Unmet Need for Family Planning in the Foni Region, a rural part of The Gambia:

a qualitative in-depth interview study

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Abstract

Background

This thesis explores the use of contraceptives in the Foni Region. There are different types of contraceptives that should be available; implants, injections, pills, male/female condom, IUD, and male/female sterilization. The most used contraceptive differs between the unmarried and married women, but the two most common types used are implants and injections.

Method

This is a qualitative study with face-to-face semi-structured interviews. The interviewees were health care workers from the five districts of Foni, recruited from different health centers and the hospital. They were both provided with an information sheet (appendix 1) and consent form to sign (appendix 2) in advance of the interview. The sample size depended on when we reached data saturation, where we ended up with a total of 17 participants.

Results

According to the interviews, most of the women seeking family planning are married. Their ages are mostly between 20-35 years. Our study revealed that the husband's role in the decision-making process is important, which affects the choice of use. The use of contraceptives can also benefit the maternal and child health care, and they mainly use it to space their births. The knowledge regarding contraceptives in the rural parts of the Gambia is of varying quality, but the health care workers are improving on that area, to reach a larger portion of the population with information. When asking if they thought of the access of contraceptives as sufficient most of the staff (92%) at Bwiam General Hospital answered “yes”, while only 40% of the staff at the health centers agreed. Everyone at the health centers agreed that the use was insufficient, while BGH were more divided, with only 50% agreeing.

Conclusion

In this project thesis we have seen some positive aspects of the family planning service in The Foni Region. However, we have also revealed some areas in need of improvement, such as the attitude towards unmarried women, knowledge in the society, the religious beliefs, and the cultural norms. In addition, the interviews also issued the use of contraceptives as a bigger problem than the access. Even though, there are regional differences, with a significant poorer supply of contraceptives to the health centers compared with BGH.

Definitions and abbreviations

BTL	Bilateral Tubal Ligation
BGH	Bwiam General Hospital
BSc	Bachelor of Sciences
CBC	Community Birth Companion
CHN	Community Health Nurse
CMS	Central Medical Store
CPR	Contraceptive Prevalence Rate
GOG	The Government of the Gambia
HC	Health Center
IUD/IUCD	Intra Uteral Device/Intra Uteral Contraceptive Device
PHC	Primary Health Care
RCH	Reproductive and Child Health
RHD	Regional Health Directorate
RMNCAH	Reproductive Maternal, Newborn Child and Adolescent Health
RMS	Regional Medical Store
SBCC	Social Behavioral Change Communication
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendance
TFR	Total Fertility Rate
VDC	Village Development Committee
VHS	Village Health Services
VHW	Village Health Worker
VSG	Village Support Group
WHO	World Health Organization

Acknowledgements

Our sincere thanks to all informants and collaborators in The Gambia who have contributed to the development of this project thesis.

This endeavor would not have been possible without our supervisor Johanne Sommerchild Sundby. Thank you for all the help, both with the planning ahead of the trip, as well as the supervision throughout the writing period. We would also like to express our deepest gratitude to Mamady Cham, at that time Chief Executive Officer at Bwiam General Hospital. Thank you for your hospitality, and for making it possible for us to go through with our study at the hospital. A special thanks to Mr. Njagga Sarr and Mr. Mathew Bass for taking care of us during our stay at BGH. We would also like to acknowledge our driver Musa for safely transporting us in between the interviews. Lastly, we want to thank our co-supervisor Siri Vangen, and the staff at BGH and the health centers in the Foni region who made it possible for us to carry out the project in The Gambia. Thank you!

1. Introduction

Total fertility rate in the Gambia is still high despite a decline in TFR over the past 20-30 years (from around 7 to around 4) (1). Population growth exceeds growth in the economy, and more land areas to accommodate a large population is difficult. The pressure on resources (jobs, health care, education, housing and transport) is demonstrated by urban and overseas migration: young people's attempt to migrate, due to limited opportunities in rural areas, and lack of growth in the job marked. For families to grow out of poverty, the high dependency rate needs to be controlled. This must be achieved through a balanced effort between education (especially girls), public information and better access to services.

One major issue related to fertility control is the use of contraceptives. We found several publications emphasizing the importance of mapping this further, for instant these two nationwide studies:

“Multiple Indicator Cluster Survey” from 2018 (2): Stated that there was an unmet need for contraception in The Gambia

- 63% of unmarried and 27% of married women had an unmet need for contraception.
- Only 28% of unmarried and 17% of married women are using birth control.

"Gambia Demographic Health Survey" from 2019-2020 (1):

- Stated that the total demand for family planning among women is about 43%.
- 24% of currently married women have an unmet need for family planning.
- 45% of sexually active women have an unmet need for family planning.
- The Contraceptive Prevalence Rate (CPR) for modern contraceptive is estimated at 19%.
- The CPR has a stark regional variation. While the CPR is 22% in Banjul (urban area), the CPR in Upper River Region is just 8%. Looked from a different angle, while the Total Fertility rate is 3.1 in Banjul, it is almost 6 in Upper River Region. These statistics give the indication that unmet need for family planning might be greater in rural areas of The Gambia.

In addition, The Government of The Gambia (GoG) acknowledged the need to reduce the maternal mortality and recognized family planning as a key strategy to achieve this goal. This

is stated in the National Health Strategic Plan (2014 to 2020) (3) and the National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy (2017 to 2026) (4).

Also, Dr. Caroline Bledsoe (American anthropologist) did a field study in rural Gambia (Farafenni, 1992-95), which led to her doctorate degree and the book Contingent Lives (1999). This research addressed anthropological subjects of reproduction, time, and aging as culturally shaped within women's conjugal lives. Most women in the West use contraceptives in order to avoid having children. Bledsoe found that in rural Gambia and other parts of sub-Saharan Africa, many women use contraceptives for the opposite reason—to have as many children as possible. One of her unexpected findings was that modern, Western contraceptives were used most frequently by older women with little to no education. They were used infrequently and briefly to space children (5).

There has been little to no qualitative studies done in this field in The Gambia the last 20 years, and therefore we see a need to map out the possible current causes of the unmet need for contraceptives among Gambian women. By exploring the practices and cultural norms regarding family planning in The Gambia, we hope to gain a better understanding as to why there is an unmet need, as shown in the mentioned studies above. These findings can be used to improve the access to family planning. As family planning is a key strategy to reduce maternal mortality, this can contribute to improve the health of the people in The Gambia. It may also contribute to a better economic situation for families or individuals, making it easier to maintain a good health.

Our goal is that our research can be used to gain a better understanding of the current situation in rural parts of The Gambia. In addition to achieving a higher level of knowledge, we hope it can contribute to the development of measures to a better access to contraceptives for all.

Development aims would be to reduce infant and child mortality, reduce maternal mortality, prevent early pregnancies, earlier reproduction and obtain better spacing between pregnancies.

2. Background

2.1 The Republic of The Gambia

2.1.1 General facts

The Gambia is a republic in Western Africa, with the official name the Republic of The Gambia. The country lies along the Gambia River, and borders to the Atlantic Ocean in the West and is surrounded by Senegal in the North, East, and South. The Gambia is the smallest mainland country in Africa, with 10,689 km^2 (6). The population is 2.336 million as of 2018. The capital is Banjul, while the most populated cities are Serekunda and Brikama (7)

There are several ethnic groups in The Gambia, including Mandikas (34%), Fulas (22,4%), Wolofs (12,6%), and others (8). The official language is English, but tribal languages are commonly used. The main religion is Islam (95,5%) (8).

The Gambia has six regions: Greater Banjul, West Coast Region, North Bank Region, Lower River Region, Central River Region, and Upper River region, as shown in the picture below.

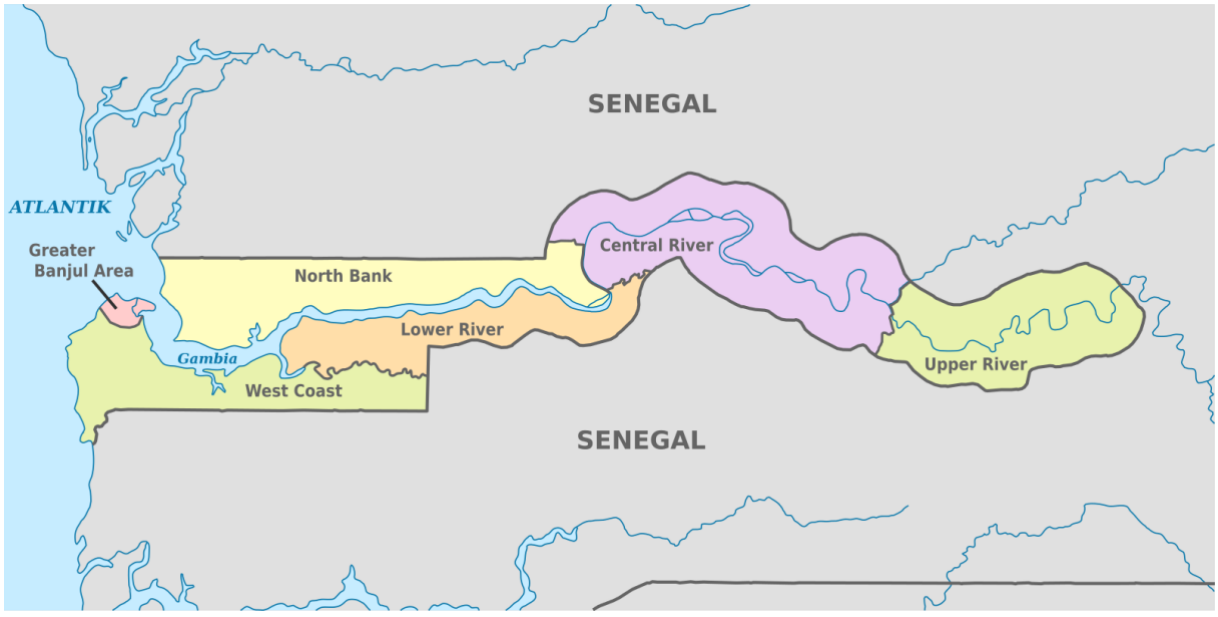

Figure 1: Regions in The Gambia

Available from: Wikipedia. *"Gambia, administrative divisions"* (Internet). (Updated 25/09/12, cited 03/01/2023) *https://it.wikipedia.org/wiki/File:Gambia,_administrative_divisions_-_de_-_colored.svg?fbclid=IwAR1K0GfxI9tu1eHcJc9TtgKSVX4VZsbwbRFNsrCOIDi9Zizg-Jtu8q80Z88*

2.1.2 Introduction to The Gambian Health Care System and the nurses function

The Gambian health care system is based on the three-tier system from 1980, inspired by the primary health care ideas developed by the Alma Ata initiative. The public health system consists of a primary, secondary, and tertiary level. These three levels will be further explained below.

The main basic health care provider in the Gambia is the nurse. To become a nurse or midwife there are different educational courses. There are four types of nurse training categories in The Gambia. First of all, they have the university education. This is a 3-year program where they become BSc (Bachelor of Sciences) nurses. The second option is within the Gambian College. This is also a 3-year training program where you become a Registered Nurse. Otherwise, you can go through the 2-year training program at the State Enrolled Nurse School, where you become an Enrolled Nurse. The fourth option is by the Community Health Nurse School. This is also a 2-year training program, where you get the title "Community Health Nurse" (9).

Each of these nurse training categories have midwifery programs that can be an extension of the nursing education. For the university education the extra course to become a midwife is for 2 years. In the Gambian College the course has a duration of 18 months, where it leads to a Diploma in Midwifery. Both the State Enrolled Nurse School and the Community Health school has an extra program for 1 year, which gives you the title "Enrolled Midwife" (9).

Doctors are also necessary for a functioning health system. To our knowledge, it's possible to study medicine in The Gambia. However, there are no current ways to specialize further without doing so in a neighboring country.

2.1.3 Primary level health services in the Foni Region

The primary level is referred to as Village Health Services (VHS) and consist of Community Birth Companions (CBC) and Village Health Workers (VHW). Often, these are the first point of contact with the health system. The CBC are mostly involved in community education of pregnant and lactating women but are not encouraged to conduct deliveries. The VHW treats common and minor health problems and conducts activities that are both health preventive and promotional. In addition, a trained Community Health Nurse (CHN) supervises Primary Health Care designated villages, and the VHS consists of a cluster of these. The Village

Development Committee (VDC) often supports the CHN in all Primary Health Care (PHC) villages across The Gambia. Presently, primary level health care also includes Outreach clinics and Community initiated clinics (9).

2.1.4 Secondary level health services in the Foni Region

The secondary level health services includes both minor and major health centers. The minor health centers have several reproductive maternal, newborn, child, and adolescent health (RMNCAH) services. This includes prenatal care, conducting deliveries, posts-partum care, and some in-patient services. According to national guidelines, a minor health center may have 20-40 beds per 15 000 people (9).

The major health centers provide the same services as the minor health centers, and additionally more advanced services in the same categories such as blood transfusions and cesarean sections. Minor health centers within the same health area can also refer patients here for more extensive care. Other services offered at major health centers are for example dental services and monitoring patients. Recently, some of the major health centers have gotten their status upgraded to District Hospitals. In accordance with national guidelines, a major health center may have between 110-150 beds for a population range of 150 000-200 000 (9).

2.1.5 Tertiary level health services in the Foni Region

The tertiary level consists of hospitals including General, Specialized and Teaching Hospitals. Hospitals provide higher level RMNCAH services greater than both Major health centers and District Hospitals. This is due to their higher capacity in terms of staff, equipment and other health care resources (9). Bwiam General Hospital (BGH) is the only tertiary level health facility in the Foni Region. BGH was established in 2003 and is one of seven public hospitals in The Gambia. It's located in Foni Kansala District in the West Coast Region. BGH provides health care services for the Foni area, parts of the Lower River Region and cross border communities in Casamance, a region south in Senegal. In March 2022, they served a population of over 70 000 only from the 5 districts of Foni (10).

The hospital has grown the last years due to increased equipment and the number of proficient health care workers. Today they have 8 wards in total: Reproductive & Child Health, OPD/A&E, Internal Medicine, Pediatric, Surgery, Ophthalmic, Obstetrics and Gynecology. In

addition they also have Laboratory, Radiology, Pharmacy, Physiotherapy, Dental and Sterilization services units (10).

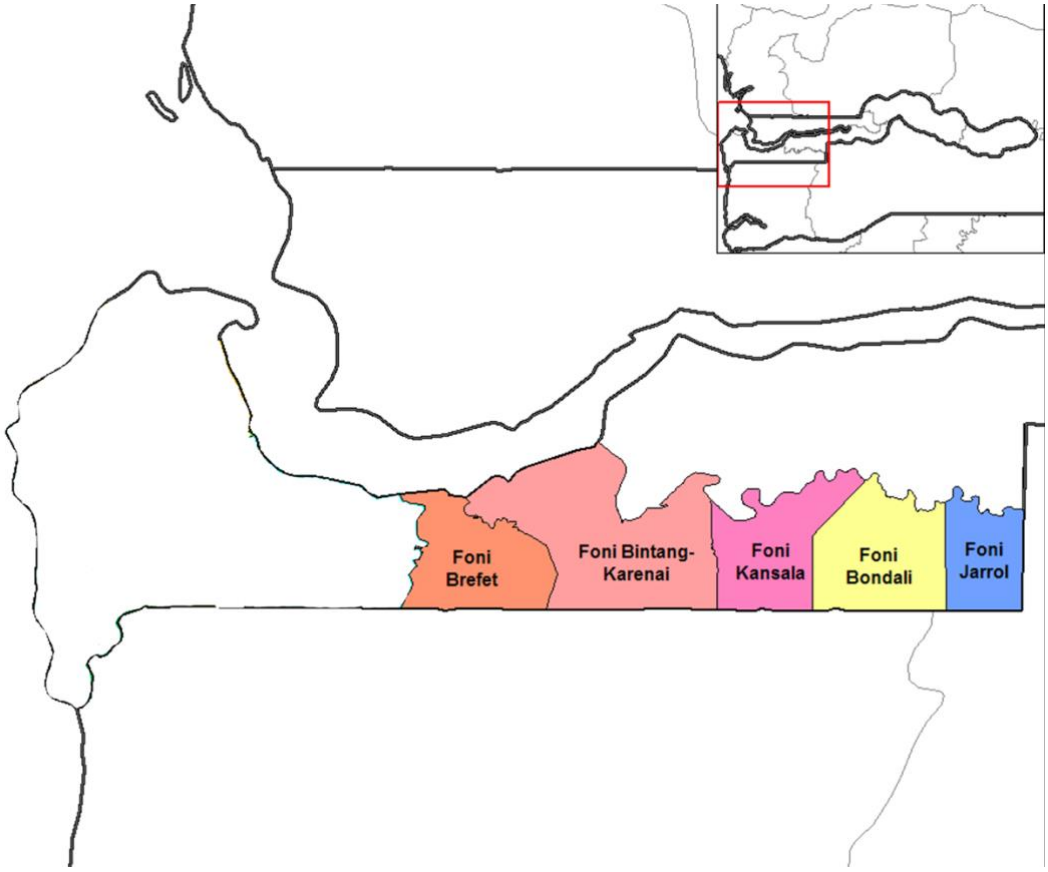

Figure 2: Division of the Foni Region, which takes part of the West Coast Region in The Gambia.

Available from: WikiWand. *"West Coast Division (The Gambia)"* (Internet). (Updated unknown, cited 03/01/2023) *https://www.wikiwand.com/en/West_Coast_Division_(Gambia)*

2.2 Different types of contraceptives used in The Foni Region

In principle, health programs in the Gambia offer a variety of contraceptive methods. In this chapter we will explain the different types of contraceptives, and the most used types in the Gambia.

2.2.1 Implant

Implanon® is an implant you can use for up to 3 years. You insert 1 implant from a preloaded applicator subdermally and it will release progestin frequently. Progestin is a synthetic progestogen which is a progesterone agonist, giving similar effect as progesterone. This contraceptive contains the progestin called "Etanogestrel". The release rate is about 60-70 µg/day the first weeks and will after that stabilize around 30-40 µg/day (11). Progestin is the main hormone in this birth control, and Implanon® is estrogen-free.

For a longer use of implant, they also prescribe ***Jadelle®***. Jadelle® is an implant for a maximum use of 5 years. This is a set of 2 flexible cylindrical implants that's inserted like a "V" in the upper arm, shown in the picture below (12). It contains "Levonorgestrel", a type of progestin. Just like Implanon®, its only composed of progesterone analogues, and no estrogen.

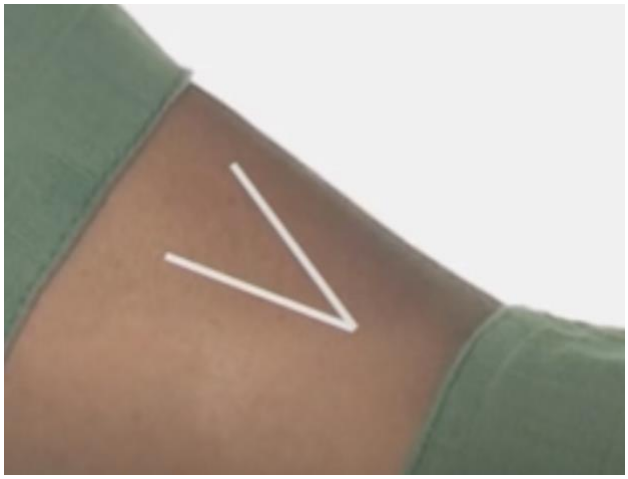

Figure 3: How the Jadelle® should be inserted.

Available from: YouTube. *"Jadelle inserted"* (Internet). (Updated 2018, cited 22/06/2022) *https://www.youtube.com/watch?v=XXRLSndJ-x4&ab_channel=DKTNIGERIA*

2.2.2 Injectable

The most used injectable is the ***Triclofem®***, which is a 3-month injection. This contains a progestin named "Medroxyprogesterone", which is the same as Depo-Provera®, used in Europe. The dosage is 1 mL with 90 days interval. This is a deep intramuscular injection, that can be administrated either in the gluteal muscle or in the deltoid muscle (13).

Figure 4: The injection Tricofem at BGH.
Available from: Private

Alternatively, you can use ***Noristerat®.*** This is a short-term injection, which will provide contraception for approximately 8 weeks. The dose is 1 ml containing 200 mg "Norethisterone", another type of progestin. It's an intramuscular injection, that should be given within the first days of the menstrual cycle, or soon after delivery or abortion (14).

2.2.3 Birth control pill/oral contraceptives

Microgynon: A birth control pill that contain both estrogen and progestin. It needs to be taken every day, approximately at the same time. A correct administration of these pills will lead to inhibition of ovulation and changes in the secretion from the cervix (15).

Microlut: these oral contraceptives only contain progestogen and is mostly known as the "mini-pill". When taken correctly, it will prevent pregnancy mainly by changing the secretion from the cervix; making it thicker so the semen don't reach the egg (16).

2.2.4 Male condom

The male condom is worn on the penis and makes a barrier between the penis and the vagina. It's made of thin latex (rubber), polyisoprene or polyurethane, and its purpose is to collect the semen. The condom is the only contraception that both prevent pregnancy and STI (17).

2.2.5 Female condom

The female condom will also protect against STI, in addition to prevent pregnancy. This is worn inside the vagina, and the purpose is to collect semen, and stop it from getting in contact with an egg (18).

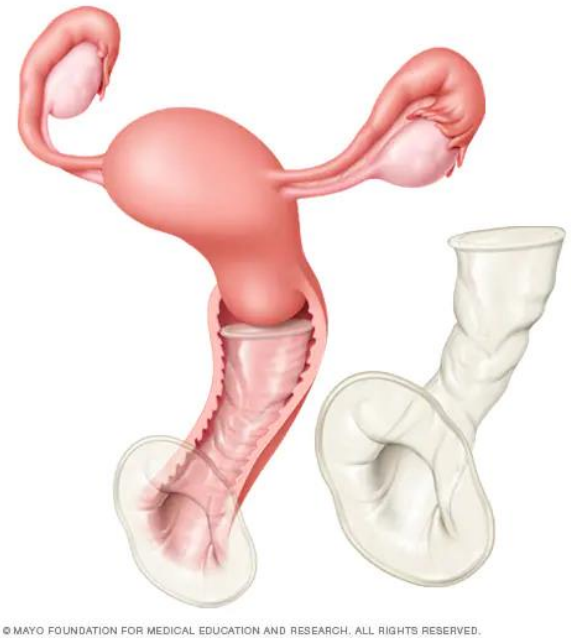

Figure 5: Illustration of the female condom.

Available from: Mayo Clinic. *«Insertion of a female condom"* (Internet). (Updated 2019, cited 03/01/2023) *https://www.mayoclinic.org/healthy-lifestyle/birth-control/multimedia/insertion-of-a-female-condom/img-20006788*

2.2.6 Intra uteral device (IUD)

It's a T-shaped, small, and flexible device that competent health care worker can insert into the uterus. Its two types available:

- **The copper IUD:** it releases copper which makes it harder for the sperm to reach the egg. It can be used for between 5-10 years (19).
- **The hormone IUD:** it releases progestogen to prevent pregnancy. It will both make the mucus in the cervix thicker, which will make it harder for the sperm to reach the egg, but also, stop the ovulation. It can be used between 3-5 years, depending on which device you choose (20).

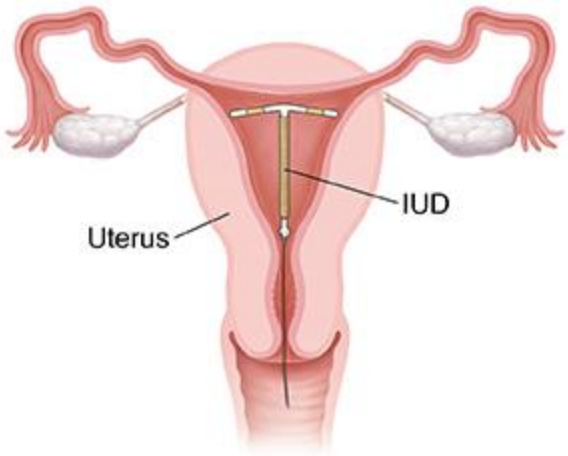

Figure 6: Illustration of the IUD.

Available from: Mount Nittany Health. *"IUD (Intrauterine Device), Birth control"* (Internet). (Updated 08/05/ 2021, cited 03/01/2023) *https://mountnittany.org/wellness-article/iud-intrauterine-device-birth-control*

2.2.7 Female sterilization

We have two types of female sterilization:

- **Bilateral tubal ligation (BTL):** A surgical procedure where you remove or put clips on the fallopian tubes. In that way, you cut the connection between the ovaries and the uterus, and therefore prevent fertilization (21).
- **Hysterectomy:** A surgical procedure where you remove the uterus. You will then lose the ability to get pregnant, and no longer have menstruation (22).

2.2.8 Male sterilization

Male sterilization, also called vasectomy, is a surgical procedure where you cut or seal the ducts that transport the semen. This type of contraceptive is permanent, and it's estimated to be more than 99% effective (23).

2.2.9 Most used contraceptive methods in The Gambia

The Gambia DHS 2019-20 Survey described the use of family planning in The Gambia. 17.1% of married women, and 41,4% of sexually active unmarried women were using any modern contraceptive method (age 15-49). The most used contraceptive methods among married women were injectables (8.1%), and implants (5,5%). For sexually active unmarried women the most used contraceptive methods were implants (19,9%), and injectables (10,9%) (1). The data collection was gathered from all the local government areas for married women, while it was only done in urban areas for unmarried sexually women, which may affect the results.

Another report that maps out the use of different types of family planning is Final Service Statistics Report 2021 from MoH (Ministry of Health, Gambia). This does not distinguish between married and unmarried, but instead shows the most frequently used family planning methods by brand names. The report states that depo was most used in 2021 with 55,5 %. Implanon and Microgynon were the second most used (24).

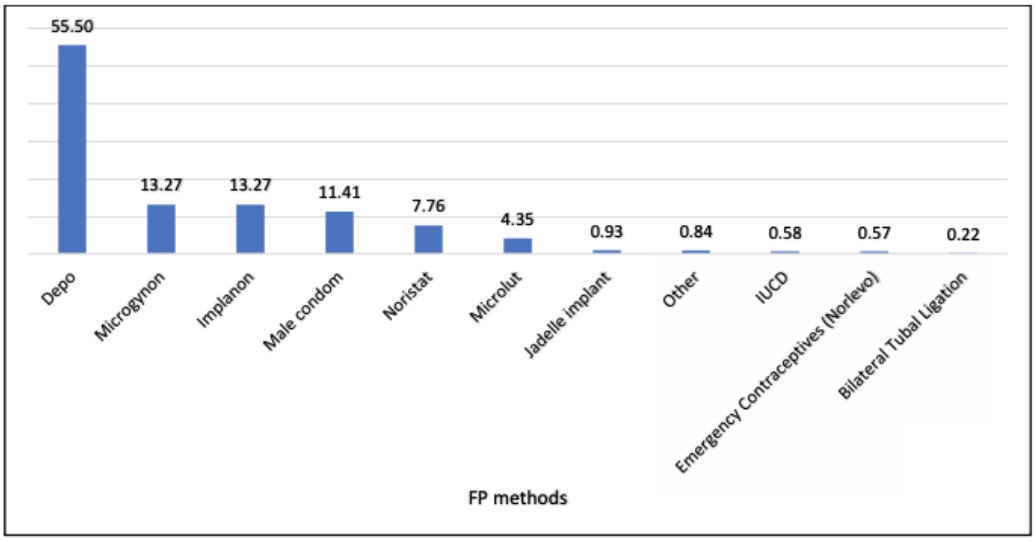

Figure 7: Percentage of the most frequent family planning usage by commodity in The Gambia, 2021.

Available from: Ministry of Health (MoH). Final Service Statistics Report 2021. The Gambia; 2021 p. 90.

2.3 Research objectives

- Get to know the process for acquiring contraceptives
- Discover the most used family planning methods
- Get an understanding on which groups who normally seeks out to the family planning provider
- Understand the husband's role in the decision of contraceptives
- Explore how contraceptives are linked to maternal and child health care
- Reveal the inhabitant's knowledge regarding contraceptives
- Get a broader understanding on how religion affects the use of contraceptives
- To explore the barriers to sufficient access of contraceptives in the Foni Region
- To explore the barriers to sufficient use of contraceptives in the Foni Region

3. Method

This qualitative research with 17 face-to-face semi-structured interviews was carried out in the Foni region of The Gambia. The participants of the interviews were health care workers with different educational backgrounds, where the majority were midwives. All health centers including Bwiam General Hospital within the five districts of Foni (Foni Jarrol, Foni Bondali, Foni Kansala, Foni Berefet and Foni Bintang) was conveniently included in this study. While the interviews were done in the Gambia, the analysis of the data and the writing of our thesis has taken place in Oslo, Norway.

3.1 Permission for conducting the study

The Faculty of Medicine at the University of Oslo approved the project before its start. Ethical clearance for the project was given by the Scientific Coordinating Committee (SCC) and Ethics Committee of The Medical Research Council (MRC) Unit the Gambia. In addition, The Norwegian center for research data (NSD) approved the project.

Permission to conduct the study at Bwiam General Hospital (BGH) was given by the Chief Executive Director, Dr. Mamady Cham. Administrative staff at BGH contacted health centers on our behalf to get permission to carry out the interviews, and scheduled time with the available staff.

3.2 Participants of the interviews

Health care workers at health centers in the Foni region and at BGH working in antenatal care, obstetrics, postnatal care, and gynecology was included in the study. This implies that personnel/staff with different professions and educational backgrounds were interviewed.

The health care workers were conveniently recruited from BGH and health centers in the Foni. Given the inadequate staffing situation in the rural located health facilities in the Gambia, not all the staff were in post providing services. Therefore, only available staff was interviewed. The age of the interviewees includes health workers from the age of 20 years and above. In our opinion within Gambian laws, these age groups can consent on their own. Both sexes were included as we are aware in The Gambia there are male and female health care workers providing Reproductive Health Services including family planning. Consequently, it was advisable to include both sexes in the study.

As stated above, participants were recruited from the local health centers in the five districts of Foni. This is because, though the dominant residents in the Foni region are the Jola tribes, we are also aware that other tribes (Fullanis, Wollofs, Mandinkas) are sparsely resident in the different districts. These tribal differences can be a factor. To cater for these differences, it is wise to include the facilities in these districts.

3.3 Recruitment procedure

The recruitment for the thesis was carried out with two different approaches, one for health care workers at the hospital, and another one for those working at the health centers.

At BGH, we introduced us to the staff at the Maternity ward. After some days of getting to know the work environment and routines we approached potential candidates during working hours. After the study background was explained, we invited the candidate to participate in the study. The information sheet was provided to read (Appendix 1). He/she were then given the time to ask questions, and they were answered by us. If he/she decided to participate, we scheduled a time and place for the interview. At the time of the interview, the participant was given the consent form to sign (Appendix 2).

Whereas for the health care workers at the health centers, the initial contact was not done directly by us. Since the health centers are scattered in the Foni region, staff in the administrative department of BGH helped us contact them beforehand. They called, gave an introduction of the study, and asked if we were permitted to interview the staff. If they gave their consent, we arranged a date and travelled to the given location. From here, the procedure was done as explained above with the information sheet, opening for questions, and signing of the consent form.

Participation in this study was voluntary and free from any form of coercion. The information sheet and consent form for the health care workers were in English, as this is the language the interviews were conducted in. None of the participants were illiterate and all could speak English.

3.4 Sample size

Our sample size was not specified before the interviews started as it was dependent on when we reached data saturation, since we weren't looking for statistical power. The expected interval was between 10-20 participants. We ended up with 17 participants, reason being that no new themes emerged during the interviews. Therefore, data saturation was achieved after circa 17 interviews.

3.5 Content of the interviews

The interviews were semi-structured, based on an interview guide (Appendix 3). All the participants were asked the same set of questions from different categories. However, they received different follow-up questions based on their answers. Therefore, during the interviews some different topics were brought up, while the main themes were the same. As a result, the interviews lasted from 20 to 53 minutes as the participants had different levels of additional information.

The interviews were conducted in a private room. One of us were in charge of asking the questions from the interview guide, while the other took written notes. Both asked additional questions. We alternated these roles during the interview period. The interviews were recorded, and afterwards we transcribed all the interviews.

3.6 Peer reviews

Fatou Jatta and Hassan Njie, both Gambian researchers currently working at The University of Oslo, provided peer/independent scientific reviews of the project.

4. Results

4.1 The health care workers interviewed

The following tables shows the distribution of the participants workplace, and the participants' educational level.

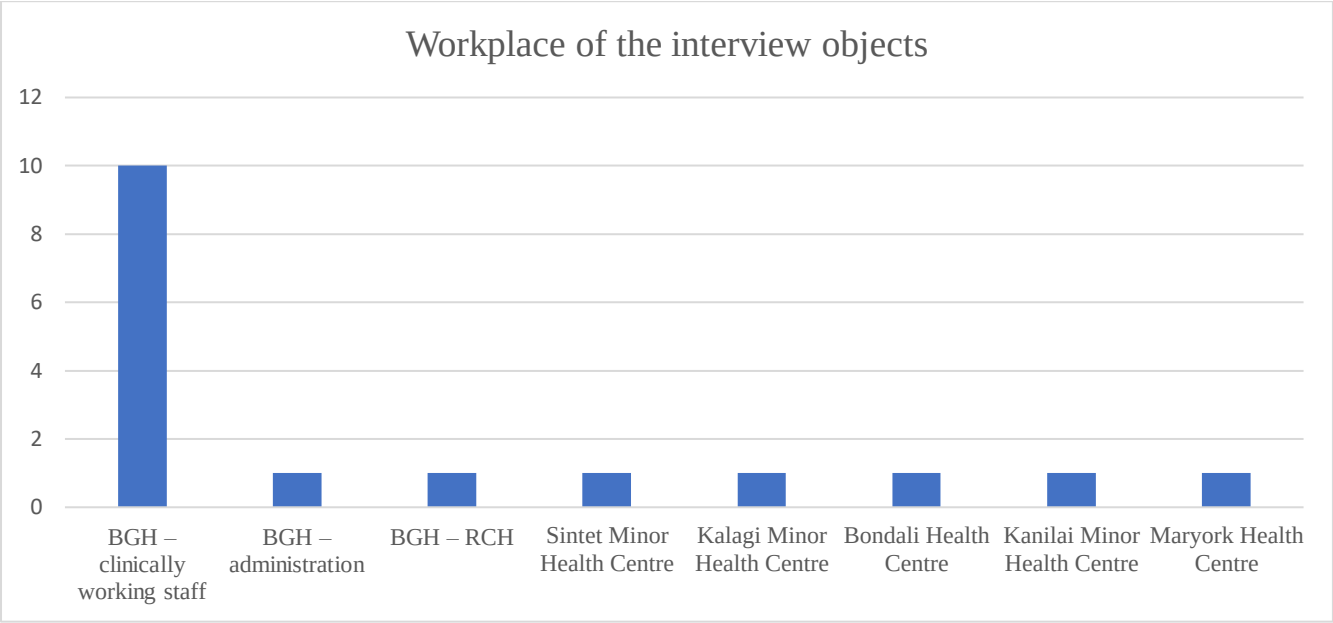

Figure 8: The bar chart above shows the different workplaces of the interview objects. Most of the collected data was done at BGH, since that is where most people are employed. At the health care centers we interviewed available staff working with contraceptives.
Available from: Private.

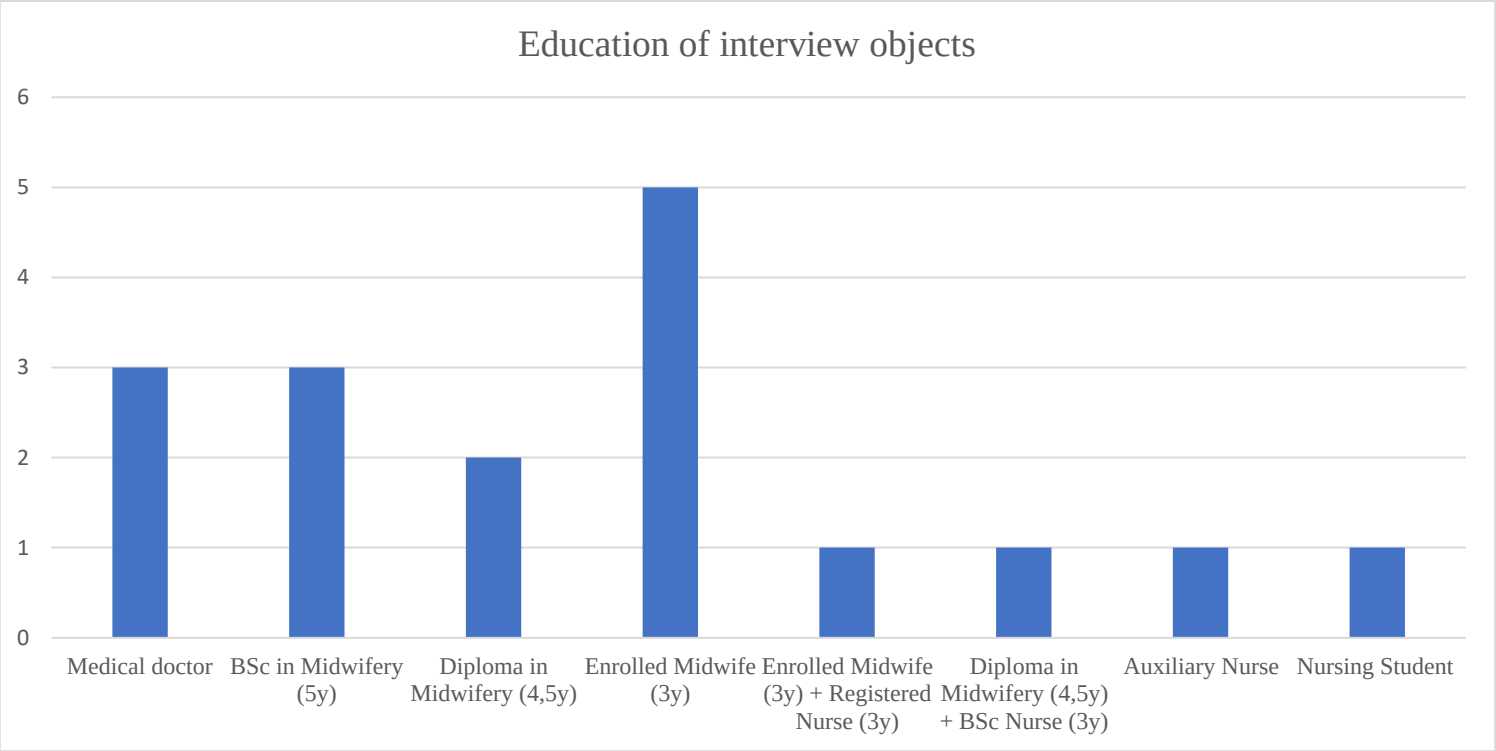

Figure 9: The bar chart above shows the education of the different interview objects. The majority were medical doctors and different types of Midwifes, while we also interviewed 1 Auxiliary Nurse and 1 Nursing Student. *Available from: Private.*

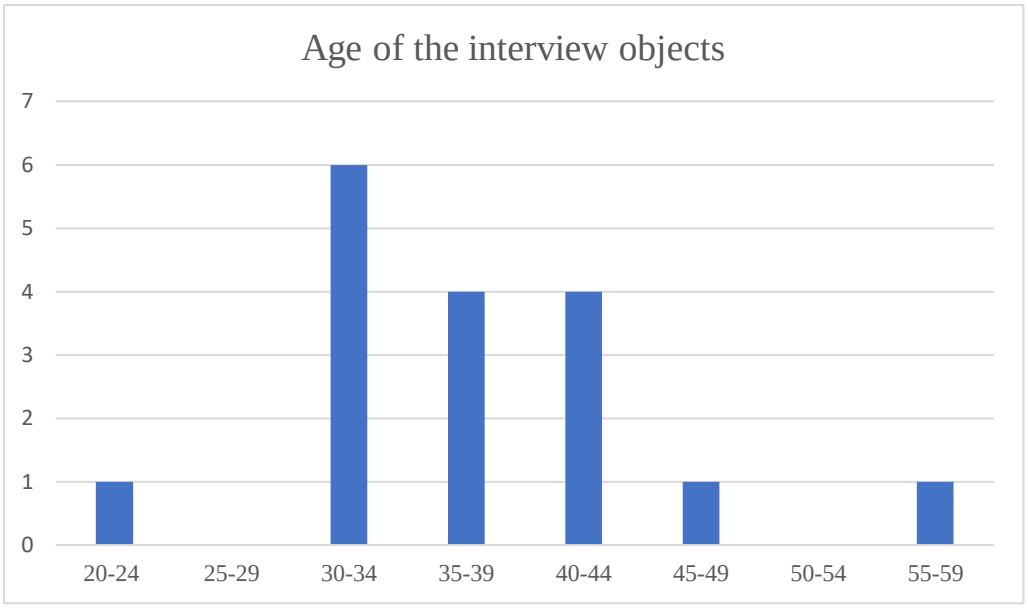

Figure 10: The bar chart above shows the age of the interview objects. We included health workers from the age of 20 and above. The majority was from 30-44 years old. *Available from: Private.*

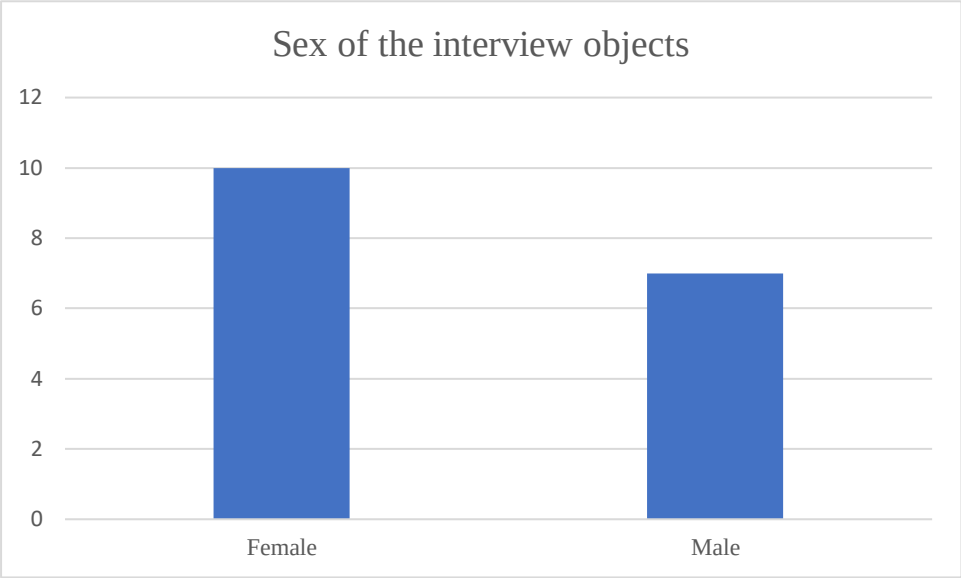

Figure 11: The bar chart above shows the sex of the interview objects. Both male and female health workers were included, and there was approximately the same amount included from each gender.
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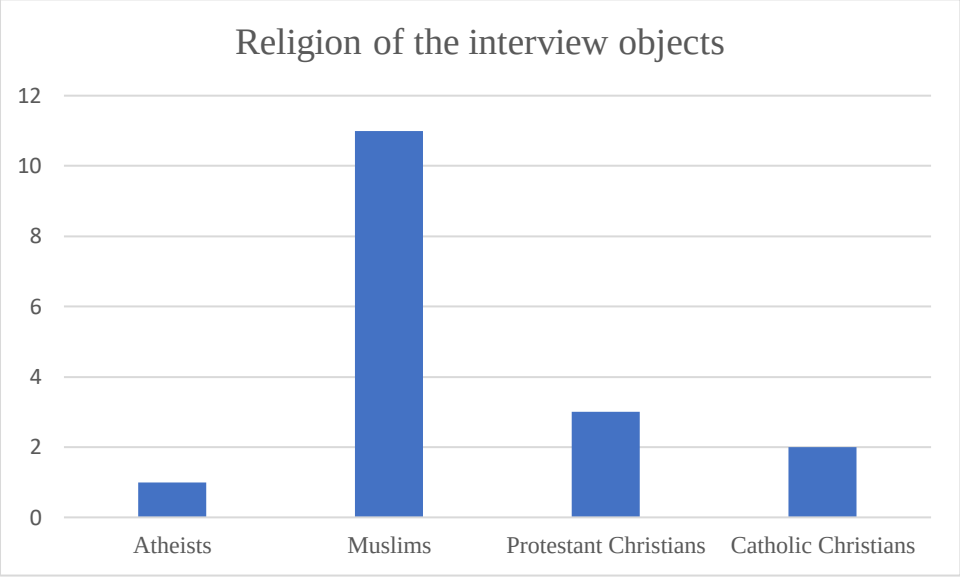

Figure 12: The table above shows the religion of the interview objects. The majority are Muslims, as expected since Islam is the main religion of The Gambia. In addition, we also interviewed some Christians, both Protestant and Catholic, and an atheist.
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4.2 Process for acquiring contraceptives

All the health care workers included in the study were asked about the process from when a woman enters the health center, until she has gotten the contraception she wants. The general impression from all the interviews were similar. The client is asked a set of questions from the family planning record card (the pink card shown below). They are then given information about the different kinds of contraceptives and are encouraged to make a choice based off their own personal preference. After they receive their choice of contraceptives, an appointment card is filled out to plan the next appointment. The results from the different parts of the process are listed below.

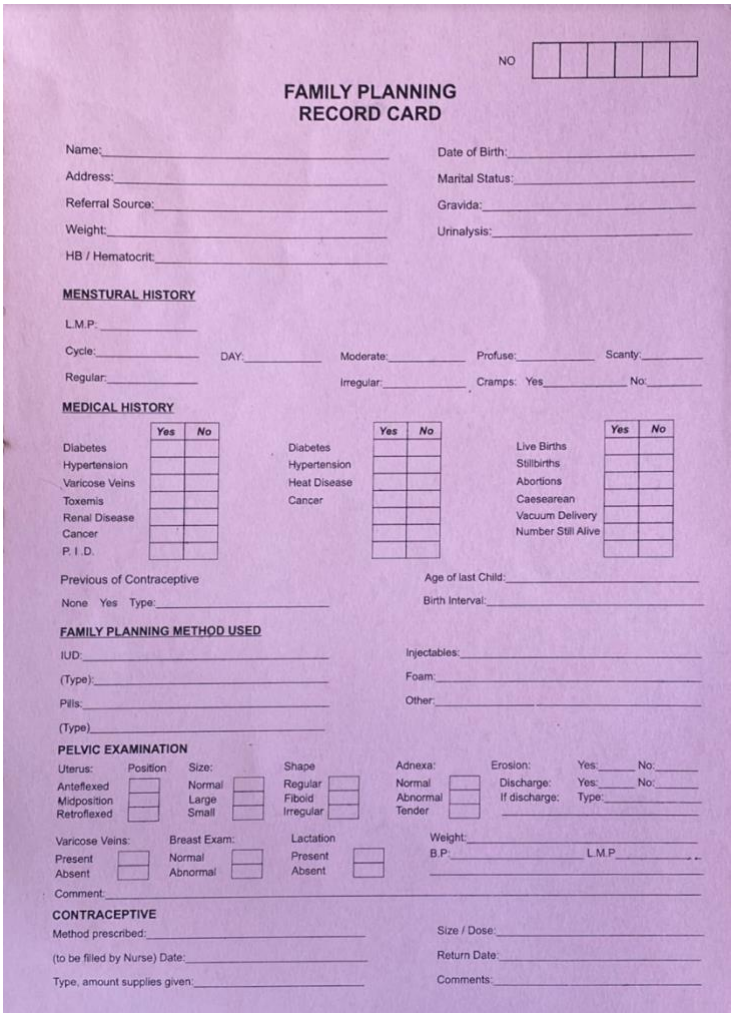
4.2.1 Guidelines used in the consultation

The following guidelines are both used in BGH and the health centers:

The consultation starts with filling out the **Family planning record card.** They are asked a series of personalia, including marital status and numbers of pregnancies. One of the health care workers stated that they were especially interested in: “The number of gestations, if she’s been pregnant before, how many kids she has now, about obstetric history, when was the last delivery”. “The next step is to ask if your partner, your husband, is aware about it. You give it (contraceptives), whether the husband know about it or not, but it’s just to know”. They always want to know the husband point of view as well.

Then they map out the menstrual history and ask when they last had their period. It’s also important to exclude the presence of other medical diseases. Thereafter, they’re asked about family planning methods used before. At specific indications they also do a pelvic examination. This must be done by a doctor, often done when a woman suffers from bleeding or pain related to the use of contraceptives.

In addition, they’ll also take the vital signs, especially the blood pressure and the weight. “Anyone with high blood pressure cannot take depot”. This will also be relevant for the other types of contraceptives containing hormones.



NO

FAMILY PLANNING RECORD CARD

Name:_____ Date of Birth:_____

Address:_____ Marital Status:_____

Referral Source:_____ Gravida:_____

Weight:_____ Urinalysis:_____

HB / Hematocrit:_____

MENSTURAL HISTORY

L.M.P:_____

Cycle:_____ DAY:_____ Moderate:_____ Profuse:_____ Scanty:_____

Regular:_____ Irregular:_____ Cramps: Yes_____ No:_____

MEDICAL HISTORY

	Yes	No
Diabetes		
Hypertension		
Varicose Veins		
Toxemis		
Renal Disease		
Cancer		
P. I. D.		

	Yes	No
Diabetes		
Hypertension		
Heat Disease		
Cancer		

	Yes	No
Live Births		
Stillbirths		
Abortions		
Caesearean		
Vacuum Delivery		
Number Still Alive		

Previous of Contraceptive

None Yes Type:_____

Age of last Child:_____

Birth Interval:_____

FAMILY PLANNING METHOD USED

IUD:_____ Injectables:_____

(Type):_____ Foam:_____

Pills:_____ Other:_____

(Type)_____

PELVIC EXAMINATION

Uterus: Position: Anteflexed, Midposition, Retroflexed

Size: Normal, Large, Small

Shape: Regular, Fiboid, Irregular

Adnexa: Normal, Abnormal, Tender

Erosion: Yes:____ No:____

Discharge: Yes:____ No:____

If discharge: Type:_____

Varicose Veins: Present, Absent

Breast Exam: Normal, Abnormal

Lactation: Present, Absent

Weight:_____

B.P:_____ L.M.P_____

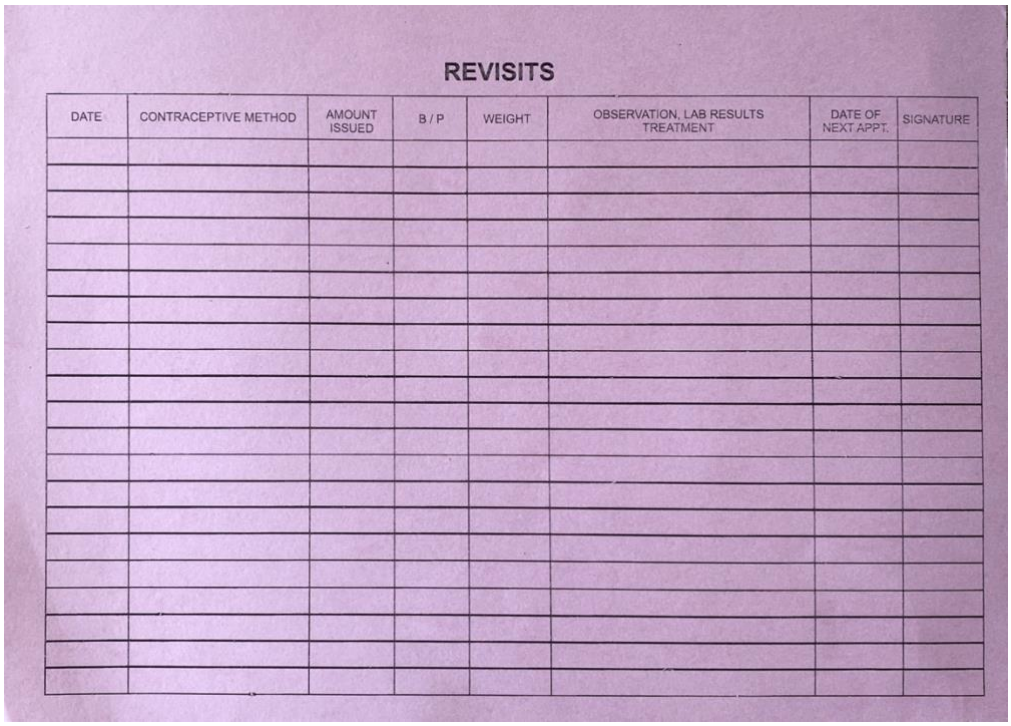
Comment:_____

CONTRACEPTIVE

Method prescribed:_____ Size / Dose:_____

(to be filled by Nurse) Date:_____ Return Date:_____

Type, amount supplies given:_____ Comments:_____



REVISITS

DATE	CONTRACEPTIVE METHOD	AMOUNT ISSUED	B / P	WEIGHT	OBSERVATION, LAB RESULTS TREATMENT	DATE OF NEXT APPT.	SIGNATURE

Figure 13: Family planning record card used in the consultation with the women.

Available from: Private

The family planning provider should then present the options of contraceptives. She will show the overview below and explain the use of the different types. “You counsel the side effects, disadvantages and advantages of the FP, and then allow her to make her own choice”. They make it clear in the consultation that they only will give information, and “that they don’t choose for them”. They are shown the different types available and will make a choice based on the information given in the consultation.

Figure 14: Overview of the contraceptives used at the Family planning clinic, BGH.
Available from: Private

Figure 15: The family planning providers at BGH showed the available types of contraceptives at the health facility and explained the use to the clients.
Available from: Private

Before they give out the contraceptives the family planning provider will make sure that the woman is not already pregnant. If the woman is on her period, she can prove it by showing it on a cotton. Otherwise, most of them need to go to the lab and take a serum HCG to rule out a pregnancy. If the test is negative, the chosen contraceptives are given to them. It's important to verify a pregnancy because some claim "have that believe that if you take FP when you are pregnant, you can abort it."

At the end of the consultation, they will be given an **Appointment card.** The purpose of this card is to schedule the next appointment. Normally, the woman will take the card home to remember the next date. However, many of the women leave the card at the family planning office. This is because they are afraid of the husband finding out they're using contraceptives. Therefore, they leave the card in the office, and seeks out the family planning provider if they have question about the next appointment.

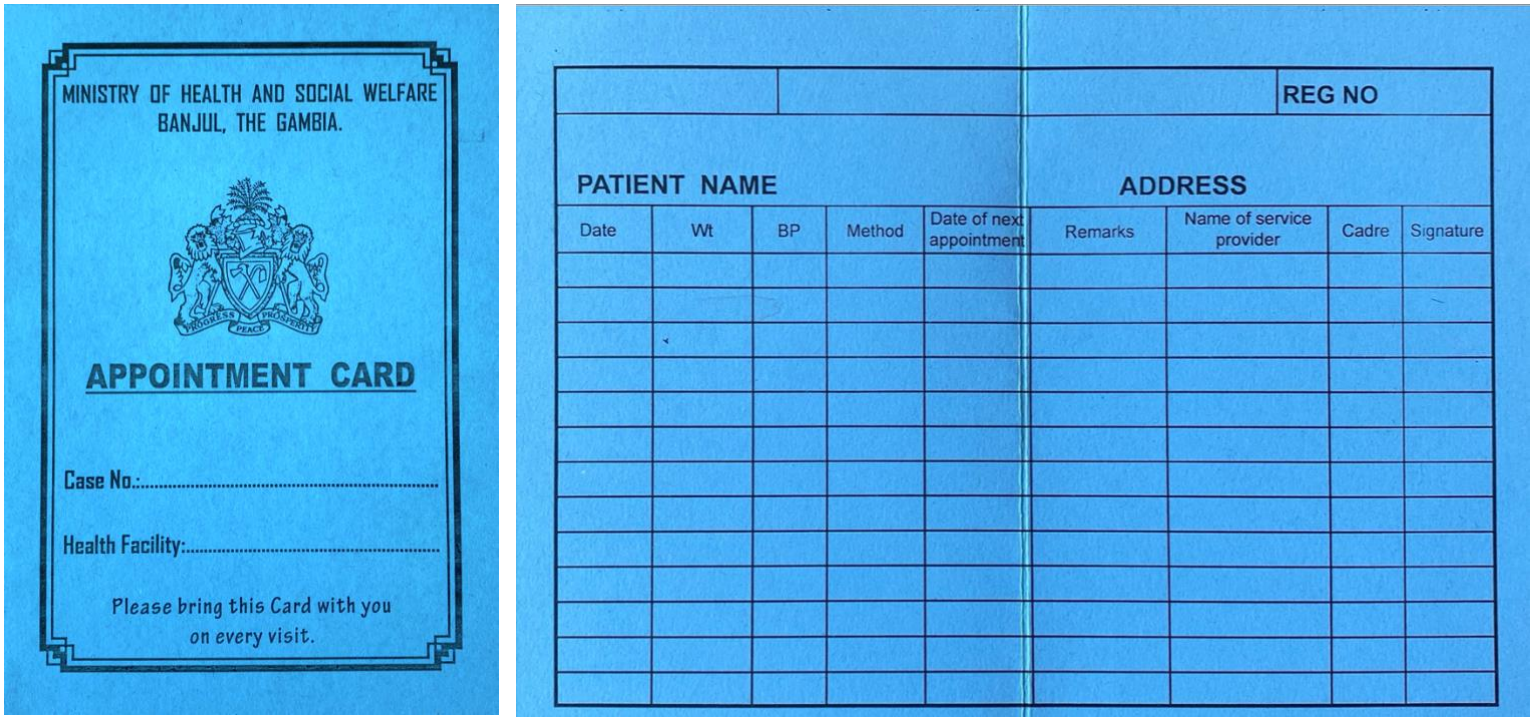


Figure 16: Appointment card given to the women after the consultation to schedule another appointment.
Available from: Private

4.2.2 The most used contraceptives

According to the interviews, the injection and the implant are the most used contraceptives in the rural parts of The Gambia. 14 mentioned the injection as the most used, while 6 mentioned the implant, as shown in the bar chart below. Few mentioned the birth control pill as the most used. Some health care workers stated that the women don't want it "Because sometimes they say that they forget the pills". Another said: "even the pill they don't like".

None mentioned using IUD as contraception. A doctor even uttered; "I never did it and I never saw the service being done. I just know it theoretically, but I never performed it." When we asked; "Are there many people using IUD?" another answered "No no, not many. Especially, the ones who don't want their husbands to know, they don't come for that. They prefer injection.". At the health centers they even responded "No, we don't have the IUD".

According to the interviews the female condom is not common either. "No, the female doesn't use it. I have never seen a female use the condom before. Even the male doesn't like to use it here". Another pointed out: "They don't know how to use it, even if you teach them they don't use". Another aspect is that they think it can disappear. "Most of them don't like the female condom because they are taught that when you put it inside it may go through your hole". This can indicate a lack of knowledge in the society.

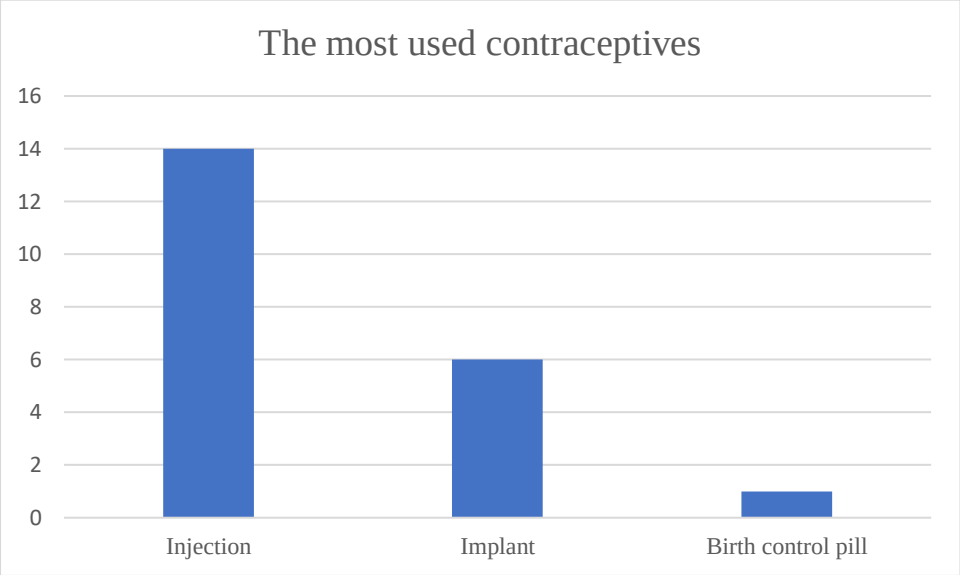


Figure 17: The interviewees were asked about the most used contraceptives. Some of them answered two types. None responded IUD, female/male condom, or female/male sterilization as the most used.
Available from: Private

4.2.3 Age of the users

The age of the clients varies from school children to women soon entering menopause. “The age limit is open” stated a nurse. The most common age is though 20-35 years. The health care workers told us a lot of stories regarding small children that they must provide contraceptives to.

A controversial, but common issue is teenagers’ pregnancy. “There is not the young lady who wanted the service, but it’s the parents, especially the mother, that want the service to be done on the young lady. So, you cannot stop them” told a health care worker. The parents want them to use the contraceptives so they can finish school. “You see some of them who are 16 or 17 years, they are in grade 10 or even grade 9, and they are pregnant. So, it affects them, and they stop going to school”. Many health care workers said that they have experienced this kind of issue.

Regarding the older clients a normal issue is “high parity”. Women may have a lot of children and seek out the family planning provider to get contraceptives. When we asked the health care workers the reason why they want contraceptives, the majority answered to space the births (time period between pregnancies). That is the most common reason, but some also come to limit the births or stop childbearing altogether. With high parity they also have a bigger risk of complications with another pregnancy, especially post-partum hemorrhages. For them, they often advice permanent contraceptives, such as BTL or hysterectomy.

4.2.4 Marital status

The interviewees all answered that the majority of the clients are married. Although, both unmarried and married women come to the family planning service to get contraceptives. Both through the interviews and the consultations that we participated on, it’s clear that the consultations vary between the unmarried and married women.

When we asked which advise they give to the unmarried women a common answer is “Well, we always advise them to abstain from sex when they are not married. To abstain from sex, that is the best.”. One of the nurses then continued, and uttered firmly “You are not married, why should you have sex??”. All though, they point out that they are not allowed to deny unmarried to use contraceptives. But when participating in the consultation, we could tell that

the advises given to the single ones where more of the convincing type. They also give the unmarried more information regarding the STIs and if they still want FP after all, they advise them to use methods that both will prevent pregnancy and protect from STIs.

The consultation for the married women is different. A big aspect here is to include the husband in the decision, if possible. “Yes. If you are married, we always want you to discuss with your husband”. However, that is pointed out as a big problem in the rural parts of The Gambia.

4.2.5 The husband’s role in the decision-making process

As stated above, an agreement with the husband is favorable. Even though, the midwives told us that it is not so common: “But you know, here this is a really big problem, because the men here don’t accept. So, woman they have to hide and come. We counsel the woman more than the man”.

This can lead to complications in the relationships. “Sometimes the women take it without the consent from the husband and fighting comes in”. Another told us that it even leads to divorce sometimes. To avoid that, the woman often chooses a contraceptive that the man is less likely to find. Injections are not visible, while birth control pills can be found, and the implant can be felt in the arm. A lot of the women also leave their appointment card at the facility, so the husband won’t be aware of them going to the family planning provider.

Regarding BTL, this is mostly recommended when a woman is suffering a complication related to birth. A midwife tells us that most of the men are not present during the birth and therefore agrees through the phone. “Because most of the time you hardly see the men (…) It’s just to call, I’m in this condition, and these people are saying that this is what I’m supposed to do. Most of the time the husband is away, so they agree”.

Some men also support the decision of contraceptives, and the family planning provider told us that a few even comes with their husband to the consultation. An argument the women often use if they have small babies, is that the contraceptives will make the woman breastfeed the baby for a longer period. A nurse said “at least for 2 years is necessary”. “So, if the partner understands and accept, the women will come”.

4.3 Contraceptive guidance and its link to MCH care

The World Health Organization (WHO) currently recommends an interval between the last live birth and the next pregnancy of at least 24 months. This recommendation is given in order to reduce the risk of adverse maternal, perinatal and infant outcomes. Birth-to-pregnancy intervals of six months or shorter are associated with elevated risk of maternal mortality. Also, birth-to-pregnancy intervals of around 18 months or shorter are associated with elevated risk of infant, neonatal and perinatal mortality, low birth weight, small size for gestational age, and pre-term delivery (25).

All the 17 interviewed were asked if the main reason for women using contraceptives were spacing or limiting births. 15 said that the majority want contraceptives for spacing births, while 2 said that the main reason is limiting births. When asked, almost all of the health care workers interviewed stated that maternal and child health care is related to family planning. Our general impression from the interviews were that family planning used to space children is important for the mother and/or the child. One said that family planning is essential for the health of the child and the mother: "Yes, it's really helpful because at least it can reduce unwanted pregnancies, and it will improve the mother's health. When she finally become pregnant, that is something that is wanted. So, the child will have a better chance of surviving because then she will take care of that child". Another focused more on the children's benefits of the mother spacing her children: "If you have to many children and there's no spacing, taking care of those children is going to be difficult, especially if the background is not strong. It's going to be difficult because you cannot educate all of them, give them clothing, feed them and other stuff. (…) Therefore, spacing is very very important."

In one of the interviews the total burden of the society was problematized, including the effect on the family. "We give family planning to space children, we don't want their kids to suffer. If they get pregnant early, it affects the mother, the other children, the breastfeeding child, it affects the father, it affects the community, it affects the country. When that child gets sick, we have to spend money. Also, bringing the child to the health facility for treatment will take time for the health personnel. And the money the government are going to spend to cater for those ones, it's a burden to all."

One of the other reasons given for child spacing and its link to MCH care were nutrition of the newborn child. Many pointed out that child spacing will reduce malnutrition problems. We asked one of the interview objects if this was because the breast-feeding stops when if the mother is pregnant again, and got the answer: “Yes, it can stop. The mother is likely forced to stop breast-feeding if she is pregnant, and that is a contributing factor for malnutrition”. This was mentioned by many, such as: “If you have a child and are taking contraceptives it will prevent you from being pregnant. The child will be breast fed until two years old and will have enough breastmilk to grow up healthy”. Another said: “When you are breastfeeding and using family planning, you can breastfeed your child for two years without being pregnant again, and that child will be healthy. But if you are not using any FP, that child can get malnourished”. This shows that many of the health care workers give the same advice as WHO, it should go at least two years between one birth and the next pregnancy.

Some stated that using family planning is important for the mother’s physical health condition in different ways. Two of the interviewed mentioned hemorrhages: “The breastfeeding of the child itself helps the uterus to contract more, it’s another way of controlling bleeding”, and “We see that when they keep giving births, it even affects the uterus, and they get postpartum hemorrhage”.

Information about family planning is given for the women in antenatal services. The women that go to the check-ups before delivery will be taught about the positive outcomes of using family planning. One of the health care workers said: “We normally talk to them when they are pregnant and tell them they have to use spacing. So, when they are at the hospital for delivery, they are again told that before you start having sex with you husband, go and join family planning”. Another one of the interview objects said that: “They get information about spacing both before and after delivery”.

As mentioned above, advice about family planning and spacing are also given in postnatal services. The women that have given birth have group health talks at the hospital, before they are discharged. A midwife educates the mothers about important topics. We observed one of these talks while we were at the Maternity ward at BGH. This was given in Mandinka, and therefore we couldn’t take notes. We were told that they discussed many things: family planning, nutrition, post-natal care, exercise, and taking care of the baby. Another said: “Before leaving after delivery, they will give a health talk about family planning and breast-

feeding procedures. Then, after six weeks you can come and get the family planning if you want.". Some also stated the importance of the husband's role in starting family planning after giving birth: "When they go home, they chat with the husband/the partner. They tell them what the nurse said, and that they maybe want to join so they can breastfeed the baby at least for 2 years. So, if the husband says yes, they come and join."

4.4 Perception of contraceptives in the society

4.4.1 Knowledge about contraceptives

The knowledge regarding contraceptives is of varying quality in the rural parts of The Gambia. Some are more educated on the field, while some have their own beliefs. As mentioned before, some for example believe that they can use contraceptives to abort an already existing pregnancy. Another misconception is that the women think they have other conditions, when they don't bleed as normal while using contraceptives. A health care worker also points out that a lot of people go to traditional doctors. "They go to traditional doctor, they come back and it's too late, it's for example gangrene. You can see everything here! They even pour sand in the wounds.".

Even though, the health care workers said that the knowledge is improving in the region. As more people get to know about the family planning system, the information will reach a larger proportion of the population. They mentioned that a lot get to know about it through friends and family. When you are admitted at maternity ward, you will also be given a lot of information, both before, during and after the birth. In addition, they have the RCH-group. This is a group that travels around and provide information and health care to the population. They do both health talks at the hospital, but also travel around to educate in the communities. Concerning the school system, there were some disagreements whether the schools contribute with information or not. Some mentioned the school as a source for information, while some said they never got any education regarding contraceptives at school. Other groups use drama form and role play to demonstrate some of these issues. They also use the radio station to reach out to the communities. Every Monday from 5-6pm, a health care worker, mostly a doctor, do a health talk about a specific topic.

4.4.2 Cultural norms and religious impact

The majority of the population in The Gambia is Muslims. They told us that "the traditional here is that some men are married to 2 to 4 wives, every two days the woman will have the chance to be with the husband. Anytime it is your turn, you will be the one doing the cooking and other stuff". When we asked if the women were okay with that, the answer were: "Yes, they don't have a choice. It's the man that decides. That's why most of them will end up

having problem, because they don't have a voice, they don't decide. It's the man that decides".

Additionally, many also want to have a lot of children. "They believe if they have more kids, it's better". When we ask why a midwife answered: "they say it's because of the prophet. The religion says lets increase our children, so that's the belief they have". Some even have 8-10 children, and when a man has up to 4 wives, that will result in big, polygamous families. When we asked if the politicians communicate anything about how many children they should have, they all answered no. "Nonono. It's the religion that have a say in that. They don't talk about the family size or number of a children that a woman should have".

The beliefs regarding contraceptives, in the religion, are divergent. Some thinks its "haram", while others understand the concept. A belief many mentioned is: "They think family planning will just expose them to prostitution, because you will not have the fear of getting pregnant". Another said, "if you explain to them, they will understand, and they will begin to appreciate it".

4.5 Access and use of contraceptives

4.5.1 Access to contraceptives (and differences at BGH versus the health centers)

In all the interviews we discussed the access to contraceptives.

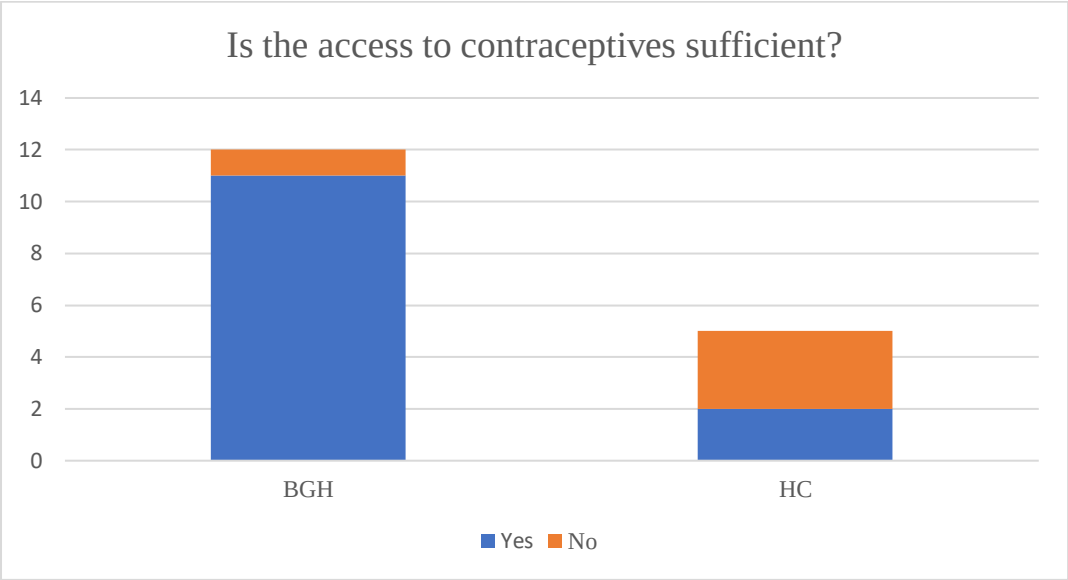


Figure 18: The bar chart above shows the health workers answer to the question "Is the access to contraceptives sufficient?". Almost all the health care workers at BGH said that the access to contraceptives were sufficient. Only 1 of the 12 interviewed at BGH meant that the access was insufficient. 40% of the interviewed at the health centers (HC), 2 of 5, meant that the access to contraceptives were sufficient, while the rest meant that the access was insufficient.
Available from: Private

Central Medical Store (CMS) is responsible to ensure drug availability to the citizens of The Gambia via hospitals and health centers. CMS directly supplies the hospitals, while the supplies to the health centers from CMS go through the regional medical stores (RMS). Furthermore, the distribution and request are done similarly. Drugs are distributed from CMS to RMS and the hospitals on a four-monthly basis, but supplementary supplies can be requested (26). The hospitals directly send their requests to CMS, whereas the health centers' requests undergo an additional step with RMS. A report from 2018 by MOH&SW (Ministry of Health and Social Welfare) found that the availability of essential medicines was hindered, one of the reasons being a weakness in the collaboration between the key players in the supply chain management (26). Drugs are supposed to be delivered to the health centers by

the RMS as stated in the Standard Operating Procedures (SOP), but instead the health centers use their ambulances to collect supplies from the RMS. As a result, both the timely deliveries and the patient care are affected and at risk (26).

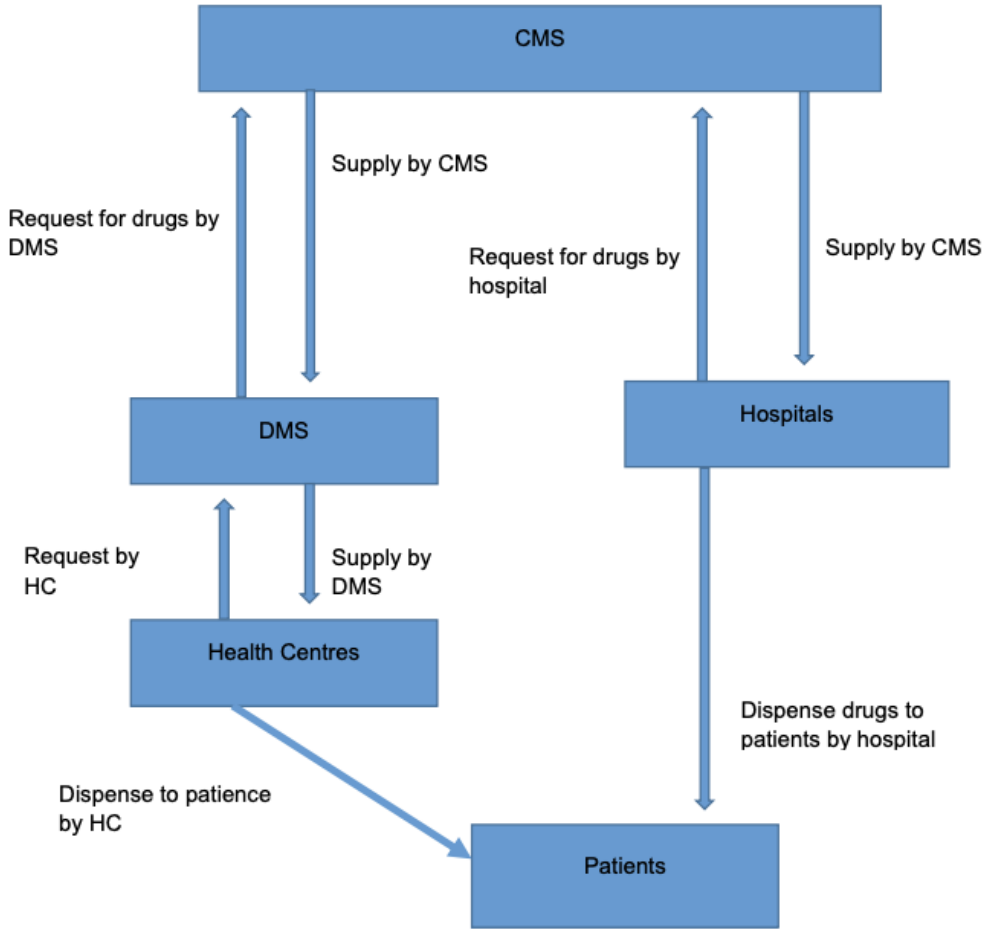


Figure 19: The figure shows the supply chain of drugs from CMS to the patients.

Available from: Ministry of Health and Social Welfare. Drug Storage and Distribution by CMS 2018. The Gambia: Ministry of Health and Social Welfare; 2018 p. 28.

This was also a recurring theme in the interviews. Several of the health care workers problematized the difference in acquiring contraceptives between the hospital and the health care centers. One working at BGH said: “Some health centers have problems because they don’t collect their commodities directly from the central medical store, they collect it from the regional medical store. At the regional they sometimes say it’s not available, and some of them are without some of the commodities.” Another health care worker at BGH said that the

health center requests supplies from RMS based on the number of clients registered in the statistics. He specified that even though this is the guideline, the demand can exceed the availability. Onward, a health care worker said that the hospital gets their supplies from the central medical store because it's tertiary level. Therefore, the hospital is able to order autonomously. Some problematized that the regional label medical store, where the health care centers get their supplies from, doesn't always have all the different types of contraceptives available. An example is that one of the health care centers didn't have male condoms available for the past 3 months, or female condoms in at least 3 years. Another health center didn't have depot available for some time, and one of the women coming in for family planning only wanted this method.

Some of the interviewed discussed the RCHs role in the distribution of contraceptives in different areas. In one of the health care centers there wasn't anyone that was trained to insert the implant. A health care worker said: "When they come and want the implant, I will give them an appointment for the RCH clinic. That is the fourth Wednesday of the month, I will tell them to come on that day and then they will give the implant". One of the staff at BGH praised the RCH for their work but said: "Some communities travel far to get FP, the trekking team don't manage to go to every community. The RCH travel but they only have some spots that they go to". Even though there are contraceptives available through BGH, health care centers and RCH in total, this may not be sufficient for everyone as some don't live close enough to utilize the service.

4.5.2 Use of contraceptives

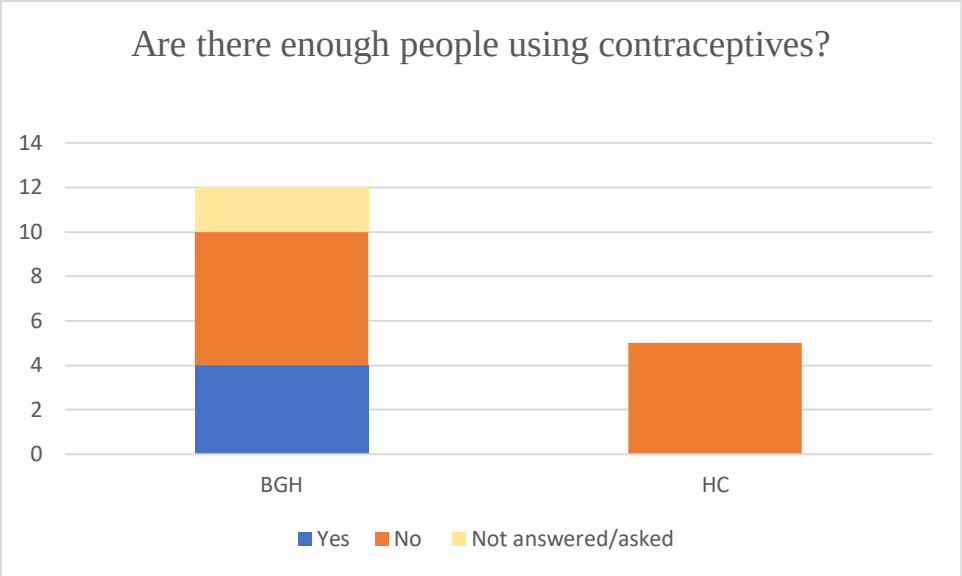


Figure 20: The bar chart above shows the health workers answer to the question “Is the use of contraceptives sufficient?”. Everyone at the HC answered that it’s insufficient. The staff at BGH were on the other hand divided; 4 health care workers answered “Yes”, while 6 answered "No”. 2 of the health care workers at BGH did not answer or get the specific question during the interview. *Available from: Private*

The majority said that the access to contraceptives is good enough. Although, while asking about the use, they mostly answered that there aren’t enough people using the accessible contraceptives. An example of this is: “The use should increase. If you look at the number of live births compared to the number of women taking contraceptives, it is not enough”. Another stated: “No, around here I don’t think enough people are using it. There are some people that you talk to about FP, but they don’t want to use it because of their beliefs”. Reasons to contraceptives not being used that was mentioned were lack of awareness, knowledge, culture/norms in the society, availability, and religious beliefs.

4.5.3 Possibilities to improve the access and use of contraceptives

Many said that a way to get more people to use contraceptives was to increase awareness and gain a better knowledge throughout the society. “What is mostly stopping them is the misconception, either from the man or from the woman. But when they are given the right knowledge, I think the use will improve.” One said that sensitization and health talks are

important to get more people to use contraceptives: “Not only in the hospitals, but in schools and markets if they can go there”. As mentioned earlier, there were different opinions whether the school was giving information about contraceptives or not. If the schools incorporate contraceptives in the study plan, it can contribute to increase awareness about family planning from an early age.

In addition, getting contraceptives available for everyone can also help escalate the use. One of the health care workers discussed that some people must travel far to get FP. This is because the trekking team can’t travel to every community, and the RCH only have some spots that they go to. “They should send FP-service out to the communities. That would be very key, so they can get information out to the communities and that they have the access.” Others meant that contraceptives were available to everyone, and that this was provided by the RCH and trekking-services.

Some pointed out that it is important to protect the privacy and anonymity of the users. “With some people, the husband doesn’t know that they are taking it, or the family don’t know. So, coming here, they maybe need a private area.” The health care workers have undertaken the duty of confidentiality, but some might be afraid to meet someone they know in the appointment queue.

Another way mentioned to increase the use of contraceptives were to involve the husbands. “We need to have male involvement in the family planning section. This is very key so that they will know that family planning is not to control births, but to provide intervals from one pregnancy to another. It’s to provide better care for their own kids and their own wife, and to manage the family size properly.” Only few men accompany their wives to medical appointments. Bundung started a practice of giving priority to the men who came with their partners, whether it was for medical service or reproductive health service. This might encourage other men to accompany their wives, as one said: “Others will go and tell them that “my colleague went with their husband, and they treated them very fine, they stayed for a longer period. Next time go with your husband and they will give you the same privilege”.”

5. Discussion

5.1 Access to contraceptives

All the health care workers included in the study were asked if access to contraceptives is sufficient. Almost all (11 of 12) at Bwiam General Hospital and less than half (2 of 5) at the health centers stated that the access was sufficient. This can be an indication that the access at the different health levels vary, i.e. between secondary and tertiary level. Still, it's important to highlight that most of the participants meant that the access was sufficient. It may represent an effort to meet women's needs for contraceptives, which we are happy to see. Nevertheless, we cannot ignore the possibility that the access to contraceptives can contribute to the already stated unmet need. Therefore, we will discuss different aspects regarding the access to contraceptives in this chapter and evaluate if they might lead to poorer access.

The hospital and the health centers have different ways of obtaining contraceptives as explained in the Results chapter. BGH get their supplies directly from CMS, unlike the health centers which must use DMS as an intermediary. Supply chain was brought up as a topic by some of the interviewees when asked about the access. Those who mentioned it had similar arguments which mainly involved that the health centers had less available contraceptives because they didn't get their supplies directly from CMS. However, many of the participants did not talk about this theme, and its therefore unclear what level of knowledge they had about this. If so, we can't predict their assessment of its importance. As a consequence, we were left with the impression that the hospitals had a more consistent supply system since there were no opposing arguments found in the interviews.

Although their supply chain differs, there are no costs for both the health centers and the hospital providing this service. This may increase the facilities' incentive to request supplies, without simultaneously having to consider their budget. Regardless of this, during the interviews we got the impression that some of the health care workers felt powerless in this situation and had little say in the process of requesting supplies which were empty in stock. This was particularly evident for the same participants that stated that the access to contraceptives was insufficient. Examples of methods the health care workers said they were lacking were male condoms and female condoms, and in some health centers these hadn't been available for months. For this reason, our perception was that the health care workers

providing family planning services had limited impact on the request and refill of contraceptives. Since there's mainly one family planning provider working at each health center, it may indicate little communication between the storages and the health centers. Accordingly, it can be a limitation in the work to improve the access of contraceptives.

Some of the family planning providers weren't trained to administer all the contraceptive methods available, for example the implant or IUD. If a woman at the health center wanted an implant, they rescheduled the appointment to the day of the month that the RCH clinic would come. This can increase the threshold of choosing this type of contraceptive since it is not as available as the others. On the other hand, it's essential that the clients can choose freely even though the necessary competence isn't present every day. When questioned about the IUD, most of the health care workers said that it wasn't in use. Some explained this by saying that few clients wanted it, while others said that no one could do the procedure. If the service was offered everywhere, some women may prefer it instead of the other currently available contraceptives. This can lead to better compliance due to the duration of the method, whereas the IUD can be used for 3 or 5 years compared to for example the pill which must be taken every day. In addition, health care workers may not suggest the mentioned types of contraceptives which require specific skills, even though they are available at the clinic. Instead, they might highlight the positive aspects of other types of family planning.

Another factor to consider regarding access to contraceptives is distance. This includes both the distance from the health center to DMS/RMS, and distance for the women to get to their nearest health center. Through available research we got the impression that one of the main issues with the supply chain to the health centers were the ambulances. DMS/RMS are supposed to deliver supplies to the health centers, but this is seldom done. Consequently, the health centers will send their ambulance when in need of supplies. This needs to be done when there are no other awaiting tasks or emergency missions. If the health center is located some distance from DMS/RMS, it will make it less likely that the ambulance will be available. Thus, the health centers located furthest away could end up having fewer opportunities to replenish their stocks. Moreover, the travel distance for the women to the nearest health center or RCH location is an aspect that can be important, especially for the use of contraceptives. Even though the RCH enables more women to be reached, it can still be too far for some. This may be because they have no efficient forms of transport, or their children cannot be left alone in the time period it would take to get a consultation and so forth.

As shown above, the access to contraceptives is dependent on the supply chain, cost, abilities of the health care workers, and proximity to the facilities providing the service.

5.2 Culture and religion

The cultural norms and the religious beliefs could also have an impact on the unmet need for family planning. The first perspective is the number of children. From the interviews many of the health care workers stated that a common belief is “the more kids, the better” and that God wants the populations to have as many children as possible. This could lead to a restrained use of contraceptives, and a thought of the methods as something against their religion. However, while some look at it as “Haram”, several practicing Muslims also accept the use of contraceptives. When we asked a midwife if they look at it as “haram” he answered “Yes, but if you explain it to them, they will understand, and they will begin to appreciate it”. Further, he told us that giving information is the key. “But if you talk to them individually, they will understand that religion actually has nothing to do with this. It is purely health issues that we need to tackle”. This illustrates the previous religious mindset but underlines an ongoing change, where they try to educate the population to a greater extent.

Marital status may also contribute to the unmet need. The majority of the community in the Foni Region share the thought of marriage as a tradition. This might lead to a bigger desire to get children and build a family, and therefore looking at contraceptives as not necessary. However, looking at the statistics from the interviews, most of the women seeking the family planning provider are married. This could also lead to a broader approval for the use of contraceptives for couples, compared to the unmarried woman.

Observing the interviews, we could sense another approach towards unmarried women when they sought out the family planning provider for contraceptives. The atmosphere got a bit more serious and the tone more convincing. When we asked the health care workers afterwards, they could confirm that “of course we give different advice for the unmarried and married ones”. One of the health care workers, who administers contraceptives on daily basis, even uttered “It’s not good for those who are not married, it’s not advisable, it’s forbidden. It’s not good for girls who are not married”. This also shows that the religious belief may be even stronger for the unmarried woman. She then continued and said that a married woman,

on the other hand, could use it, after communication and allowance from the husband. This emphasizes the different approach towards the women in the Foni region.

Despite this belief, the health care workers are aware of the consequences denying the users to get the contraceptives they want. They told us that they "always advise them to abstain from sex when they are not married". They also made it clear that they know they are obligated to give the service. "We always counsel on that and give the information. But they still want to join, and what can you do? You have to give" said a health care worker. This leads to an understanding that, in theory, practice should be the same for the married and the unmarried in the population. Even though, this reveals a healthcare worker with less desire to provide healthcare for one group of people in the region. We also question whether the reason why few unmarried women visit the health centers, and the hospitals is precisely because of this attitude. They could be faced with the idea of contraceptives as illegal and become a stigmatized group in the society, which can be a contributing factor to the unmet need for family planning regarding the unmarried women.

Another aspect is the number of wives for a man. Polygynous unions are common for the rural parts of the Gambia, with approximately 50% living this way (27). This is one of the most known forms of polygamy, which indicate that a man can have multiple wives, while a woman only can have one husband (28). In Gambia the practice is families with 2 to 4 wives per man, where a man for example can have 6-10 children with each woman. This is a natural way of life in the rural areas of the Gambia, which can increase the total number of children. This is because in some families it turns into a competition between the wives. "For example, the first wife has 8 children and you have only 2-3 children, and then they have to compete. So because of that they get a lot of children" told a midwife. This is in contrast to for example Norway, where it is illegal to engage in a polygamous relationship. This could be a contributing factor to why the total fertility rate in Norway is low, more specific 1,56 (29) while it's still 4,4 in The Gambia (1).

Although, we have seen a drastic decrease in the fertility rate throughout the last 20-30 years in The Gambia. This can indicate that the development is moving towards the Western standards. An example that underlines this, is the way of living in the Serrekunda or Banjul region. If you move just 100 km further north-west, you can see that the traditions have already changed drastically on the coast of The Gambia. Here you find a higher number of

monogamy unions, with as much as 81% monogamy in the south of Banjul (27). This shows that the Gambian areas are adapting more and more to the western traditions, and perhaps it will spread throughout the rest of the Gambia within some years.

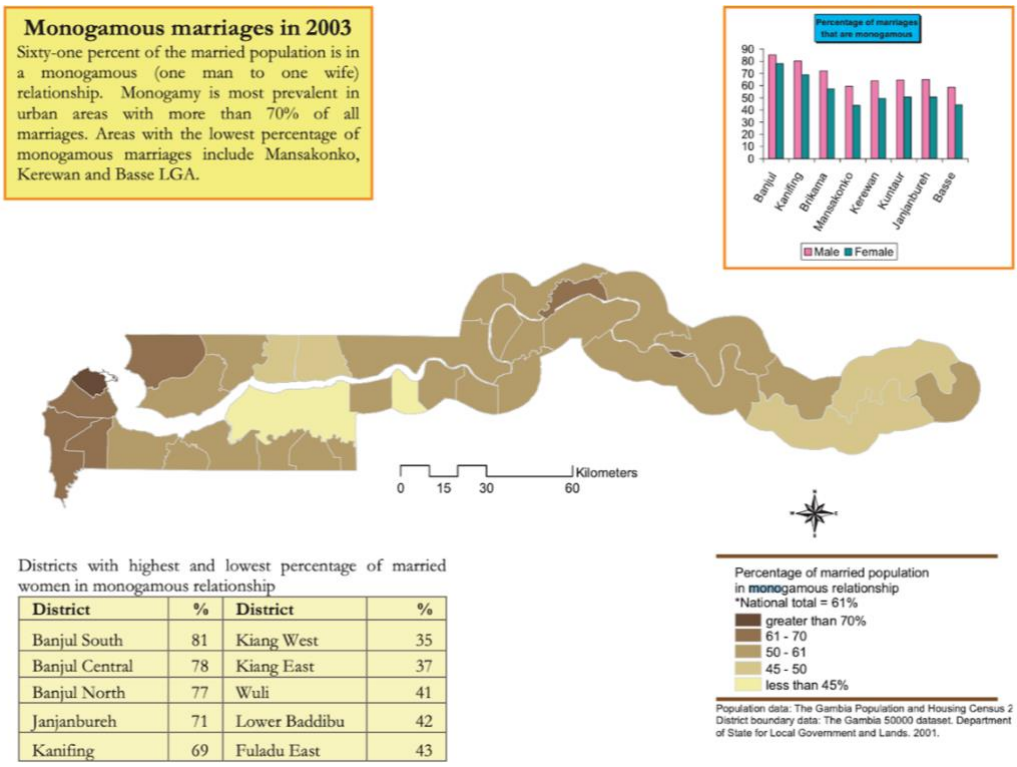


Figure 21: Map showing the percentage of monogamous marriage in the different areas of the Gambia.

Available from: The Gambia Bureau of Statistics (GBoS). The Gambia: Atlas of 2003 Population and Housing Census. The Gambia; 2006 Aug p. 55.

Additionally, the husband's point of view can make an impact. Throughout the interviews the health care worker explained the men as the person who mostly takes the decisions in the family. In some families the man will understand and accept, and the woman will therefore come to the family planning provider. In other occasions, the husband doesn't allow the woman to use contraceptives. They don't consent, which results in fewer women seeking the family planning provider, contributing to the unmet need for family planning.

In addition, these disagreements also affect the choice of contraceptives. Even though some husbands don't allow the woman to use the family planning methods, the woman comes secretly. "Sometimes women will come and take it without the consent of her husband. This

can lead to fighting or they can even seek divorce" told a health care worker. To avoid family conflict the woman uses specific strategies to not get caught in the lie. They for example leave their blue appointment card at the family planning office, so it will not be found at home. Additionally, they also choose contraceptive methods that are less likely to be revealed. Implants can be felt in the arm and pills can easily be found, while injections are invisible. This might be a reason why the injections are listed as the most used contraceptives among married women in the Survey: The Gambia DHS from 2019-2020 (1). Likewise, it is mentioned as the most used contraceptive from our interviews with the health care workers.

Throughout the interviews, when we asked about the politicians' engagement in family planning and contraceptives all the 17 interviewees answered that they did not communicate anything about these topics. The responses were all pointing in the same direction "No no no", "Never heard of ", "No, they don't do it". They made it clear that these issues are not discussed by the politicians. Some also elaborated their answers by adding "It's the religion that has a say in that. The politicians don't talk about the family size or number of children that a woman should have." and "Politicians in the Gambia are not involved in that. Religion is the main reason for family size". This again underlines the importance of religion in this society. This also shows that they may listen more to the religious speakers than to the politicians. Although the politicians don't speak about it, we were taught that some Imams discuss contraceptives at religious meetings once in a while. A health care worker also pointed out that the politicians are not able to control the population. Nevertheless, we believe that if the politicians had emphasized the lack of contraceptive use as a problem in society, it would contribute to a broader understanding. It could increase the level of knowledge, and by using their voices they could have an extensive impact and reach even larger portions of the population. They could educate the community even more and clarify the problems regarding contraceptives and family planning in the rural parts of the Gambia, in extension of the religious work.

5.3 Knowledge about contraceptives

One aspect is the hierarchy, where the health care workers look at the users as incompetent and don't trust them. For example, when they come to get a family planning method, the health care workers demand to physically see the blood on a cotton, if the user claims to be menstruating. "You need to see proof, either at the HCG-form or menstruation, because sometimes they will deny it or lie to get contraceptives". Another aspect is the lack of knowledge regarding contraceptives throughout the region. Some say that they come for family planning because they believe that if you take family planning while being pregnant, you can abort it. This shows a lack in knowledge concerning the physiological mechanisms of contraception and could lead to the use being reduced from its potential.

When we asked the interviewees about possible ways to improve the use of contraceptives the majority listed up information and educating the inhabitants as a favorable strategy. This shows that knowledge is perceived as an important factor to increase the use of contraceptives by the health care workers. As mentioned above, the politicians can do their part, but other ways to reach out to the community could be by the TV, radio, and other media channels. Many of the health care workers also mentioned none or few lectures about these topics in school, which should be included for all in the school teaching as the children grow older. They should also get more information about the different family planning methods, so they know what's available and can adjust their choice to their family situation.

Along with information to the women utilizing the service, informing the men is emphasized by several of the interviewees. Besides educating children and teens through courses at school, many suggested that it is important to integrate the same principles in the local community so that the information reaches men of all ages. This can include social and behavioral change communication (SBCC) and village support groups (VSGs) and might ensure a more rapid change in the perception of contraceptives. An example of this from the interviews are that there's ongoing research in the region about male involvement in reproductive health. Another example is that Bundung Maternal and Child Health Hospital prioritize the women that bring their husbands to appointments. Both examples indicate that there's a current awareness around the importance of the husband's role, and that health care workers put in an effort to increase their knowledge and involvement.

Even though there are indications that male involvement is an area more people are getting involved in, it seems like there's remaining work left to reach a desired level. When asked about ways to improve the use of contraceptives, most of the health care workers' answers contained men in one way or another. "If we involve the men, the rate of family planning would be higher", "male involvement is key", and "It's low involvement for men when it comes to family planning in this area" are statements exemplifying this. A way to lower the skepticism against contraceptives can be advocating for family planning by using factual arguments about its benefits, such as the health advantages for both the mother and child. The desensitization may take some time, but it is important to work continuously to normalize the concept and be clear about its importance.

5.4 Limitations

In this study, we included health care workers in our sample, and not the users of the contraceptives. This decision was partly practical and partly budget based. We were advised not to interview the women directly because it could lead to difficulties in the process of getting our research ethically approved. An interpreter would also be a considerable cost to us since the entire project is self-funded. A positive aspect of interviewing the health care workers is getting their overall impression of the women coming for family planning. On the other hand, this can lead to their answers being generalized and show less of the variation between the individuals. Also, the health care workers will interpret the women's behavior and answer subjectively from their point of view. This also needs to be considered when analyzing the results.

Due to our obligations at medical school, we couldn't stay for more than one month in The Gambia. We hoped that the trip could have been longer, but we had to be back in Oslo before the semester started. Additionally, we both got Covid-19 during our stay in Bwiam and had to stay isolated for 6 days as stated by the national guidelines at the time. Although we reached information saturation through our interviews, we had planned to use other sources of information in addition to the interviews. We wanted to get a broader insight by joining the RCH/trekking and observe more patient consultations at the family planning service. It would also have been useful to meet the village health workers to observe the primary level health care. Unfortunately, we couldn't prioritize these activities the remaining time we had in Bwiam after the end of the isolation period.

Most of the interviews were conducted at Bwiam General Hospital, while 5 of 17 were done at health centers. There were several differences between the health centers and BGH. This includes ways of getting their supplies, possibilities for interdisciplinary collaboration, number of employees at work and more. Therefore, if more health centers were included, our results may have been slightly altered.

5.5 Sources of error

The interviews were conducted in English. Even though all the participants knew and spoke English, this may have influenced the communication as it is their second language. If we were unsure whether we had understood them correctly, we always asked follow-up questions to get the answers clarified and/or elaborated. Furthermore, there was great variation from participant to participant in how comprehensive the answers were. Some were perceived as more reserved, while others were detailed and spontaneously discussed other topics. This is made visible by the duration of the interviews, which varied from 20 to over 50 minutes. This implies that we got more information from some of the interviews, and that the amount of information is not evenly distributed throughout the interviews.

It's important that we understand and are aware of our cultural background while interpreting the results. The cultural norms, health systems and economic situation of Norway and The Gambia differ from each other. Despite our awareness of these disparities and a focus on being objective, our understanding of the findings in the study may be colored by our point of view. With this in mind, it has been important for us to understand the results in the context in which they were obtained, and propose measures based on current local conditions.

Another aspect is the generalizability of the study. A common problem for qualitative studies is the difficulty of drawing generalizable conclusions. This is because of the limited sample sizes, even with precise analysis methods. As noted, we need to be aware that the findings can be biased and unrepresentative for the Foni region as a whole. Nevertheless, the Foni region is a limited geographical area where the population has several similarities. Therefore, the findings can also be argued to have some transferability to the entire region.

6. Conclusion

A positive aspect is that the contraceptives in the Foni Region are free for all, both for the users but also for the health facilities when demanding supplies. As a result, family planning being free for the facilities can increase the access, and family planning being free for the women can increase the use. The health care workers also know their obligation to provide contraceptives for all women seeking the family planning provider. These could be factors that decreases the unmet need for family planning.

Even though, while conducting the study, we could also reveal some areas of improvement in the Foni Region. One of these was the different treatment based on the woman's marital status. Another aspect is the level of knowledge in the society. It's clear that the inhabitants need more common knowledge regarding contraceptives in order to reach the future goal of every woman having the possibility to use contraceptives. The health care workers specifically pointed out more involvement and information to the husband as an intervention to increase the use of contraceptives. The religious believes and cultural norms for a family size may also be contributing factors to why the use of contraceptives is insufficient in the community.

In addition, the health care workers stated that the use of contraceptives were a bigger problem than the access overall in the Region. Even though, there were regional differences regarding the access of contraceptives. The study shows a significant deviation between the availability of contraceptives at BGH and at the health centers. While 92% at BGH thought the access was sufficient, only 40% at the health centers agreed to that. As the main differences between the secondary and the tertiary level are the supply chain and staff available, these two factors might be possible explanations as to why the two groups disagreed. A change of the supply system to the health centers could therefore be a possible solution to improve the access overall.

These are our main findings as to why there is an unmet need for family planning. These findings can be used for further research and to implement changes to reduce the unmet need for contraceptives in the Foni Region in The Gambia.

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Appendices

Appendix 1: Information sheet

PARTICIPANT INFORMATION SHEET

Version Date

Study Title:

SCC/Protocol No:	

Sponsor & Funder:

What is informed consent?

You are invited to take part in a research study. Participating in a research study is not the same as getting regular medical care. The purpose of normal medical care is to improve one's health. The purpose of a research study is to gather information that may be useful in the future for the whole population. It is your decision to take part and you can stop at any time without giving any reason.

Before you decide you need to understand why the study is being done and what will happen in it. Please take time to read the following information or get the information explained to you in your language. Listen carefully. You can ask questions if there is anything that you do not understand. Ask for it to be explained until you are satisfied. You may also wish to speak your spouse, family members or others before deciding to take part in the study.

If you decide to join 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 the consent form.

Why is this study being done?

To get a broader understanding of the access to contraceptives in The Gambia.

In the Gambia, total fertility rate is still high despite a decline in fertility over the past 20-30 years (from around 7 to around 4). Population growth exceeds growth in the economy, and more land areas to accommodate a large population is difficult. The pressure on resources is demonstrated by urban and overseas migration: young people's attempt to migrate, due to limited opportunities in rural areas, and lack of growth in the job marked. For families to grow out of poverty, the high dependency rate needs to be controlled. Aims would be to reduce infant and child mortality, prevent early pregnancies, earlier reproduction and obtain better spacing between pregnancies.

There has been little to no research done in this field in The Gambia the last 20 years, and therefore we see a need to map out the possible causes. The results of the study will be made available to your community.

What does this study involve?
This is a qualitative study, where we will ask you questions regarding the practices at the health center and cultural norms in the society. This will be a semi-structured interview, where you'll be able to elaborate on your opinions and experiences. We will record the interview and take notes.

Why are you being asked to participate?

You are being asked to participate on the grounds that you are a health care worker.

Since our study is qualitative, our sample size will be restricted. The specific number of participants are not defined, but our goal is to have variation within the group so we can reach data saturation.

Who is responsible for the research project?

The University of Oslo is the institution responsible for the project, in cooperation with Dr. Mamady Cham at Bwiam General Hospital. Dr. Johanne S. Sundby and Dr. Siri Vangen are our supervisors during the project.

What benefits can you expect in the study?
You will be a part of a project that will contribute to a broader understanding of access to contraceptives, that will benefit your own community.

What harm or discomfort can you expect in the study?
Potential risks for the individuals can be misrepresentation, and distress during the interviews. We will do everything in our power to avoid this from happening. Except from this, there will be no possible harm or discomfort.

Will you be compensated for participating in the study?
You will not get paid by the study, but MRC will provide transport or give you back the money for your transport.

What happens if you refuse to participate in the study or change your mind later?
Participation in the project is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw. It will not affect your place of work or employer.
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?
The data obtained in the study will be kept safely in a research base provided by the University of Oslo. We will only use your personal data for the purpose(s) specified in this information letter. All information that is collected about you in the course of the study will be kept strictly confidential. Your personal information will only be available to the study team members. The participants will not be recognizable in the publication. All data will be deleted by the end of the research project, scheduled January 2023.

Your rights

So long as you can be identified in the collected data, you have the right to:

- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- contact the local Ethics Committee for any other issue.

Who should you contact if you have questions?
If you have questions about the project, or want to exercise your rights, contact:

- Study staff:
    - Maud H. Renaut
        - By telephone: +47 90214526 (Gambian telephone number will be available as soon as we arrive in The Gambia).
        - By email: m.h.renaut@studmed.uio.no
    - Hanna Pettersen
        - By telephone: +47 95015776. (Gambian telephone number will be available as soon as we arrive in The Gambia).
        - By email: Hanna.pettersen@studmed.uio.no
- Supervisor at the University of Oslo: Johanne S. Sundby on +47 90558704.
- NSD – The Norwegian Centre for Research Data AS, by email: (personverntjenester@nsd.no) or by telephone: +47 55582117.
- Local Ethics Committee by email: ethics@mrc.gm

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

Who has reviewed this study?
This study has been checked by scientists at the Medical Research Council and by the Gambia Government/MRC Joint Ethics Committee. The Ethics Committee protects your rights and wellbeing and has given permission for it to take place.

Appendix 2: Consent Form

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 happy with the answers that have been provided,
- understand that I allow access to the information about me by the persons described in the information sheet,
- had enough time to think about whether I want to take part in this study,
- agree to take part in this study.

Tick as appropriate

I agree for my samples to be shipped outside of The Gambia Yes ☐ No ☐

I agree to further research on my samples including genetic testing Yes ☐ No ☐

Participant's signature/ thumbprint* ☐

_____

Date Time

Printed name of witness* _____

Printed name of person obtaining consent _____

I attest that I have explained the study information accurately in _____ and was understood to the best of my knowledge by the participant. The participant has freely given consent to participate *in the presence of the above-named 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.*

Appendix 3: Interview guide

Interview guide

About the health workers

- Age and gender
- Education (type of nurser health worker)
- How long have you been working at the health center?
- What is your main task at work?
- Do you provide contraceptive health care?

At the health center

- What's your tasks at work related to contraceptives?
- Can you tell us about the process from when a woman enters the health center, until she has gotten the contraception she wants/needs?
    - Who will she talk to at the health center? Questions asked related to sexual health/husband/partner
    - Health history and heredity?
    - Medical examination?
    - Choice of contraception?
- Do you have any guidelines you have to follow?

Users of the health center

- Which age groups do you provide contraceptives to?
    - Which age groups are the most common?
- Are the users mostly married or unmarried?
- What do you think is the main reason women come here? (Spacing or limiting births)
- How do you think the users experience using your services?
    - Do they seem pleased?
    - Do they come back?
- How do you communicate outwards? How do the users find you?
- Do you think contraceptive guidance is linked to MCH care?
    - If so, how?

Attitudes and values in the society

- What's your impression of the cultural norms in the society concerning contraceptives?
- What are the ideals regarding family planning?
    - What's being communicated from the politicians?
- What do you think is common knowledge about contraceptives in this area?
    - Where do they get their information from?
- Do you feel that the access to contraceptives is sufficient?
- According to a survey from 2020, there's an unmet need for contraceptives. Does this match your impression? If so, what do you think are the barriers to attain access for all?