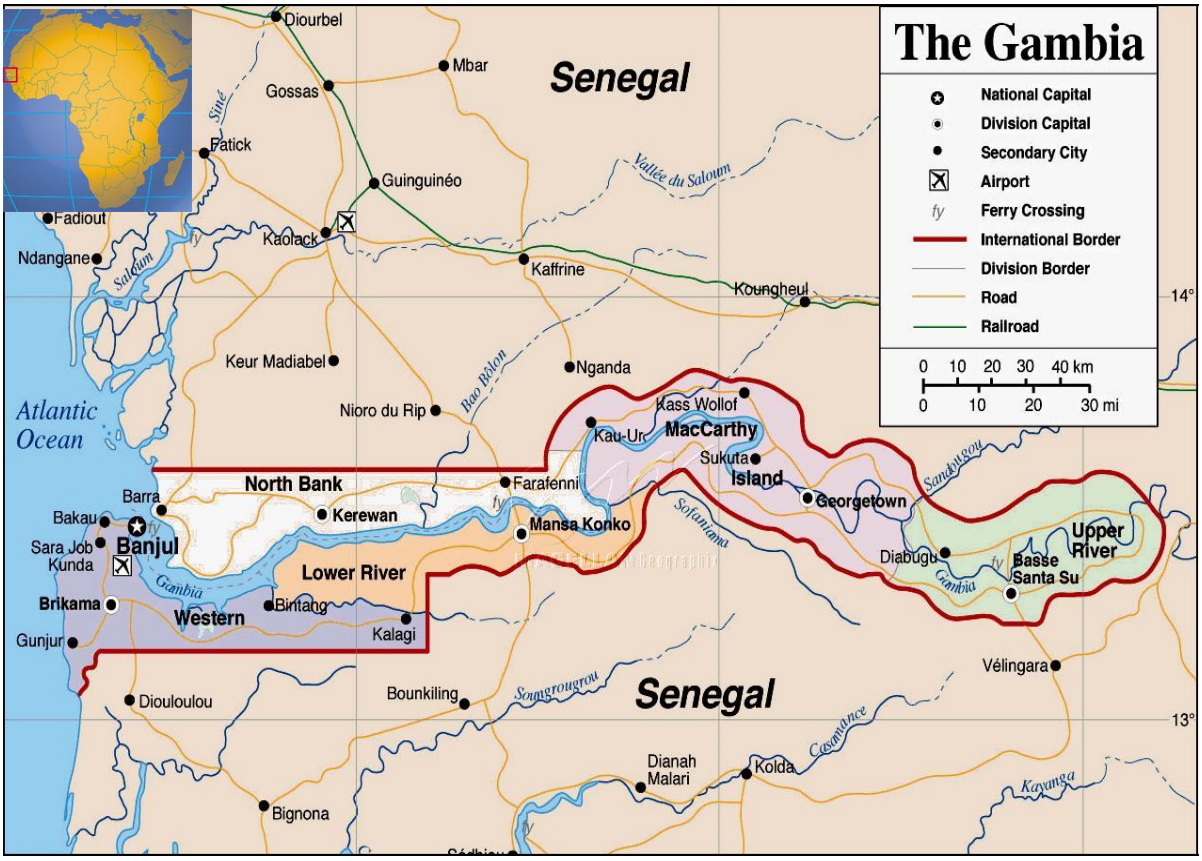

Figure 1

The Gambia, the smiling coast of Africa is a small country on the West African coast, surrounded by Senegal except in the west where it opens into the Atlantic Ocean. Its capital city is Banjul. The Gambia has a narrow area of 11,300sq km (4,362sq miles) long and a width that varies from 24 to 48 kilometres, wider at where it opens into the Atlantic Ocean. The River Gambia runs across the country dividing it into almost two equal parts, the north and the southern banks.

The Gambia was colonized by Britain and it attained its independence on the 18th February 1965 under the leadership of Sir Dawda Kairaba Jawara. Sir Dawda ruled the country from independence until 22nd July 1994 when he was overthrown in a military coup under the leadership of the present president HE Yahya A. J. J. Jammeh.

The Gambia has a population of 1.791 million with 57% of the population living in the urban areas which makes it more densely populated than the rest of the country (GDHS, 2013).

Twenty three percent (23%) about 386 Thousands of the population are adolescents 10-19 years. The percentage of girls aged 15-19 who are married is 25%. The total fertility rate of the Gambia is 5.6 and the number of births per 1000 girls aged 15-19 is 104. The life expectancy of the Gambia is 59 for men and 63 for women (United Nation, 2011, WHO 2012).

The country has a tropical climate characterized by 2 seasons, rainy season from June-October and dry season November-May. About 75% of the population are substantial farmers and the main crops grown in the country are rice, millet, maize, groundnut, cassava and findy. These crops are grown during the rainy season and during the dry season they are engaged in horticultural gardening, which makes the country blessed with fruits and vegetables all the year round. In addition to farming some of the farmers also rear domestic animals and poultry and some are engaged in fishing.

The Gambia has numerous ethnic groups and the most common local languages are Mandingka, Wolof, Fulla, Jola and Sarehuleh. Although the various ethnic groups differ culturally and socially, their communal life share similar structures which gives them a unifying bond. However, each ethnic group has their own traditional clothes, foods, music and dance.

The Gambia enjoys a socio-cultural diversity where African, Western and Arab-Islamic culture co-exists, although the Arab-Islamic culture such as polygamy and extended family dominates. Culturally, men in the Gambia can have up to four wives regardless of their religion affiliation. In the rural setting usually all the wives stay together in the same compound, but in the urban setting depending on the economic status of the individual, the wives may live in the same house or separated. If in the polygamous setting the wives have to stay in the same house, each of them will have their own room and the man rotates or the man may have his own bedroom and the wives take it in turn to sleep there. If the wives are separated, then is the man who rotates spending a day or two in each house depending on the number of wives he has.

The extended family setting is usually a set-up where three to four different generations of a family like grandparents, parents, children and grandchildren live together in a big single family house. The set-up is such that you have uncles, aunties, cousins, nephews, nieces and

the like with each family having their own corner and depending on their relationship they may have one kitchen and the women will take it in turn to cook. This makes it difficult for somebody who is not a family member to know which child belongs to which parent. In addition, there are also some relatives or other extended family member who come from the rural areas, either for educational purpose or for employment opportunities which makes the houses over crowed and congested. Family houses are referred to as "Kunda" and they are usually given the family name for example Khan Kunda and even though it may be occupied by a different family who may not necessarily have the same family name, the name doesn't change.

Culturally adolescent girls in the Gambia are more controlled than boys. The boys are usually separated from the main building (boy's courters) and you can have up to three of them sharing a room depending on how many of them you have in the house. Girls have to sleep in their mother's or guardian's room or they share with their sisters', cousins or any extended family member that may live in the house in order to keep an eye on them. But if you have many of them in the house as in the extended family set-up, controlling them becomes more problematic.

It is also a custom in the urban areas for women to employ house maids to assist in the house work especially if they are working themselves. Most of these young girls come from the rural areas or the neighbouring Senegal region of Cassamance and therefore when they come they are integrated into the extended family setting which make it impossible to give them the care and control they need. Some of them are fortunate to sleep at their workplace but for those who don't sleep there they will go to work in the morning, then come to sleep in their host house and sometimes you have a lot of them at the same time.

Moreover The Gambia's culture and tradition is such that parents rarely discuss with their adolescent children and in particular girls on issues related to their puberty or sex. The opposing view is that "providing adolescents with information about their sexuality and, especially with reproductive health services will encourage early sexual activity and promiscuity" (UNFPA, 2000).

There is no comprehensive program that specifically addresses the health needs of the adolescents and youth population in the Gambia. The current setup of maternal and child

health and family planning (MCH/FP) services provide little or no access to information and services for unmarried adolescents and youth.

Lack of information, knowledge and low awareness about reproductive health issues is a major problem for adolescents in The Gambia and their main sources of reproductive health information is through friends, radio and school/teacher. Coupled with this, there is limited access to modern family planning services which also exposes girls to unplanned and unwanted pregnancies and subsequently dropping out of school, low employment opportunities, sexually transmitted infections, unsafe abortions, and forced marriage (UNFPA, 2000).

Adolescents' health is greatly affected by not only the inadequate provision of reproductive and sexual health services, but also to a major extends by religious and socio-cultural issues and values. Premarital sex is both religiously and culturally unacceptable and majority of the population, 64.7% believed in virginity at marriage (UNFPA, 2000). Furthermore, some sorts of punishments are inflicted in all cases where a girl has a boyfriend or become pregnant before marriage. Some of these punishments include beating, insults and stigmatization and to some extend sending the girl out of the house (UNFPA, 2000).

To avoid pregnancy before marriage, which is believed to bring shame and dishonour to the family, girls are usually given up for marriage at an early age and they are more restricted and control than the boys. Furthermore, in cultures where female genital mutilation/cutting (FGM/C) is practiced, the girls are sealed during the process leaving a small passage for urine and menstrual flow and this seal is removed on the night she is taken to her husband.

In order to avert unwanted pregnancy and its consequences and also early marriage among adolescents the need for family life education (FLE) was advocated for and through collaborations with the Ministry of Education, Health, UNFPA and UNESCO a curriculum was developed and incorporated in the junior and secondary school curricula in 1995 but the program later experienced numerous challenges and resistance from parents (UNFPA, 2000). The need to keep girls longer in school in order to increase their age at marriage was also advocated for and the implementation of the free education for girls initiative through the President Empowerment for Girls Education Project (PEGEP).

The Gambia Family Planning Association (GFPA) through its youth-to-youth, adolescent reproductive health management project trained about 200 youths peer counsellors (UNFPA, 2000) and in 2009 they established the first and only youth clinic, The New World for Youth in Bundung. The youth clinic is situated in the youth centre and this was initiated to create a more conducive environment for the young people to utilize the services provided by the clinic. Apart from the clinic there is a library, skill training centre, recreation facilities in the youth centre and thus make it more convenient for young people to go in for the clinic services without being suspected or questioned. The Ministry of Health also introduced the emergency contraceptive in the health system in 2013 with the aim of reducing unplanned pregnancy especially among girls.

Despite all the efforts made and the numerous activities being carried to improve the health and economic status of girls in terms of empowerment and free education, every year 104 in every 1000 girls between 15 -19 years in the Gambia gives birth (United Nation, 2011) and even though there are no data on abortions it is stated that abortion claims more adolescents' lives in the Gambia (Gemini News Services 2013).

It is stated that within countries, adolescent births are more likely to occur among poor, less educated and rural population, however, in the Gambia teenage pregnancy among unmarried girls in the urban areas is still a problem.

1.2.2: Religion

The Gambia is a secular state with freedom of religious expression. 95.3% of the population are Muslims, 4.1% Christians and the remaining 0.6% believe in Traditional African Religion and others. Despite having the highest percentage in the country, Muslims have a high tolerance and relaxed attitude towards other religions. The Christian populations are more concentrated in the urban area. However, in the rural areas the main adherents to the Christian faith are those who were previously of the African traditional religion, such as the Karoninka, Manjagos, Jolas and the Balantas.

The relationship between Muslims and Christians has been close in their daily social life, in the workplace and also in the education systems because most Muslims go to missionary schools. Muslims and Christians in the Gambia intermarry and within the extended family, there can be both Muslims and Christians. They attend each other's wedding, naming ceremonies and funerals. All state functions are preceded with prayers by leaders of both

religious communities and the leaders of both religious communities have joined voices to point out moral wrongdoings in society at large.

In the Gambia, the form of religious practice in Islam is mostly from the teachings of the Holy Quran and Hadith combined with some animist and fetishist which existed long before Islam. There are also Christians who practice animism. Both Islam and Christianity recognized that some cultural practices had to be tolerated as long as the principle of the one God was upheld.

Before the coming of Islam and Christianity in Africa, Africans belief in and practiced the African Traditional Religion. They had sacred places where rituals, prayers and worship were conducted and even after the people converted to Islam and Christianity some of these sacred places and traditional beliefs are still being practiced. In the Gambia both Muslims and Christians still practice some of these beliefs for both Muslims and Christians visit sacred places, visit ”Marabous” practice witchcrafts and use charms.

The major religious feasts in the Gambia are the two Eids, “Mawlou Nabi” commonly known as “Gamo” (celebrating the birth of The Holy Prophet), the Islamic new year “Ashoura” commonly known as “Tamharet”, Christmas, Easter and Assumption Day, commonly known as “Sang Marie”. It is also important to know that there are no fixed dates for the Islamic feast because they are based on the sighting of the moon. (http://www.accessgambia.com)

1.2.3: Education system

The education system of the Gambia is divided into four levels: the lower basic which consists of six years primary education, grade 1 to six; junior secondary level or middle schools which is from grade 7 to 9; the senior secondary level or high school which is from grade 10 to 12 and the tertiary levels. The age limit to start grade 1 is six years, but in the urban areas children attend three year kindergarten before the primary level. Primary education in the public schools of the Gambia is free and in the junior secondary level it is free for girls. However books, stationeries, uniforms and other expenses have to be provided by parents. It is also important to know that for someone to proceed to the next higher level you must sit and pass the exams in grade six, nine and twelve. For the primary level it is a national exam but the grade 9 and 12 are regional exams conducted by the West African Examination Council for all the West African English speaking countries.

1.2.4: The economy

The Gambia belongs to the less developed country (LDC) category with per capita Gross Domestic Product of around $300. The Gambia is ranked 172 out of 185 in the HDI with an estimated 62% of the population living below the poverty line with great disparity between rural and urban areas. While Agriculture is the main employer of labour, with 75% of the population depending on agriculture as a source of income, its contribution to GDP is about 20%. Peanut is the only exported crop and there is fluctuation in the market prices. The country depends largely on foreign aid to fill the gaps in its balance of payment. Tourism is also a source of foreign exchange for the country, but the system does not open all year round, it opens in October and closes in February (MOHSW, 2011).

1.2.5: Health system

The government is the major provider of health services in The Gambia. The public health care system has three levels, based on the primary health care strategy. Presently, services are provided by seven hospitals at the tertiary level, 47 health centres at the secondary level and 492 health posts at the primary level. The system is complemented by 34 private and NGO clinics. In The Gambia the majority of health facilities and personnel are located in urban areas resulting in inequitable access to care. Four out of the seven hospitals are located in the urban area with two major and twelve minor health centres. There are also disparities among the seven health regions, with the Western Region, which is now divided into 1and 2, having most of the resources. Western Region 1or Greater Banjul Area is the urban area and Western Region 2 is the semi-urban starting from Brikama. For most communities, the first point of contact with health care services is the informal sector through traditional healers (Ministry of Health and Social Welfare, 2011).

The lowest level for health service provision is the community health post. This provides the very basic minimum health package to the village. The service providers are the village health workers (VHW) with very minimal training and traditional birth attendants (TBAs) with limited additional training. The VHW provides treatment for uncomplicated malaria, diarrhoea, minor injuries, worm infestation and stomach pain. The village health services are complemented by village outpatient department (OPD) clinics and the reproductive and child health (RCH) trekking visits from the health centres. The RCH package includes: antenatal care, family Planning, birth registration, child immunization, weight monitoring and

limited treatment for the sick (Ministry of Health and Social Welfare, 2011). There are no special clinics for children above 5 years and adolescents. In the event that they need health care services, they have to use the out-patient clinics.

In addition to the public health sector, there are private and NGOs facilities. Private sector health service provision includes the private for- profit and private for nonprofits. These are few and small sizes, each with a bed capacity less than 50. The large majority are located in the Greater Banjul Area, making choice in health service delivery point in the rural community non-existence (Ministry of Health and Social Welfare, 2011).

1.2.6: The department of social welfare

The Department of Social Welfare is a unit under the Ministry of Health and Social Welfare. It is responsible for advocating, promoting, protecting, and providing for the rights of the most vulnerable groups in the society.

The department consists of Adult and Elderly care Unit, Child Care Unit, Disability Unit and Training, Monitoring and Evaluation Unit. The child care unit consists of four subunits namely; the child support, maintenance and juvenile justice, adoption and child placement, shelter for children and SCB child drop-in centre.

The Adoption and Child Placement unit is responsible for assessment of vulnerable children, including orphans, abandoned babies and children at risk and their placement in an institution such as the shelter for children, SOS children's village or Sinchu Orphanage or with a foster family. The unit is also responsible for the processing of foster care, adoption and support for minors who travel when the need arise. They are also responsible for International Social Services, family tracing and unification services, preparation of adoption and foster care reports to the children's court and the provision of counselling on child protection issues.

The Child Support, Maintenance and Juvenile Justice Unit is responsible for addressing family issues where child support is needed. This includes paternity dispute and custody settlement, child maintenance dispute and juvenile justice where minors are in conflict or contact with the law. The majority of the cases that report to this unit are related to child support and 90% of these cases are reported by women. In 2011, 37 child supports and 5 custody cases were registered with the unit and these figures increased to 388 and 142 in 2012 and 301 and 127 in 2013. The maintenances or child support cases and custodies

include cases from both single parents and cases of divorced and the cases that they cannot handle are referred to the children's court (Department of social welfare, 2013).

1.3: *Problem statement*

In developing countries the reproductive health of adolescents is a challenge for their survival and health, especially for girls who have a considerably higher risk of sexually transmitted infections than boys and are exposed to unplanned pregnancy and its consequences (United Nation, 2011).

Adolescent pregnancies occur because of a combination of social norms, traditions and economic constraints and at the same time, because of resistance to sex education by parents (United Nation, 2011). They also have limited access to sexual and reproductive health information and services. Adolescents' sexual and reproductive health are affected by inadequate laws and policies to protect their reproductive health rights and ill- equipped health system that at times inadvertently breach confidentiality, hold inconvenient opening hours and are unfriendly and judgmental to adolescents (United Nation, 2011). Family planning services are incorporated in the RCH services which make contraceptives, access for adolescents difficult because they lack privacy. These factors contribute to the increased global burden of adolescent pregnancy and its social, political and financial consequences which negatively impact the adolescent's life, their families and the society at large (United Nation, 2011). As a result, many adolescents become pregnant before they even know how to avoid unwanted pregnancy (WHO, 2012).

Like their peers in many developing countries, the reproductive health of adolescents in the Gambia is affected by cultural, socio-economical and political factors. The adolescent population of the Gambia has increased and as a result, there are less job opportunities, especially for those who have not completed their education. These coupled with the ideology of going to Europe make adolescents to engage in relationships with people who are older (i.e. Sugar daddies and mummies).

Adolescents in the Gambia are not informed of their sexual and reproductive health and rights because parents don't talk to their children about sex and there is no where they can access information regarding their sexuality. The reproductive health services that are available in the public sector are only provided during the morning, which is not convenient for adolescents. There is no privacy for them in these facilities and this deters them from

accessing services that address their sexual and reproductive health needs. In addition, they don't have access to safe abortion services which further increase their risk of complications from unplanned pregnancies and unsafe abortion.

Even though adolescents' pregnancy has been the focus of numerous studies over the past "knowledge about the phenomena of adolescent pregnancy and prevention still continues to be elusive and at best tentative" (Spear and Lock, 2003). As far as literature search is concerned, there are limited published studies on unplanned pregnancy among adolescents in the Gambia. This study therefore, aims to explore adolescents' views on the factors underlying this global phenomenon among unmarried adolescents in urban areas of the Gambia.

1.4: *Justification of the study*

Unplanned pregnancies among unmarried adolescents are a public health problem and also a neglected area of study in the Gambia. Finding out from the girls themselves about factors contributing to their pregnancies is essential in effectively addressing this problem. Although much has been done to investigate the magnitude of adolescent pregnancy and the experiences and challenges encountered by these young women, there are still unclear answers as to why it persists.

WHO and UNICEF reports indicate the lack of data on adolescent pregnancy, sexual and reproductive health from many developing countries, including the Gambia (WHO, 2012, UNICEF, 2011). A systematic review of research on unplanned pregnancy among adolescents also pointed out the need for more research on the phenomena surrounding adolescent pregnancy (Nyamongo et al 2005). Unfortunately, there are very limited data on adolescent pregnancy in The Gambia therefore this study will form a foundation for further research in this area.

1.5: *Aim and Objectives of the study*

1.5.1: Aim of the study

The overall aim of the study was to explore the factors influencing unplanned pregnancies among unmarried adolescents in the urban areas of the Gambia

1.5.2: Specific objectives

The specific objectives of the study were to:

- Explore the perceptions of unmarried, pregnant and adolescent mothers on pregnancy and childbearing.
- Explore the experiences and challenges in terms of stigma and support of unmarried, pregnant and adolescent mothers
- Investigate the awareness level of unmarried pregnant adolescents and mothers on how to avoid pregnancies and STIs

1.6: *Research questions*

- What cultural, socio-economical and policy related factors influence unplanned pregnancies among unmarried adolescent girls in urban areas of the Gambia?
- How do unmarried pregnant adolescents and adolescent mothers perceive pregnancy and childbearing?
- What are the challenges and experiences of unmarried pregnant adolescents and adolescent mothers in terms of stigma and support during pregnancy and as adolescent mothers?
- Where do unmarried pregnant adolescents and adolescent mothers access information about pregnancy and STI prevention measures?

Chapter 2: Literature review

2.1: *Literature review*

Adolescents as defined by the United Nations are individuals age 10 -19 years, those in the second decade of their lives. It is the phase that separates early childhood and adulthood, a period that requires special attention and protection (United Nation, 2011). During this stage they undergo physical, emotional, psychological and physiological changes and are exposed to risks and challenges like accidents, violence, exploitation, rape, risky behaviours like tobacco consumption and peer pressure just to name a few. It is also during this stage that they begin to explore their sexuality and have sexual relationships which might put them at risk of sexual and reproductive health problems like early and unintended pregnancy, unsafe abortions, sexually transmitted infections including HIV, and sexual coercion and violence (United Nation, 2011).

Studies have shown that adolescent girls die from pregnancy-related causes than from any other cause. Girls between the age of 15 and 19 years are twice as likely to die from a maternal death than women in their 20s (Nove et al, 2014).This is because they have not completed their growth, particularly in height and pelvic size, and their reproductive organs are not well developed. They are also at greater risk of instrumental deliveries, prolonged and obstructed labour, which can lead to stress incontinence, vasico-vaginal fistulae (VVF), recto-vaginal fistulae (RVF) or permanent injury like nerve damage or death for both the mother and the infant.

The potential health, social, and economic disadvantages that adolescent mothers face are widely recognised, and their right to access adequate reproductive health care has been enshrined in a series of important international agreements and documents such as the WHO guideline on preventing early pregnancy and reproductive outcomes, the ICPD declaration on sexual and reproductive health rights, the millennium development goals, the international Planned Parenthood Federation Chapter and the United Nations chapters that protect people's rights (Nove et al, 2014).

Emotional instability is common during pregnancy due to the hormones of pregnancy. It may be exacerbated if the pregnancy is unplanned and unwanted. Pressure from the family or the negative attitude by the partner towards the pregnancy, may cause some adolescents to experience low self-esteem, anxiety, fear, and even depression (Ilika and Anthony, 2004).

Early pregnancy and childbearing are typically associated with less education and lower future income for young mothers because once they become pregnant they tend to drop out of school. Unmarried pregnant adolescents have particular problems such as discrimination by families, school, church and society (Ilika and Anthony, 2004). In many countries girls who become pregnant are not allowed to continue schooling and even before the official expulsion, most of them would often have left school because of feelings of shame. Furthermore, many of the adolescents who become pregnant are forced to marry early which potentially perpetuate the poverty cycle due to the restriction of their limited chances of having a well paid job and the only option they have is to work for low wages instead of gainful employment. Also, in most countries motherhood for unwed teens can result in social ostracism (Ilika and Anthony, 2004).

According to the findings from this study, some of these girls faced problems like discrimination, violence and psycho-social stress and forced marriage (Ilika and Anthony, 2004). In their explorative study aimed at identifying the characteristics and factors influencing unintended pregnancy among unmarried adolescents and young women in a rural community, 136 unmarried teens with unintended pregnancy, attending a Christian hospital in Ozubulu, a rural community in south-east Nigeria, from January 1998 to December 2001 were included. Through using semi-structured questionnaire and in-depth interview guide to collect data, findings revealed that over 75% of the girls had their first sexual intercourse in their adolescent age, over 69% had multiple partners and only 13.5% had ever used condoms. Over 95% exchanged sex for money or gifts. The major gifts were money to supplement school fees and to buy other necessities such as cosmetics and clothes, snacks, food and drinks, and free rides to school or workplace (Ilika and Anthony, 2004).

They also noted that 97% suffered violence such as physical and verbal abuse from family members because of the pregnancy. Most of the adolescents or young women experienced major stressors, such as school and job termination, religious sanction, discrimination and stigmatization as a result of the unintended pregnancy and partner's negative attitude. Most of the participants reported they were rejected by their partners who often refused to admit being responsible for the pregnancy. Participants also reported being denied marriage and financial support in spite of past expressions of love and promises by their partners. Most of the partners were much older men, a situation that made it difficult for the girls to negotiate safe

sex. Only 8.8% considered the fear of STDs and HIV/AIDS as a stressor (Ilika and Anthony, 2004).

Furthermore, 59% of the adolescents or young women who sought termination of pregnancy tried local concoctions such as Andrew's liver salt, hot pepper soup, hot drinks and ergometrine tablets or injection bought from patent medicine stores. In some cases, local medicine men also inserted local herbs into the vagina to induce abortion (Ilika and Anthony, 2004).

With regards to pregnancy prevention the young women suggested that the best way to avoid unintended pregnancy in the future was to abstain from sex. They considered the use of condoms impracticable because it is unacceptable to their parents and religion, which insist on premarital abstinence from sex. They also feared that if their parents were to find condoms in their rooms or bags they would punish them. They also reported that condoms are not easily accessible, and to negotiate to buy condoms from local medicine shops attracts branding the young unmarried adolescent as promiscuous. They rather preferred to use emergency contraception, which they understood to be a drug they could take immediately after sex to prevent getting pregnant (Ilika and Anthony, 2004).

In another study conducted among low-income African-American, Mexican-American, and Caucasian pregnant adolescents aged 18 years in the United State stigma was explored. It was observed that, two out of five adolescents reported feeling stigmatized by their pregnancy and that they were at increased risk of social isolation and abuse (Constance et al, 2004). Some correlation between stigma and self-reported behaviours such as substance use, exposure to violence, family support and criticism were identified. Stigmatized adolescents reported having seriously considered abortion, being afraid to tell parents about the pregnancy, had the feeling that parents/teachers thought pregnancy was a mistake, and feeling abandoned by their partners.

The authors concluded and recommend that these young women may need special attention during and after pregnancy to develop concrete strategies to care for themselves and their children and also to complete their education and avoid becoming clinically depressed (Constance et al, 2004).

For the National Survey of Reproductive and Contraceptive knowledge, 660 young adult men and women aged 18-29 were interviewed. The aim of the study was to assess the factors associated with perceived likelihood of pregnancy. Data was collected via telephone interviews using a random-digit dial. The sample included unmarried young adult males 43%

and females 57% who were sexually experienced, were not trying to get pregnant and had previously used contraceptive (Melanie et al, 2015).

The results revealed significant associations between several environmental and personal variables and young adults' likelihood of becoming pregnant within the next year. With regards to environmental factors, 41.2% of participants who attended religious services once a week and 36% who attempted three times a month expressed some belief of pregnancy likelihood where as 25.1% who never attended religious services expressed at least some belief of becoming pregnant within the next year (Melanie et al, 2015).

Among the personal factors, 62.1% of the participants who indicated that it was not important to avoid a pregnancy were significantly more likely to report that they may become pregnant within the next year as compared to 24.7% who indicated that it was "very important" to avoid a pregnancy. Similar findings were observed among participants who agreed that a pregnancy could happen whether or not they used contraceptive (38.9%). In contrast, the remaining 61.1% who believed that pregnancy could happen regardless of contraceptive use reported that they were less likely to get pregnant in the next year (Melanie et al, 2015).

In addition, 57.1% of the participants who agreed that birth control was morally wrong reported a potential pregnancy in the next year as compared to 30.3% of participants who disagreed with the statement. Approximately 27% of participants who strongly agreed that they had enough information to avoid pregnancy reported pregnancy likelihood as compared to 44% of those who disagreed with that statement (Melanie et al, 2015).

In an explorative study aimed at understanding what pregnant adolescents view as the advantages and disadvantages of having an infant during their teen years, Rosengard and colleagues included 247 adolescents age 12-19 years attending first prenatal care visit to a women's primary care clinic in Providence, Rhode Island (Rosengard et al, 2005). Advantages of teen pregnancy included enhancing connections with somebody they love who will love them, positive changes towards life, benefits, and practical considerations in terms of deciding for themselves and taking up the responsibility of caring for their infants.

The disadvantages reported were lack of preparedness of the body both physically and psychologically, changes in their body image and having to care for the baby, interference

with their schooling and social life and having to depend on their parents and state for financial support were reported. It was also realized that differences among groups were based on age, ethnicity, intendedness of the current pregnancy, and previous history of pregnancy and parenting (Rosengard et al, 2005).

In a cross- sectional survey that used secondary data from South African Demographic and Health Survey (SADHS), 1,395 women aged 15-24 who had been pregnant at the time of and/or three years preceding the survey were interviewed. The aim was to examine the distribution of and factors associated with unintended pregnancy among South African youth. According to Latifat et al (2007) there was a high level of unintended pregnancies (72%) among youths with 29% of the pregnancies wanted. Five critical predictors of unintended pregnancy among South African youth were age group, region, marital status, education and relationship with the last sexual partner.

They observed that the risk of unintended pregnancy was less likely among the 20-24 years old relative to the adolescents 15-19 years (AOR- 0.42, CI- 0.29-0.62, p value- 0.000). It was also found out that the higher the level of education, the more likely the experience of unintended pregnancy. The respondents with higher education were more likely to experience an unintended pregnancy (AOR- 4.27, CI- 1.44- 12.65, p-value = 0.009). Respondents not living together with their partners had a higher risk of unintended pregnancy (AOR- 3.88, CI- 2.76- 5.47, p-value = 0.000). Respondents whose last sexual partners were their regular or casual partners were also more likely to experience an unintended pregnancy relative to respondents whose last sexual partners were their marital partners (Latifat et al, 2007).

In another study conducted in South Africa that explored the experiences of teenage pregnancy among Xhosa families, 10 pregnant teenagers, eight mothers, two fathers, seven grandmothers and three grandfathers from the same families were interviewed independently and privately. The results showed that pregnant teenagers experienced emotional turmoil as they strived to cope with their pregnancies. These emotions occurred because the teenagers blamed themselves, and were angry that they had not used contraceptives as directed by the midwife at the clinic, or for not being strong enough to refuse to engage in a sexual relationship until they were ready to be mothers. They were inclined to be oversensitive and angry with themselves, their families and their peers (James et al, 2011).

The stigma of pregnancy made them feel hurt, stupid, sad, disgraced, in despair and morally wrong. They also experienced a change in their relationships with significant others due to expectations that were not met and role confusion which led to crises. It was also found out that parents experienced overwhelming emotions due to the unexpected pregnancy of their child, and loss of control as the pregnancy could not be reversed and the grandparents of pregnant teenagers experienced the pregnancy as a family disturbance (James et al, 2011).

In a study analyzing the impact of adolescent pregnancy on the future life of young mothers in terms of social, familial, and educational changes in Austria, all adolescents delivering at an age of 17 years or less within a time frame of 5 years. Out of these 186 adolescents who had delivered, 131 participated in the study. Through telephone interviews, 16 developed questions and a well recognized questionnaire on life satisfaction were used to collect data.
The participants were split into two groups: those who delivered within 2.5 years and 2.5–5 years after delivery and they were compared in terms of relationship, employment status, child care, and support.

Findings revealed that there were significant differences concerning relationship with partners, education and educational level, employment status, means of subsistence, person in a position of trust, close friends and current contraceptive use (Zeck et al, 2007). Fewer women in the second group were married to the child's father or lived with him, but those who had a new partner or lived alone were more in this group. They also had a significantly better social network with a higher number of close friends, more independence, better education and employment status. No statistical differences were found concerning future pregnancies as well as child care (Zeck et al, 2007).

In a similar study conducted in Dallas, Texas the researchers investigated the effect of unplanned pregnancy on the long-term implications (15 years) of mother–child relationships. (Nelson et al, 2012). Their findings showed that among first-time mothers, unplanned pregnancy was associated with negative relationship between mothers and their adolescent children at age 15 years, $AR(371) = -.10$, $p < .05$. The experience of an unplanned pregnancy was related to higher maternal depression symptoms M (-0.02), SD (0.75) and Range (-1.10 to 3.44) and high parenting stress M (-0.06), SD (0.73) and Range (-1.67 to 2.29) over the first three years. High maternal depressive symptoms over those early years were, in turn,

related to more conflict and hostility in the parent–adolescent relationship (Nelson et al 2012).

Chapter 3: Methodology

3.1: *Study design*:

In this chapter the methods used to investigate the factors contributing to unplanned pregnancy among unmarried adolescents in urban Gambia, their perceptions with regards to child bearing, pregnancy and STIs prevention and to explore their experiences during pregnancy and as adolescent mothers are described.

Since the study was aimed at exploring issues related to why unmarried adolescents were becoming pregnant, understanding the phenomena of pregnancy outside marriage and also to explore the experiences lived by these adolescents, a qualitative research was conducted.

A qualitative study design was used in this study**.** The qualitative study design originated from the social and behavioural sciences and it is used when exploring issues, trying to understand a phenomenon or in answering questions like why, how and in what way are peoples' life affected. It is usually designed in a way that can reveal the participants' range of behaviour and their perceptions as to why they should behave in that manner (Pope et al, 2000).

Qualitative research provides the researcher with opportunities to observe record and interpret non-verbal communication such as body language and voice intonation as part of a respondents' feedback during an interview. The researcher also has the opportunity to probe in and to ask for clarification, i.e. "help me understand why you feel that way" enabling him or her to reach beyond what was said initially and the reasons why participants felt that way (Pope et al 2000). Qualitative methods such as participant observations enhances interaction between the researcher and the study participants, enabling him/her to share their perceptions, feelings, reactions and emotions which they might not disclose or share during an interview or focus group discussion. What they tell you might be different from their real life situations in terms of what they do, how they behave and what they believe (Pope et al 2000).

Furthermore qualitative research is especially effective in obtaining culturally sensitive information from a specific study population regarding their values, opinions, behaviours and social contexts. It also produces findings that were not predetermined and are applicable beyond the immediate study boundaries, making it necessary to go further to do other research. Qualitative research seeks to understand the perspective of the local population on a particular issue or problem and is effective in identifying intangible factors, such as social

norms, gender norms, socioeconomic status, ethnicity and religion which may not be apparent in the research overview (Pope et al 2000).

3.2: *Theoretical perspectives*

The theoretical perspective that was used in this study is what Husserl named the science of pure phenomena "phenomenological". According to him people are sometimes certain about how thing appears in their situations, but for them to be conscious of this certainty, anything that was outside their immediate experience is ignored. "In this way the external world is reduced to the contents of personal consciousness and realities are thus treated as pure phenomena, which is the only absolute data from where to begin with" (Groenewald, 2004). The primary objective of using phenomenological approach is to analyze and develop detailed meaning, structure and essence of the lived experience of a person, or a group around a specific phenomenon (Groenewald, 2004, Marilyn et al, 2011). It can also explore means to uncover deep understanding of those experiences from the perspective of the individuals and groups who had lived that experience. In this study the phenomenon of interest was unplanned pregnancy among unmarried adolescents and the dimensions are the socio-cultural, economical and political dimensions of the adolescence pregnancy, their perceptions on pregnancy and childbearing, their experiences and their awareness levels on pregnancy and STI prevention.

"Phenomenology is the illumination of the specific" (Lester, 1999). According to Lester, it is used to identify people's experiences through how they are perceived by the people who lived it. It usually relies on inductive qualitative methods to gather deep information about the participants. Phenomenological approaches are based on a paradigm of personal knowledge and the experiences that participants are subjected to. It also emphasizes the importance of personal perspective and interpretation of these experiences. They are used for understanding the subjective experience of participants and gain insight of what motivates people and what are the reasons behind their actions, instead of using "taken- for-granted assumptions and conventional wisdom" (Lester, 1999).

Phenomenological approaches most of the time describe what participants perceived or experiences rather than explaining how they are experienced (Husserl, 1970, Lester, 1999) and they do not necessarily begin with a theory instead, it begins with the phenomena under consideration and how the researcher collects the data will depend on the manner that participants can "express their phenomenal experience" (Simon and Goes, 2011).

Phenomenological approach underpinned this study to enable me to explore the experiences of adolescents who were pregnant or have recently become a mother.

GENDER RIGHTS FRAMEWORK

Figure 2: **The gender and rights model**

The main theoretical perspective that ground this study was the gender and rights approach. Gender as defined by the Inter-Agency Standing Committee (IASC) is the social differences between females and males throughout the life cycle that are learned, and though deeply rooted in every culture, are changeable over time (IASC, 2006). Gender has wide variations both within and between cultures and it determines the roles which are generally considered appropriate by a particular society for either a man or a woman in a social or interpersonal relationship, power and resources for females and males in any culture (IASC, 2006).

In heterosexual relationships, the sexual and reproductive health rights (SRHR) of women are directly affected. This is because in gender relations, whenever the "doing" of masculinity and femininity are at play, it is the women who suffer the consequences. Gender relations are relevant for determining women's capacity to act in a way to protect themselves against sexually transmitted infections, pregnancies and unwanted sexual acts (Wood, 1998; Goicolea, 2010).

Despite the connections between adolescent pregnancies and SRHR and gender relations, it has been realized that their sexual and reproductive health rights and the gender relation issues are seldom considered in research. The risk approach still dominates and as a result the findings reinforce a negative conceptualization of adolescents and young people, "focus on pregnancy as an isolated event, and place the main responsibility for adolescent pregnancy prevention on the adolescent girls themselves" (Goicolea, 2010).

Adolescent pregnancies occur as a result of sexual intercourse which is either in a stable relationship or as a consequence of sexual abuse. Theses pregnancies may also occur if the adolescents don't have access to contraceptives or safe abortion services and may lead to maternal morbidities. All these phenomena belong to the sphere of sexual and reproductive health. Exploring all the interconnected events may help us to better understand the experience of an unplanned pregnancy among unmarried adolescents (Goicolea, 2010). Adolescent pregnancy must be embodied in a female body if we need to understand it because "all the events that surrounds it occur in a particular time and place, and those circumstances affect not only one isolated individual, but many others that share the same time and setting, and this transforms an individual experience into a public health issue" (Goicolea, 2010).

According to her, how each girl experiences her pregnancy is different from the other depending on her level of education, her ability to demand for and exercise her sexual and reproductive rights, her status and whether the pregnancy was wanted or it resulted from coercive sexual intercourse. The social environment and the health system can also have an influence on the girl's ability to exercise her reproductive health rights because the social institution are not gender neutral and are strongly influenced by the gender order (Goicolea, 2010).

The framework tries to explain how the gender and rights perspective could be combined to explore adolescent pregnancies because even though there are gaps between them there are also parallelisms, interconnected by freedom and agency on the left and gender order and regimes and entitlements on the right. "The double-edged arrows attempt to express that not only structures influence individuals' capability to make decisions and exercise rights, but also individuals might have an influence on the way gender regimes operate and the system of sexual and reproductive health they are entitled to" (Goicolea 2010).

Using this framework in this study has been relevant in exploring the factors contributing to unplanned pregnancy since pregnancy and all the other events that are connected to it directly affect the reproductive health rights of these adolescents; their access to sex education and information, contraceptive services and use, the agency needed to exercise these rights that they are entitled to and their capabilities to make decisions regarding their sexuality and fertility.

The framework was also relevant in the discussion of the social construction of the institutions that are not gender neutral and because they are influenced by the gender order, they affect the adolescent's freedom to exercise her sexual and reproductive health rights. In the Gambian context, the sexual and reproductive health rights of women and adolescent girls are affected because of the social construction of their gender relationships. Early, arranged and polygamous marriages are common practices in the Gambia which deny women, especially adolescent girl the capability to make decisions about their sexuality or to protect themselves against sexually transmitted infections and unwanted pregnancies or to refuse an unwanted sexual act especially if they are married.

Unmarried adolescents also encounter the same problems as shown in this study. Indeed, due to their vulnerability, they are engaged in unprotected sexual intercourse, usually in a multiple relationship where some of their partners are married and are far older than they are (sugar daddies) which makes it difficult for them to refuse unwanted sex or to negotiate for safer sex practices.

3.3: *Data collection methods*:

Pregnancy outside of marriage is not socially, culturally or religiously acceptable in the Gambian context and is therefore associated with stigma and shame. The data for this study were collected using in-depth interviews and a focus group discussion. Before the actual data collection, a lot of literature was reviewed to give me an insight of how studies on unplanned pregnancies were conducted, which methods were used to collect the data and in which setting were they conducted. Since there were no studies done in the Gambia, I needed some information about the Gambia.

My search for information took me to the Department of Social Welfare where I spent five weeks internship from the 5th August to 4th September 2014 observing how social workers and their clients interact. During the stated period I spent four days with the training unit

itself, two weeks with the Adoption and Child Placement Unit and two weeks with the Child Support, Maintenance and Juvenile Justice Unit. These latter two units are responsible for all matter related to babies who are abandoned, paternity disputes, child maintenance and support, children at risk, including children of mentally ill women, children on the move[1], and adolescents who have a family dispute, especially due to problems related to pregnancy, rape or early marriage.

Although there were no records of the prevalence of adolescent pregnancies or abortions, there were records of the annual number of babies abandoned, records of paternity dispute cases and child maintenance and support. I was also able to establish an entry point in case a need arose to refer a client for support.

To explore the experiences of these young women during their pregnancies and as adolescent mothers and to dig down to the root cause of why these young girls became pregnant, in-depth interviews and focus group discussions were used to collect data**.** Each of these methods has strengths and weaknesses.

3.3.1.: In-depth interviews

In-depth interviewing is appropriate to gain insight into individual evaluations of specific issues and it allows the researcher to understand the experiences of other people as well as their meaning in a more natural form. It is more appropriate if the subject or issue is in the nature of something controversial, sensitive or tabooed (Newton, 2010). There is flexibility and the interviewer can adjust and change directions as the interview is taking place and one can follow thoughts, feelings and ideas behind the response given. In in-depth interviews, more valid information about attitudes, values, opinions and how respondents conceptualized things is obtained. The informal atmosphere can encourage the respondent to be open and honest. There is time for the respondent, in peace, to further develop and give reasons for her individual point of views without being influenced by the opinions of other respondents. Asking participants about their perceptions of pregnancy or their experiences with regards to stigma and support will give the researcher the opportunity to understand how they think and feel (Warren, 2001, Newton, 2010).

[1] "Children on the move" refers to run away from home and they don't have anywhere to stay, so they just move around. It is more common among children who are sent to the traditional boarding institution ("Dara") to learn the Quran and they sometimes have to cross borders to come to the Gambia.

The weakness of this method is that a limited number of interviews can take place because it is time consuming. It is difficult to compare the results because each interview is unique. Because of the small sample size, the results are unlikely to be representative of a particular population. In addition, collecting of data is being time consuming, so too is the data analysis (Warren, 2001, Newton, 2010). Also, there is a power imbalance between the researcher and the participant and their reaction is artificial, in that their interaction does not reflect a real interactive situation.

In-depth interviews were carried out from October 2014 to January 2015. During this period, participants were informed and recruited in the study with the help of the midwives who were working with them. After they were identified and informed by the midwives that somebody was doing a study on unplanned pregnancy, if they wished to participate then they were introduced to the researcher. She would then go with them in the office of the head midwife, introduce herself and give them detailed information about the study and if they say they would like to participate, then their consents were sought.

Participants who were less than 18 years were in addition also provided with the parent's/ guardian's information document and the consent form for their parents or guardians to sign if they would allow them to participate in the study and they would bring it along when they were coming for the interview. The day, time and place of the interview were decided by the participants. Depending on where they want it to be conducted arrangements were made to meet their convenience.

Of the 15 respondents, 11 were interviewed twice in order to explore the coping responses to their challenges that were noted during the first interviews and the experiences of those who have delivered as adolescent mothers. Twenty four of the interviews were conducted at the 3 different health facilities and the remaining two took place at the participants' respective homes. The interviews lasted between eighteen minutes and one hour. The local languages used during the interviews were Wolof and Mandingka. One participant was interviewed in English, thirteen in Wolof by me and one was conducted in Mandingka with the help of my interpreter. Wolof is the most common spoken language in the Senegambia region with about 7million speakers and is understood by many people residing in the urban areas. Mandingka are the majority in the Gambia with 42% of the population, yet even though only 16% of the Gambian population are Wolof, the Wolof language and culture have a disproportionate

influence in the urban area especially the capital where the majority of the population are Wolof.

However, both Wolof and Mandingka are not written languages, therefore all the interviews were tape recorded, transcribed verbatim and translated directly into English. The interview guide was used, but it was not strictly adhered to because as the interview was going on other issues came up and they were discussed before proceeding. However it was referred to at all times to avoid being carried away from the main themes. The wordings of the questions were sometimes changed to ensure understanding and clarity of the participants because Wolof was not their mother tongue.

The interviews were usually opened with informal greetings and participants were reminded of what was involved in the study and even though they have consented to participate in the study, their consent to record the interviews was soughed before the interview started. They were also asked to reintroduce themselves during the initial interviews and about their background. Following this they were asked about their relationship with their parents and how easy it was for them to talk to their parents, which lead us to the core aspect of the interview, which include the following: young peoples' source of information about sex and reproductive health; their access to reproductive health services; their perception on pregnancy and childbearing; their experiences as adolescent mothers and their levels of awareness on pregnancy and STI prevention. There were probes during the interviews and they were usually concluded by summarizing the most important points that they have said and also asking if there was anything that I have not asked them and they would want to share with me or if they have any questions.

During the first interviews those whose pregnancies were term were requested to inform me when they deliver so that the second interview could be conducted. After the initial interview some of them used to call me just to greet. I was also calling them from time to time to see how they were doing and these informal discussions created a lot of openness and trust between me and them and also some of their family members. All the second interviews took place at the health facilities and 1 was conducted in English and 10 were in Wolof.

3.3.2: Focus group discussion

A focus group discussion (FGD), as a data collection method, 'involved more than one participant per data collection session' (Barbour, 2007). It is an informal discussion among a

group of selected individuals who share common characteristics and interest about a particular topic (Barbour, 2007). It is a widely accepted and legitimate research method that determines attitudes, experiences, perceptions, and knowledge on a wide range of topics in many fields of endeavour. Focus groups lead to the voicing of attitudes and insights not readily attainable from other qualitative forms of data collection like the individual interview (Barbour, 2007).

The weaknesses of this method are that the effect of group dynamic can affect the interaction of the participants. Some of the participants may dominate the discussion while others may not participate in the discussion which may affect the findings, as the reflections and opinions of those not taking part will not be captured. Another weakness of the method is the social context in which it is conducted, because participants may not feel comfortable to openly talk about their experiences or opinions on the issue being discussed without being judged or ridiculed by other members of the group. The presence of some members in the group may intimidate some participants and they may conform to the dominant ideas that are presented. (Hopkins 2007:530, Hollander, 2004, Barbour, 2007).

One FGD was organized during the last week of the data collection. The aim was to generate more information about the phenomena under study and their experiences as they discuss among themselves. It was conducted at Fajikunda health centre, when the RCH staffs were away on trek (outreach clinic) and the clinic was free for use with limited interruption. It included six participants from the study and it was done in Wolof

Even though they all participated in the study, they didn't know each other, so the researcher had to inform them that all those present were part of the study to make sure they feel safe and secure to discuss their experiences openly. Participants were also asked to introduce themselves before the discussion started.

The discussion began with a presentation of the preliminary results from the interviews in order to stimulate an interesting and valuable discussion. It lasted for 76 minutes and snacks were provided.

3.4: *Data collection tools*

Data were collected through in-depth interview and focus group discussion using an interview guide with probes that was developed, pre-tested and translated into the local

languages that the participant understood. A tape recorder and notepad were also used to record the interview and to take notes during the data collection process.

3.5: *Study setting – Public Health Centres in Western Region 1*

The study was conducted in the public health centres located in Western Region 1. Western Region1 or Greater Banjul Area is the urban area and because of its location along the coast it is now called West Coast Region. It is the most densely populated region in the Gambia with a population of 758,153 inhabitants (HMIS, 2013). As mentioned in the county profile, the majority of health facilities and personnel are located in this region resulting in inequitable access to health care. Four out of the seven hospitals in the Gambia are located in Western 1 with one major and five minor health centres, making the region more advantage in terms of resources and manpower. The health centres in this region are; Fajikunda major health centre, Bakau, Serekunda, Sukuta, Brufut and Banjulinding health centre.

The health centres are the entry point for health care in the Gambia. They are the main providers of reproductive and child health services and they also serve as the referral point for services like, obstetric emergencies, other medical and surgical conditions and blood transfusion services. The minor health centre provide up to 70 percent of the Basic Health Care Package need of the population (HIMS, 2013).

The health centres have different units, namely the Reproductive and Child Health Unit (RCH), the labour, antenatal and postnatal wards which are run by midwives, the outpatient and inpatient departments, TB units, the laboratory department, the pharmacy, the finance, and records units. However, even though there are doctors, pharmacy assistants and other health professionals, the health centres are headed by midwives.

The reproductive and child health (RCH) units consist of the antenatal clinics, counselling services, postnatal clinics, family planning clinics and child welfare clinics for children under five and they function only in the morning. Under the children welfare clinic, you have the weighing and growth monitoring, immunization and the treatment of minor common illnesses. The RCH has both based and outreach clinics. The based clinics are the once that are conducted in the health facility and each of the circuits in their catchment area is allocated a day in the week for them to come for RCH services and the outreach clinics are when the staff go out to meet the people in their localities usually in a health post. Due to their large catchment area Serekunda and Bakau health centres don’t have out-reach clinics, Fajikunda

has two, one every second week and Sukuta, Banjulinding and Brufut have more outreach than based clinics.

Data collection was conducted at the Serekunda, Fajikunda and Bakau health centres. Health centres are the key providers of antenatal, intrapartum and post natal care for the local population in the Gambia and these facilities are located in the most densely populated areas in the region. They also have the largest catchment area coverage, the highest registered antenatal services and deliveries in the region. In 2013, Western Region 1 has the highest rate of newly registered antenatal and newly registered antenatals below 15 years (HIMS, 2013).

3.6: *Study population*

The study participants were unmarried adolescent girls who were either pregnant during the time of data collection or had delivered within two months up to one year at the time of the data collection period. These adolescents were residing in Western Region1 and were coming for ante-natal care services in the public health centres mentioned above, postnatal care services or bringing their children for infant welfare services. These facilities were selected in order to capture a diversity of ethnic groups and the different economic, social and cultural backgrounds.

3.6.1: Inclusion criteria

All adolescent girls between the ages of 12 to 19 who were unmarried and pregnant or had delivered within two months up to one year were included in the study. Only those coming for antenatal care, postnatal care or infant welfare services at the public health centres located in the Western Region 1 were recruited. Only those who were willing to participate voluntarily were included in the study. In addition, for participants who were less than 18 years old, consent from their parents/guardians was obtained before recruited.

3.6.2: Exclusion criteria

All married adolescents were excluded from this study. In addition, unmarried adolescents with mental disorder, but were pregnant or had delivered with two months up to one year were excluded. Unmarried adolescents who were less than 18 years, pregnant or had delivered within two months up to one year, but, did not have a parent's or guardian's consent were also excluded from the study.

3.7: *Sampling*

Sampling is the process used to select cases for inclusion in the research study (Polit & Beck, 2008). In a qualitative research it is described as relatively limited, based on saturation, not representative and the size of the sample is not statistically determined (Sarantakos, 2000). The sampling method used for this study was purposive sampling. Purposive sampling involves the conscious selection of certain subjects, elements, events or incidents that have rich information regarding the phenomena under study (Polit & Beck, 2008). According to Burns and Grove (2005), information-rich persons are to be selected for the purpose of the study. In this study a sample of 15 unmarried adolescents who were pregnant or had recently delivered were selected for the study.

3.7.1: Recruiting process

The study participants were recruited from three of the public health facilities in Western Region 1. In order to be able to recruit these adolescents, the need to get the assistance of the service providers who deliver RH services was recognized. Prior to the commencing of the data collection, all the six health centres in the region were visited and the project and its objectives were explained to the unit heads and the RCH staff. Arrangements were made with the midwives to keep the researcher informed whenever there was an eligible case in their facilities. The midwives were to inform them that there was a study going on and if they wished to participate, their contact numbers would be collected for the researcher if she was not around, then they would be contacted and an appointment made. This arrangement was made because it was impossible for the researcher to be at the different health centres at the same time. She was only going on their busiest clinic days.

After a whole week, calls were not coming so the plan needed to be revised. Instead of waiting for the calls, the midwives at the RCH clinics were called from time to time to see if there were any cases. If yes, they were contacted. At the initial stage the contact numbers that were received were contacted to make appointments with them, but 3 of those numbers were never reachable, 2 hang off the moment a study was mentioned and there was 1 who would always keep you on hold.

Then it was later decided that it was best to be based at the clinic of the different health centres. With the help of the clinic staff, participants were identified and recruited during the

clinic sessions and the appointments for the interview made. Two of the participants were recruited from Serekunda health centre, two from Bakau and eleven from Fajikunda major health centre. 11 of the participants were recruited at the RCH clinics, two at the labour wards and two at the infant welfare clinic (IWC) when they came to change their antenatal card for the IWC. For the mothers who were coming for IWC it was difficult to identify them because their marital status, which is the only way they can be identified, is only indicated on the antenatal card and not on the IWC card.

3.8: *Data analysis*

Thematic analysis was used to analyze the data. The data analysis in this study relies on what Green and Thorogood described as the inductive process. In the inductive method of analysis, the process is cyclical in the sense that while the data is being collected, it is analyzed, and then a provisional coding scheme is developed and used to suggest further sampling. With more analysis, emerging themes are interpreted and there is a constant comparison of the indicators, cases and data sets (Green and Thorogood, 2009).

The data analysis started during the data collection process and continued more systematically after returning from the fieldwork. From the first day of the data collection whenever I returned from the field I would listen to the audio tapes of the interviews to familiarize myself with the data. At the same time the notes that were jotted down were reviewed and the issues that came up during the informal conversation written down. Eight of the interviews were transcribed and translated into English during the field work which gave me the opportunity to hear the interviews repeatedly as they were being transcribed. During this period I was also able to compare the responses from the participants in terms of similarities, differences, contradictions and gaps between the narratives. Combined with the informal conversations I had with them it gave me an overview of the preliminary findings.

After returning from the fieldwork the remaining seven interviews, plus the 11 second interviews and the focus group discussion were transcribed before the data was formally analyzed. After the transcription of the data, themes were identified, notations made to record ideas that were identified after which the data was put into categories and subcategories that better answered the research questions. Then a coding scheme that best defines the themes that have been identified were created to provide a way to organize the data for further analysis using colour codes. The research questions gave structure to the data analysis.

3.9: *Trustworthiness of the data collected*

Trustworthiness in general term is, to what extent does the readers of a research report trust the findings, interpretations and conclusion. That is, is what was presented herein credible, confirmable, dependable and transferable?

Credibility

For a research study to be credible it has to answer the research questions and relate the realities of the participants. The findings should also be reported in such a way that accurately reflect the participant's opinions, perceptions and experiences through the transparent description of the choices made in the research process.

To ensure credibility, different data collection methods were used to collect data (triangulation). The method used included in-depth interviewing, one focus group discussion and informal conversations with the participants. This helped to broaden the results from an individual perspective to the wider context. The data were also collected from participants from different ethnicity and family backgrounds, varying ages and educational backgrounds which also helped to enrich and contextualize the analysis. Furthermore, in seeking to analyze the data from different perspectives, different theories were explored.

Transferability

Transferability is about showing that the findings have applicability in other contexts. With regards to transferability, the findings are transferable to rural areas as adolescents in the Gambia are exposed to the same cultural, socioeconomic, policies and health system factors that are contributing to unplanned pregnancy. They are also exposed to the same socialization agents like school, the extended family system, religious and cultural events. However, some aspects of the findings may be less transferable in the rural areas due to differences in access to media, family planning services and private services.

The findings may be transferable to other urban adolescents in Africa and around the globe where traditional norms and gender roles greatly influence their sexuality and reproductive health, where adolescents are exposed to the same low socioeconomic status and where the socializing agents are the school, the family and health care institutions.

Dependability

Dependability is about the possibility of having the same findings if the research was repeated. For a research to be reliable the researcher being the main tool in a qualitative research should record the changes that occurred in the research setting and establish how these changes can affect the research approach. For a research to be dependable, there should be consistency in the inquiry process and there is the need for an independent editor who ensure whether the researcher was careless in the collection, analysis or reporting of data. The findings also have to be credible and transferable. This was ensured through triangulation.

Confirmability

Confirmability refers to the degree at which others can confirm the findings of a research and to what extent are the findings shaped by the respondents and not the bias, interest or motivation of the researcher. This was ensured through reflexivity.

Reflexivity

"Reflexivity is the consciousness awareness of the researcher in the research process, the decisions we make in the research process and the relationship or the impact it has on the other" (Engward & Davis 2015). It involves "reflection of how one is inserted in grids of power relations and politics and how that influences the research method, its interpretation and knowledge production" (Sultana, 2007).

Even though reflexivity is complicated in the way the researcher relates to the participants, what can and cannot be done, it is important that it occurs from the beginning and continue to the end of the research because this strengthen the researchers' commitment to conduct good research based on "building mutual relations, respect and recognition" (Sultana, 2007).

My twenty years of practice in the health field as a nurse midwife and also a lecturer in the Nursing and Midwifery Training Institutions gave me a privilege to be known and to know many nurses and midwives providing reproductive health services. This brings in what Sultana refers to as different dynamics in terms of being considered "insider-outsider" and the politics of representations. I was considered an insider because I am a senior midwife and the students who were on attachment at the health facilities also see me as their lecturer even though I was there as a student on fieldwork. They would ask me questions about things they

didn't know or if I wanted to add anything to what they said during the health talks, and sometimes to confirm a presentation of the fetus or the height of the fundus. I was also helping to fill their lab forms, weighing or giving clients, their Intermittent Preventive Therapy (IPT) and iron tablets. This gave me the opportunity to interact with the clients even before they were identified.

Considering the ethical issues related to doing research, especially with vulnerable groups, I tried as much as possible to remain an outsider because I didn't want clients to give their consent to participate because I was a senior midwife. So I never put on a uniform when I went into the field and I always informed the participants that even though I was a nurse, I was not working in the health facility and not participating would not affect the care they would receive from the service providers.

The Gambia enjoys a social dynamic where the different ethnic groups have a joking relationship. My tribe has a joking relationship with the Jolas and the Serere. I am also from the northern bank and there is also a joking relationship between us and the people from the southern bank. This joking relationship helps me to interact freely, crack jokes and make fun of each other with the clients even before they are informed about the study. Pregnant women are also teased at and they are called "Ndey Kumba[2]" so whenever I walked into the antenatal clinic I would tease them and these interactions created trust and openness between me and my participants.

I was placed in certain categories, exerted authority and subservience, and I had to negotiate these relationships on a continual basis. My educational background, status as a parent, dress code, and age could have widened the distance and interactive gap between me and my study participants, but my ability to engage in regular conversation in the local dialect enabled me to bridge gaps and become more accepted among my participants over time. I am privileged to be educated up to this level and to be employed. On the other hand, my participants are very young people, whose education may have been hampered by the pregnancy and their future is ascertained for they may not go back to school.

This may have had some implication on reflexivity because for a research to be conducted in the more fully reflexive mode, it requires that the researcher identify and locate herself in the

[22] Ndey means mother and Kumba is tradional female name. So Ndey Kumba literally announces their motherhood even though they always deny being pregnant.

research. In trying to locate myself in the research I used to dress in trousers, jeans or skirts at least to look a little bit younger. And because they were pregnant they have to dress in the traditional wrapper or long loose dress which makes them look a little older. My children are 16 and 19 years old and their interaction with the adolescent girls in the house we were staying gave me the opportunity to learn a lot about the young people language and culture of socialization. I always took the opportunity to greet my participants with "nakam" instead of the usual formal greetings and would also joke about my appearance.

My nursing and midwifery background gave me some hands on experience in dealing with the burden of unplanned teenage pregnancy, its complications and consequences through interaction with patients and their relatives when they seek for health care services. Through some of the difficulties they encountered in terms of getting the basic necessities need during labour and delivery, I realized that even though unplanned pregnancies among adolescents is not a disease that requires treatment or something that was about to be eradicated, it is a global and public health problem affecting mostly the poor, the uneducated and the marginalized.

3.1.0: *Ethical consideration*

Before the Pure Food and Drug Act was passed in 1906 and the Nuremberg Code, in 1946, the world has witnessed lots of crimes against humanity in the name of research. There were no regulations or concerns regarding research ethics on humans and experiments were often conducted on vulnerable people without informing them of the dangers associated with such experiments (CIOMS, 2002). This led to the formulation of many codes, principles and guidelines to protect the integrity of individual research subjects in biomedical and health related research. According to the CIOMS guideline "special justification is required in inviting vulnerable individuals to participate as research subjects and, if they are selected, the means of protecting their rights and welfare must be strictly applied" (CIOMS, 2002). The guideline also addresses the research ethics principles on human subjects and according to those principles a research should be conducted in accordance to three basic principles, namely respect for persons, beneficence and justice (CIOMS, 2002).

Since my research study involved human subjects who are among the vulnerable population, ethical clearance was sought from Norway Research Ethical Committee (REK) and it was approved before I went for the field work. I have also applied for NSD because my project

has some form of entering "personal data" in a computer which may indirectly identify participants. Ethical clearance was also sought from the Local, Ethical Committee in The Gambia: The Research and Publication Committee (REPUBLIC), University of the Gambia; The Gambia Government/ Medical Research Council Joint Ethical Committee and the director of health services. This was in line with the requirements of guideline 3 of CIOMS (2002) and the study was approved by all these bodies.

The consent to participate could be written and oral depending on circumstances (UNESCO, 2008) such as participants' preference. All the participants were informed about the study verbally and those who could read were then given the participant information sheet for better understanding of what was involved in the study. For those who could not read, a detailed explanation of all that was involved in the study was given to them before their consent was sought in the presence of the midwife who was an independent witness. However, those who wished to give oral consents for the purpose of anonymity and confidentiality were given without an independent witness. The choice was left with them to decide.

The participants were assured that they could withdraw from the study any time if they wish without giving any reasons and that their withdrawal from the study would not affect the care they would receive or their relationship with care providers.

There is also debate over remuneration to study participants. Some suggested that participants should not be paid for participating in a research because this can create a form of coercion. However, according to Benatar coercion should not be associated with incentives. Giving a small amount of financial support to participants for time and travel is considered acceptable (Benatar, 2002). CIOMS & WHO (2008) guidelines also stated that, small amount of cash compensation may be given to participants who do not receive direct benefit from the research for the inconveniences in participating in the research. They were informed that they would not be paid for participating in the research, but to show my appreciation participants were given a small amount of, D500 about 100NOK each for their travel and time taken to be interviewed.

In addition to getting consent to participate in the research, consent to record the interviews were sought before the interviews and to ensure that anonymity and confidentiality were

maintained, their names were anonymized. Fictitious Wolof names were associated with the narratives from the interviews.

Furthermore, in addition to getting consent from all the participants, consent was also obtained from parents or guardians of the participants who were less than 18 years to allow their children to participate in the study. They were given adequate information about the study.

According to the CIOMS and WHO guidelines, health related research must contribute to the well being of the society and the population that are made subjects should benefit from the results of the study. However, even though the study may not directly benefit the participants, but the findings may trigger comprehensive programmes that directly address adolescents' sexual and reproductive health in the near future in order to reduce adolescent pregnancies and its consequences.

3.1.1: *Data storage*

According to guideline 18 of the CIOMS (2008), research involving human subjects may involve data collection and storage, which when disclosed to third parties may cause harm or distress. Researchers should therefore "protect the confidentiality of such information and omit the data that might lead to identification of study subjects" (CIOMS, 2008). They should also inform their participants the precautions that will be taken to protect their confidentiality which can cause physical, psychological, social or economic harm to the individual, their families to the society at large (CIOMS, 2008).

The reality concerning the protection of privacy and confidentiality of medical records, laboratory samples and other participant information in medical research in Africa is that most African countries do not have a well established data handling system which makes protection of confidentiality and privacy of participants and patients' information safe.

This situation seems similar in most developing countries in Africa in which Gambia is not an exception. Medical records in the health system of the Gambia are in the form of registries and these registers are accessible by anybody within the health systems. To ensure that anonymity and confidentiality was maintained regarding collection, storage and access, fictitious names were associated with the narratives from the interviews. The recordings and

transcript information were kept under strict control in a password protected folder and a locker with keys that no other person could access.

Chapter 4: Findings

4.0: *Findings*

In this chapter the findings from 15 in-depth and one focus group discussion are presented according to the emerging themes. These themes were chosen as they were the most recurring issues that emerged from the data based on what participants perceived as the factors contributing to their pregnancies and the main challenges experienced as adolescent mothers. The findings are divided into six subsections: demographic findings; factors contributing to unplanned pregnancy among unmarried adolescents; the perception of participants on pregnancy and childbearing; living the life of single adolescent motherhood; coping response to the challenges of single motherhood and avoiding recurrence and STIs.

4.1: *Demographic*

The 15 participants in this study were between the ages of 16 and 19. Five of them were 16 years old, one was 17, seven were 18 and two were 19. With regards to their level of education, it was discovered that the highest attained level was grade 12. Two completed their grade 12, two were in grade 11 at the time they got pregnant, two were in grade 10, three completed grade 9. One dropped in grade 7, two in grade 6, one in grade 4, one in grade 3 and one never attended school. It was also discovered that among those who were in grade 11 one was attending Arabic school and among those who were in grade 10, one was attending a French school. All the participants were first time mothers.

The participants in this study were from different ethnic background. Among them, seven were Jolas, two were Fullas, two Mandingkas and the remaining four were Bambara, Manjago, Serere and Susu. All the participants were living in the urban areas at the time of the interview. However, one was staying with her aunt in Cassamance (Senegal) before she got pregnant and one was not settled in one place. She sometimes stayed with her mother in the provinces and sometimes in the urban area with either her brother or her aunt, the one with whom she was staying with at the time of the interview.

Regarding the family set-up they come from, it was noted that five lived with both parents and among them two were from nuclear families, one from a polygamous family and the other two lived with their parents in an extended family compound. Another five lived with single parents and among them, two lived with their fathers and step-mothers, one with her mom and step-father, and the other two lived with their mothers, one divorced and the other

widowed. The remaining five lived in an extended family set-up with relatives, two with the paternal aunts, one with a maternal aunt and the remaining two lived with their grandmothers. However, these grandmothers were not the biological parent of their parents and none of them could explain how they were related to these grandmothers.

4.2: *Factors contributing to unplanned pregnancy*

To explore the factors contributing to unplanned pregnancy among unmarried adolescents, their experiences on talking about sex and reproductive health, their source of information and their access to services that prevent pregnancy was sought. Participants were also asked about their opinion on why young girls in the Gambia get pregnant. The most recurring themes that emerged from the data were the culture of silence, the power of external forces and increased dependency.

4.2.1: *The culture of silence*

Sex is a subject that is not commonly mentioned in the family. Talking about sex is something that is culturally regarded as a taboo in the Gambian setting. The word "sex" is something that even adults don't mention among themselves and if it happens to come up during a conversation other words are used to describe it. The terms used also depends on the age category of the individual. For elderly people the term usually used are "Tedah" meaning to lie down, "Saye" which literally means marriage, "Jotteh" meaning dispute or "Saher" meaning in between. Younger people used terms like "Laal" meaning to touch or "Dimbalanteh" meaning to help each other. The only time the word sex is voiced out is when it is used to insult somebody, most often the person's mother.

It was observed in the interviews and also during the focus group discussion that, none of the girls ever mention the word sex. The response they gave were no, we never talk about "that", we don't talk about "it", that is not a children's issue, I cannot discuss "that" with them or I just overheard "it" when they were talking among themselves. This shows how suppressed it has been in the culture. The tradition is most likely going to continue because if the adolescents, who are the future parents, are made to believe that sex and sexuality are things that should not be talked about, thus the cycle of silence is inevitable.

When participants were asked about their experiences on talking about sex with their parents, one of them said she talks about everything with her mother, another one said her auntie told her not to sleep with a man three days after her menses and she would ask her every month if

she has seen her period and 13 of the respondents said they had no experience of talking about sex and reproductive health with their parents as narrated by Nogoi, Basin, Matty and Yandeh.

My mom wouldn't talk to me about those things, neither could my dad. So is like among my family none of them have ever talked to me about that… Before I got pregnant, I could usually have a dialogue with them; tell them anything I want because they've been just open and free to me. Is like being so attached to them, especially my dad, I can talk to him, I cannot talk to him about this female issues or anything about boys or anything like that. So it's like we could talk to each other about the pass, his life and everything but it was like the jokes we share most. And my mum too we don't really share a lot, but then we do chat and then we were always together… [Nogoi, 19years]

We don't talk about that; we don't even sit and chat. I go to school, come back, do the housework, do my assignments and read or go to sleep. If I need something I would tell her (my aunt), but sometimes I want to ask her about something, but I feel afraid to ask her, she doesn't want to discuss anything with me. [Basin, 16years]

Yes, we discussed it. My aunt told me not to sleep with a man three days after menses. She always asks if am seeing my menses. [Matty, 19years]

This shows that at the family level young girls are not informed or they are misinformed about sex. In the case of Nogoi, even though she was so close to her dad, she could not talk to him about female issues or about boys. This is because of their gender difference, but if she was as close to the mom as she was close to the dad, then she might have discussed it with her. In the case of Basin even where, as she wanted to find out things related to her sexual and reproductive health, she felt reluctant because she was afraid of the aunt. As for Matty, she had that privilege because her aunt's daughter had three children as an adolescent, one at grade 7, another at grade 9 and the third one in grade 11. Another girl who was staying with them also got pregnant while she was a teenager, so the aunt didn't want her to fall in the same trap as the others.

It was also stated by participants that there was nowhere in the Gambia where young people can go for information regarding sexual and reproductive health matters and the only way they learnt about it was from friends, at school or when they overheard it from other people. However, when participants were asked where young people in the Gambia get information

about sex and reproductive health, five said they didn't know from where to get information, six of them said it was mentioned in population and family life education and science lessons at the junior secondary school, two said they heard about it when they watch movies, and two heard about it from friends or other people and as related by Yandeh, Mbombeh and Soun.

No, we don't have information from home, we just hear about it from people outside …during conversations, you hear people talking and you would listen or you watch TV and hear about it when you watch films. In grade 10 also, during the science classes they sometimes explain about reproduction. [Yandeh, 18years]

You can get it from the TV when you watch movies or at school during POP FLE class. They used to tell us, but now they stopped it. Now is only during science and home science classes. [Mbombeh, 18years]

I don't know where they get the information from. [Soun, 16years]

Media, school and friends are the main source of information when it comes to sex, sexual and reproductive health for young people in the Gambia. This also shows that if the girl has not attended school or dropped out at a lower grade where they are not taught science or home science, then their chances of getting information about sex are limited as in the case of Soun. Even though Yandey discusses everything with her mother, here she said "we don't have the information from home, you hear people talking and you would listen." This means that her mother did not inform her about sex, but they watch films together and during the discussion she would listen to their conversation.

4.2.2: ***Low access and the use of services to avoid pregnancy***

Young people in the Gambia especially the unmarried girls don't have access to services to prevent them from pregnancy. When participants were asked where unmarried adolescence access services to avoid pregnancy, three of them said from the private pharmacies or private facilities while two others said from the public health centers. However 10 of them said there are no services for adolescents to prevent pregnancy and even if there are services available, they don't know where to access them as quoted by Yandeh, Nogoi and Hamin.

I don't know where to access those services. I don't even know if they are available. [Yandeh, 18years]

Those services are not accessible at the public hospitals, because when you are unmarried, you wouldn't be in your senses to ask for a pill if you at least have some dignity in you or unless when you are twenty or twenty one. As adolescent it doesn't cross your mind or if it does, it would be 40 out of 100%. It is either you go to the pharmacist who goes just after his money or you go to a private hospital. In a public hospital you are expected to see a family member, a friend or anything and you cannot do this in the open. So you can hardly visit a public hospital. [Nogoi, 19years]

You can get it from the health facilities. Just go and tell them you want to join and they will give you. [Hamin, 16years]

Even though the services are available at the public facilities as mentioned by Hamin, utilization by unmarried adolescents who know about their availability is restricted because they cannot go to get those services in the open for the fear of meeting someone they know as highlighted by Nogoi. If these services were available in a different setting where young people could go without being stigmatized or without having the fear that they might find a family member or friend, or if they were provided by young people like themselves, then they would use them. There is a gap between the access of services and usage.

4.2.3: Unmet economic needs and survival strategy

It was also discovered that all the participants came from families with low income earning. Their parents or guardians are either not working or they do low paid jobs like laundry on contract basis, cooks, masons, painter man, carpenters or mechanic. These jobs are not only paid poorly but they are also not regular because they don't work every day. When they were asked about the family earnings 13 of the participants said their family earning was not enough to meet their family's basic needs. However, five of them indicated that young girls get pregnant because they had needs that they could not solve and their parents didn't have money to give them, which warranted them to go to men for assistance and instead of helping them; they were fooled as stated by Nogoi and Fanna.

Your mum is working day and night and then you could see there is no means she could just make enough for herself and then you feel obliged to help her in anyways. You could go out there and you know someone is really interested in you and the person could pay your bills and everything. Then you go out on a date with him and then he will be providing your needs and then the next thing, he will be sleeping with you. [Nogoi, 19years]

They lie to us, the men they make promises that they don't fulfil. They will tell us that I am doing this and that, I will give you this and that and if you believe in what they are saying and you give yourself to them when all that they were saying was not true.

R - Why do you think young girls allow men to fool them?

Money can put them in that mess, if they want money. You may need something and you don't have anybody to solve it for you, so if you tell them, they use that opportunity to sleep with you. [Fanna, 16 years]

Low economic status can increase the vulnerability of young unmarried girls. Due to their economic deprivation, they are less educated and therefore have a low social status, which denies them the power to negotiate for safer sex. Their vulnerability exposes them not only to coercive sexual intercourse, but also to potential STIs and unplanned pregnancies. This also illustrates that in order to gain their economic and social needs from their partners; they have to give something in exchange "sex".

4.2.4: *Curious about discovering their sexuality*

Curiosity was reported by participants as a contributing factor to unplanned pregnancy among unmarried adolescents. Four of the participants said young girls get pregnant because they are fussy and they want to know and instead of the being enlightened about sexuality, they try to find out for themselves as quoted by Yandeh.

A lot of things, you know many of them get involved because of "sop ak daign kumpa" (they are very fussy). Curiosity makes some of them to be pregnant. They just want to know. [Yandeh, 18years]

Because of their rapid physical and physiological development, adolescents are curious about their sexuality and they explore it by engaging in sexual relations even before they know the risks involved. Since they are not informed or educated about sex and the risk involved in having unsafe sex, they would do the experiment on their own.

4.2.5: The power of an external force: Satan and God

The participants identified power of an external force to be a contributing factor of pregnancy among unmarried adolescents. On one hand, we have the devil commonly called Satan and

on the other hand God. The views from three of the participants show that Satan pushes them into what they thought was never going to happen as elated by Dado.

As I told you before "sungkutuya" (when you are a teenager) you only think of enjoying, you like everything. You…. So during that time you are enjoying yourself, you know Satan is more powerful than both of you and as a result what you don't expect may happen between…. And you will not realize that until when you miss your menses. [Dado, 18years]

I agree with them because Satan has the strength to push young people into a situation they have not necessarily wanted. However the work of Satan appears to be associated with the desire of young people for enjoyment.

Contrary, despite the fact that participants said that it is not good to get pregnant when you are not married, four of the participants perceived pregnancy as something that the individual doesn't have control over. To them it was their "destiny", something that has already been decided by God that it was going to happen to them and no matter what it was going to happen, they cannot do anything about it. They believed that pregnancy was something that was ordained by God to befall on them and there was nothing they could have done to prevent it as highlighted by Ndahteh and Horja.

You know it is a not a pleasant saying and it is not nice, but what Allah has written for you it must happen... you must get it. If He says you are going to have a pregnancy before you get married by force you will have it even if you have to tear the earth and enter inside. [Ndahteh, 18years]

It can be reduced, but then to stop it totally… you know if God wished you to have it when you are not married you will have it. May be, but I know little can be done about it because it is God who decides over what happen to the individual and the person cannot do anything about it. [Horja, 17 years]

Moreover, it was highlighted that the power of God to ordained whatever He wishes of an individual and they have to accept it as their faith because they could not have avoided it. However, associating pregnancy to the will of God may have been used as a cover to avoid the stigma and shame associated with the pregnancy.

4.2.6: Poor parental care

Poor parental care was perceived by participants as a factor contributing to unplanned pregnancies among adolescents. To them parenting is more than having your child at home all the time or giving her food and clothing. Instead, parents should have dialogue with their children and inform them of how to protect themselves against pregnancy.

Like your parents think caring about you is just giving you food or just having you home when the right time, when its pass seven, having you around when school closes, just your constant stay at home is protecting you, having you. But that is just not enough, as parents you should be enlightening your child about the dangers of teenage pregnancy. Having a dialogue… open dialogue with your child on how she can protect herself and all the things. That is also caring for your child. [Nogoi, 19 years]

Here, the need for parents to use other mechanisms to protect their daughters from pregnancy instead of just restricting them from going out was highlighted. It is very important for parents to be more open with their children, have dialogue with them, inform them about the reality and enlighten them about the dangers of unsafe sex and teenage pregnancy, then they will be able to protect themselves.

4.2.7: The influence of social environment

Other factors that were perceived by participants as factors contributing to unplanned pregnancy are the moral values of the children being corrupted and peer influence on material gain. Seeing your friends have something and you envy them was also mentioned as a factor. Because of their love for materials they see with their friends and not knowing how their friends got those materials, many adolescents will engage in relationships that lead them to unplanned pregnancy. Also seeing what their parents do in the house or when they watch movies, influences young people to go and put it into practice.

You know now it is like young girls are getting pregnant more than the married women. ... Maybe the generation we are in now... you know in this present generation all the children are corrupted. You know before and now are not the same... you know before a girl and a boy could sleep on the same bed and you would not have sex when you are not married... You know, before girls used to go for dancing... to hall and sometimes you spent two nights and the boys would just hold the girls and dance with them but to sleep with them, no they never

slept with them. But now (haleyu gigain darng yahur, haleyu gorryi darng hahur) the girls are tainted and the boys are tainted, [18years]

R - But you don't know why they are tainted or corrupted?

No...but let me give you one example, if you have a child and you sleep with her in the same room and this child is now aware of everything that is going on in the house and you are there with your husband, whatever you people are doing, she is watching and whatever they see in the house that is what they are going to do when they go outside... You know that I have seen. Also watching this, watching these Nigerian films... You know watching these movies also corrupt the children, yes, that is also one of the causes and it is happening. [Ndahteh, 18 years]

Some people when they envy you or their friends have this and they don't have it, so is either by hook or hark that they must have what their friends have and that is like following up those rich guys who could provide just anything and then be with them and thinking that, that's the best way to protect a relationship is by having sexual intercourse with them and then mess themselves up. [Nogoi, 19years]

Even though watching movies was regarded as a source of sex and sexuality information for young people, they contributed to the corrupted moral values of the young people. It has also shown that even though parents put their young girls in their rooms to keep an eye on them and to protect them, they are contributing to the destruction of their moral values. The young people's love for material gain can also put them into a situation which they regard as "messing them up."

4.2.8: Failed preventive method

Among the traditional methods to prevent pregnancy is the used of "charms". These are verses from the Quran that are written and covered with leather or animal skin and it is tied around the waist. It was perceived by participants that one of the factors contributing to unplanned pregnancy is when you have the charm and it fails.

Another reason is because they tie the charm which they believed would protect them from pregnancy as long as they have it and it fails; they have the belief that it works when it doesn't. [Matty, 19 years]

4.3: *Perceptions of participants on pregnancy and childbearing*

To explore the perception of the participants on pregnancy and childbearing, their perceptions on baby dumping, what motivated them to carry on with the pregnancy and their views on pregnancy outside marriage were sought.

A pregnancy outside marriage was perceived negatively by 14 of the respondents: something that is "not good", something that is culturally, morally and religiously "wrong" and something that should be avoided as stated by Nogoi.

That is very devastating, very, very painful because then you will lose your status in the society, at family level and then you might even lose it at religious level if you don't take your time. It's like at family level they've been degraded, been called the loser, and being called names and everything, people, degrades you and if you don't have high self-esteem, you degrade yourself too, and that is you would never rise up on your feet again, that would be the end of it for you totally. You will never be able to sustain yourself nor the child. It is really wrong, but then it's not something we should take awfully hard, but at least learn from it. To regret it to death is really stupid because you wouldn't have benefitted anything from it, but to learn from it. Look at every single step since it started till the day it ended. Every good thing you've achieved about it, and every bad thing you've achieved about it. Was it really worth it or was it really just not worth it…. It is not really right, not just morally or religiously. But considering the emotional and physical pain you go through, the rejection of the society and family and everyone was not just worth it. [Nogoi, 19years]

This illustrates that even though it is wrong to get pregnant when you are not married, it is something that you can learn from because after going through all the torments from the family and the society, you need to gather all your pieces and begin a new life. It also means that you need to be strong to be on your feet again.

However, contrary to how these participants perceived pregnancy outside of marriage, another participant perceived it as something positive. To her, it is something that is good, even though she knows that it is not accepted culturally and religiously.

To be pregnant while you are not married, you know pregnancy is something that we found here, we found it here, is not something that… we found it here. Even adults sometimes they will not be married and they will get pregnant. If you see them you will think that they are married when they are not.

R - So what is your opinion about that?

That is, that is something that is good for if people see your child they would say this is so, so's child here is so, so's child. [Daga, 18years]

This illustrates how important it is for her to have somebody she regards as a family despite all the difficulties.

4.3.1: Pregnancy as an obstacle for their future

It was also perceived by three of the participants that pregnancy was an obstacle to their schooling and future. To them the girls should concentrate on their education and wait until when they are married before they get pregnant.

It is not good. One should wait until when they get married. You will not be able to continue with your education and if you are working you cannot continue with your work. [Basin, 16years]

Young girls should be enlightened about the risk involved and advised to stop following the boys. It is not good. They should hold themselves (abstain) until when they have a husband. Ah, they should wait. They should concentrate on their books until after they have completed, if God help them, they will have a good job and will be able to take care of their needs. [Fanna, 16years]

Here the importance of education to the future of young people and the issue of enlightening the young girls were highlighted.

4.3.2: A pregnancy outside marriage is "forbidden"

Even though both Muslims and Christians believe in pre-destination, when it comes to sex or pregnancy outside marriage it is forbidden by both religions. Two of the respondents perceived pregnancy outside marriage as a "sin", something that is "forbidden" by God.

4.3.3: Pregnancy outside marriage means facing difficulties alone

Pregnancy was perceived by five of the participants as a burden and a difficulty which they have to face alone because their education is not complete and they are not working. They

have needs that they cannot solve and the baby will also have needs. It was also perceived as a problem, especially when the partner denies being responsible for the pregnancy.

For me it is difficult, it is a problem and is difficult, especially if you have… you have problems like me the one who made me pregnant denies being responsible for the pregnancy. Sometimes you will have problems and sometimes those problems are not solved. Now is a problem because I do everything for myself, I don't have someone to support me. It is something that is not good. [Matty, 19 years]

You are not married and you are not working so you will not have what you need to care for it. [Mbombeh, 18 years]

The burden of being pregnant when you are not married and some of the potential challenges that they are faced with are highlighted here.

Generally, when an unplanned pregnancy occurs, abortion is one of the many difficult decisions the girl has to make and many of them who attempt to get rid of the pregnancy most of the time do so in an unsafe way. Moreover, having an abortion means also dealing with moral values around the way abortion is perceived in the society as most of the time it is perceived as a sin, as a murder, something that you can die from and it is legally condemned. Three of the participants in this study wanted to abort their pregnancies. To explore their perceptions on abortion, participants were asked what motivated them to carry on with their pregnancy.

My auntie and grandma said I should not. They said they would take me to the police if I even attempt to [Mbombeh, 18years]

I tried all means to remove it. Tried everything I thought could destroy it, but didn't. I was preached by my mother when she realized what I was doing. She advised me to maintain it and to avoid double death. [Dado, 18years]

I think about my relationship with God first and then about the life I am carrying. It was unfair to get rid of it just to cover up a shame. Facing the society is less severe than God's punishment for taking a soul and I don't know what the child would become tomorrow. [Nogoi, 19years]

To kill a person is not good. If you kill a person when you die you will meet that person. It is better to kill yourself than to kill a person. It is not that I don't know, I have learned what the Quran said about that. [Ndahteh, 18years]

I know what I did was wrong, it is a sin, so if I should remove the pregnancy that means I am going to have two sins and if I die God will put me into hell fire.[Fanna, 16years]

Some of the girls wanted to avoid committing what they considered as another sin because of the fear of being punished by God. Those who might undergo an abortion may do so to cover up the shame and stigma attached to unplanned pregnancy without considering the severity of the punishment from God.

4.3.4: Not knowing if you can get pregnant again

One of the complications of unsafe abortion is secondary infertility because the uterus could be perforated during the process or the tubes can get blocked due to secondary infections. Three of the participants said they carried on with their pregnancies because they didn't know if this was the only pregnancy they were going to have.

I don't know if that was the only pregnancy I would get and I don't know what that person is going to be tomorrow. [Soun, 16years]

This highlights that due to the uncertainty of having another pregnancy, adolescents are determined to face and accept all the criticism and humiliation from the society. It also illustrates the high expectations they have for their children because these children can become very important people in the future and would take care of them.

Another difficult and controversial decision that many young women in the Gambia who experienced an unplanned pregnancy take is baby dumping. This is a practice where mothers abandon their babies. This practice is common in the Gambia however; none of the participants who had already delivered had done so for reasons which will be highlighted further in this section. Their perceptions on baby dumping were explored. They perceived baby dumping as something negative and inhumane, to them it is better to give the baby away to someone, to take it to the SOS or to abort it even though abortion was condemned as quoted by Nogoi and Ndahteh.

It [baby dumping] is not good. After going through pregnancy, the pains from day one up to the time you give birth. They said all that they wanted to say or did what they wanted to do, going through labour, the pains and everything instead of giving the love and care you decide to dump it. To me, at least when you are aborting a child, you don't really see it, but then to have the heart, something that is of you, to just throw it away, walk away and never look back, I don't think it's right, no it's really awkward. In my opinion, it is wrong. [Nogoi, 19years]

It is not good. Why not kill it while it is in your abdomen, is better to destroy it. You know in our area someone got pregnant, she ran away… delivered and threw the baby away…. It was eaten by dogs. She this thing… the neck of the baby and put it in a plastic bag and threw it in the garbage area. … It smelt and the police came and they have to bury it there because the dogs had eaten the leg and one hand. [Ndahteh, 18years]

Abandoning a baby is illegal. To discourage the practice if you are reported or caught you are taken to court. If the baby is alive, you are reunited and monitored closely, but in the event that the baby died, you are charged for murder and the law is enforced.

Those who throw their babies, they are brave; they are very brave. Your own child, the one you delivered from your abdomen after going through labour and delivery you take that child and throw it away. You go up to the hospital, you get tired while delivering your child, then you go and throw it away, ah, that is very painful and somebody else will pick that child and take it to the police and if the police get rid of you they will lock you up. [Daga, 18 years]

Here the issue of police getting rid of you and locking you up illustrates how the society uses the law to dissuade the practice. It also highlights the pains and difficulties associated with labour and delivery. It also means that, you need to be a brave person for you to go through the process of pregnancy and delivery, just to end up throwing the baby away.

That is not good. I know you will not have your baby, going through all the difficulties and suffering then you go and place it somewhere or you throw it away, it is something very bad. If you don't want it, it is better you give it away to somebody. There are many people who want a child and they don't have it; or you take it to SOS. [Yandeh, 18years]

You know how painful and difficult it is to be pregnant and from there you go and throw it away that is not good. Before you throw it away you should give to someone. Before you

make it to suffer is better to give it away rather than throwing it. You can give it away. [Hamin, 16years]

The women should stop that. After being pregnant and people know you are pregnant then you deliver and throw the baby that is not good. They should know that it is just an ordeal and should hold and care for their babies. They can also give it away to somebody who wants it or take it to SOS, is better. [Fanna, 16years]

That is a limitation of the psyche. After going through labour pains and the difficulties, you didn't die. After you have already delivered no matter how difficult it is, you should hold the child. It is the limitation of the thinking capacity. After survival from a narrow escape, which was unexpected, it is even better to give it away. [Dado, 18years]

I don't know what is there problem. After going through all the suffering during pregnancy and delivery, you didn't die from it and the baby didn't die. God gave you all this and you go and throw the baby. Every individual is unique but that is bad may be they don't want the baby. [Horja, 17years]

Each of the above highlights the different feelings of the participants on abandoning babies and the possible options that could be taken to avoid the practice. They believed that if young people who experienced an unplanned pregnancy could access services where they could give their babies for adoption or fostering then, the practice would stop.

4.4: *Living the life of single motherhood*

The findings from the interviews revealed that when these adolescents realized that they were pregnant, they were worried and were concerned about their schooling being interrupted, how they were going to be viewed by society, the reaction of their families, and what would happen next.

4.4.1: *Concerns and worries upon realizing the pregnancy*

It was discovered that when participants realized that they were pregnant, seven of them were worried about their parents; how they were going to tell their parents that they were pregnant and what would be the reactions of the family to the pregnancy; would they be kicked out of the house, would they be trusted again, forgiven or accepted by their parents as highlighted by Nogoi.

My main concerns and worries were my parents. My parents were my main concerns and worries and then my child was also my concern and worry. But pertaining to what achievement I could make after that and anything was not something I could debate about because may be the time would be delayed, but then I know for sure with God's grace I will reach my goal. This is an obstacle not just something that would stand in my way forever unless I chose it. But my parents, will I ever get them to, will I ever get them back? Will they ever forgive me? Would they ever accept me again? That constantly tormented me to an extent that I decided just, ah, run away and evacuated without anyone's knowledge.

R - So you left?

No, I didn't really leave because if I had, she once told me she would rather die in poverty than having me leave to a place I don't know and this paralyzed every action that I ever intended to take, like to leave the compound. … If I leave the house my mum will never heal from it and so might never forgive me as well. So the best I could do was not to run away from my problems but to face it. So I decided to stay and later on I told my parents… my mom what was going on. [19years]

This shows how gender can affect people's relationship, because the pregnancy is directly related to female issues, and as she mentioned earlier, she could not talk to her dad about female issues, she told her mom.

4.4.1.1: Interruption of schooling due to the pregnancy

When an unplanned pregnancy occurs in an unmarried adolescent who is going to school, there is usually an interruption because in the Gambia pregnant girls are not allowed to attend school until after they have delivered. In most instances, even before the pregnancy is known, the shame and stigma attached to the pregnancy prevent them from attending school. In the Gambia, girls who get pregnant can go back to school after they have delivered, but they cannot go back to their former school and they may repeat the grade they were. Seven of the participants were worried about their schooling because even if they are going back to school it will be after one academic year and they have to look for another school as quoted by Basin.

I was worried about my schooling and was going to destroy it because I wanted to continue with my schooling. It was two months and I told my aunt that I was pregnant, but I want to destroy it, but she didn't agree. [16years]

4.4.1.2: Delivering their babies would be difficult

Two of the participants were worried about how they were going to deliver their babies because they were teenagers and small and they also feared that delivering their babies would be difficult as indicated by Daga and Fanna.

I didn't know I was pregnant, somebody took me to a nearby pharmacy, that person checked me and told me I was pregnant. I said to myself, I don't know why. What put me into this? I said I don't know what put me into this. If I sit down I used to think about all that. I used to say I don't know how I am going to get this child. May I get it in an easy way... I used to pray so that I will have my child in peace. I used to think about all that… Is my grandmother going to talk or refuse for me to stay in the house? [Daga, 18 years]

I was worried about my mother. How was she going to react and how was I going to tell her, that was my main worries. I was also worried about when I am going to deliver because it was a teenage pregnancy. [Fanna, 16years]

4.4.1.3: Family conditions not favourable for survival

Coming from a family where everybody struggles is worrying and if an unplanned pregnancy shows up, life becomes more complicated. Three participants reported being worried about their home situation, their poor economic status and how they were going to care for their babies.

Yes, that time I wanted to destroy it because you know my mother doesn't have anything, my father also does not have anything but I wanted to, you know... ah! You know my father is poor, so the only choice they have is to go me, ah... to work on the swamps... grow rice to feed the family or to sell the rice before they can earn something or they fetch firewood to sell or make charcoal and sell it in order to get something if not they cannot survive. So I was thinking about all that and I went to the extent of wanting to drink poison, but my… one of my aunties found myself in the room mixing substance and she went and called my uncle.

R - But why did you go to that extent?

Ah! Before I throw away my... You know this... This, if it happens to you everybody is talking, everybody is saying something and you know my father is poor. [Ndahteh, 18 years]

Due to their low economic status, these girls were worried about how the pregnancy exacerbates the poverty situation in their families, because it will be difficult employment opportunity in order to be able to care for themselves and also their children.

4.4.1.4: Partner denies being responsible

Generally it was common in the Gambia for partners of unmarried adolescents to deny being responsible for the pregnancy, especially if they themselves were also young. It was discovered that the partners of the participants were between the ages of 20 and 26 and some of them were still going to school. Three of the participants were worried whether their partners would accept the responsibility of the pregnancy.

4.4.1.5: The gossips from people

When pregnancy becomes eminent in an unmarried situation, people gossip about it; sometimes, in the absence of the person who's pregnant, but also while the person is present. Adolescents who have an unplanned pregnancy are usually worried about this. Four of the participants were worried about what people would say; they were ashamed.

I was worried about my mother knowing about it and what people were going to say. I was worried about so many things. I was also thinking about so many things. I was afraid to tell or discuss it with anyone, I just kept quiet. [Yandeh, 18years]

My main worry was that I was not the only girl living in the compound. Many people were there, including my uncles and their families and you know the issue of half sister. You know when pregnancy becomes known often there is a lot of talking, and a lot of issues from people. They may even make your parents to do something that they didn't want to, this is what I mean… they will talk.. It was difficult to face the reality so I tried to remove it. [Dado, 18year]

This shows that some of these girls were worried about other people and the society than their families and this may lead them to take actions which could be detrimental to their lives.

4.4.2: *Reactions of the family*

The finding from the study showed that families reacted differently to the pregnancy of their children. The men had the final decision when it came to family matters. Mothers would cry, talk and insult the girls, but these were the most extreme reactions. When the men said they should stop, that would be the end of the story. Similarly, in the cases where the men reacted negatively to the pregnancy, the mothers could not do anything about it. Some of the family reactions reported by the participants were physical violence, verbal assaults and stopping all the support they were giving and expulsion from home. However, there were some families who did not react violently, they either asked who was responsible and is the person has accepted the responsibility or just ignored the girl.

4.4.2.1: Expulsion from home

In some families when a girl who is not married get pregnant, she is expelled from the house and they have to go and look for somewhere to stay until when the situation calms down or somebody pleads on their behalf for their parents to forgive them. Three of the respondents were expelled out of the house by their families; one by her step-dad, but she never mentioned it until when we accidentally met at the department of social welfare, the other one by the daughter of the woman who raised her and one by her own father.

My mum would have never imagined that I would get pregnant.… Emotionally, she felt that I was really depressed but didn't know the reason why and she could not force it out of me. It was in the middle of the night when I told her and she realized that I was sweating and tears were draining down. She asked me to go to bed till in the morning we will talk about it. She asked if the person knows about it and if he has accepted. She said she would never tell my dad because she didn't want to have an issue with him; I have to do that myself. I told my step-mom who told my dad and he had to call me in and ask me if I was raped and then asked me how, then I said no and he was even more upset. He told me that I would have to leave the house. He said many threats, cursed me, cursed the child, wished we were dead, and said many awful things. And I had to leave the house, stay with a friend for a few days and later went back.

R - So you left home or he asked you to leave?

He constantly said for some days that I would have to leave, I would have to leave and every day he saw me he was getting more and more upset, then I had to leave. [Nogoi, 19 years]

My grandmother didn't say anything, she didn't even ask me. Her daughter said that she would throw me out of the house. Even that day I slept on the veranda. I came back and I found my mattress was thrown outside. I entered the house and she started insulting me. She called me the child of a prostitute, a bastard and my grandmother was standing at the window listening to her daughter, hearing everything she was telling me, calling me a bastard, daughter of a prostitute. She was telling me everything, everything that you can think of and her mum knew she was talking to me and she just kept quiet. [Daga, 18 years]

4.4.2.2: Physical abuse

One of the most common forms of punishment that adolescents who get pregnant receive from their families is physical abuse. It was discovered that two of the participants were severely assaulted physically; one by her uncle because she was stubborn and she refused to tell them who was responsible for the pregnancy and the other by her mother.

My dad sent for me, but I didn't go because he said he was going to kill me. My mom used to beat me all the time. She was disgraced. [Hamin, 16 years]

4.4.2.3: Verbal abuse

Families sometimes display their anger by verbally assaulting the girls when they become pregnant as was the case for five of the participants.

My sister said that he was just going to waste my time. She said a lot of things. My mom also talked, but I didn't hear everything that she said, because when she started talking I entered in my room, locked the door and put the pillow over my ears. Yes, she was up-set with me, she didn't like it and I was going to have a bad name due to the pregnancy. [Yandeh, 18years]

I was ashamed, I don't even go out, and even to sit outside was a problem I have always been indoors. The nasty words I hear from them sometimes, they hurt you. The unpleasant words and the abuses are just too much and you cannot do anything about it. [Ndahteh, 18years]

Hu! ... They were very annoyed with me. They insulted me. All of them were annoyed, my uncles, my mum and her husband. He said what I did was wrong and I should not have done it. I was going to school and he was paying my school fees and doing everything he can for me. He also said I would not corrupt his daughters. [Fanna, 16years]

4.4.2.4: Emotional mother

Some people react to situations by crying, especially when there is not much that can be done to remedy the situation. Three of the participants reported that their mothers cried when they knew of their pregnancies because they were disgraced.

She cried. She said I have given the neighbours something to curse her with; I will make them to insult her in the neighbourhood. They said I am very young. [Ndumbeh, 18years]

4.4.2.5: Ignored by family members

It is a common Gambian saying that when you see or hear of something that is too big for the mouth to mention you just allow it to pass by. Four of the participants reported that they were totally ignored by their families and they didn't have anything to do with them.

My auntie wouldn't talk to me or say anything. She abandoned me completely. She said I should not have anything to do with her and if I want I can call my parents to come and take me. [Horja, 17 years]

They didn't say anything; they just left me inside and they were stressed. [Adah, 16 years]

My dad wouldn't talk to me; he wouldn't say anything except for greetings that is the only thing we share now. [Nogoi, 19years]

4.4.2.6: No more support

To show these adolescents that they were really disappointed with them, some families stopped all the financial and material support they were giving to them. Two said the family stopped all the support they were giving them as expressed by Mbombeh and Dado.

My uncle said he will not do anything for me now. He has nothing to do with me, he only gives commands when he needs something. My dad stopped processing my visa; I was supposed to go to his brother in Europe, but he stopped everything. [Mbombeh, 18years]

My brothers used to send me clothes and money, but they have stopped everything they were doing for me. [Dado, 18years]

However, there were two who reported that they were just asking who was responsible, if the person had accepted the pregnancy and they also wanted to talk to them. Three of the

participants said that there were no reactions of their families and the reason two of them gave was their father said it was a mistake, not intentional, they should be left alone. The reason given by the third one was because she was not staying with her parents and all the women in the family, she was staying with had a child before they got married, so they could not tell her anything.

I didn't hear anything from my parents and none of my aunts said anything to me. Maybe in my back or is because they had also lived it because all of them had a child before they were married. [Ndahteh, 18years]

4.4.3: *Challenges faced during pregnancy*

Adolescents who become single mothers usually go through a lot of challenges during pregnancy and childbirth and also as young mothers. The findings showed that some of the challenges experienced by the respondents include partners breaking up with them, not visiting, not supporting or moving to other places. It was also noted that some of these pregnant and young mothers had to work as house girls to earn a living, some experienced minor ailments, physical and emotional pains. Even though this was their first child, some of these young mothers received no support from their family. Other challenges experienced by participants were financial constraints which made them sometimes stay without food and not being able to attend antenatal care because they didn't have an identity card or a birth certificate which proved their nationality, and had to pay for the services and hardships.

4.4.3.1: Economic hardship

If you are expelled from home or when everybody turned their back on you and you didn't have anywhere you can turn to then life becomes really hard and challenging. Another common problem faced by adolescents when they become pregnant is financial hardship which can lead many of them to venture into so many things just to earn a living. It was discovered that nine of the participants had financial challenges as quoted by Matty, Ndahteh and Daga.

My partner denied his responsibility and has stopped all the support he was giving me. I have to start working, but what I am earning is not enough. I didn't have a birth certificate so I had to pay for the antenatal card. [Matty, 18 years]

Just hardship, hardship I mean, I suffered because I didn't have somebody to give me lunch or breakfast, take care of my child, or helped me hold him when I am doing something. It was difficult, I was just roaming around and after I came to this lady she said she cannot hire me because of the pregnancy. I had to do the housework while I stay there even though I was not paid and even if I lie down at night I don't sleep, but I needed somewhere to lay my head on. [Daga, 18 years]

... Nobody gives me breakfast so sometimes if I don't have anything to buy bread, I will have to wait for lunch and again the food is not enough for everybody, it is small. My uncle is the one who usually collects the money, which my boyfriend pays for my upkeep, but he doesn't give it to me. Even if I have to come here I would ask him for fares to come to the clinic, but he doesn't give it to me. [Ndahteh, 18years]

This illustrates how unmarried adolescents who experienced unplanned pregnancy suffer in the family as seen in the case of ndahteh, her family is not doing anything for her and they are collecting the money that was meant for her and using it for their personal needs.

4.4.3.2: Abandonment

Apart from denying the pregnancy, partners would neither visit nor give any form of support seven of the participants reported that they were abandoned by their partners

My partner stopped visiting when my pregnancy was about five months. He wouldn't call and if I called him he gave excuses. He said he was travelling, but I later realized that he didn't go and he never deposited the money he said he was going to put in my account. The challenges were too severe and really depressing. [Nogoi, 19 years]

4.4.3.3: Sickness and pains

Hyper emesis (excessive vomiting) is a very common disorder during the early stage of pregnancy and as the pregnancy advances the pregnant woman may experience minor pains and ailments. These disorders of pregnancy are usually not severe but distressing as seen in the cases of Horja, Fanna and Dado.

I was always sick, weak and feeling dizzy. I could not do anything for myself and whatever I eat I will vomit. If she gives me food and I cannot eat it, she will place it there and go. [Horja, 17years]

I used to have pains and stress. I also used to think a lot. Those were my main challenges. [Fanna, 16years]

I had difficulties at the initial stage because I was always sick. There were lots of other issues. My partner only called, but didn't come to see me or send me anything. I wanted to kill myself; it was too much for me. [Dado, 18 years]

This illustrates some of the problems encountered by these young girls as a result of their pregnancies. It also shows that these adolescents lacked support from both their families and their partners.

4.4.4: *Life as a mother*

Being a mother is not easy, especially when one is young and unmarried and receiving little to no support from one's family. As a mother the pattern of life has to change in order to cope with the challenges of motherhood. Eight of the participants had already delivered so the findings herein, reflect their experiences as new mothers. The findings showed that many of them felt that is was not easy, that they were disabled in certain aspects of their lives.

4.4.4.1: Unable to go back to school

When you drop out of school because of an unplanned pregnancy, you are eager to return school the moment you deliver. But, as a mother they cannot because they needed to care for their babies, especially during the first six months before they could leave them with someone. Two of the participants reported that they could not return to school because of their babies.

Well, sometimes when I look at my child and look back at the things that I went through when I was pregnant from the onset till date, I feel like the load has now been lifted from my head and now I have it in my hands. It was painful and it is difficult because I am disabled in certain things like going back to school, spending a lot of time outside, no longer sleeping hours, because now my child determines what time I sleep, and financial problems to care for the child. [Nogoi, 19 years]

4.4.4.2: Sleepless nights and no social life

The first two months of motherhood are challenging because some cannot have the usual long hours of sleeping one is used to having prior to the new baby. You need to wake up from time

to time to breastfeed or to change the nappy of the baby. All the participants experienced sleepless nights and having to wake up early in the morning to wash the baby's clothes before going to work. These young mothers also mentioned having problems going out or spending much time outside because they either had to care for their babies or they didn't have anybody to hold the baby for them even when they were busy doing something else.

A lot of things have changed in my life. Now I don't go out or if I go out I spend less time outside. I have to care for my baby. I used to have sleepless nights, but now I am becoming used to it. [Fanna, 16 year]

I used to go outing, but now I cannot go to the beach. I have nobody to hold him for me and I need to care for him. I have no money for our needs. [Adah, 16 years]

It is not easy. I was increased (episiotomy[3]) during delivery and sometimes it pains, sometimes not. Is not easy taking care of the child, changing nappies, washing, everything. [Sagar, 18years]

As seen here, they cannot sleep when their babies are awake and they have to care for them.

4.4.4.3: Increased dependency

It was also discovered that some of them had financial problems to care for the baby and they had to depend on their parents for things like soap to wash the baby's clothes, baby clothes and lotions. Four of the participants said they had to depend on their families for the things they need to care for their babies.

I have sleepless nights. Also, I had to stop the job I was doing. Now I don't have money and have to depend on my dad for all the things I need. If they have, they will help me and if they don't have I just sit and wait for things like soap and the other needs of the baby. I don't have breakfast sometimes and have to wait for lunch. [Basin, 16 years]

It is going to be very hard, hardship I mean. I cannot care for myself not to talk about caring for the baby. I am hoping to get some assistance from the woman I am staying with. She said

[3] Episiotomy is a surgical incision made on the perineal body to increase the vaginal opening during childbirth. Because the midwives usually informed them that I have cut the area to give more space for the baby to pass, the literal term use when referring to episiotomy is increase. I am going to increase you, I was increased or she was increased.

she was not going to pay me now, but then when I deliver she would start paying me. [Daga, 18 years]

They didn't have any other means of generating income for their basic needs and have to depend on families and other people.

4.4.4.4: Unachieved aims

Adolescent mothers sometimes are not being able to achieve their aims because they have not completed their schooling.

I could not achieve my aim because I didn't finish my school. I cannot have a good job neither my parents' blessing. I have so many problems with the family and I don't have any help from home. [Ndahteh, 18years]

It also shows that it was because of the pregnancy that she was having problems with the family and they were refusing to help her with the baby.

4.4.4.5: Joy of motherhood

However, one of the participants shared the positive side of motherhood. According to her, motherhood is joyful and wonderful.

So I am disabled in certain things and am trying to balance it with the joy of motherhood, I think... I think I just… Hmm, not prepared for this but it's just ok… You are being forced to face the reality. I mean, if you haven't grown up, it means you are being forced to grow up, forced to take up responsibility and forced to do things that you didn't just imagine you would go through. You have to say it is annoying; you have to say it's too much stress, but then you ha... You must say it is really wonderful too, because when you look at your child, and, and sometimes you don't know if the pain is greater or the love is greater. [Nogoi, 19 years]

This shows that motherhood is not only pains and stress, but there are things which make it to be a wonderful experience.

4.4.5: *Responses to the challenges of motherhood*

In order to overcome their challenges most of these adolescents had to develop coping responses and make plans for the future.

4.4.5.1: Crying as a coping response

Many people when hurt or when they are going through difficulties would cope by bursting into tears and cry it out. The finding from the data showed that four of the respondents when asked how they were coping with their challenges said, they coped by crying.

Only crying, I cope with crying. I think about a lot of things that I would have been doing now if I was not pregnant, but I cannot do them. [Yandeh, 18 years]

It was her co-wife who was even helping me but she later adopted my grandmother's attitude towards me. I sometimes sit and cry and wished my dad was alive. [Daga, 18 years]

I cry. I think of so many things. [Ndahteh, 18 years]

Ah, now things are ok and I have to accept it, but I used to cry.[Ndumbeh]

4.4.5.2: Relocating

It is also common for adolescents who get pregnant to move to another place where they are not well known until when they deliver or until when the tension goes down. Three of the participants said they had to leave their families to go and stay somewhere else because things were just too much for them.

4.4.5.3: Staying indoors, paying a deaf ear to gossip

To avoid the gossips, the shame and the stigma it was felt that the best way to tackle the situation was to stay indoors because then people would not see you or to pretend that you don't hear what they are saying. Four of the participants said they were always indoors because whenever they went out people would look at them and would talk about them. Two said they had to keep a deaf ear to what people said even though what they were saying was true. They felt stigmatized but then the only thing they could do was to calm down.

I don't go out; people will look at me and they will talk, that is what I am running away from. Even if I need to buy something I will wait until it is dark, then I would go to the shop and buy it. [Yandeh, 18years]

I don't go out even to sit in the parlour to watch TV or to chat I don't do it. [Horja, 17 years]

I lately calm down even though I was going through a very painful period. I left everything in the hands of God, knowing that He would do what is best for me. [Fanna, 16 years]

4.4.5.4: Informing the parents of partner

Sometime when you feel things are not going in the right direction you have to look for other possible means. It was discovered that three of the participants contacted the parents of their partners when they denied being responsible for their pregnancies.

Since I told him that I was pregnant, he doesn't call me, and he didn't tell me anything. You know, so I notice things are not going in the right direction so when I got better I went there, I went to his mother's house and I told his parents. [Horja, 17 years]

I told him and he didn't agree so we went and informed his mom then his mother told him... he can insist, but he is going to care for the child. [Matty, 19 years]

The issue of involving the parents of the partners is highlighted. Since the partners denied being responsible for the pregnancy, they needed to inform and involve their parents.

4.4.5.5: Creating means to survive

In order to cope with the hardship and to overcome their financial difficulties some of the participants had to engage in some income generating activities like petty trading, washing for people on contract basis or working as house maids. Five of the participants had already started doing something to sustain themselves and to their babies.

Now I sell breakfast to at least take care of my needs and I also buy perfumes and give it on credit basis till month ends. [Nogoi, 19years]

I do laundry and they pay me on a contract basis. [Basin, 16years]

I sell at the school… at St Peters; I am selling for one woman. [Matty19 years]

I am working for one lady around our area; she is not very far from our house. I am working as a house maid. [Hamin, 16 years]

To make ends meet, these mothers had to do something to earn a living. Even though they didn't have good jobs, they had to look for survival means.

4.4.5.6: Future plans

It was found out that seven of the study participants had plans to go back to school, even if their parents were not willing to pay for them. Some said they were going to work so that they could pay for themselves. Four of them were planning to continue with the work they were doing now as house maids, and three said they were not yet sure of what they wanted to do, whether to work as housemaids or to go and learn skills.

4.5: *Preventing recurrence and STIs*

To avoid getting pregnant again and also getting STIs these adolescent mothers need to have some knowledge as to how pregnancy and STIs are prevented. To assess their awareness level, participants were asked how pregnancy and STIs could be prevented.

4.5.1: *Don't know how to prevent pregnancy and STIs*

Not knowing how to protect themselves against pregnancy and STIs can make many young girls to engage in unsafe and unprotected sexual intercourse which puts them at a greater risk of unplanned pregnancy and STIs including HIV. Five of the participants didn't know how pregnancy and STIs are prevented.

4.5.2: *Family planning*

Family planning is the term used to describe all the modern contraceptive methods in the Gambia. Usually people don't specify which method they are using but when asked they would say that they are using family planning or that one can take family planning. Six of the participants said that family planning can prevent pregnancy, but for STIs they didn't know.

4.5.3: *Abstinence*

Not having sex is another way of avoiding pregnancy and STIs. If you don't have sex there is no way you can get pregnant or contract an infection. Eight of the participants said abstinence could prevent pregnancy and STIs.

4.5.4: *Condom*

Condom is the only family planning method that can prevent both pregnancy and STIs and it is the best method for unmarried people and people with multiple partners. However, four of the participants said condoms can prevent STIs but not pregnancy.

… Yes using condoms and abstinence are the two ways I know that can prevent having sexually transmitted infections, but for pregnancy, you can use family planning. [Nogoi, 19 years]

You can use family planning or condom and not to sleep with a man because if you don't sleep with a man you will not get pregnant. [Hamin, 16 years]

4.5.5: *Pill and injection*

Oral contraceptives and injections are modern family planning methods. They are hormonal that prevent pregnancy, but they don't protect the person using them from STIs. One of the participants said you can use pills and another one said she heard of the injection.

4.5.6: *Traditional methods*

There are also some traditional methods of family planning and one of the methods mentioned is the used of charm to avoid pregnancy. One of the participants said one can use traditional methods to avoid pregnancy.

Chapter 5: Discussion

5.1: *Discussion*

In this chapter the findings will be discussed under the following: 1) The culture of silence 2) The power of external forces and 3) Increased dependency. The discussion will be framed around the gender and right model looking at the connections between adolescent pregnancy, sexual and reproductive right and gender relations: and how socio-cultural and gender norms are incorporated into adolescent pregnancy through the social institution such as the family, school, health sector and social welfare. Adolescent pregnancy is an individual experience, and the circumstances which lead to her pregnancy, differ greatly from one girl to another. Individual experiences will also differ depending on her socioeconomic status her level of education and access to reproductive health counselling and services.

Theme 1: The culture of silence

The construction of the social institutions where the adolescents are entangled such as the family, school, health systems, religion and welfare system, highly influence girls' capability to exercise their sexual and reproductive rights. In the Gambia, at the family level, it is the responsibility of the parents, especially the mothers to pass on the cultural norms and values to their daughters and also to help them develop their sexuality. However, this study identified knowledge gap among adolescents regarding sex, their sexuality and pregnancy prevention.

Most of the participants (13) had never discussed sex with family members, relying instead on information from peers, friends and the media. There are disadvantages in using these sources for information because they are most of the time inaccurate and misleading. The friends of the same age usually don't have adequate knowledge themselves and as a result young people are misguided. Some of the information from media is not necessarily intended for educational purposes, but entertainment which may mislead these young people about sex and sexuality. Moreover, they are controversial to the socio-cultural norms of the Gambia. Sex education requires the collective responsibility of the whole family and the society at large, but because adolescents don't talk about it at home, it ends up not being discussed or even mentioned in public. These relate to key findings from research conducted in Ethiopia; Ghana, Burkina Faso, Malawi and Uganda; and Brazil that identified cultural taboo, shame and lack of communication were reasons that hinder communication between parents and

adolescents about sex matters (Amuyunzu-Nyamongo et al, 2005, Ayalew et al, 2014, Nove et al 2014, Oliveira-Campos, 2014 and Kebede, 2015). On the other hand, our findings are the opposite of those reported on a study conducted in the USA by Morgan, Thorne and Zurbriggen in 2010, where participants described openness and comfort about talking about sexual topics with both mother and father and increased mutuality with parents during the college years; extend to the traditionally taboo topic of sexuality.

Since sex education is not taking place at the family level among the participants in this study, and then the society might have to take on a larger responsibility to educate young people about their sexual and reproductive health. However, there is also a vacuum in the area in the Gambia. At the school level, it is important to note that there are no special programs at the junior or senior secondary schools that specifically inform adolescents about sex, sexuality or reproductive health and what they learn during a science; biology or home science lesson does not address everything they need to know about sex and pregnancy prevention and contraceptives. Even though there are peer educators in some schools, their effectiveness is questionable because for the most part they didn't have any formal sexual and reproductive health education that would equip them with accurate knowledge that they could transfer to their peers. There is a need for education authorities to review their policies and develop a comprehensive sex education curriculum that would address the knowledge gap of young people at the different levels of the education system.

The culture of silence does not stop at the family level and schools, but extend to the health systems. The adolescents' access to family planning information and services in the Gambia is affected by health system structures, service delivery policies and social norms which make it even more difficult to prevent adolescent pregnancies and other consequences of unsafe sex. Even though the public health facilities provide family planning services, the services are not adolescent friendly. There is only one youth clinic in the Gambia and that one is not even a government facility. And due to its strategic location, it is not known to many young people and it provides services for older people living in that locality.

In order for the health care providers to address the reproductive health needs of young people and to prevent adolescent pregnancies and its consequences, there is the need to restructure the way services are delivered. They could either create youth clinics in the health centres or create convenient opening hours where young people would not have to mix with married women. This would allow them to access and utilize the reproductive health services

without having the fear of meeting people they know and they don't want to be judged, labelled or stigmatized. In this study it was realized that unmarried adolescents would prefer to go to the private pharmacy for pills because there, the pharmacist is just after money and because at the public health facilities, these services are incorporated into the main reproductive and child health services where they would most likely meet someone who knows them and might report them. Similar findings were identified in a study conducted in Ethiopia, where young women who were seeking for abortion services could not use the public facilities because they were used by married women from their communities who might know them and might report them (Kebede, 2015).

In this study, most of the participants didn't know what services were available to protect them from pregnancy or where they could access them. The health care providers need to sensitize the young people. They should also look for strategies of reaching adolescents either at the school or at the community levels because information is power and if they are empowered then, they would be able to protect themselves against an unwanted pregnancy. They would also have negotiating powers and to take self defence or something that would help them to avoid being rape. The health care providers should also advocate for and come up with strategies that would make the clinics more youth friendly and less stigmatizing for the protection of the privacy of the young people if they decided to use the services.

Theme 2: The power of an external force: the social and economic environment

The social environment, including peers, the social construction of the gender relationships and economic status of the girl and her family had influence upon the participants' freedom to exercise their sexual and reproductive rights. Adolescent pregnancies among the participants and probably among other Gambian unmarried adolescents occur because the adolescents are ignorant, poor and voiceless. Adolescent girls from financially deprived families are usually challenged with unmet economic needs. Because of their low socio-economic status these adolescent girls found themselves, and their desire to keep up with their peers, they had to look for survival strategies which in one way or the other affect their sexual and reproductive health and rights. In the Gambia, the family systems and structures are not gender neutral. Women and girls depend mainly on men for their needs and survival and as a result, they cannot make decisions regarding when to have sex, when to get pregnant and the decision to use contraceptives. It is the men who have the final say and when they made their decisions, the women cannot act against them.

According to the sexual and reproductive health rights (SRHR) every individual has the right to a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experience that is free of infection, coercion, discrimination and violence. They should also have the right to decide if, when and how often to have children (ICPD, 1994). This is never the case for young people in the Gambia especially those from poor families.

Most of these adolescents engaged in sexual relationships, not for pleasure but because of poverty. They are not only disrespected, but they are also exposed to potential infections, exploitation and violence. And because they lack the information, they cannot make decisions about contraceptive use. The social environment also has influence on the girl's sexual and reproductive health. Through their socialization with peers, adolescent girls are exposed to temptation which might push them to engage in an unsafe sexual intercourse against their wish. These temptations could be from peers on material gain or from a partner pressure.

In this study, some of the participants had sex but because they had unmet economic needs which their parents could not solve for them. This resulted in their partners taking advantage of them, resulting in an unplanned pregnancy, and potentially exposing them to STIs, violence and stigmatization. This is in accordance with findings from studies conducted in Brazil, Sri Lanka, USA and many Sub Sahara African countries which indicated that over 95% of participants had sex for economic reasons and exchanged sex for money or gifts and poverty pushed them into having transactional sex with older men to meet their basic needs, even though it increased their risk of unintended pregnancy (Ilika and Anthony, 2004, Amuyunzu-Nyamongo et al, 2005, Hawkinsa et al, 2009, McCleary-Sills et al, 2013, Madondo, 2013, Nove et al 2014, Oliveira-Campos,2014 and Jordal et al, 2015). Girls not being able to protect themselves from coercive sex due to gender and power inequalities were also identified.

Oftentimes in the Gambia when these pregnancies occur, families, schools, communities and societies demoralized the young people who became pregnant outside marriage and sometimes their mothers instead of looking at the circumstances that may have put these girls into that situation. To avoid the shame and stigma attached to being pregnant outside of marriage, some of these young women may consider undergoing unsafe abortion, don't seek health care services or in some extreme cases abandon their babies after delivery.

These findings are in line with the key findings from previous studies conducted in Nigeria, Tanzania and USA, which showed that the adults and community members blamed the girls alone for putting themselves at risk and stigmatized adolescents who reported having seriously considered abortion (Constance et al, 2004, Ilika and Anthony, 2004 and McCleary-Sills, 2013). These studies also noted that the girls were afraid to tell parents about pregnancy, felt that parents/teachers thought pregnancy was a mistake, felt abandoned by their partners and were at increased risk of social isolation and abuse. Ninety-seven percent of them also suffered violence such as beating and verbal abuse from family members and experienced major stressors, such as school and job termination and partner's negative attitude. Most of the participants reported they were rejected by their partners who often refused to admit being responsible for the pregnancy, and denied them marriage and financial support in spite of past expressions of love and promises (Constance et al, 2004, Ilika and Anthony, 2004 and McCleary- Sills, 2013).

Theme 3: Increase dependency and self blame

To live the life of a single adolescent mother in the Gambia means going through hardships, all alone. In most instances, even if the girl was not expelled from the house, she will have to live the rest of her life with abuses and torments. It also means she has to depend on her parents or other people for physical and financial support because when a child is born to a child, it is the parents who take up the responsibility to care for both of them if they can afford to. There are no social services that address or give support to single mothers in the Gambia. It also means that she cannot have a decent job that could cover her own basic needs, not to mention the needs of the child. Due to all these challenges, they regret what has happed and blame themselves.

This is in line with the key findings from South Africa that showed that pregnant teenagers experienced emotional turmoil as they strived to cope with their pregnancy. These emotions occurred because they blamed themselves, and were angry that they had not been strong enough to refuse to engage in a sexual relationship until they were ready to be mothers. They were inclined to be oversensitive and angry with themselves, their families and their peers. The participants also experienced a change in their relationships with their parents due to

expectations that were not met because their parents were not supporting them which led to role confusion which led to crisis. (James et al, 2011).

An unplanned pregnancy or unmarried adolescent mother can occur as a result of factors such as disadvantage family status, poverty, low education level and lack of economic opportunities which forced unmarried adolescent girls to engage in unprotected sexual intercourse (Madondo, 2013). Since these problems are less likely to be solved within a short time frame, adolescent mothers have a higher risk of getting pregnant again because they cannot continue to depend on their parents for the rest of their lives.

Furthermore, because they still have unmet needs, they would engage in another relationship which would increase their vulnerability of becoming pregnant again. They will get pregnant because they don't know how to avoid pregnancy or they don't have access to sexual and reproductive health education and services as concluded by Guzzo and Furstenberg Jr (2007). In that study, among the participants who were not married during their first birth, 14% had subsequent births with another partner, and 41% of those who had two or more children had had multiple partners. They concluded that, "the context in which the first births occur sets the stage for subsequent childbearing" (Guzzo and Furstenberg, Jr, 2007).

Instead of treating adolescent pregnancy as an isolated event and putting the blame on the adolescents themselves to prevent these pregnancies, the social institutions need to recognise that a joint effort from the family, the communities and stake holders to advocate, revise policies and develop strategic plans that would help these young women to access timely and accurate reproductive health information services through sex education; to be able to exercise their sexual and reproductive health rights; complete their education or to be trained on skills that would reduce their chances of remaining poor instead of expelling them from home and refusing to support them financially.

Chapter 6: Implications and conclusion

Limitation of the study

Any attempt to organize a topic as broad and complex as adolescent pregnancy involved some oversimplification, which might have obscured critical distinctions or excluded important points. Also, for the most part, the perspective was one-sided, that of pregnant adolescents and adolescent mothers. When investigating such controversial issues such as sexual activity and teenage pregnancy, the participants may have very different perceptions of the situation than those surrounding them, or the public at large. Thus, it can be argued adolescent pregnancy/motherhood was studied without sufficiently addressing the variety of perspectives from different categories of people and settings. The inclusion of the parents and guardian's perspective would have provided a valuable perspective as to why they don't talk to their children about sex, their opinions as to why these girls are getting pregnant, their experiences and the reasons behind their reactions to the pregnancy of their children. Investigating the issue from the girl's perspective does not, however, diminish the significance of documenting the perceptions and experiences of those who are directly affected. Such documentation is of value in its own right, giving voice to the experiences and realities of marginalized adolescent girls.

Another limitation of the study was that the researcher was an older person. A midwife interviewing adolescents of her children's age group, who were also less economically privileged and the power dynamic may have influenced their responses. The researcher could have appointed a research assistance who was at least in the early twenties at least to narrow the age gap and the perception of patronising or judging them.

Another challenge was collecting data from the different health facilities. Relying on the midwives to get participants was challenging because three of the facilities never contacted me even though they promised that they would if they had a case and anytime they were contacted they would reassure me that they would inform me whenever there was a case. This might have also contributed to sampling bias.

Another limitation of the study was selection bias due to having to obtain consent from the parents or guardians of participants below 18 years. During the recruiting process, 10 potential participants were given the parent's consent form to be taken to their parents or

guardians to sign and they would bring them when coming for the interview but only six came back for the interview. There were three who were pregnant with their second child, all of them signed the consent, but none of them came for the interview. Those who did not return to be the interview might have had a very different perspective.

Another limitation of the study was that the information on their experiences was collected retrospectively and this may have influenced what information participants remembered and shared due to recall bias. Participants might not have shared their experiences because they were bad experiences and they didn't want to recall or disclose anything related to those situations. However, probing questions might help a little to reduce recall bias, and in this study four of the participants did not do the follow-up interviews.

Lastly, due to the large amount of data collected, it was impossible to incorporate everything from the data. The raw data consisted of 214 pages of interview transcripts plus the notes of the informal conversations and observations.

Strengths of the study

- This study is the first of its kind in the Gambia that investigated about adolescent pregnancy and therefore contributed to the existing literatures on unplanned pregnancy.
- The study enables these young women's voices to be heard through their perceptions and experiences that they shared during the interviews and the focus group discussion.
- The research could be used as evidence to advocate for programmes that would address the reproductive health needs of adolescents in the Gambia
- The study findings could also be used as a base to generate research questions that could be studied in the future.

Implications of the study

The phenomena surrounding adolescent pregnancy differ from culture to culture. In this study the findings showed that the majority of the participants had never discussed sex with their parents. The implication this may have is any programme trying to promote a healthy sex life

among adolescents would have to overcome a lot of cultural barriers. To overcome these barriers, they explore on the possibilities of integrating sex education in the junior secondary schools as a core subject. This would also mean that they have to train teachers in this area to be able to handle the topics, so the teachers' training programme could be an entry point for implementing such project. The school peer educators could also be given formal training on how to promote health sex among their peers. At the community levels, youth clubs could be involved in order to access its members.

The adolescents mentioned that there was nowhere in the Gambia where they could go for sexual and reproductive health information. Any programme trying to improve on the reproductive health of these adolescents would need to create youth clinics within the existing facilities and also to identify and train young people on communication strategies so that they would be able to develop health messages and use them to disseminate information to their peers. They could also look into the possibility of sponsoring a health sex poster or essay competition among adolescents.

The findings also showed that these adolescents didn't utilize the reproductive health services that are currently provided at the reproductive health clinics due to the fear of meeting someone they know. Another implication is making sure that reproductive health services protect and promote their privacy and confidentiality. Some of these young mothers could be recruited and trained as peer educators and counsellors in their communities

Recommendations

The research has raised many challenges as to how unplanned pregnancies can be prevented among unmarried adolescents, how the sexual and reproductive health of adolescents in the Gambia can be improved. There are many challenges affecting adolescents reproductive health requiring strategies that are culturally acceptable to eradicate pre-marital pregnancies and unsafe abortions in the Gambia. Although there are many issues that came up from the findings of this study, I will focus on these key recommendations:

- Develop strategies that would train new and improve the knowledge and communication skills of the existing peer educators in order for them to be able to disseminate sexual and reproductive health information among their fellow youths.

- Since young people do not utilize the reproductive health services because they are afraid to meet somebody they know, peer educators should be trained to deliver services to young people in their own setting (school or community).
- Establish adolescent reproductive health clinics on days when the health facilities are less busy for examples Saturdays or afternoon clinics.
- Integrate the reproductive health services and the social welfare services so that adolescents needing social support can benefit from these services.
- Advocate for more research in the area of adolescent reproductive health that would give adolescents a voice and to contextualise the individual's dynamic experiences within their social settings. This will significantly contribute to the development of locally appropriate and culturally sensitive sexual health interventions.

Suggestions for future research

This study exposed several issues that could be the focus of future research. Some research topics could be:

- Unplanned pregnancy among unmarried adolescent in the Rural Gambia
- negotiating sex by unmarried adolescents in heterosexual relationships
- Perceptions of young unmarried men regarding pregnancy and childbearing
- Perceptions and experiences of parents regarding the pregnancy of their daughters
- Perceptions of parents on talking about sex with their adolescent children
- Perceptions of health care providers on providing contraceptives to unmarried adolescents

Conclusion

Unplanned pregnancies among unmarried adolescents had been an area of study that was given limited attention in the Gambia. This qualitative research was the first empirical study that investigated the factors surrounding unplanned pregnancy among unmarried adolescents. The aim of this study was to explore the factors contributing to unplanned pregnancy among unmarried adolescents in the Gambia through phenomenological approach.

The contributing factors that were identified were interdependent suggesting that pregnancy among unmarried adolescents cannot be treated as an isolated event or as the problem of the

girl alone because it has implications on the family, the community and the society at large. Since pregnancy is interconnected with other events like sexual intercourse, contraceptive access, use and failure and maternity care, breaking the culture of silence would help to reduce unplanned pregnancies and its consequences. The unmet economic needs of these adolescents and their families need to be addressed if we have to put an end to these pregnancies. The social environment also needs to be looked at in order to address the external forces that have influence on these pregnancies.

In this regard, in order to address the issue of unplanned and unwanted pregnancy among unmarried adolescents, there is the need for more research in the area of adolescent sexual and reproductive health and interventions that would inform young people about their sexual and reproductive health and rights. There is also the need for intervention strategies that would provide sex education to these young people and to inform them of how and where to get services that would protect them from pregnancy. Families should also recognise the importance of having open dialogue with their daughters and educating them on how to protect themselves against unplanned pregnancy and its consequences. They should also support adolescents who became pregnant instead of blaming, stigmatizing and punishing them. Being pregnant as an unwed adolescent is stressful and being abandoned by a partner make things more complicated. Partners should therefore take up the responsibility to protect these girls against pregnancy and in the event that they become pregnant, they should give them maximum support.

Unplanned pregnancy is a public health problem in the Gambia that affects the poor, the minority and the less educated and to overcome the problem, it needs collective efforts of the families, the communities, the policy makers and the state at large.

References

1. Amuyunzu-Nyamongo, M., Biddlecom, A.E., Ouedraogo, C.,Vanessa Woog, V. (2005*): Qualitative Evidence on Adolescents' Views of Sexual and Reproductive Health in Sub-Saharan Africa*;Occasional Report No. 16
2. Angelsen, A., Larsen, H. O., Lund, J. F., Smith-Hall, C., Wunder, S. (2011). Measuring Livelihood and Enviromental Dependency: Methods for Research and Fieldwork. ISBN: 978-1-84971-132-6 – ISBN 978-1-84971-133-3
3. Ansari, F.R., (2006). *Islam to the modern mind*. Lectures in South Africa 1970& 1972. Fourth edition: p232-237.
4. Assini-Meytin, L.C. and K.M. Green, *Long-Term Consequences of Adolescent Parenthood among African-American Urban Youth: A Propensity Score Matching Approach.* J Adolesc Health, 2015.
5. Atuyambe, L.M., (2008). *Adolescent motherhood in Uganda: Dilemmas, health seekinf behaviour and coping responses*
6. Ayalew, M., Mengistie, B., Semahegn, A. (2014). *Adolescent - parent communication on sexual and reproductive health issues among high school students in Dire Dawa, Eastern Ethiopia: a cross sectional study.* Reproductive Health 2014, 11:77
7. Barbour. (2007). *Introducing focus group discussion; Uses and abuses of focus group*
8. Barroso, C., *Beyond Cairo: sexual and reproductive rights of young people in the new development agenda.* Glob Public Health, 2014. **9**(6): p. 639-46.
9. Benatar, S. R. (2002) *Reflection and recommendations on research ethics in developing countries*. Social Science and Medicine 51 1131-1141
10. Bilajac, I. S. (2011). *Informed consent- Conceptual, empirical and normative issues*
11. Bonel, C. (2004). *Why is teenage pregnancy conceptualized as a social problem?* Culture, Health & Sexuality; ISSN 1369-1058 print/ISSN 1464-5351. DOI: 10.1080/13691050310001643025
12. Bryman and Alan. 2nd Edition (2004). Interviewing in qualitative research; In Social Research methods: Oxfort University press
13. Burns, N. and Grove, J. S. (2005). The practice of Nursing research: Coduct, critique & utilization 5th ed. St. Louis, Missours: Elsevier Saunders
14. Byamugisha, J.K., (2007). *Emergency contraceptive among young people in Uganda: User and provider perspectives*

15. Chandra-Mouli, V.(2015). *The world has much to do to achieve the international conference on population and development's adolescent-health objective. Sexual and reproductive health care;* http://dx.doi.org/10.1016/j.srhr.2014.12.01.
16. Chant, S. and Evans, A. *(2010). Looking for the one(s): young love and urban poverty in The Gambia.* Environment and urbanization 2010 22: 353; DOI: 10.1177/0956247810379822
17. CIOMS, WHO, (2002) *International Ethical Guidelines for Biomedical Research Involving Human Subjects* http://www.recerca.uab.es/ceeah/docs/CIOMS
18. CIOMS, WHO, (2008). *International ethical guidelines for epidemiological studies*: Ethical studies in social sciences.
19. Cluver, F., D. Elkonin, and C. Young, *Experiences of sexual relationships of young black women in an atmosphere of coercion.* Sahara j, 2013. **10**(1): p. 8-16.
20. Coelho, E. A. C, Souza Andrade, M. L., Vitoriano, L. V. T., Jesus Souza, J., Silva, D. O., Gusmão, M. E. N., Nascimento, E. R., Almeida, M. S. (2012). *Association between unplanned pregnancy and the socioeconomic context of women in the area of family health:* Acta Paul Enferm. 2012;25 (3):415-22.
21. Cohen, L., Manion, L., Morison, K. 6th Edition. (2007) *Research methods in education*.: Poutledgefalmer
22. Collin-Vézina, D., et al. *A preliminary mapping of individual, rela-tional, and social factors that impede disclosure of childhood sexual abuse*. Child Abuse & Neglect (2015), http://dx.doi.org/10.1016/j.chiabu.2015.03.010
23. Constance, M., Wiemann, C .M, Rickert, V. I, Berenson, A. B, Robert, J. & Volk, R. J. (2004). *Are pregnant adolescents stigmatized by pregnancy?* Elsevier: Journal of Adolescent Health 36 (2005) 352.e1–352.e7
24. Craig, A.P & Richter-Strydon .L.M. (1983). *Unplanned pregnancies among urban Zulu schoolgirls* Sa Medical Journal volume 63 19
25. Creswell, J. W. (1998). *Qualitative Inquiry and Research Design Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications.
26. Druetz, T., Kadio, K., Haddad, S., Kouanda, S., Ridde, V. (2014). *Do community health workers perceive mechanisms associated with the success of community case management of malaria? A qualitative study from Burkina Faso*. Doi.org/10.1016/jsocscimed.2014.11.053
27. Engward, H. and G. Davis, *Being reflexive in qualitative grounded theory: discussion and application of a model of reflexivity.* J Adv Nurs, 2015.

28. Francis health sciences: Culture, Health & Sexuality, vol. 6, no. 3, 255–272
29. Frost, J. J. Oslak, S. (1999) *Teenagers' Pregnancy Intentions And Decisions: A Study of Young Women in California Choosing To Give Birth*: Occasional Report No. 2;December 1999
30. Gambia Government (2011) *Ministry of Health Health Policy*
31. Green, J., Thorogood, N., (2009).*Qualitative methods for health research*. Second edition
32. Goicolea,I, (2013). *Adolescent pregnancies in the Amazon Basin of Ecuador: a rights and gender approach to adolescents' sexual and reproductive healt*h VOL3
33. Groenewald, T. (2004). *A phenomenological research design*; International journal of qualitative research
34. Gruskin, S. and T.K. Ravindran, *Realising the ICPD 20 years later: shifting the paradigms for research and education.* Glob Public Health, 2014. **9**(6): p. 647-52.
35. Guillemin, M., Heggen, K. (2008). *Rapport and respect: Negotiating ethical relations between researcher and participant*
36. Guzzo, K. B. and Furstenberg, Jr, F. K. (2007). *Multipartnered Fertility among Young Women with a Nonmarital First Birth: Prevalence and Risk Factors*: Perspectives on Sexuala and Reproductive Health, 2007, 39(1):29-38,doi: 10.1363/3902907
37. Haberland, N.A., *The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies*. Int Perspect Sex Reprod Health, 2015. **41**(1): p. 31-42.
38. Hainsworth, G., Engel, D.M.C, Simon, C, Rahimtoola, M., Ghiron, L. J. (2014). *Scale-up of Adolescent Contraceptive Services: Lessons From a 5-Country Comparative Analysis.* Volume 66, Supplement 2, (J Acquir Immune Defic Syndr 2014;66:S200–S208)
39. Hanwellw, R., Silva, V., Yoosuf,A., Karunaratne, S., Silva, P. (2012). *Religious Beliefs, Possession States, and Spirits: Three Case Studies from Sri Lanka*. Article ID232740, 3 pages. Doi:10.1155/2012/232740
40. Hawkins, K., N. Price, and F. Mussa, *Milking the cow: young women's construction of identity and risk in age-disparate transactional sexual relationships in Maputo, Mozambique.* Glob Public Health, 2009. **4**(2): p. 169-82.
41. Hendrixson, A. (2014). *Beyond bonus or bomb: upholding the sexual and reproductive health of young people.* Reproductive health matters, Volume 22 Number 43. Doi: 10.1016/S0968-8080(14)43765-

42. Heslop, J. and R. Banda, *Moving beyond the "male perpetrator, female victim" discourse in addressing sex and relationships for HIV prevention: peer research in Eastern Zambia.* Reprod Health Matters, 2013. **21**(41): p. 225-33.
43. Hollander, J. A. (2004). *The Social Contexts of Focus Groups*
44. Holloway, I. (1997). *Basic Concepts for Qualitative Research*. London: Blackwell Science.
45. Hopkins, P.E. (2007). *Thinking critically and creatively about focus groups*: Volume 39, Issue 4 Pages 415–558; DOI: 10.1111/j.1475-4762.2007.00766.x
46. http://www.accessgambia.com/information/religion.html#top
47. Inter-Agency Standing committee, (2006) *Women, girls, boys and men, Different needs-equal opportunities.* Gender handbook on humanitarian action
48. IPPF Chapter Guidelines on Sexual and Reproductive Health. (2003). International Planned Parenthood Federatio
49. Jackie, A., Nelson, & O'Brien .M. (2012). *Does an Unplanned Pregnancy Have Long-Term Implications for Mother–Child Relationships?* Journal of Family Issues 2012 33: 506 DOI: 10.1177/0192513X11420820
50. Jacob, S.A., Furgerson, S.P. (2012). *Writing Interview Protocols and Conducting Interviews: Tips for Students New to the Field of Qualitative Research.* The Qualitative Report 2012 Volume 17, T&L Art. 6, 1-10
51. James, S., Rooyen, D. V, & Strumpher, J. (2011). *Experiences of teenage pregnancy among Xhosa families*. Elsevier : Midwifery 28 (2012) 190–197
52. Jodal, M.(2014). *Living up to the ideal of respectability; Sexual and reproductive health rights implication for unmarried migrant workers, single mother, and women in prostitution in Sri Lanka*
53. Jordal, M., Wijewardena, K., Öhman, A., Essén, B., Olsson, P. (2015). '*Disrespectful men, disrespectable women': Men'sperceptions on heterosexual relationships and premarital sex in a Sri Lankan Free Trade Zone*. BMC International Health and Human Rights (2015) 15:3 DOI 10.1186/s12914-015-0040-4
54. K. Hawkinsa, N. Price, F. Mussa. (2009). *Milking the cow: Young women's construction of identity and risk in age-disparate transactional sexual relationships in Maputo, Mozambique,* Global Public Health: An International Jornal for Research, Policy and Practice, 4:2, 169-182.DOI:10.1080/17441690701589813
55. Kebede, M. T. (2015). *Young women and induced abortion in Ethiopia: A qualitative study on sexuality, stigma and silence, ISBN978-82-8264-971-1*

56. Kleep, K.I., Flisher,A.J., Kaaya, S.F. (2008). *Promoting adolescent sexual and reproductive health in East and Southern Africa*
57. Kornides, M.L., et al., *Factors associated with young adults' pregnancy likelihood.* J Midwifery Womens Health, 2015. **60**(2): p. 158-68.
58. Latifat, D. G., Ibisomi, C. & Odimegwu, O. (2007).*Predictors of Unintended Pregnancy among South African Youth.* Eastern Africa Social Science Research Review, Volume 23, *DOI: 10.1353/eas.2007.0001*
59. Lawton J: *Gaining and maintaining consent: Ethical concerns raised in a study of dying patients* D01:10:1177/10497320119389; Qual Health Res 2001 11:693
60. Lelean, S. (1982). *The implementation of research findings in to nursing practice*. ht. J. Nurs. Sfud., Vol. 19, No. 4, pp. X3-230. OXlO-7489/82/040223~~ $03.00/O Per&mm Press Ltd.
61. Lester, S. (1999). *An introduction to phenomenological research*. Stan Lester Developments, Taunton
62. Lincoln, Y. S. & Guba, E.G. (1985). *Naturalistic Inyuariy*. Newbury Park, CA: Sage Publications.
63. Lusti-Narasimhan, M., et al., *Advancing the sexual and reproductive health and human rights of women beyond 2015.* Bjog, 2014. **121 Suppl 5**: p. 1-2.
64. Macvarish, J. (2010). *The effect of 'risk-thinking' on the contemporary*
65. *construction of teenage motherhood*, Health, Risk & Society, 12:4, 313-322, DOI:
66. 10.1080/13698571003789724
67. Madondo, T. T. (2013) *Adolescence pregnancies and their impact on communities*. Exchange on HIV, AIDS, Sexuality and Gender. Access April, 2014. www.safaids.net
68. Marengo, E., et al., *Unplanned pregnancies and reproductive health among women with bipolar disorder.* J Affect Disord, 2015. **178**: p. 201-205.
69. Marilyn, K., Simon, Goes, J. (2011). *What is phenomenological research?* www.dissertation recipes.com
70. Mattingly, C. (2005). *Toward a vulnerable ethics of research practice DOI:10.1177/1363459305056413; 1363-4593; Vol 9(4): 453–471*
71. McCleary-Sills, J., Douglas, Z., Rwehumbiza, A., Hamisi, A., Mabalae, R. (2013). *Gendered norms, sexual exploitation and adolescent pregnancy in rural Tanzania.* Reprod Health Matters, 2013. **21**(41): p.97-105. Doi:10.1016/S0968-8080(13)41682-8

72. Merriam, S. (1988). Case study in education: A qualitative approach. San Francisco, CA: Jossey-Bass.
73. Miles, M. B. & Huberman, A M. (1994). *Qualitative Data Analysis* (2nd edition). Thousand Oaks, CA: Sage Publications.
74. Morgan, E.M., Thorne, A., Eileen L. Zurbriggen, E.L. (2010). *A Longitudinal Study of Conversations with Parents About Sex and Dating During College*. American Psychological Association: 2010, Vol. 46, No. 1, 139–150 0012-1649/10/$12.00 DOI: 10.1037/a0016931
75. Morrow, V. (2008). *Ethical dilemmas in research with children and young people about their social environment*: Children's Geographies, Vol 6, No 1, 2008 pp 49.61
76. Newton, N.,(2010). *The use of semi-structured interviews in qualitative research: Strengths and weaknesses. Exploring qualiative method*
77. Nove, A., Matthews, Z., Neal, S., Virginia, A. (2014).*Maternal mortality in adolescents compared with women of other ages:* evidence from 144 countries doi:10.1016/S2214-109X(13)70179-7
78. Oliveira-Campos, M., Nunes, M. L., Madeira,F. C., Santos, M. G., Bregmann, S. R., Malta, D. C., Giatti, L., Barreto, S. M. (2012).*Sexual behavior among Brazilian adolescents, National Adolescent School-based Health Survey* (PeNSE 2012). DOI: 10.1590/1809-4503201400050010
79. Omer, A. B., Knut W. Ruyter Revised Jan Helge Solbakk, January 2012 Medical Research Ethics – Lesson 3 *Involvement and protection of vulnerable populations in research*; Lesson 4 (2009) *Confidentiality, protection of privacy and genetic research;* Review by the Research Ethics Committee
80. Pinheiro, R.T., et al., *Suicidal behavior in pregnant teenagers in southern Brazil: social, obstetric and psychiatric correlates.* J Affect Disord, 2012. **136**(3): p. 520-5.
81. Polit, D. F., Beck, C.T. (2006). *The Content Validity Index:Are You Sure You Know What's Being Reported? Critique and Recommendations*. Research in Nursing & Health, 2006, 29, 489–497; DOI: 10.1002/nur.20147
82. Polit, D.F. and Beck. (2008) *Nursing Research. Principles and Methods*
83. Pope,C., Zieblang,S.,Mays, N.(2000) *Qualitative research in health care; Analysing qualitative data*. Vol320
84. Rolleri, L. A. (2013). *Understanding Gender and Gender Equality*. ACT for Youth Center of Excellence

85. Rosengard, C., Pollock, L., Weitzen, S., Meers, A., Maureen, G., & Phipps, M.G. (2005). *Concepts of the Advantages and Disadvantages of Teenage Childbearing among Pregnant Adolescents*. Phipps Pediatrics 2006;118;503: DOI:10.1542/peds.2005-3058
86. Salami, K.K., M. Ayegboyin, and I.A. Adedeji, *Unmet social needs and teenage pregnancy in Ogbomosho, South-western Nigeria.* Afr Health Sci, 2014. **14**(4): p. -66.
87. Santelli, J., Rochat, R., Hatfield-Timajchy, K., Gilbert, B. C., Curtis, K., Cabral, R., & Schieve, L. (2003). *The measurement and meaning of unintended pregnancy*. Perspectives on sexual and reproductive health, *35*(2), 94-101.
88. Sarantakos, S. (2000). *Social research*. South Yarra (Australia): MacMillan Education.
89. Sax, L. (2010). *Being and becoming a body: moral implications of teenage pregnancy in a shantytown in Porto Alegre, Brazil Culture,* Health & Sexuality Vol. 12, No. 3, April 2010, 323–334
90. Sheikh, S.A. (2007). *The importance of ethics in medical research*
91. Silica, A., Anthony,I. 2004 *Unintended Pregnancy among Unmarried Adolescents and Young Women in Anambra State,South East Nigeria* (Afr J Reprod Health 2004; 8[3]: 92-102)
92. Singh, S., Sedgh, G., Hussain, R. (2010). *Unintended Pregnancy: Worldwide Levels,Trends, and Outcomes:* Volume 41 Number 4 December 2010 241
93. Sippel, S., *ICPD beyond 2014: moving beyond missed opportunities and compromises in the fulfilment of sexual and reproductive health and rights.* Glob Public Health, 2014. **9**(6): p. 620-30.
94. Skramstad, H. (2008). *Making and managing femaleness, fertility and motherhood within an urban Gambian area*
95. Snelgrove, S.R., *Conducting qualitative longitudinal research using interpretative phenomenological analysis.* Nurse Res, 2014. **22**(1): p. 20-5.
96. Sommerfelt, T. (2013). *Choreographies of Proximity and Distance: Marriage among rural Wollof-speakers in contemporary Gambia*. ISSN 1504-3991
97. Spear, H. J., Lock, S. (2003). *Qualitative Research on Adolescent Pregnancy: A Descriptive Review and Analysis. Journal of Pediatric Nursing*, Vol 18, No 6 (December), 2003: doi:10.1016/S0882-5963(03)00160-X

98. Stover, J., Rosen, J., Kasedde, S., Idele, P., McClure, C. (2014). *The Impact and Cost of the HIV/AIDS Investment Framework for Adolescents.* Volume 66, Supplement 2, July 1, 2014 (J Acquir Immune Defic Syndr 2014;66:S170–S175)

99. Sultana, F. (2007). *Reflexivity, Positionality and Participatory Ethics: Negotiating Fieldwork Dilemmas in International Research*

100. Sundby, J., *Young people's sexual and reproductive health rights.* Best Practice Research Clinical Obstetrics & Gynaecology, 2006. **20**(3):p. 355-68.

101. Taylor-Powell, E., Renner, M. (2003). *Analyzing Qualitative Data*

102. Temmerman, M., R. Khosla, and L. Say, *Sexual and reproductive health and rights: a global development, health, and human rights priority.* Lancet, 2014. **384** (9941): p. e30-1.

103. The Department of Social Welfare annual reports: 2011, 2012 and 2013

104. The Gambia. (2013). *Health Information Management System*. (HIMS). Ministry of Health and Social Welfare

105. UNESCO. *(2008), Report of the International Bioethics Committee of UNESCO on consent. http://ethics.iarc.fr/Documents/IBC_consent.pdf Accessed on 11th May 2013*

106. UNFPA, Gambia Government. (2000). *Report on the National survey on Adolescent / Youth Health.* Banjul: Government of the Gambia.

107. UNICEF. (2011).*The state of the world's children 2011: Adolescence An age of opportunity*. UNICEF. ISBN: 978.92.806.4556.2

108. UNICEF. (2003). *Study on the sexual abuse and exploitation of children in the Gambia*

109. UNICEF. The Gambia. (2000). *Early marriage and teenage pregnancy report*

110. U.S. Department of Health & Human Services (1949) "*Trials of War Criminals Before the Nuremberg Military Tribunals under Control Council Law* No. 10", Vol. 2, pp. 181-182. Washington, D.C.: U.S. Government Printing Office. http://www.hhs.gov/ohrp/archive/nurcode.html

111. Vogel,J.P., Pileggi-Castro, C., Chandra-Mouli, V., et al Arch Dis Child (2015*). Millennium Development Goal 5 and adolescents: looking back, moving forward*; (supppl 1): s43-s47. Doi10.11236/archdischild.2013.305514

112. Vuttanont, U., Greenhalgh, T., Griffin, M., Boynton, P. (2006). *"Smart boys" and "Sweet girls"—sex education needs in Thai teenagers: a mixed-method study*: www.thelancet.com Vol 368 December 9, 2006

113. Warren, A.B.C. (2001) *Qualitative interviewing*

114. Warenius, L. (2008). *Sexual and reproductive health for young people in Kenya and Zambia: Providers' attitude and young people's need and experiences*

115. WHO. (2011). *Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries;* A Practical Guide: WHO/FWC/MCA/12.02 ISBN: 978 92 4 1502221 4. WHO

116. WHO. (2006). *Promoting and safeguarding the sexual and reproductive health of adolescents:* Policy brief.4: Implementing the global reproductive health strategy

117. WMA. (2008). *Declaration of Helsinki – Ethical Principles for Medical Research*

118. Xu, H., Mberu, B.U., Goldberg, R.E., &Luke, N. (2013): *Dimensions of Rural-to-Urban Migration and Premarital Pregnancy in Kenya*. The ANNALS of the American Academy of Political and Social Science 2013 648: 104 DOI: 10.1177/0002716213480792

119. Zeck , W., Bjelic-Radisic, V., Josef Haas, J., & Greimel, E. (2007). *Impact of Adolescent Pregnancy on the Future Life of Young Mothers in Terms of Social, Familial, and Educational Changes*. Elsevier: Journal of Adolescent Health 41 (2007) 380–388

Appendix

Ethical Approvals

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Vivi Opdal	22845526	25.06.2014	2014/910/REK sør-øst A
			Deres dato:	**Deres referanse:**
			13.05.2014	

Vår referanse må oppgis ved alle henvendelser

Johanne Sundby
Universitetet i Oslo

2014/910 Ikke planlagte graviditeter blant ugift ungdom i Gambia

Forskningsansvarlig: Universitetet i Oslo
Prosjektleder: Johanne Sundby

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) A i møtet den 12.06.2014. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikklovens § 4.

Prosjektbeskrivelse (revidert av REK)

Formålet med dette prosjektet er å undersøke årsaker og holdninger til ikke planlagt graviditet hos gambiske ungdommer. På verdensbasis er komplikasjoner i forbindelse med graviditet eller abort utført av andre enn helsepersonell en av de vanligste dødsårsakene hos unge jenter (15-19 år). I Gambia er 23 % av befolkningen i denne aldersgruppen, og det har aldri vært gjennomført noen studie av hvilke faktorer som fører til graviditet hos ungdommer i landet. 15 ugifte jenter, enten gravide eller som nettopp har født, og som er i kontakt med offentlig helsevesen, vil bli bedt om å delta i en spørreundersøkelse. Samtykke fra foreldre eller verge innhentes i tillegg der jentene er under 18 år. For de jentene som ikke kan lese, vil samtykkeinformasjonen bli oversatt til det lokale språket slik at de kan forstå innholdet før de eventuelt samtykker. Intervjueren er en erfaren jordmor.

Komiteens vurdering

Formålet med dette prosjektet er å undersøke årsaker og holdninger til ikke planlagt graviditet. Etter komiteens vurdering er ikke prosjektet å anse som medisinsk og helsefaglig forskning etter helseforskningslovens definisjon.

Hva som er medisinsk og helsefaglig forskning fremgår av helseforskningsloven § 4 bokstav a hvor medisinsk og helsefaglig forskning er definert slik: "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Formålet er avgjørende, ikke om forskningen utføres av helsepersonell eller på pasienter eller benytter helseopplysninger.

Vedtak

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2, og kan derfor gjennomføres uten godkjenning av REK. Det er institusjonens ansvar på å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern.

Besøksadresse: Gullhaugveien 1-3, 0484 Oslo
Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK Sørøst A. Klagefristen er tre uker fra mottak av dette brevet, jf. forvaltningsloven § 29.

Med vennlig hilsen

Knut Engedal
Professor dr. med.
Leder

Vivi Opdal
seniorrådgiver

Kopi til: *universitetsdirektor@uio.no*

UNIVERSITY OF THE GAMBIA

SCHOOL OF MEDICINE & ALLIED HEALTH SCIENCES
RESEARCH AND PUBLICATION COMMITTEE (RePubliC)

12th September 2014

Ms Kumba Khan
University of Oslo
Oslo

Dear Ms Khan,

Re: Project #R014 035 V2: "Unplanned Pregnancy among Unmarried Adolescents in The Gambia"

Thank you for resubmitting the above project including your clarifications in your letter dated 2nd September 2014. The Chair has reviewed your responses to the queries raised by the Committee at its July 21 meeting.

Your project is approved and will now be forwarded to the Gambia Government/MRC Joint Ethics Committee for review.

Best wishes,

.....
Dr. Ousman Nyan
Chair

Cc: File

P.O. Box 1646 Banjul; Tel: +220 4201407; Mob: +220 9934848; Email: onyan@utg.edu.gm

REPUBLIC OF THE GAMBIA

MINISTRY OF HEALTH & SOCIAL WELFARE
THE QUADRANGLE
BANJUL

Tel: 4227300/4227301 Fax: 4229325

Ref: DHS/AD/2014/01 **27th August 2014**

Kumba Khan
C/o Gambia College
School of Nursing & Midwifery
Marina Parade
Banjul

PERMISSION TO CONDUCT RESEARCH

I write to acknowledge receipt of your letter dated 26th August 2014 about the above captioned subject.

I am please to inform you that approval has been granted for you to proceed on the above proposed research.

By a copy of this letter, the Regional Health Director – Western Region I is hereby informed.

Please be assured of our continuous support and cooperation.

Yours sincerely,

.....

Dr. Momodou Lamin Waggeh
Director of Health Services

Cc: Regional Health Director – Western Region I

Files

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Johanne Sundby
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 23.04.2015 *Vår ref: 42768/3/HIT /RH* *Deres dato:* *Deres ref:*

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 12.03.2015. All nødvendig informasjon om prosjektet forelå 22.04.2015. Meldingen gjelder prosjektet:

42768	*Unplanned pregnancy among unmarried adolescents in urban Gambia*
Daglig ansvarlig	*Johanne Sundby*
Student	*Kumba Khan*

Personvernombudet har vurdert prosjektet på bakgrunn av den informasjon vi har fått om gjennomføringen, og finner at behandlingen av personopplysninger er omfattet av meldeplikten iht. personopplysningsloven § 7-27.

Personvernombudet registrerer at datainnsamlingen startet opp 30.10.2014. I brev datert 6.3.2015 skriver Institutt for helse og samfunn at flere prosjekt ved masterprogrammet «International Community Health (ICH) ved en feiltakelse ikke har blitt meldt til NSD etter at de ble vurdert til å falle utenfor helseforskningsloven av REK, og at det nå ryddes opp i dette.

Personvernombudet finner det positivt at instituttet har oppdaget avvikene og nå rydder opp. Vi anbefaler at instituttet fremover gir god opplæring til forskere, studenter og veiledere om at meldeplikten til personvernombudet gjelder dersom det skal behandles personopplysninger til forskningsformål som ikke omfattes av helseforskningsloven. Prosjekter som omfattes av meldeplikten skal meldes senest 30 dager før oppstart. I prosjekter som foretar elektronisk behandling av sensitive personopplysninger skal det også foreligge tilrådning fra personvernombudet eller konsesjon fra Datatilsynet før behandlingen tar til. Brudd på meldeplikten innebærer at det har vært foretatt behandling av personopplysninger uten gyldig behandlingsgrunnlag i henhold til personopplysningslovens bestemmelser.

Brudd på meldeplikten innebærer samtidig et brudd på Universitetet i Oslo sine prosedyrer for internkontroll med personvern i forskning. Det vises til avtale mellom Universitetet i Oslo og personvernombudet ved NSD. Personvernombudets forhåndskontroll av meldepliktige forskningsprosjekter inngår som en viktig del av den lovpålagte internkontrollen Universitetet i Oslo gjennomfører med sin behandling av personopplysninger. I avtalen mellom NSD og Universitetet i Oslo fremgår det at prosjekter som skal foreta behandling av personopplysninger skal meldes i god tid før innsamling og registrering tar til.

Prosjektvurdering

Det fremgår at prosjektet ble vurdert av REK sør-øst (ref. ref. 2014/910), som vurderte det slik at prosjektet ikke ble omfattet av helseforskningsloven.

Det fremgår videre at prosjektet har mottatt godkjenning fra forskningsetisk komité i Gambia.

Formålet er å utforske faktorer som påvirker ikke planlagt graviditet blant unge jenter i urbane områder i Gambia.

Utvalget ble informert skriftlig og muntlig om prosjektet og samtykket til deltakelse. For deltakere under 18 år ble også foreldre bedt om å gi sitt samtykke. Informasjonsskrivet er for det meste godt utformet, men følgende burde ha vært tilføyd:

- At Universitetet i Oslo er behandlingsansvarlig institusjon
- Navn og kontaktinformasjon for veileder
- Dato for prosjektslutt og anonymisering.

Det behandles sensitive personopplysninger om etnisk bakgrunn, helseforhold og seksuelle forhold.

Personvernombudet legger til grunn at forsker etterfølger Universitetet i Oslo sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc/mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 31.05.2015. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)

Avslutning

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med personvernombudet, samt personopplysningsloven med forskrifter.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.05.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

42768

Ta gjerne kontakt dersom noe er uklart

Vennlig hilsen

Katrine Utaaker Segadal

Hildur Thorarensen

Kopi:
Institutt for helse og samfunn, Universitetet i Oslo: Kumba Khan, Olav M Troviks Vei 66 H109, 0864 OSLO

PARTICIPANT INFORMATION SHEET

Version Date:
31st
July2014

Study Title: Unplanned pregnancy among unmarried adolescents in Urban Gambia

SCC:		Protocol:	

Sponsors: EECONPOP Project: Reproductive Health Care Cost, University of Oslo

What is informed consent?

You are invited to take part in this research study. Participating in this research study is not the same as getting regular medical care. The purpose of this research study is to gather information that may be useful for the whole population in the future.

Before you decide you need to understand that all information about this study and what it will involve. Please take time to read the following information or get the information explained to you in your language. Listen carefully and feel free to ask if there is anything that you do not understand. Ask for it to be explained until you are satisfied. You may also wish to consult your parents, family members or others before deciding to take part in the study.

If you decide to join in the study, you will need to sign or thumbprint a consent form saying you agree to be in the study. You will receive a copy of this. Please note that it is your choice to take part and you can stop from taking part in this study at any time, if you so wish.

Why is this study being done?

The study is being done to explore the socio-cultural, economical, political, environmental, and health system factors that influences unplanned pregnancy among unmarried adolescents. It will also investigate your perceptions, experiences and challenges during pregnancy and as young mothers. The results of the study will be made available to the Ministry of Health and recommendations will be given aimed at improving the care delivery to adolescent mothers.

What does this study involve?

The study will involve in-depth interviewing of young women between the ages of 12-19 years who are unmarried, pregnant or have delivered within a year about the factors contributing to pregnancy among unmarried adolescents, how you see motherhood as well as

the socio-cultural situation in which you live. The interview will take about an hour and will be done in a private room in the clinic or any place of your choice. If you agree, a tape recorder will be used to assist in data capturing. This study has nothing to do with your antenatal care and not wishing to participate will not affect the services you receive from the health care providers.

If the research study needs to be stopped, you will be informed and you will have your normal antenatal care.

What harm or discomfort can you expect in the study?

No harm is intended because of the participation in the study, but I do acknowledge the sensitivity of the subjects to be discussed.

What benefits can you expect in the study?

There is no knowledge about the situation of adolescents' pregnancy in the Gambia so the study will provide bases for future planning and to develop a strategy for intervention. This might benefit you and all unmarried adolescents who have experienced and those who have not yet pregnancy and childbirth.

Will you be compensated for participating in the study?

You will not get paid for participation, but you will get the costs for the transport reimbursed.

Are there other products or treatment?

There is no other product or treatment in the study.

What happens if you refuse to participate in the study or change your mind later?

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. This will not have any consequences on the quality of care that you are supposed to receive. If you agree to participate at this time, you may later on withdraw your consent without your treatment being affected in any way.

If you agree to participate in the study, you are entitled to have access to what information is registered about you. You are further entitled to correct any mistakes in the information we have registered. If you withdraw from the study, you are entitled to demand that the collected

data are deleted, unless the data have already been incorporated in analyses or used in scientific publications.

Should any new information become available during the study that may affect your participation, you will be informed as soon as possible.

How will personal records remain confidential and who will have access to it?

All information that is collected about you in the course of the study will be kept strictly confidential. The data that are registered about you will only be used for the purpose of the study as described above. All the data will be processed without name, ID number or other directly recognisable type of information. A code number will link you to your data through a list of names. Only authorised personnel will have access to the list of names and be able to identify you.

As far as possible, all attempts will be made to publish the result in such a way that it will not be possible to identify you in the results of the study when these are published.

Your personal information will only be available to the study team members and might be seen by some rightful persons from the Ethics Committee, Government authorities and sponsors.

Who should you contact if you have questions?

If you have any queries regarding the study you can contact Kumba Khan on 7774550/ 3774550, and you can always call these personal numbers given to you. If you have any concerns you can also contact staff at your health centre.

Please feel free to ask any question you might have about the research study.

Who has reviewed this study?

This study has been reviewed and approved by the scientific committee of the University of the Gambia, a panel of scientists at the Medical Research Council and the Gambia Government/MRC Joint Ethics Committee, which consists of scientists and lay persons to protect your rights and wellbeing.

CONSENT FORM

Participant Identification Number: |__|__|__|__|__|__|__|__|__|__|__|__|

_____

(Printed name of participant)

☐ I have read the written information **OR**

☐ I have had the information explained to me by study personnel in a language that I understand and I

- confirm that my choice to participate is entirely voluntarily,
- confirm that I have had the opportunity to ask questions about this study and I am satisfied with the answers and explanations that have been provided,
- understand that I grant access to data about me to authorised persons described in the information sheet,
- have received time to consider to take part in this study,
- agree to take part in this study.

Participant's signature/ thumbprint* | _____

Date (dd/mmm/yyyy) Time (24hr)

Printed name of impartial witness* _____

Signature of impartial witness* _____ _____

Date (dd/mmm/yyyy) Time (24hr)

Printed name of person obtaining consent _____

I have to the best of my knowledge explained the study information accurately in _____ to the respondent, and I attest that she has freely given consent to participate in the presence of the above named impartial witness (where applicable).

Signature of person obtaining consent _____ _____

Date (dd/mmm/yyyy) Time (24hr)

** Only required if the participant is unable to read or write.*

A copy of this informed consent document has been provided to the participant.

PARTICIPANT INFORMATION SHEET

Version Date

Study Title: Study Title: Unplanned pregnancy among unmarried adolescents in Urban Gambia

SCC:		Protocol:	

Sponsor: EECONPOP Project: Reproductive Health Care Cost, University of Oslo

What is informed consent?

You are invited to let your child take part in a research study. Before you decide, you need to understand why the research study is being done and what it will involve. Please take time to read the following information or get the information explained to you in your language. Listen carefully and feel free to ask if there is anything that is not clear or you do not understand. You may also wish to consult your spouse, family members, friends or others before deciding to let your child take part in the study.

If you decide to allow your child to join in the study, you will need to sign or put a thumbprint on a consent form saying you agree for your child to be in the study. You will receive a copy of this.

Why is this study being done?

The study is being done to explore the socio-cultural, economical, political, environmental, and health system factors that influences unplanned pregnancy among unmarried adolescents. It will also investigate the perceptions, experiences and challenges faced by these young mothers during pregnancy and child rearing.

The results of the study will be made available to your community

The results of the study will be made available to your community.

What does this study involve?

The study will involve in-depth interviewing of young women between the ages of 12-19 years who are unmarried, pregnant or have delivered within a year about the factors contributing to pregnancy among unmarried adolescents, how these young mothers see motherhood as well as the socio-cultural situation in which they live. The interview will take about an hour and will be done in a private room in the clinic or any place of their choice. This study has nothing to do with her antenatal/post or child care and not wishing to participate will not affect the services she received from the health care providers

If the research study needs to be stopped, you will be informed and your child will have the normal medical care.

What harm or discomfort can you expect in the study?
No harm is intended because of the participation in the study, but I do acknowledge the sensitivity of the subjects to be discussed.

What benefits can you expect in the study?
There is no knowledge about the situation of adolescents' pregnancy in the Gambia so the study will provide bases for future planning and to develop a strategy for intervention. This might benefit your child and all unmarried adolescents who have experienced pregnancy and childbirth.

Will you be compensated for your child's/ward's participation in the study?
You will not get paid for participation of your child in the study, but she will get the costs for the transport reimbursed.

Are there other products or treatment?
No

What happens if you refuse to participate in the study or change your mind later?
You are free to let your child participate or not in the study and you have the right to stop her participating at anytime without giving a reason. This will not affect the care that your child would normally receive.

Participation in the study is voluntary. You can withdraw your consent for the participation of your child in the study at any time and without stating any particular reason. This will not have any consequences for her future treatment. If you agree to participate at this time, you may later on withdraw your consent without her treatment being affected in any way.

Should any new information become available during the study that may affect your child's participation, you will be informed as soon as possible.

How your child's information will be kept and who will be allowed to see it?
All information that is collected about your child in the course of the study will be kept strictly confidential. Your child's personal information will only be available to the study team members and might be seen by some rightful persons from the Ethics Committee, Government authorities and sponsor.

Who should you contact if you have questions?
If you have any queries or concerns you can contact Kumba Khan on 7774550 or 3774550 and you can always call the personal numbers given to you. If you have any concerns you can also contact staff at your health centre or clinic.

Please feel free to ask any question you might have about the research study.

Who has reviewed this study?

This study has been reviewed and approved by the scientific committee of the University of the Gambia, a panel of scientists at the Medical Research Council and the Gambia Government/MRC Joint Ethics Committee, which consists of scientists and lay persons to protect your rights and wellbeing.

CONSENT / ASSENT FORM

Participant's Name _____

Participant's Identification Number: |__|__|__|__|__|_|__|__|__|__|

_____ **OR** _____

(Printed name of parent) (Printed name of guardian)

☐ I have read the written information **OR**

☐ I have had the information explained to me by study personnel in a language that I understand and I

- confirm that my choice to let my child participate is entirely voluntarily,
- confirm that I have had the opportunity to ask questions about this study and I am satisfied with the answers and explanations that have been provided,
- understand that I grant access to data about my child to authorised persons described in the information sheet,
- have received time to consider to let my child take part in this study
- agree to allow my child take part in this study.

Tick as appropriate

I agree to further research on my child's samples as described in the information sheet Yes ☐ No ☐

Participant's signature/ thumbprint* for **assent** (child aged 12-17 years) ☐

_____
Date (dd/mmm/yyyy) Time (24hr)

Participant's parent/guardian signature/thumbprint* ☐

_____
Date (dd/mmm/yyyy) Time (24hr)

Printed Name of Person obtaining consent _____

I attest that I have explained the study information accurately in _____ to, and was understood to the best of my knowledge by, the participant/parent/guardian and that he/she has freely given consent to participate *in the presence of the above named impartial witness (where applicable).

Signature of Person obtaining consent _____ _____
Date (dd/mmm/yyyy) Time (24hr)

Interview guide for in-depth interview

1. Demographic data:

   Age (in years)…….

   Ethnic group …….

   Ever attended formal school? Yes/No

   If yes, Highest level of education ……

   Religion ……..

   Parity ……
2. What is the structure (set-up) of the family you come from? (Extended /Nuclear /single parent family?)
3. Who provides for the family?
4. What is your opinion about the family's earnings capacity with regards to taking care of the family's basic needs?
5. Can you describe any extended responsibility you undertake (e.g. income generation) for your family?
6. Before you got pregnant what /how was life like for you?
7. What was your own experience on talking about sex, sexuality and reproductive health?
8. Some people find it difficult to talk to their parents about sex, sexuality and reproductive health, what is your experience on this before you became pregnant as compared to now?
9. Where do young people in the Gambia get information about sexual and reproductive health? What is your opinion about that?
10. Where do unmarried adolescents access services to avoid pregnancy and how?
11. Why do think young girls in The Gambia become pregnant?
12. What are your views about pregnancy among girls who are not married?
13. Tell me about your relationship with your partner, what type of relation was it?
14. When you realized that you were pregnant, what were your main concerns and worries?
15. What were the reactions of your family when they realized that you were pregnant?
16. Think about the time you were pregnant what were some of the challenges you faced? How do you manage to cope with these challenges?

17. Many young girls who become pregnant out of wedlock seek to destroy or remove the pregnancy, what motivated you to carry the pregnancy to term?
18. Now that you are a mother how has life changed for you?
19. What is your opinion about having a baby and throwing him/her away?
20. In your opinion how is an unplanned pregnancy or sexually transmitted infection avoided?

INTERVIEW GUIDE FOR IN-DEPTH INTERVIEW (WOLLOF)

1. Demographic data:

   Nyata att nga am?.....

   Lui sa het?/ Si ban het nga buka?.....

   Mus nga gangeh nasaran? Waaw/ dedet

   Sudeh waaw, fanla sha gangeh emm?.....

   Ban deneh nga boka?.....

   Nyata doom nga am?.....
2. Si ban fason family/ keur nga jogea? (keur bu mak/ keur bu ndaw/ ku saiut)
3. Ku amea keur bi?/ Kan mor deh depance keur bi
4. Lui sah halat ci nyata ci halis la keur bi di am purr yoreh dunduh njobot?
5. Mun nga ma wahma sah yenen warugal (legai) ci keur bi?
6. Bala ngai dorn birr/ naka nga dorn dudeh? Nakala keur melon
7. Lan mo neka sah experience ci wah mbiri sai ak jurr?
8. Halay you bari dange deh am jafehjafeh purr wahtan ak sen wa jurr ci aferi sai, luisah experience bala ngai birr bobah ak lagi?/ Nakala yormbeh won pur nga wahtan ak sa wa jurr ci aferi sai
9. Fanla halea yi ci Gambia deh hameh aferi sai?/ ameh hebarr ci mberri sai? Lui sah halat ci lolu?
10. Fanla halea yu saiut deh ameh lulen di arr ci birr ak naka?
11. Lui sah halat ci lutah halea yu jigane ni deh omba ci Gambia?/ lutah nyudeh birr?
12. Lui sah jisjis si halay yu jigane you deh birr the saiut?/ birr feka moung jekarr
13. Wah ma sah diganteh ak sah partner/ andahndorr bi, lunekon sain dianteh/ sen diganteh num mel?
14. Bunga hamea neh birr nga lunekon sah titange ak halat bu nyeka?
15. Sah wa keur lunge def bunge hamea neh danga birr?
16. Halatal bunga birreh lu nekon sah yenen jafejafe? Naka nga def beh rombah ak jafejafe yoyu?
17. Haleh yu bari birr nange teh yaha/ genneh birr bi, lula nyagh beh nga contineh sah birr bi?
18. Lagi neka nga yay, naka lah sah dundah waychekur/ chanze?
19. Lui sah halat si nyui am dome bepareh ngu sanikoh?
20. Si sa halat naka nga muna moitoo omba boo parellut wala jagoroh yuiwalay si saye?

INTERVIEW GUIDE FOR IN-DEPTH INTERVIEW MANDINGKA

1. Demographic data:

   Yea sangi jelu leh soto?…….

   Menemu ila sio ti? …….

   Ineneh tata carangee bugoto? Haa/ hanii

   Naya tara ko wolum, ila karanyo makamo danta munto leh?……

   Munemu ila dino ti? ……..

   Ya ding jalu laa soto?……
2. Ebota dimbaya siifa nyadi lehkono? (sue baa/ sue nding/ mussu kentango)
3. Jama leka dimbaya balundi?
4. Ela miroto alla korrda aka sulah kodo jelulela purr ka dinbaya balundi?
5. Yea munge sashi leta dinbaya la balundoto?
6. Janni ebeh kono soto la ila baluo benung nyadi leh?
7. Menemu inla experience purr ka futu kuwoo katcha aning din soto?
8. Dindin jam ka koleya sorto purr keh katcha eni la wululan ming beh dending kewoo ning muso taama nunto ning sanyi?
9. Gambian dindingol ka kibaro soto mintoleh ming beh dending ka sunku ndinyol tanka kono ma juno la? Menemu ila mira lo wokuwoto?
10. Iteh yalong sungkutun ndinyo nyanta kata mintoleh kaferole tar minge sa tanka konomaa junolah?
11. Meneh kasabuh foh sunkutun ndinole ka konoma junna Gambia kono?
12. Menemu ila mira loto mim beh dending sunkutun ndingol ming kah konoma asa tarra imang futu?
13. Mineh beh tehma ning kambano ming yaa kono mandi?
14. Biring yalong yakono taa mineh keta ela jakalooti?
15. Ela sue kono moly eh muneh keh biring ya longko konobelah?
16. Emirah kabiring ekonoma ta menemu ela kolehya aning jakal kuwo ti? Yae wo tambindih nyadi?
17. Sungkutu jama leke la kono tinya, muneh yatina etah mayta tinya?
18. Sanyi dinnyo beh bulu ela baluwo beh nyadileh?
19. Menehmu ela mirah loto ka dinyo wulu fokah pareh ya faye?
20. E lla miralotoo mo nyantamunehkella kafang tanka konola a satara amang pareh wala kuran ngo ming ka soto futuwotoo.