Adolescent Unplanned Pregnancy in the Pacific

VANUATU

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Contents

Executive summary

This report is part of a larger study designed to shed light on the experiences of adolescent girls and young women in Vanuatu, Chuuk State and Tonga who face unplanned pregnancy and motherhood. The study also investigated traditional and contemporary knowledge and practices of fertility limitation, from the viewpoints of older women.

Rates of unplanned adolescent pregnancy are high in many Pacific Islands countries. Issues facing adolescent girls with regard to sexual and reproductive health are implicated in social, cultural and economic development, and in human rights imperatives in the region. Young women in the Pacific navigate sexual and reproductive decision-making in increasingly complex social and cultural contexts. Understanding the realities of unplanned pregnancy in Vanuatu requires attention to the lived experiences and perspectives of the young women and girls themselves.

In Vanuatu, 36 face-to-face interviews and two focus group discussions were conducted with girls and young women, aged 16–19 years, who have experienced unintended pregnancy and motherhood, and with women over the age of 50. Data was collected in the provinces of Shefa, Sanma and Tafea. Interviews enquired into personal family and relationship stories and relevant contextual information, including access to sexual and reproductive health services; enablers and constraints to decision-making and action; traditional knowledge and practices of fertility control; and the role of older women in these matters. The sample was non-random and therefore the findings describe this sample only and are not generalisable to the wider population.

The interview data showed that young participants were frightened and did not know what to do or where to turn when they discovered they were pregnant.

Most of the young participants in this sample had felt so desperate at finding themselves pregnant that they felt their only option was to end the pregnancy.

Same-age girlfriends, sisters and sister-cousins were the first people to whom pregnancy was voluntarily disclosed. However, those girls and women were usually no better informed about fertility control than the pregnant girl herself.

The young participants had limited access to few reliable sources of information about sexual and reproductive health. Consequently, knowledge about contraception was low. Few had confirmed their pregnancies before four months. None of the young participants had discussed sex or contraception with their parents. School sex education coverage was patchy and inadequate. Information shared among friends was often unreliable.

Violent jolts to the stomach, jumping into the sea, friends walking on stomachs and backs, drinking large quantities of lemon juice and other acidic drinks, eating soap, drinking kava, drinking strong alcohol, extreme exercise and heavy lifting were reported as measures girls and women resort to in order to bring on miscarriage ('spoilem baby'). It was also reported that, most often, those home remedies failed. Many of the practices cited are dangerous for the young women and also pose significant risks to the development of the foetus if a miscarriage does not result.

Many participants consulted a *kastom* medicine provider for 'traditional leaf' to end their unplanned pregnancy. The leaf preparations were taken orally. In most cases, the preparation had been bought from a local man and it did not bring about a miscarriage. Those whose use of kastom leaf had caused a miscarriage said that there was a lot of bleeding.

Desire to end the pregnancy was driven by fear of parental anger and of social and educational exclusion. On the evidence of participant stories, these fears were often justified. Anger from the family was most often expressed verbally, but some participants had been physically beaten by family members. A few reported physical violence from boyfriends.

Most of the participants in our sample were living with family members and both the young mother and her child were supported by their family. The consequent financial burden was often a source of tension. Very few of the young mothers in our sample were cohabiting with the father of their baby.

Among the Tafea participants, it was common for single great-grandmothers to bring up the children alone, which imposed heavy financial and stress burdens on those older women. Older women also reported feeling ill-equipped to advise and protect young girls whose behaviours the older women perceived as being beyond their control. The strategies that older women themselves had used to prevent or space pregnancies were no longer viable, useful or acceptable to their granddaughters.

Despite having become pregnant within ongoing rather than casual sexual relationships, the young women in this sample overwhelmingly bore the financial and social burden of the unplanned pregnancy. Pregnancy limited access to education. Responses of school authorities to student pregnancy, and attitudes of the participants themselves to education, varied. Those who had continued their education were highly motivated to do so, had family support, and lived in Shefa. The cost and availability of appropriate courses were barriers to continued study.

The attitudes of maternity clinic staff towards very young expectant mothers were inconsistent and experiences within the health care system were mixed. Many girls and young women had a good experience at the hospital when they went to confirm their pregnancy, but some were treated harshly and berated or made to feel ashamed.

A number of potential participants who were too young to be included in the study presented for interview. The experiences of those who become pregnant in early adolescence are likely to differ in significant ways from those of women who become pregnant in late adolescence. There is a need for information on early adolescent pregnancy in Vanuatu.

The findings of this report indicate the need for responses within the education system to retain girls and young mothers in school; the sensitisation of clinical and antenatal services to the vulnerabilities of pregnant adolescents; the design of sexual and reproductive health services and contraceptive education specifically for early adolescents; and legal entitlements for all women, regardless of age, to contraception, safe pregnancy terminations and protection from violence.

1 Aims and objectives

This report presents findings from data collected in Vanuatu as part of research into adolescent unplanned pregnancy in three Pacific Island States: Vanuatu, Tonga and Chuuk State. Rates of unplanned adolescent pregnancy are high in many Pacific Islands countries. Issues facing adolescent girls with regard to sexual and reproductive health are implicated in social, cultural and economic development, and in human rights imperatives in the region. Young women in the Pacific navigate sexual and reproductive decision-making in increasingly complex social and cultural contexts. Those contexts do not generally enable young women to speak openly about such matters. In acknowledgement of this situation, the *Pacific Women* Advisory Group on Research identified the need for research in order to better understand the experiences of unplanned pregnancy among young women in the Pacific. Researchers and stakeholders with an understanding of adolescent pregnancy in the Pacific gathered in Suva in July 2018 to confirm the need and discuss the brief for the research. Their insights inform the focus and methodology of this study. The research was funded by the Australian government's Gender Equality Fund through the Pacific Women Shaping Pacific Development (*Pacific Women*) program. A research team from the University of New South Wales was contracted to undertake the study.

Data collection at the three sites aimed to shed light on the contemporary context and realities of adolescents in Vanuatu, Tonga and Chuuk State who face unplanned pregnancy and motherhood. An account of the lived experiences and perspectives of the young women and girls themselves is necessary to gain an adequate grasp of those realities. In addition to personal, family and relationship stories, the study enquired into access to sexual and reproductive health services; enablers and constraints to decision-making and action; traditional knowledge and practices of fertility control; and the role of older women in these matters.

The research employed in-depth ethnographic interviews with girls and young women, aged 16–19 years, who have experienced unintended pregnancy and motherhood. The study also investigated traditional and contemporary knowledge around fertility limitation practices, including from the viewpoints of older women, using face-to-face interview methods and focus groups with older women. Data collection was undertaken at three sites in Vanuatu, at three sites in Tonga, and on Weno in Chuuk, including in isolated and mountainous areas.

The findings have direct programmatic implications for the development of culturally informed and age-appropriate sexual and reproductive health, social support and educational services for adolescent mothers and young girls. The need for such services is indicated by high teenage fertility rates (see Table 1, p. 6). The findings also offer insights into the significance of wider health and social policy and programming for this group and contribute to a regional evidence base. Through its methodology, the study centralises the experiences of, and gives voice to, the young women themselves, the wellbeing of whom has human rights and gender equity implications in the Pacific.

The objectives of the research were:

- to understand the issues associated with unplanned adolescent pregnancy from the point of view of young women in Vanuatu, Tonga and Chuuk State
- to understand the social and structural factors impacting young women who experience adolescent pregnancy and motherhood in Vanuatu, Tonga and Chuuk State
- to better understand the use of traditional and other practices of fertility limitation, in Vanuatu, Tonga and Chuuk State, and the impact on the experience of adolescent pregnancy and motherhood
- to give voice to adolescent girls in the Pacific.

2 Literature review

2.1 Adolescent unplanned pregnancy

Adolescents bear a disproportionate burden of poor sexual and reproductive health outcomes in lower- and middle-income countries (Patton et al., 2016). The 2030 Agenda for Sustainable Development includes 17 Sustainable Development Goals. Goal 3 on health and wellbeing aims to 'ensure healthy lives and promote well-being for all at all ages'. The target indicator for goal 3.7 on sexual reproductive health is a reduction of adolescent birth rates. In the Pacific, the Moana Declaration of 2013, as endorsed by Pacific parliamentarians, focuses on sexual and reproductive health and acknowledges the need to prevent unplanned pregnancies and prioritise sexual and reproductive health services for adolescents (UNFPA, 2013b).

The adolescent fertility rate among women aged 15–19 years is far lower in developed Pacific rim countries such as Australia, with an estimated 10 births per 1,000 women aged 15–19 years in 2017 (ABS, 2018), and New Zealand, with an estimated 15 births per 1,000 women aged 15–19 years in 2017 (Statistics New Zealand, 2019), compared to the data provided in Table 1. As indicated in Table 1, Vanuatu has the third-highest adolescent fertility rate in the region. Notably, the Federated States of Micronesia (FSM) has the second-highest maternal mortality rate after Papua New Guinea.

Adolescent pregnancy and motherhood can have long-term negative impacts on the health and social and economic wellbeing of mother and child (Patton et al., 2016; Sawyer et al., 2012; UNFPA, 2013b; UNFPA, 2013c). Adolescence is a time of critical development, as physiology, cognition, psychology and social functioning develop rapidly. Unmet need for contraception, lack of information and lack of bodily autonomy can lead to unplanned adolescent pregnancy (UNFPA, 2013a). Young women tend to bear the burden of adolescent pregnancy and motherhood, which can have a long-term negative impact on their health and social and economic wellbeing (Patton et al., 2016; Sawyer et al., 2012; UNFPA, 2013a). Depression, unsafe abortion, and pregnancy and labour complications are serious health risks due to adolescent pregnancy (UNFPA, 2013a), which is associated with increased risk of low birth weight, pre-term births and stillbirths (UNFPA, 2013b).

The impact of adolescent pregnancy extends beyond that on the individual mother (Sawyer et al., 2012). In low- and middle-income countries, 'health inequities related to social and cultural norms, gender power imbalance, education and socio-economic deprivation affect young and unmarried women in particular' (Bell et al., 2018, p. 5). Any stigma and marginalisation associated with teen motherhood will exacerbate those impacts. Teenage pregnancy often leads girls and young women to drop out of school. It limits income-earning potential for the mothers and can also limit their opportunities and choices (UNFPA, 2013a; Viner et al., 2012). In the Pacific, adolescent fertility and related outcomes have wider implications for development, as well as gender equity and human rights imperatives (Kennedy et al., 2013b; UNFPA, 2013a).

Adolescents are a neglected group in health and social programming (Bearinger, Sieving, Ferguson, & Sharma, 2007), and knowledge on how best to promote adolescent sexual and reproductive health is patchy (Bell et al., 2018; O'Connor, 2018). Much of the critical literature on teenage pregnancy derives from a Western context and focuses on clinical services to reduce adolescent fertility. However, it has been argued that the health and wellbeing of adolescent mothers in the Pacific would be better served by attention to cultural and social features of the society than by a focus on contraceptive technologies (McPherson, 2016).

Table 1: Reproductive Health Indicators for Pacific Island countries[1]

	Adolescent fertility rate (births per 1,000 women 15–19 years)	Total fertility rate (births per 1,000 women 15–49 years)	Unmet family planning rate (percentage of women 15–49 years)	Contraceptive prevalence rate (percentage of women 15–49 years)	Maternal mortality ratio (per 100,000 women 15–44 years)
Cooks	67.7 (2009–13)*	2.7 (2009–13)*	–	48 (2001–05)*	0 (2008–12)*
FSM	44 (2010)*	3.5 (2010)*	44 (2002)*	40 (2009)*	140.6 (2016)[2]
Fiji[3]	23.1 (2015–17)	2.9 (2015–17)	20 (2000)*	38.4 (2013)*	14 (2015–17)
Kiribati	49 (2010)*	3.9 (2010)*	28 (2009)*	22.3 (2009)*	90 (2015)[4]
RMI	85 (2011)*	3.4 (2011)*	2.4 (2009)*	16 (2010)*	105 (2007–11)*
Nauru	94.3 (2011–13)*	3.9 (2011–13)*	23.5 (2007)*	25.1 (2007)*	0 (2011–13)*
Niue[5]	19.9 (2007–11)*	2.7 (1987–2016)	–	22.6 (2001)*	0 (1996–2016)
Palau	27 (2015)*	2.2 (2015)*	–	22.3 (2010)*	0 (2010)*
PNG[6]	68 (2016–18)	4.2 (2016–18)	25.9 (2016–18)	36.7 (2016–18)	215 (2015)[7]
Samoa[8]	56 (2010–14)	5.1 (2010–14)	34.8 (2010–14)	15.3 (2010–14)	51 (2015)[9]
Solomon Islands	77 (2015)*	4.4 (2015)*	34.7 (2015)*	29.3 (2015)*	114 (2015)[10]
Tokelau	29.8 (2006–11)*	2.1 (2015)*	–	–	–
Tonga	31.9 (2016)*	4.1 (2009–12)*	25.2 (2012)*	28.4 (2012)*	124 (2015)[11]
Tuvalu	28 (2012)*	3 (2012–16)*	24.2 (2007)*	31 (2007)	0 (2010)*
Vanuatu	81 (2013)*	4.2 (2013)*	24.2 (2013)*	47 (2013)*	78 (2015)[12]

1 Up-to-date data is not available for all countries. Statistics marked with an * have been sourced from SPC, *National Minimum Development Indicators*. Retrieved from http://www.spc.int/nmdi/maternal_health. Other sources are footnoted.

2 Source: Government of Federated States of Micronesia (FSM). (2017). *Title V 2018 MCH Block Grant Application and 2016 Annual Report. Palikir, Pohnpei: Department of Health and Social Affairs, FSM National Government*. Retrieved from https://mchb.tvisdata.hrsa.gov/uploadedfiles/StateSubmittedFiles/2018/FM/FM_TitleV_PrintVersion.pdf.

3 Unless marked with an *, the source of the Fiji statistics is Fiji Bureau of Statistics (FBoS), Registrar General's Office (Ministry of Justice, CRO) & Ministry of Health & Medical Services (MoHMS). (2019). *Republic of Fiji Vital Statistics Report 2012–2017*. Retrieved from https://www.statsfiji.gov.fj/index.php/statistics/social-statistics/vital-statistics-report.

4 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

5 Unless marked with an *, the source of the Niue statistics is Statistics and Immigration Office Ministry of Finance and Planning Government of Niue. (2018). *Niue Vital Statistics Report 2012–2016*. Retrieved from http://beta.sdd.spc.int/media/212.

6 Unless otherwise indicated, the source for the Papua New Guinea statistics is National Statistical Office (NSO) [Papua New Guinea] and ICF. (2019). *Papua New Guinea Demographic and Health Survey 2016–18: Key Indicators Report*. Port Moresby, PNG, and Rockville, Maryland, USA: NSO and ICF.

7 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

8 Unless marked with an *, the source of the Samoa statistics is Samoa Bureau of Statistics & Ministry of Health. (2015). *Samoa Demographic and Health Survey 2014*. Retrieved from https://www.sbs.gov.ws/digi/Samoa%20DHS%202014.pdf.

9 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

10 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

11 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

12 Retrieved from https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being.

2.2 Adolescent sexual and reproductive health in the Pacific

There is some data on various aspects of sexual and reproductive health in some Pacific Island countries, but the amount that focuses on young people is limited. Within the literature on sexual and reproductive health and adolescent pregnancy, cultural taboos surrounding sexuality and the shame associated with the discussion of sex is a common theme. These taboos discourage communication about sex in families, schools and churches. Consequently, adolescents tend to have limited knowledge about sex and sexuality and limited access to sexual and reproductive health services (Jenkins & Buchanan-Aruwafu, 2006; O'Connor, 2018). The impact of such taboos is also highly gendered.

In the Solomon Islands, taboos about the discussion of sex are strong and act as a barrier to discussing sex in certain contexts. These taboos also serve as a barrier in the provision of sexual and reproductive health services (Buchanan-Aruwafu, Maebiru, & Aruwafu, 2003; Raman, Nicholls, Pitakaka, Gapirongo, & Hou, 2015). Buchanan-Aruwafu, Maebiru and Aruwafu (2003) highlighted how discussion of sexuality is regulated through gendered social norms, with shame and gossip playing a key role. Yet, young Solomon Islanders in Auki have developed indirect ways of speaking about sex and sexuality by using slang and metaphors. Similarly, in Papua New Guinea, the shame surrounding pregnancy outside of marriage, and gossip that focuses on the young mothers rather than the fathers, directs the blame for unplanned pregnancy on young women (Kelly et al., 2010).

Research on unmet need for contraception and knowledge and attitudes towards contraception and sexual education has been conducted in Fiji; however, few of these studies focus on adolescents (see Lincoln, Mohammadnezhad, & Rokoduru, 2017; Naidu, Heller, Koroi, Deakin, & Gayaneshwar, 2017; Naz, 2014; Varani-Norton, 2014). One study that focused on the outcomes of adolescent pregnancy in Suva, Fiji found that teenage pregnancy, as in other countries, tends to be high risk and that health interventions should be tailored for young women to reduce adverse health outcomes, including perinatal death (Mahe, Khan, Mohammadnezhad, Salusalu, & Rokoduru, 2018).

Recent Fijian data highlighted the role of emotions in adolescent sexual and reproductive decision-making, calling for greater attention to the subjective views and understandings of adolescents themselves and to the socio-cultural and structural environments that shape them (O'Connor, Rawstorne, Devi, Iniakwala, & Razee, 2018). It was found that adolescents place emphasis on confidence, resilience and access to services, yet adolescent iTaukei women's priorities diverged from this norm in that their priorities focused on preventing shame and preserving their sexual reputation (O'Connor, 2018). At the same time, adolescent women desired agency and freedom in relation to sexual and reproductive wellbeing (O'Connor et al., 2018).

Because they do not require a doctor's prescription, condoms are often the easiest contraception for young people to first access. In writing about factors related to condom use among young people in Tonga and Vanuatu, McMillan and Worth (2011) pointed to a mismatch between condom knowledge and condom use practice and in doing so stressed the role that wider socio-cultural factors – rather than simply knowledge – have on condom use. They noted the way in which the importance of shame regulated behaviour and limited not only access to condoms but also their use: condom use was associated with casual sex and promiscuity and most young Tongan women interviewed expressed resistance to condom use in order to uphold a respectable feminine identity (McMillan & Worth, 2011).

Research among adolescents in Vanuatu also suggests that socio-cultural norms and taboos are the most significant barrier to youth accessing sexual and reproductive health services (Family Planning New Zealand, 2019; Kennedy et al., 2014). Information for adolescents has tended to focus on sexually transmissible infections (STI) and HIV, while young people have indicated a preference for more information about pregnancy, condom use, puberty, sexuality and relationships (Kennedy et al., 2014). Similarly, research among young Cook Islanders found that they had little knowledge of pregnancy and prevention of STI and that they want knowledge and communication skills, particularly about contraception and teenage pregnancy, to enhance their understanding and decision-making related to sexuality (Futter-Puati, 2017).

A study focused on experiences of teenage pregnancy in the Cook Islands found that participants reacted to learning they were pregnant with denial and fear. Abortion emerged as a key theme, with all participants having considered abortion but none able to obtain one (White, Mann, & Larkan, 2017). This study found that the cultural importance of motherhood meant that these young women also had positive feelings about motherhood (White, Mann, & Larkan, 2018). In the Pacific, children are valued for their contribution to the family as a source of labour and social support. The family structure includes children who have been informally adopted and accepted as part of the family, often but not always adopted from the extended family (Farran & Corrin, 2019). Farran and Corrin (2019) noted that high rates of teenage pregnancy mean that there are also high rates of informal interfamily adoption, but incomplete data makes it difficult to assess the scale of adoption of babies of teenage mothers.

Knowledge about the social and structural elements that frame adolescent decision-making around sex and reproduction in other Pacific Island societies is currently limited. Most data on adolescent pregnancy in the Pacific are quantitative, providing little purchase on factors impacting high rates, or experiences and range of consequences, of adolescent pregnancy.[1] Furthermore, while traditional healers are an acknowledged part of the informal health system in the Pacific (Kennedy et al., 2013a), there are no data on traditional methods of fertility limitation, nor on the role of traditional knowledge in fertility decisions (Kennedy et al., 2013a; Kennedy et al., 2014).

Globally, it is estimated that, among 15–19-year-old women, 3.2 million unsafe abortions take place in developing countries each year (Shah & Ahman, 2012). The stigma surrounding abortion, laws that make abortion illegal, a lack of youth-friendly services, and the constrained agency of young women act as barriers to adolescent women and girls accessing safe abortion services (IPPF, 2014).

Little is known about women's experiences of fertility limitation in the Pacific. Jolly (2002b) noted that some women in the Pacific still use indigenous methods of herbal medicines, massage and other means, as well as biomedical preparations, to induce abortion and that little research has been done on abortion practices in the contemporary Pacific. Research on abortion in the Pacific context is needed to better understand practices and links to maternal mortality (FPI & SPC, 2009). As noted by Chetty and Faleatua (2015), access to information about sexual and reproductive health, as well as contraceptive commodities, is difficult and access to safe abortion is simply not an option for adolescents in the Pacific. The International Planned Parenthood Federation has put forth a set of promising practices to strengthen abortion service provision to young women that includes integration with other youth programs; increasing staff

1 Bell et al. (2018) describe plans to undertake qualitative research focused on the social context and the lived experiences of pregnancy for young women and young men to inform the development of youth-specific health promotion responses to pregnancy in Papua New Guinea.

commitment; focusing on confidentiality and autonomy; utilising a harm reduction model; understanding consent laws; peer promotion; applying a buddy system; advocacy by example; and social media and mobile outreach (IPPF, 2014).

There is limited documentation of unplanned pregnancy and abortion in Papua New Guinea (see Sanga, Costa, & Mola, 2010; Vallely et al., 2014). With an estimated 733 maternal deaths per 100,000 live births, Papua New Guinea has an extremely high rate of maternal mortality (NSO-PNG, 2009). A study that examined 21 maternal deaths at Goroka General Hospital between 2005 and 2008 found that 10 deaths (48 per cent) were due to sepsis after birth or following induced abortion. Of the three deaths of women under the age of 19 years, all were due to complications from unsafe induced abortions (Sanga et al., 2010). The study documented the case of a 17-year-old girl who was single, sexually active and facing an unplanned pregnancy. She had never sought contraception, as she thought that it was only available to married women. The girl obtained herbs traditionally used to induce abortion because she felt that her relatives would not accept her pregnancy and because she wanted to continue her education. She died of sepsis three weeks after she attempted to induce an abortion (Sanga et al., 2010). Similarly, another study in Papua New Guinea found that women who induced abortion were significantly more likely to be younger, single and studying, with a pregnancy that was unplanned and unwanted, compared to women who had a spontaneous abortion (Vallely et al., 2014). The study reported women inducing abortion by misoprostol (50 per cent), physical means (22 per cent), traditional herbs (11 per cent), cultural beliefs/sorcery (7 per cent) and other means (9 per cent) (Vallely et al., 2014).

A 2015 study conducted by the Vanuatu Family Health Association focused on induced abortion in Vanuatu, examining attitudes and practices of communities and key informants (health providers, herbalists, chiefs and legal representatives). The study respondents cited consumption of lemon fruit, kastom medicine, vigorous exercise, inserting objects into the uterus and taking contraceptive pills as being methods to induce abortion (Tao, Ssenabulya, & Van Dora, 2015). Respondents from urban areas suggested that the reasons why a woman might have an abortion included fear of parents or others finding out (14 per cent); insufficient resources (10 per cent); continuing career/school (7 per cent); incest (5 per cent); rape (4 per cent); too many children (2 per cent); and other reasons (7 per cent) (Tao, Ssenabulya, & Van Dora, 2015). A study on recent family planning in rural Vanuatu found that when abortion arose during discussions on unplanned pregnancy, the dominant perception was that it is morally wrong. In-depth interviews were conducted with 12 women, with one woman noting that she had terminated her own pregnancy and another describing her unsuccessful attempt to access an abortion (Family Planning New Zealand, 2019). While discussing the scenario of unintended pregnancy among Fijian youth, some participants said they would keep the pregnancy a secret and they would consider seeking an abortion, despite accessibility to safe abortion being limited (O'Connor, 2018).

Context-specific strategies are necessary to create an enabling environment for adolescent sexual and reproductive health and the wellbeing of adolescent mothers in the Pacific (Kennedy et al., 2013a). These strategies must be informed by the lived experiences of young women. Yet research on the topic seldom includes the voices of adolescent mothers themselves (Barcelos & Gubrium, 2014; Mann, Cardona, & Gómez, 2015).

3 Methodology

3.1 Research design

This research addresses methodological and empirical gaps in knowledge about unplanned adolescent pregnancy in Vanuatu, Tonga and Chuuk State. The findings are intended to inform the development of targeted health and social policy and programming; raise the profile of young women's voices; and, consequently, help further human rights and gender equity in the Pacific.

The study was designed to produce ethnographic data on issues associated with adolescent unplanned pregnancy and motherhood in Vanuatu, Tonga and Chuuk State. Ethnographic methods produce detailed or 'thick' (Geertz, 1973) description and prioritise the subjective realities of the research participants (Glaser & Strauss, 1967), characteristics that are important when we seek a nuanced understanding of factors affecting decision-making and underpinning behaviours, and the meanings of actions and events in the lives of participants. Ethnographic methods are increasingly used in development research (see van Donge, 2006) and in public health and service user research (Stahler & Cohen, 2000; Ratner, 1993).

Qualitative in-depth face-to-face interviews were conducted with young women (16–19 years old) who have experienced unintended pregnancy in Vanuatu, Tonga and Chuuk State. The collection of personal story data enabled the mapping of issues related to adolescent unplanned pregnancy and motherhood, as they have played out in the lives of 63 young Pacific women. In acknowledgement of the ongoing cultural importance and use of traditional medicines in many Pacific countries, the study includes enquiries into traditional as well as contemporary means of fertility control and the role and viewpoints of older women in those three countries. Focus group discussions are highly effective means of revealing accepted group norms. Because of this, focus group discussions collect a different type of information than can be garnered from private interviews, and the opinions and views expressed in these discussions may even be at odds with the personal beliefs and experiences of the individuals who are part of that group.

3.2 Ethical approvals

Prior to the commencement of fieldwork, applications were submitted and approvals were obtained from the UNSW Human Subjects Ethics Committee, UNSW Australia, the FSM Department of Health and Social Affairs Institutional Review Board, the Tongan Government and the Ethics Committee of the Ministry of Public Health Vanuatu.

3.3 Data collection and analysis

The study aimed to produce nuanced accounts of a range of factors impacting on the experiences of unplanned adolescent pregnancy and motherhood, and to explore the key thematic areas. Data was collected through 20–25 face-to-face interviews in each country with participants 16–19 years old who have had an unintended pregnancy. Participants were recruited through convenience and snowball sampling. Interviews followed the General Interview Guide method and were conversational in style. Interviewers first asked the young participants to tell their own story. Further open-ended questions enquired into how the participant managed unintended pregnancy and motherhood; the consequences of the pregnancy; access to information on fertility control; access to and use of both traditional and contemporary knowledge around fertility control; and enablers and barriers to decision-making and action. Interviews were voluntary and all participants were provided with verbal

and written information about the study and gave verbal and written consent to be interviewed. Interviews generally took approximately 30 minutes and most interviews were recorded. The majority of interviews were conducted in the participants' first language by local research assistants who had been trained for this project. A smaller number were conducted in English by a chief investigator. The training of research assistants focused on the aims of the data collection; principles and practice of qualitative data collection; ethical considerations when collecting data on sensitive subjects; and child protection during research. All research assistants, interviewers and translators engaged on this study signed a strict confidentiality agreement prior to beginning any work on the project.

A total of 94 face-to-face interviews and five focus groups discussions were conducted in Vanuatu, Tonga and Chuuk State during June and July 2019. This included:

- 63 face-to-face interviews with 16–19-year-old young women who had experienced unplanned pregnancy
- 31 interviews with women who were over 50 years of age or grandmothers
- five focus group discussions with women who were over 50 years of age or grandmothers.

Interviewers debriefed with a chief investigator following each interview.

In each country, local Pacific women interviewers were trained and employed. The data collection documents and instruments, as well as the interview contents, were discussed constantly with those interviewers. Pacific early career (academic) researchers were involved in the analysis of data.

3.4 The study in Vanuatu

Vanuatu has a population of more than 270,000 people spread across an archipelago of 82 small islands. It is estimated that 75.6 per cent of the population live in rural areas (UNFPA, 2015). In 2009, it was estimated that 57.8 per cent of the female population were between the ages of 15 and 49 years (UNFPA, 2015). The high burden of adolescent unintended pregnancy has been identified as a problem nationally (Prime Minister's Office, 2010). However, young age at first pregnancy may also be in part an outcome of young age at marriage. In 2007, it was reported that 24% of women were married before 18 years of age (MICS, 2007). According to the 2009 census, the adolescent (15–19 years) fertility rate was markedly higher in rural areas of Vanuatu (77/1000) than in urban areas (40/1000) (VNSO, 2009).

As with much of the Pacific, available reproductive health indicator statistics are difficult to compare due to variance in frequency, coverage, collection sites and estimation methods. Regardless of these limitations, it is evident that maternal mortality is high compared to the rest of the region. Carter and colleagues (2016) estimates showed an increasing annual maternal mortality ratio from 70 per 100,000 births for the period 1979–2001 – a figure which was taken from the labour ward at Port Vila hospital (Grace and Vurobaravu, 2003) – to 130 per 100,000 births for the period 1999–2009. Trends are somewhat unclear, however, as Hogan and colleagues modelled estimates of maternal mortality in Vanuatu as 230/100,000 for the year 2000 and 178/100,000 in 2008 (Hogan et al., 2010). Recent SPC data gives a figure of 78 per 100,000 for 2015.

In addition, there are differences between rural and urban data and between outcomes from health facility type. While data from community health facilities compared to hospital sources showed that proportional mortality was remarkably similar for major causes of death, this was not the case

for maternal deaths (Carter et al., 2016). Maternal deaths were markedly higher in community health facilities than in hospitals. Maternal deaths made up 10% of adult female deaths 15–59 years in community health facility and 4–5% in hospital data, and 8% as a weighted national estimate (Carter et al., 2016). In urban areas, 92% of births were in health facilities and 87% of births were delivered by skilled personnel (MICS, 2007). In rural areas, 78% of births were in health facilities and 72% were delivered by skilled personnel (MICS, 2007).

According to a 2011 comprehensive household survey conducted by the Vanuatu Women's Centre, there are high rates of intimate partner violence, with 60 per cent of women reported to have experienced physical and/or sexual violence (UNFPA, 2015). Notably, 41 per cent of first sexual experiences were forced and/or unwanted (UNFPA, 2015). The adolescent birth rate is 66 (40 urban and 77 rural) per 1,000 women aged 15–19 years and is one of the highest in the Pacific region (UNFPA, 2015). Abortion is illegal in Vanuatu, except if it is medically needed to save a woman's life. There is a limited number of reported cases of women facing legal action after they presented to a clinic following an abortion (UNFPA, 2015).

Data collection for the Vanuatu study took place during May and June 2019. Vanuatu data was collected from the provinces of Shefa, Sanma and Tafea. In total, 36 face-to-face interviews were conducted in Vanuatu and two focus group discussions were held. All but one of those interviews was in Bislama. In Shefa 14 face-to-face interviews were conducted with 16–19-year-olds, two face-to-face interviews were conducted with women over 50, and one focus group discussion was held with seven older women. In Sanma, five face-to-face interviews were conducted with 16–19-year-olds and five face-to-face interviews were conducted with women over 50. In Tafea, seven face-to-face interviews were conducted with 16–19-year-olds, three face-to-face interviews were conducted with women over 50, and one focus group was held with 10 older women. On Tafea, three girls who presented to be interviewed had to be declined because they were younger than 16 years of age.

Four local research assistants were recruited, received training and were engaged to work on the data collection in Vanuatu. Crucial logistical support for participant recruitment and data collection on Tafea was provided by CARE Vanuatu, which runs projects that aim to keep girls in school, provide more learning opportunities and better health care for girls and women, and change community attitudes to violence. Program staff are embedded in the communities they work in and with. Members of the CARE team who regularly conduct outreach to young women living in rural areas extended invitations to young mothers to participate. Interview days were planned to coincide with other local programs aimed at young mothers. There was no obligation or pressure on those attendees to present for interview, and no records were kept of who did the interviews. Other young interviewees made their own way to the interview site and were provided with bus fare to return home. In Shefa, snowball recruitment was seeded by community invitations spread by word of mouth through several communities with which the research team had initial connections. One of the research assistants was herself still at school and extended invitations to young participants through youth networks, including school and sports groups. Recruitment was opportunistic in Sanma and began by telling women in the markets about the project and the criteria for inclusion. Mothers with babies on the streets who were obviously young were also informed about the research and invited to participate or to refer others.

All data collection documents used in Vanuatu, including the Participant Information Sheets and Consent Forms, were

translated from English to Bislama. Signed consent was gained for all interviews. In addition, consent was verbally confirmed and recorded. Twenty-eight of the interviews were recorded. A further eight interviewees declined to be recorded but agreed to be interviewed and extensive notes were taken. The older women in the focus groups also declined to be recorded. The older women said that they were shy about anyone hearing their voice on tape. The younger women who declined to be recorded were fearful of being in some way exposed on social media. They also cited television dramas with narratives around secretive recordings and negative outcomes.

Bislama interviews were translated into English and those translations were then checked against the original audio files and verified by a second translator. All potentially identifying data was deleted or altered at the time of transcription. Translated and transcribed files were coded by at least two different researchers and code categories were generated independently. Code identification was attentive to the dominant themes that emerged from the interviews, as well as topics laid out in the study's terms of reference. Initial data sets were compared for each category, final codes were confirmed, and coding trees and coded data sets were created. As the interview numbers were relatively small, all coding and set compilation was done manually. This manual method has the advantages of facilitating a high level of familiarity with the transcripts and allowing the consideration of the interviews as individual cases as well as in data fragments.

4 Results and discussion

4.1 Experiences of unintended pregnancy and motherhood

This study is grounded in young women's experiences of pregnancy and motherhood. While the results presented here aim to describe and highlight experiences that were common among the participants in our study sample, we also present divergent experiences.

In the following section, data on key topic areas are described and summarised.[2] Particular attention is paid to the range of experiences and views expressed, as well as to commonalities. There is a heavy focus on the use of direct quotations in order to give strong voice to the participants. All names have been changed and the names assigned to the quotations are *not* the participants' real names.

This study sample is non-random and as such it cannot claim, nor was it intended, to be statistically representative of all unplanned adolescent pregnancies in Vanuatu. Throughout the reporting of results, words such as 'a few', 'some' and 'many' are used instead of exact numbers. The resultant imprecision is deliberate and intended to prevent misinterpretation or misrepresentation of the data. Documentation of exact numbers or percentages of participants who reported the same experience, circumstance, practice or belief could otherwise be taken to suggest, erroneously, that such percentages are generalisable to the wider population.

4.1.1 Family and community attitudes

As well as being worried about the reaction of family members, other common fears when participants found themselves pregnant were of gossip and exclusion. Betty's concerns were most typical of the sample:

> *[N]ews started spreading, spreading out in my community and people knew that I was pregnant. I felt that I did not want it, I was embarrassed. I thought that I would not be able to join sports, or go to school. Because I was too young I felt that people would talk about me.*
>
> (Betty, pregnant at 17, Sanma)

Anna, 17, from Shefa, equated community with gossip, saying 'I was afraid that people would talk about it … I was afraid because we live in a community'. Paula found that community attitudes to her pregnancy and subsequent miscarriage were mixed:

> *There was talk that went around, people talked about me and that I made a mistake, but also a lot of people encouraged me, especially the mamas [older women]. Some talked to me harshly, saying 'you know you spoiled a person, that was a person'. I said 'yes but I didn't know'. But there were a lot of people who encouraged me and said 'Next time! Let this be the first and the last [mistake/miscarriage]' and that I shouldn't do bad things or make a mistake again.*
>
> (Paula, 18, Shefa)

2 The interviewees emphasised different elements of their own stories and, as those emphases differed slightly between the three country data sets, the topic headings vary slightly between the country reports.

Kaye had a baby at 18. Even though her parents opposed her relationship with the baby's father, she said that everyone was happy about the baby:

> *After delivery I came home. The neighbours, friends, family members they were happy that we have a little baby and when they'd come, every morning they would bring food and gifts and presents.*
>
> (Kaye, 18, Shefa)

Indeed, in these narratives, community and wider family appear to become more supportive over time and attitudes changed once the baby was born. Jill remembered:

> *I became stressed out during the first months of my pregnancy because of what I was up against: the gossip and my relatives' words hurt me. But then later all of them apologised to me. My mum was, and still is, the most helpful. I was adopted by my mum's sister when I was a baby. My real mum also lives just next door so both my two mums have been taking good care of me and giving me advice and seeing that I get what I need – money, baby's stuff, etc. My mum who I'm living with now apologised for how they had illtreated me, and did my laundry and cooked for me when I was pregnant. My two mums were very close to me because they knew there was a baby in me and that the baby and I had to be looked after.*
>
> (Jill, 19, Shefa)

Parents' first responses were almost invariably negative. Anger was the most commonly described family reaction. One of the participants described her father wanting to kick her out of the house, although eventually he relented:

> *My Dad was not happy, he was mad. He told me, 'girl, you stand up, take your basket, and go and see that boy. I do not want to see you anymore in my house', and my Mum too supported what my Dad said and they turned me out then. I am still with them though. I cried and I knew I was wrong and they finally accepted me back.*
>
> (Ilona, 19, Tafea)

Mostly anger towards pregnant adolescents was expressed verbally, but some participants said that they were physically beaten by their family members.

A few participants also reported physical violence from boyfriends – but, perhaps because few of the young women lived with their partners, this was not common in this sample. Although they do not live together and he provides no financial support, Jill described a relationship with the baby's father that is marked by violent episodes:

> *My boyfriend is a good man but he can sometimes do nasty things to me when he gets mad. He comes over and sees me in our bush kitchen. We can talk like we want but when he's mad we often argue, or he could throw a stone at me. He does not support the baby and I financially.*
>
> (Jill, 19, Shefa)

The participants invariably described meekly accepting any verbal abuse they received, as they felt guilty:

> *I just shut up when they were letting out their anger on me because I felt guilty.*
>
> (Ella, 17, Shefa)

> *Dad and mum … they couldn't talk to me properly, they talked hard at me, and we came home. Dad got angry at me, brothers came and got cross with me, the small mummies [female relations] too came and got angry at me. I stayed quiet and they all got angry with me for a long time.*
>
> (Mary, 16, Tafea)

Sometimes, other members of the family were more supportive than the parents:

> *My mum and dad, they did not like me, they started getting cross with me but my aunty and my uncle, there were good to me, they helped me, talked well to me. My aunty came with me, we went to the hospital and did my first visit.*
>
> (Tricia, 17, Tafea)

Ilona described the intervention of an uncle who somehow knew about her predicament. Accompanied by a friend, she was on her way to seek kastom medicine to end her pregnancy:

> *I came past one of my uncles who is a pastor. He called me and asked me, 'where are you two going?' and we tried lying to him but he knew, so he called me and held my hand and said 'what you are doing is not a good thing'. And he helped me because he talked to my parents to tell them about the situation that I am in. What he did at that time, we came, stayed together, shared food, and he discussed it with my parents. My parents reactions were, at that time, not too good.*
>
> (Ilona, 19, Tafea)

The reactions of family and community members demonstrate that the participants' fears of gossip, stigma and exclusion were usually well founded.

4.1.2 Postnatal experiences and motherhood

Despite early tensions and anger, most of the participants in our sample and their babies were still living with family members. Both the young mother and her child were usually being supported by their family. As Mary said:

> *Mum and Dad they bought the clothes, food for me, they bought all the things for me and the baby, whatever we needed at the hospital, Mum and Dad bought.*
>
> (Mary, 16, Tafea)

Although the girls were usually treated harshly by family during their pregnancy, most families had a change of heart once the baby was born:

> *My parents would get angry at me, saying 'school first', and 'why do you do this?' and get angry. But after I gave birth then they stopped getting cross at me. They were glad and 'til now they're happy with the baby.*
>
> (Nora, 19, Shefa)

> *Mum was mad at me when she found out about my pregnancy. But soon after she became very caring. She talked very nicely. She looked after me very well during my pregnancy and now my baby is like another son of hers.*
>
> (Jill, 19, Shefa)

Nora, like nearly all the young mothers, said that her baby was a source of great happiness:

> *When I went to give birth to the baby there was a happiness in me that I never felt in my life before.*
>
> (Nora, 19, Shefa)

The baby had a positive effect on her and her family:

> *I was 17 going 18 when I gave birth to her – after that I started seeing that in the house, my parents were happy with the baby, like my mum and dad, her grandparents were happy with her. And a good thing is that my Dad was always drunk but when the baby was born he limits his drunkenness, like his alcohol stopped. So yeah that is one good thing is that I see that the family is happy, they are happy to have a grandchild. One good thing too is that some things I didn't not how know to do, I learned. I learned a lot of things.*
>
> (Nora, 19, Shefa)

Ongoing tensions within the family did remain for some of the young mothers. Along with shame, the financial burden placed on the wider family was frequently a source of resentment from brothers. Jill said:

> *My older brothers were always arguing with me. Even though they've apologised, they still sometimes get upset when they see me … going on about why I didn't stop myself from getting pregnant and causing more work for our parents – about making them care for me and the baby, and because I still can't support myself and the baby financially.*
>
> (Jill, 19, Shefa)

While adolescent motherhood sometimes caused financial problems for the wider family, this was especially so for older women left caring for both mother and child. Most of the young mothers and their babies continued to live with parents or a grandmother. Some young mothers stay home and care for the child – but others described themselves as being as free as they were before. In Tafea in particular, it was common for single great-grandmothers to care for the children while the younger generations worked. Only one in our sample was adopted out of the family. In that case, the young mother had been disowned by her own family. Several other participants told of the family of the baby's father or others wishing to adopt the child.

Not all the participants reconciled with their family. Vera, 17, from an outer island, was beaten badly by various family members, and kicked out of home once her parents discovered that she was five months pregnant. She stayed with a friend and was taken in and cared for by the pastors of a church. Those pastors seemed to feel that they owned the baby as a result and they took it with them to another island:

> *[The baby's father] heard that we went to the hospital and it was a little girl. He came down and saw the child looked exactly like him. The pastor yelled at him and said 'you cannot take that little girl, she's mine, I paid everything already, I will adopt her'. I stayed with the pastor for one year three months, and then they took me back to my uncle, and they took the little girl back to [another island].*
>
> (Vera, 17, Tafea)

Very few of the young mothers in our sample were cohabiting with the father of their baby. In a small number of cases, financial support was provided by the father's family, but this was not common. In one case, the father's family was caring for the baby.

4.1.3 Relationship with father of baby

Only one of the participants in this study said that she became pregnant as the result of a casual relationship or once-only sex. While not all the fathers of the babies were significantly older, many were. Many of the older men were married or in other relationships.

Several of the young mothers who had initially set up house with the child's father found that the man had other women and other households, for whom they would be regularly abandoned. For example, Betty said that returning to Sanma after visiting her family home:

> *He was no longer with us. He let go of us and went and stayed with some other family, and then if he wanted to come back he would come back to the two of us, and then go back again. And then he never thought of coming back to us.*
>
> (Betty, pregnant at 16, Sanma)

Carol also found that her partner just disappeared from her life:

> *I went to deliver and after my delivery he didn't stay anymore with the little one. He just left us. And then I heard that he went and lived with a different woman again.*
>
> (Carol, pregnant at 17, Sanma)

Some girls were away from family – living on another island for school or working as a house girl – at the time they became pregnant:

> *I came back to Sanma to school, and I was going back and forth to school and I was taking a bus. Every morning to go to school I was going on that bus and every afternoon when I was coming home. I started following the bus driver for a while and then I started being friends [going out] with the bus driver. I followed the bus driver and we stayed together for a while and our friendship became strong.*
>
> (Betty, pregnant at 16, Sanma)

When young girls were away from home for school or work, they were often attracted to friendships with, and perhaps susceptible to the sexual attentions of, older men linked to home and community. Whether with older or younger men, the sexual relationships developed as a result of regular contact through daily travel or work activities.

Some of the same-age fathers were relatives, such as second cousins. Others were neighbours or school mates. Ella, 17, living in Shefa, kept the same-age father's identity a secret so that he would not get kicked out of school and because she believes her family would attack him. The parents of same-age fathers also often acted to safeguard the boy's future prospects, by banning the relationship or by sending him overseas to study.

Young or old, the partner's first response was often to deny paternity:

> *I tried my best to tell the boy who I had the affair with, who was my neighbour. After I told him, he was angry with me and he didn't want to accept that he had a baby from me because we were too young to have babies, we were still in school.*
>
> (Gina, 17, Shefa)

> *The news then reached my boyfriend and the first thing which my boyfriend said to his family was that the child was not his. I told him that it was his, the bus driver's, but they said, no, it was not his.*
>
> (Betty, 16, Sanma)

> *I decided to go and stay with my partner, the one that I became pregnant to. When I went and told him, he ignored me: he said, 'No, that child is not mine'.*
>
> (Ilona, pregnant at 17, Tafea)

Another young woman, Nora, 19, from Shefa, said that her boyfriend wanted her to seek out kastom medicine for fertility limitation. After she refused to do so, he ended the relationship. He refused to have anything to do with the baby after it was born.

Not all young participants wanted a relationship with the baby's father. Sometimes this was because they described him as no good, disreputable, a drinker, a drug user, already married or a relation. Xena, 17, from Shefa, said that her boyfriend smoked too much marijuana, so she kept away from him. Others, like Ilona, could not forgive an early rejection. She said:

> *My little girl was two years and he thought he would just come back to me but me, I just ignored him 'cause of what he said the first time, where he refused to know the child. So me, I am not with the baby's daddy.*
>
> (Ilona, 19, Tafea)

While other participants had become pregnant to a boyfriend or regular partner, Anna became pregnant as the result of a casual relationship. She told the boy of her pregnancy. Although there was no pressure from family, they had initially tried to develop the relationship. They do not see each other anymore:

> *We were friends I think for about three months, and we saw that we were wrong [for one another] and that we had made a mistake.*
>
> (Anna, 17, Shefa)

Ursula described becoming pregnant by an old boyfriend who came to see her when she was working as a house girl in Shefa and away from home. He abandoned her during her pregnancy. She did not tell her parents until much later:

> *I said it's ok and I looked after the child … When I went [home to family]. That was finished, he saw his child no more. He forgot about us.*
>
> (Ursula, 16, Shefa)

One of the grandmothers described putting pressure on a boy's family for him to marry her pregnant granddaughter, even though the couple was young. In exchange for their getting married, she undertook to support the young couple. She said:

> *I don't want any children with no father … [His parents] didn't want him to marry my [grand]daughter, but I said 'it's too late. If you don't, I am going to go to court and you have to pay for these children. So do you have the money? You people don't work!'*
>
> (Yolanda, grandmother, Tafea)

Yolanda subsequently supported the young family financially. She described imposing a lot of rules.

One of the young participants did get married to her 19-year-old boyfriend after becoming pregnant at 17. It was his parents who decided that they should marry:

> *When I was still in school and after I found out that I was pregnant I told my partner. When I told my partner, he told his parents and his family decided that we would get married.*
>
> (Fiona, 18, Shefa)

But Fiona miscarried and the relationship did not last. Several of the other participants also tried living with their baby's father after the birth, but subsequently separated either by mutual agreement or because the man left – usually to return to a previous relationship.

Although Gina's boyfriend was initially angry about the pregnancy, he had a change of heart as the baby became more of a reality. They decided to move in together after the baby was born, but their relationship also did not last:

> *I was five to six months – my stomach was big – the father of the baby saw me. He felt sorry for me and he helped me to pay for things for the baby, but I still lived with my parents until I went to deliver. After I went to deliver, we went and lived together but we were too young, so we had some issues and we argued all the time. So I went back and lived with my parents, my mum and my dad.*
>
> (Gina, 17, Shefa)

Another participant described how she had also tried living with her partner:

> *The baby was born and his dad came, came to us at the house and said we should go back to his place. We went and lived in his place for some months. He went to Vila and was living with a woman in Vila and left me and the small boy, we came back to [her parents'] house. We came back and stayed at the house and mum and dad they said 'he let you guys go, that's ok, you come and we will look after him [the baby] and you will go back to school'. When I heard this I was glad.*
>
> (Mary, 16, Tafea)

Most of the participants ended up being very young single mothers. Among this group, the babies' fathers had determined the relationship more often than had the young mothers. It was common for the pregnant girls and young mothers to be abandoned, but sometimes the young women had refused or ended relationships with the fathers of their babies. While there was a little evidence of forced marriages, parents had just as often banned the relationship.

4.1.4 Older women's views

Older women, as grandmothers and great-grandmothers and other women in the family, impacted on the young women's experiences of unintended pregnancy. While they often acted as a source of support and advice, older women were not equipped to provide practical or up-to-date contraceptive information. They were, however, heavily implicated in great-grandchild support – sometimes after already having parented their grandchild.

Sometimes older women in the family had noticed the pregnancy before the girl had disclosed or acknowledged it herself:

> *A lot of the older women, they all knew that I was pregnant and all of them asked me, if I was. I said 'I don't know' 'cause I never went to a clinic to check. When they'd ask, I'd say 'I don't know if I'm pregnant'. After that they'd say 'yes, we can tell that you are pregnant'. Then when it came to that three months and I had my miscarriage, I think back to what they had said but I didn't have any determination to go check, to find out, and I never went.*
>
> (Paula, 18, Shefa)

Older women also tended to offer dietary and other advice after the participants had been to a clinic. That advice appears to be of mixed value. Kaye, for example, said:

> *[Older women] told me I must eat a lot of cabbage, drink plenty water, 'cause when I go and deliver it will be easy – and not to fold my legs, to sit properly, 'cause it will go around the baby's neck. Me, I thought it was a lie, but when I went to deliver the baby the cord was around the baby.*
>
> (Kaye, 18, Shefa)

Much of the advice given by older women and the strategies that they themselves had relied on to prevent or space pregnancies were no longer viable, useful or acceptable to their granddaughters. Those strategies relied heavily on separating adolescent girls from men and boys once girls reached the age of menstruation. During the focus group discussions, the older women referred to the effects of social change: young women had more freedom to walk around alone now, whereas in the past girls were more constrained and were afraid of boys. While the older women valued education for girls, they also felt that education meant that girls did not listen to their parents anymore and were harder to control. They lamented that in the past young women had stayed at home until the man came to ask for them, but that now the girls go looking for boys.

Many of the older women blamed technology and especially the way that mobile phones, the internet and social media allowed young girls to be constantly in contact with boys and men – even when they were confined to the house. As one grandmother said, attempts at confinement were now futile:

> *You know they sneak out in the night. When the father and mother sleep they go out. To a night club or when they've made a date somewhere or they want to go and see the boys then they go out, sneak out so when they're pregnant it is a bit hard to say … it's too late.*
>
> (Yolanda, grandmother, Tafea)

Several of the older women described finding themselves, or seeing many others, left to care for a baby, while the baby's mother continued to go out. Consequently, the older women often attributed teen pregnancy to the unruliness and irresponsibility of the young. One grandmother said:

> *Girls are going out clubbing, going around with married men, and they don't care about their families. They do whatever they want and when they get pregnant they depend on their parents to look after them. After giving birth, when the baby is not yet strong, they go around, and don't care about the baby. They don't listen to parents.*
>
> (Zadie, grandmother, Shefa)

The older women who participated in focus group discussions in Tafea talked about this issue at length. The main problem, as they described it, was largely financial. They were concerned with who would support the baby into the future and pay for education. Those older women in the family who were themselves dependent on the wider family for financial support were frequently considered to be in the best situation to be primary caregivers to babies of unmarried mothers, because the older women were not in paid employment. Young and old alike agreed that 'life is hard now', in reference to the monetarisation of life and the need to have cash to pay for things. As one articulated:

> *In this life now, on Tafea, we can live and we make a food garden but you know we need other things to live with too.*
>
> (Yolanda, grandmother, Tafea)

Paying school fees and ensuring that a child gets a good education was one of the main concerns voiced by both young and old participants. It appears that in many cases adolescent pregnancy in Vanuatu has serious implications for the financial and stress burden of older women as well as young mothers.

Indeed, in the focus group discussions, the older women agreed that the real problem of unplanned pregnancy among adolescents was a practical financial issue – who will care for and pay for the baby – rather than a moral issue of being unmarried. While they cited the difficulties that grandmothers faced in trying to control children when there was no father, the dominant view in the focus groups was that grandmothers should look after the babies so that the young mothers could work, or would not need to marry. The older women themselves had taken various approaches to adolescent pregnancy in their own family and to what they thought was best for the young people's futures. Yolanda talked about financially supporting her 13-year-old granddaughter, the same-age boy to whom she became pregnant, and their baby. She was insistent that they become a family and that the girl took responsibility for childcare. She claims to be unusual in this insistence that the young take responsibility for childcare.

4.1.5 Aspirations: hopes, plans, fears and regrets

Young participants were asked what was good and what was bad about being a young mother. They were also asked about their hopes and fears for the future. Some, like Nora, lamented the loss of social life:

> *When you have a baby you regret, like, I should enjoy life first. You see your friends, they go to school, they work, and you are staying at home with your baby. But for me, I regret being a mother because I am not at school anymore and I am not working. I am just at home looking after her. That's a challenge, like, a thing that is not good.*
>
> (Nora, 19, Shefa)

However, only a small number of participants expressed regret at leaving school. Even fewer talked about continuing education or had plans to return to study or training.

The most common worry that young mothers cited was about being able to pay for the child's education in later years. Kaye said:

> *I want that they [my children] must get a good education for their future, and that they don't make trouble, and they must have a good job to look after me and my partner. They have a good job and have a happy family and find a good partner and have a happy family because nowadays everything is money.*
>
> (Kaye, 18, Shefa)

While their own education was not universally valued by the young mothers themselves, they positioned their children's education as ensuring job prospects and thus a happy family life. Their most commonly voiced aspiration for themselves was to find a good man:

> *I will find a dad for her and tell him 'I already have one [child], I worked hard for her, so if you want me you will look after me and my small girl'. When he says yes and I see that we are staying well together we can do something good for ourselves for our kids too and go to the island and make a house for us.*
>
> (Xena, 17, Shefa)

Children themselves were viewed as sources of hope for the future in one way or another. While boys might grow up to earn money for the family, many interviewees described being happy to have a little girl so that the girl could grow up to care for her mother.

Fiona, 18, from Shefa, was pregnant but miscarried. She now stays at home and her mother supports her financially. Although she feels that she should look for a job, her main desire is for more children. Several interviewees had gone on to have another baby with a different man. As Fiona said, 'having a baby is having a future'.

4.1.6 Reactions to unintended pregnancy

Nearly all the young participants in this study described being frightened and not knowing what to do or where to turn as their first reaction to discovering that they were pregnant. The first physical symptoms came as a surprise and the participants were often slow to recognise or acknowledge that they indicated pregnancy. Same-age girlfriends, sisters and sister-cousins were the first people to whom most of the study participants voluntarily disclosed their pregnancy. Reactions to unintended pregnancy are described in the accounts of these young women:

> *When I did what I did, I did not think that I would get pregnant.*
>
> (Carol, pregnant at 17, Sanma)[3]

> *I did not expect anything like I would be pregnant or what – but one time I was at home and I felt like vomiting and then I felt dizzy. I wanted to sleep. I did not want food. I started to think badly now that something is wrong with me.*
>
> (Betty, pregnant at 17, Sanma

3 Not the interviewee's real name. All names have been changed to protect participants' identities. In some cases, the age of the participant when pregnant is noted where it is relevant, rather than their age at the time of the interview.

Primarily, the participants were frightened of telling their parents. They were often more immediately worried about what their parents would say than about having a baby. Some participants were also concerned about how other members of the family might react:

> *My big brother too is not too good, [I was scared] he might hit me really badly.*
>
> (Anna, pregnant at 17, Shefa)

Whom to tell was a key concern for the young participants. In some cases, mothers and other female family members noticed the symptoms of pregnancy before the girl had told anyone else. Same-aged girlfriends, usually the first to be told, were no better equipped to know what to do than the pregnant girl herself. As one participant said:

> *When I was first pregnant I was very afraid … I told one of my best friends where we keep secrets, I told her. She asked me, so what will you do? I don't know now.*
>
> (Carol, 17, Sanma)

Very few of the interviewees had chosen to tell the boy or man to whom they had become pregnant, even when they wanted to do so:

> *One thought that got me was that I was pregnant and I was thinking, who will I tell and I was afraid to tell the boy, the bus driver.*
>
> (Betty, 16, Sanma)

Largely because of a tendency to ignore symptoms, a fear of disclosure, and a lack of knowledge about what to do next, few of our interviewees had confirmed their pregnancies before four months.

Christine, who was still studying when she found out she was pregnant at 19 years old, did confirm her pregnancy early. She was the only participant who sought clinical advice on ending the pregnancy. Otherwise, her initial responses were typical of the rest of the participants in that her first thoughts were about how her life would change, guilt towards her parents, how she was going to tell them, and a desire for termination:

> *I decided by myself to go [for a pregnancy test at Wan Smol Bag clinic]. I didn't even tell it to my parents, I went by myself. So I went and checked. I went and saw a woman who was in there and I asked, I wanted to take the pregnancy test so she helped me. Once we checked it, after we did the test, she told me it was positive. Once she told me that it was positive, I had tears in my eyes – I thought about my school, and the hard work that my parents had done for me. I started crying and started telling the woman in the clinic, and I asked her, please if you can help me to get fertility limitation. The woman told me, 'no, the law is too strong, it does not allow fertility limitations'. So I just went back to the house with tears. I didn't know how I was going to tell my mum.*
>
> (Christine, pregnant at 19, Shefa)

Gina similarly talked about how the pregnancy, what it meant for her future, and whether she was equipped to cope all preyed on her mind:

> *I felt bad and sometimes at night I couldn't sleep well: I stayed [home] and worried a lot; because I need to keep going to school; because I thought of my future and if the child comes, I won't be able to look after it; because I am too young.*
>
> (Gina, 17, Shefa)

Fiona was primarily concerned about her health and her ability to look after two babies when she found that she was pregnant with twins at 17 years old. She said:

> *I went and saw the doctor when I was three months and I found out that I had twins … I got advice from my family especially my mum and some of my friends. They advised me not to do heavy work and drink alcohol or smoke and not drink kava but have good healthy food like island food. So for me, what I worried about was my health 'cause I was too young to have two babies like twins. Like for me what I was thinking was who will help me now with my two babies.*
>
> (Fiona, 18, Shefa)

Many other participants described feeling very guilty. Their sense of wrongdoing rendered them passive in the face of abuse from others:

> *My immediate family were very upset and mad when they found out about my pregnancy. I just shut up when they were letting out their anger on me because I felt guilty. It was like I had done something very bad.*
>
> (Ella, pregnant at 17, Shefa)

But not all the young mothers felt shame at having a baby and, although unplanned, pregnancy was welcomed by a small number of participants. Kaye, from Shefa, who had become pregnant to a steady boyfriend at age 18, said that although 'it was a mistake, we did not plan it … The good thing was that me and my partner we were glad that I was pregnant, and I was happy that I was going to have a little baby.'

4.1.7 Knowledge of reproduction and contraception

Knowledge about contraception and sexual and reproductive health was poor among this group. The majority of interviewees stated that they did not know about contraception before they became pregnant, and several said that they did not actually understand that they could become pregnant. Sources of reliable information were limited. As one young woman said:

> *I had no idea about how to prevent pregnancy until after I delivered my baby, when I had a family planning session with the nurses at the hospital.*
>
> (Jill, 19, Shefa)

Despite the many signs, some girls said that they did not know they were pregnant:

> *I did not even know that I was pregnant. After a while my stomach started showing, I started vomiting and started becoming sick from it. After I didn't see my period, the first month I thought it was normal and in my mind, I thought I will see it next month.*
>
> (Paula, 18, Shefa)

None of the young participants in this study had discussed sex or contraception with their parents or significantly older family members. School sex education was the only reputable source of information cited as having been available pre-pregnancy. However, school program coverage appeared to be patchy and erratic for reasons such as the following:

> *I didn't go to school all the time, we skip classes, I didn't go that often to school.*
>
> (Anna, pregnant at 17, Shefa)

The SmolBag came around but I missed that lesson.

(Shirley, pregnant at 16, Shefa)

Another participant, Odette, commented on how parental and other adult gatekeeping prevented girls from having access to community programs and activities that offered sex education and contraceptive information:

If it's at school ok – but on the island – when they say these things [sex and contraceptive education] you will see mothers and fathers. Not me [because] when they come and talk, my Mum and my Dad they start chasing us away.

(Odette, pregnant at 15, Tafea)

Consequently, many of the participants had little or no knowledge of contraception before their pregnancy. The little information that most participants received was from friends or cousins. Some of those sources were less trustworthy than others, as one young woman explained:

My parents they never talk about the safety side [of sexual relationships]. I learned from my friends who used to tell me, 'when you go to see that boy, you must use a condom, you must use it, if not you will become pregnant'. And when I came back to town to Sanma and I said to use condom the boy said, 'no, no, no, there is a way to do it, we don't need to use condom'. So I listened to him 'cause I liked him.

(Betty, pregnant at 17, Sanma)

Friends also offered information on ways of terminating a pregnancy and on whom to go to for kastom medicine. Most participants who tried home remedies, or had sought out kastom medicine to procure a miscarriage, were accompanied by a girlfriend. Carol remembered her friend trying to help her to end the pregnancy:

She said if I want, 'when we finish school we will go and I will make a plastic bottle full of lemon juice and you drink it'. After I thought about it, I said 'ok that's ok'. After we went, she made it. I drank one plastic bottle of lemon but it was no solution that I could see. I think it was what God wanted – that I must have a baby. 'Cause when I was drinking it nothing happened.

(Carol, 17, Sanma)

Ella, 17, from Shefa, did know about contraceptives but said she had been embarrassed to go to the hospital to access them. In school, she had learned about the rhythm method[4] of contraception. She finally went to the clinic with her grandmother after she realised that she was pregnant. The staff at the clinic were kind and gave her good advice on how to take care of herself and the baby.

The maternity clinics in hospitals provided postnatal contraception information and advised about different options. For several participants, especially those who were out of school when they became pregnant, this was the first reliable contraceptive information they had ever received.

4 When combined with close attention to, and regular documentation of, body temperature, this method is useful for calculating the most fertile times. A notoriously unreliable way of preventing pregnancy, it also relies on communication with, and cooperation of, the male partner.

4.1.8 Attempts to end pregnancy

Termination of the pregnancy was one of the first thoughts for many of the participants. Most girls had heard that there were ways to end a pregnancy, but few were sure of exactly what to do. As one young woman said:

> *I think there are a lot of women who do it, but I don't know them … they say to drink the leaf and then carry heavy things.*
>
> (Lisa, 18, Shefa)

Regardless of this lack of knowledge or experience, most participants had attempted to bring on a miscarriage in some manner or another. In particular, the girls who were still in school and who did not want to leave school tried to terminate their pregnancies. They were often aided by a friend. Only one of the participants had considered a clinical termination procedure, and most were unaware of the existence of such procedures.

Participants' efforts to induce miscarriage included violent jolts to the stomach by jumping into the sea, having friends walk on their stomachs and backs, drinking large quantities of lemon juice and other acidic drinks, and eating soap. Other efforts were based on doing things that pregnant women are advised to avoid, such as drinking kava, drinking strong alcohol, extreme exercise and heavy lifting. Most often, those home remedies failed.

Many participants also consulted a kastom medicine provider, as these young woman recounted:

> *I was 17 years going towards 18 years and I was still in in school, in Year 9 and about to go into Year 10. When I first found out I didn't have my period I shared it with my best friend, and we planned to spoil the baby. Really, we went to, we tried our best to drink some leaves but it didn't work. And then after that we came up with the idea to drink hot stuff [strong spirits]. After we drank the hot stuff – I drank one half bottle – but even that did not work out. After that I went and stayed home [quit school].*
>
> (Gina, 19, Shefa)

> *I told a friend that I was pregnant and after they tried to tell me that 'No! You have to spoil it.' They brought lemon to drink so I can kill the baby. We used to get on the bed and they would stand on my stomach, we tried hard to kill the baby but they didn't know how … we got onto the bed and she stood on my back, and my other friend brought lemon and would mix it in a plastic bottle and I would drink it, just like that. But my stomach kept growing, it wasn't even dead. When I went for the check-up they told me it's good.*
>
> (Anna, pregnant at 17, Shefa)

Betty described doing repeated belly flops off the wharf in an attempt to terminate her pregnancy:

I told them [my girlfriends], 'I am vomiting, and I get dizzy and I don't feel like eating' and the two of them said 'you are pregnant', and I said 'I don't want it'. They said 'we have to do something', and they felt sorry for me so they said, 'ok, we go to the wharf and you must jump, you have to run and jump'. So starting from then every Sunday they came and we used to go jump off the wharf. I expected to see my period after that, but no sign.

(Betty, pregnant at 17, Sanma)

When that did not work, Betty attempted to get kastom medicine:

I knew a man who did leaves, so I thought I would tell the man to make a leaf for me to spoil it [terminate the pregnancy]. So one afternoon I carried a plastic [bottle] of kava and went to see him and was telling stories with him and his old woman and he said, 'you never come here to drink kava with us so what is making you come drink kava now'. I said, 'I am coming because I have a need', he said, 'what need?' I said 'I came so that you can make me a leaf so I can spoil it, I didn't get my period so I want it so I can spoil the child in my stomach'. The man never talked but the old woman said, 'no no no no, this man will not do the leaf for you. If you don't want the baby, you give the baby to us because we don't have any children.' The other things I tried: I drank kava; I smoked; I started drinking strong drinks. I thought the drinks would spoil the baby but no, and my stomach started showing out.

(Betty, 17, Sanma)

Another woman described her experience with attempting to induce a miscarriage by using kastom medicine:

I went and saw one aunty [older woman] and we took some leaves and then they started saying [it would cost] – it was a lot of money – they said 70,000 [vatu]. So I went and saw a boyfriend, my ex, I told him because he used to help me and we bought that medicine … we went and got that medicine from a man at [X] village. And that man told me, asked me, if the baby's daddy agrees with fertility limitation, then we'll spoil the baby, but if the baby's dad does not agree then we will not. So I told him, yes the dad agrees. After we took the medicine, he gave, he told me that I would take it for four days. So I took the medicine for four days. The four days passed, and the last bottle that I took I vomited all the medicine out, then I thought that I would see some changes. I thought that I would see that the baby was killed, but no.

(Helen, 19, Tafea)

In her account, Helen alluded to the view that men should decide what happens with the pregnancy and should agree with any termination. While this issue was not raised so directly in other participant accounts, the opinions and reactions of men in the family were very central to participant concerns.

Most girls tried multiple approaches to terminate the pregnancy:

I got scared. I told one of my sisters … and we went to North Tafea and we ran away, all the way, to try to get the medicine to spoil the baby. So we went to North Tafea, me and my sister. We went and they squeezed a leaf, a friend of my sister's squeezed the leaf and brought it to her to give me, and I started drinking. Every morning we used to go jump in their sea at a huge rock. We used to jump and jump, and I used to drink the leaf medicine. I tried my best to spoil the baby but could not, so the big sister told my mum and dad.

(Queenie, 16, Tafea)

While the desire for fertility limitation was usually driven by not wanting to leave school and by fear of parents, Ilona said that she had decided to try to abort once her boyfriend rejected her:

I insisted he was the child's father but he ignored me, saying 'no, the child is not mine', and I started thinking, I came up with the idea that I would kill the child, and I decided to kill the child. So I told one of my friends, one of my sisters, I shared it with her, and she shared it with an old man so that we might go and see him and so he would help me to spoil the baby. Then we went and saw the old man and I told him my story and the old man said, ok, he would help me to spoil the baby. There was a fee, so one day I had to pay him 1,000 [vatu] so I went and took the treatment two times from him to kill the baby.

(Ilona, pregnant at 17, Tafea)

Few of these efforts described by participants resulted in miscarriage – not even the kastom medicines that the young people paid to buy. However, some participants did recount successful intentional miscarriages – their own or those of other women. Soap eating was mentioned numerous times and Rita described causing two miscarriages by eating soap and also taking kastom leaf medicine:

I didn't want to have the baby anymore. I went to the store, I was buying Protex, I bought Lux, I bought GIV. The next thing I saw, I saw my period… [the next time she became pregnant] … I ate soap again. I went and bought some more soap and started eating soap again. I kept eating the soap because I didn't want to go back to the hospital for them to clean me. Later I saw one security guy at work and shared my heart with him and he said 'ok I will make a leaf for you …' he squeezed it for me and gave it to me and I drank. I drank and he said 'it ok now, you will stay and see the dirty stuff coming out now …' I guess he went to see one aunty from Tafea, after he made my local medicine leaf, I paid her 3,000 [vatu] for those 1.5 litre plastic bottles, and I drank it for two days, and he made one more plastic bottle for me which I will pay for 5,000 [vatu] and that one is to stop the soap, stop everything so after he does it all my insides will be clean.

(Rita, 18, Shefa)

After her first soap-induced miscarriage, Rita had presented at the hospital and underwent dilation and curettage. After her experience there, she chose not to go back a second time. For other participants, fertility limitation was never considered due to moral or religious beliefs or because they wanted to have a baby:

> *I don't support fertility limitation. The baby is already inside of you. Why kill a baby?*
>
> (Jill, 19, Shefa)

Despite the pregnancy having been unplanned, Paula grieved over her accidental miscarriage:

> *I had a miscarriage. I think I did some heavy lifting that I shouldn't have. I knew then I had been pregnant … I cried, my heart was sore I cried that I spoiled one of God's creations … when you spoil it, when it is dead inside of you the pain you feel is worse than if you have a live baby that you give birth to.*
>
> (Paula, 18, Shefa)

The experiences of Jill and Paula were not the norm, however. Most of the participants did not want to continue their pregnancy. Despite limited knowledge of how to induce miscarriage, numerous participants attempted it. Few of them were able to end the pregnancy.

4.2 Social and structural factors

This section discusses the social and structural factors that impact on experiences of adolescent unplanned pregnancy, as they emerged through the interviewee narratives.

4.2.1 Access to education

Responses by school authorities, and the girls themselves, to education for pregnant adolescents varied. In addition, several participants said that their parents had pulled them out of school when they found that they were pregnant, often because they did not want to continue paying school fees. Queenie left school early because of fees:

> *In Year 8, I was schooling for a while and I sat for the exam and I got a letter asking for the school fee and after I got the letter I didn't go to school anymore.*
>
> (Queenie, 16, Tafea)

Some, like Abigail, had left school at a very young age and prior to getting pregnant:

> *When I was 11 years, I was in class six and my mum and dad did not want to pay for my school fees so I stayed home, and I used to sleep with young boys.*
>
> (Abigail, pregnant at 16, Tafea)

Some participants had been excluded from school by the principal because they were pregnant:

> *I think the teachers, and all the people at home too, all of them knew already [that I was pregnant], so they went and reported to the principal I think, or some of them reported to the teacher and the teacher told the principal and the principal said to meet me at the office. I went to the office and he said 'I will remove you from school'.*
>
> (Anna, pregnant at 17, Tafea)

Other participants had chosen to leave school once they knew they were pregnant. Carol, 17, from Sanma, said, 'I stayed in school when I was pregnant until three months. Then I decided I wouldn't go to school.' Helen had been deeply disappointed to find her educational prospects curtailed:

> *I got a scholarship to go and study overseas. I went and I came back then I did not plan, I was really feeling strongly that I need to finish my school but somehow, my boyfriend, he must have had some thoughts to have a baby so he came and saw me in Vila, we spent a week together and then he went back to the island and I was pregnant.*
>
> (Helen, 19, Tafea)

Some participants had managed to continue their education after having a baby:

> *I started to think and having regrets, because I wanted to go to school but I needed to work so that I could look after my baby. So I found a job, and I worked and looked after my baby for a while until the baby was two years. Then I went back to school to continue my education. I continued with my schooling, and later I will find a good job so that I will have a good future.*
>
> (Gina, 17, Shefa)

Others did not see a reason to go back to school once they were mothers.

Those who had continued their education were very motivated to do so and had family support. They also lived in Shefa. Other participants cited cost and availability of appropriate courses as barriers that had prevented continued study.

Ella, 19, from Shefa, said that she would like to see work experience, training and support programs that allow young mothers to obtain professional employment, instead of just sewing and cooking. She pointed out that Youth Challenge Vanuatu has a program for over-18-year-olds, but that places are limited and it is too difficult to gain admittance. She worried about finances and how she would support her child. Ella noted the gendered unfairness of the situation. She said:

> *At a technical school, there are good opportunities, but us girls we must go through these things [special applications]. Not like the father, if the father was going to school, he can still go on and study.*
>
> (Ella, pregnant at 17, Shefa)

Anna, 17, from Shefa, hoped to be able to work in the future. She described her plans to do technical training in hospitality accounts as soon as her baby is older, but lamented the cost of fees and said that it is expensive to attend the University of the South Pacific. For other families, school fees were already a barrier to continued education.

4.2.2 Contraceptive and reproductive health information and maternity services

None of the participants had received information about sex or contraception from their mothers, or from older women in the family, until after their pregnancy was confirmed. Some of the participants had talked to their friends, but those friends were generally equally poorly informed. According to these participants, there had been little discussion among friends or with boyfriends about contraceptives before the pregnancy. Some suggested that boyfriends had resisted condom use. Few of the participants in this study had received any sex education at school, and it is not clear whether that is because it is delivered only to more senior age groups, or whether it is not part of the curricula of many schools.

Antenatal services at the hospital were often the first place where the young participants had received reliable contraceptive advice. The 'stick' (contraceptive implant) was the only contraceptive specifically mentioned as having being learned about and made available after pregnancy. None knew about the emergency contraceptive pill, which is available through the Family Health Association. The services provided were mostly well received, particularly in Shefa, but some participants had been berated and made to feel ashamed. Also, some had been too embarrassed or scared to go for contraceptive advice or access, even when they knew it was available there.

Experiences within the health care system were mixed. Many girls and young women in this study described a good experience at the Port Vila hospital, particularly those who were accompanied by their mothers. They were given general maternal health, dietary and contraceptive advice. For most participants, this was the first time they had been given any such information. Kaye described a positive experience with a private clinic in Shefa:

> *When they heard that I was pregnant, all of them too were shocked. But they helped me, 'cause it was a mistake, so they helped me and encouraged me that after delivery I must take family planning to stop me getting pregnant again, or to space my children.*
>
> (Kaye, 18, Shefa)

But not all participants had positive experiences. Rita, 18, from Shefa, went to the hospital following her first self-induced miscarriage, but was reluctant to go a second time. A number of the girls expressed fears about their capacity to give birth and be a mother. Anna, 17, from Shefa, said, 'I was afraid because I was too young'. Some of this fear may have been caused by the response of maternity service providers. Mary told of being frightened by the nurses in Tafea hospital – even though she went with her mother:

> *Me and my mum, we went, we walked to the hospital. When I went to see the nurse, they came, they asked me, how old are you? I said 'I am 15 years', they got cross with me. Some nurses came and talked hard to me, saying women or girls like you cannot be pregnant at 15 because it's dangerous and can cause sickness like death or something like that. I sat down quietly, and they got angry at me.*
>
> (Mary, 16, Tafea)

Many participants were subjected to judgement by health care workers. Queenie was also told off at the Tafea hospital. She described the nurses as being angry when she went to visit the hospital with her aunty. The maternity nurses in Shefa were not always kind either. Anna, who went to the hospital with her sister, said:

> *They talked a lot, they got angry with me, said that inside of me is still not strong … when I went to deliver the baby when they saw my age they started getting cross with me … they got angry and said 'here at the hospital the right age to give birth is 20, you came at an early age'. I did not feel good and I was embarrassed.*
>
> (Anna, 17, Shefa)

4.2.3 Gendered expectations and identity

Despite the fact that most of the participants had been desperately scared and unhappy to find themselves pregnant, and were usually treated very poorly by family and community during pregnancy, the birth of the baby often appeared to redeem the young women in the eyes of the family and, consequently, themselves. The baby was almost invariably highly valued and in some cases was treated almost as a commodity. Thus, it is not surprising that motherhood was experienced as a positive identity.

Most participants expressed few personal aspirations or ambitions for themselves beyond motherhood, a good relationship and economic security. While a few participants said that they hoped for financial and other independence that might be gained through a good job or education, most said that they hoped for a relationship with a good man who would provide that security. In addition, families of adolescent parents appeared more prepared to sacrifice a girl's education than that of a boy because of a pregnancy. Both these elements may reflect social expectations that the man would provide the financial stability in the relationship – even though that expectation was not borne out by the experience of most participants.

Kastom has become an issue of national identity in Vanuatu, but many have argued that it is also fraught with respect to the entrenchment of unequal gender relations. One of the older women described kastom practices as lacking principles of gender equality – principles that she learned elsewhere:

> *I am a kastom lady. I grew up with the kastom with my parents, but I went to Australia … I was a Bahai, and there Bahai brings equality between man and woman … so I grew up with those two religions, like kastom and Bahai they show rules to live by. So I grew up with [belief in] equality.*
>
> (Yolanda, grandmother, Tafea)

In their lives to date, the narratives of young participants in this study showed little evidence of having been able to make, or bring to fruition, major decisions about their own futures. One exception perhaps was that many of the young women interviewed were able to decide not to continue a relationship. Few of the pregnancies had, for one reason or another, resulted in ongoing domestic relationships between the young parents. By far, most of these pregnancies resulted in young single motherhood.

4.3 Knowledge and practices of traditional methods of fertility limitation

Older participants were asked to talk about what they knew of, and thought about, traditional methods of limiting fertility and spacing family. Questions were framed with reference to methods of 'family spacing', as a notion that is more inclusive than 'contraception'. The young participants were asked if they knew of traditional means of fertility limitation or ending unwanted pregnancy, and if so had they used them.

Many of the young participants reported seeking out 'traditional leaf' to end their unplanned pregnancy. The leaf preparations were taken orally. Kastom remedies that were supplied to them by kastom medicine people inevitably cost money and prices varied dramatically. The non-relative suppliers of kastom medicine were all men. However, none of the medicines bought this way had worked. Some other cases in which a female family member provided the 'leaf medicine' proved more effective. All participants had heard of kastom medicine for the ending of pregnancies, but few claim to know how to prepare it. As these participants shared:

> *I know a leaf, the leaf is like a flower, the leaves are red … I think the older women before, they used to do kastom and today we are still holding on to that kastom.*
>
> (Crystal, pregnant at 16, Shefa)

> *It is a leaf, there is a lot of it that we use to and plant around our yards … I don't know the name too well but its colour is red and when you squeeze it, it's black and they use the end of the leaf to 'spoilem baby'.*
>
> (Anna, 17, Shefa)

> *I know that women can terminate their pregnancy with leaf medicine or go see a doctor but I am not so sure what happens on those visits. I don't know anyone who has been successful with that … I don't know who people could go to for traditional termination.*
>
> (Jill, 19, Shefa)

Most of our young participants had tried kastom medicine when they first discovered their pregnancy. As Vera said:

> *I didn't see my period and I tried to, planned to spoil it, and one sister came and said, we'll go and drink, so we went to drink [kastom medicine] … we tried, tried and nothing. I went, I got money and gave it to him, tried two times, tried three times.*
>
> (Vera, 17, Tafea)

In most cases, kastom medicine did not bring about a miscarriage. Those who have successfully used kastom leaf to cause a miscarriage say that there is a lot of bleeding. One grandmother said:

> *[My granddaughter] said the bus driver she got pregnant to helped her to miscarry by giving her a local medicine that he knows from his grandmother, which he had helped a few girls for unwanted babies. She said she drank the local medicine three times and started feeling pain 'til she saw blood and she thought it was normal, as that is what the boy told her: that she will see a lot of blood, then she will no longer be pregnant.*
>
> (Brenda, 71, Sanma)

Not all older women had any experience of kastom methods:

> *I knew that there is kastom way of family planning but I did not use that, I gave birth to one, then when they got big, I carried another one and like that until I got all nine.*
>
> (Diane, 65, Sanma)

Diane is a nurse and a Catholic and her religion very much shaped her view of fertility limitation. She was disparaging of kastom medicine and strongly advised against it. Diane was more positive about modern contraception. However, she also thought that babies and infertility are both God's will and should be accepted as such. According to Diane, any form of fertility limitation is wrong – kastom or clinical.

Cultural approaches to family spacing identified by older women included practices of physical separation of women and men prior to marriage and during the period of lactation, as well as herbs to bring about miscarriage. Only the use of herbs was described as a method that is still used.

> *There is medicine for that which is a leaf that she drinks. That medicine is given to a mother to stop having children and we'll give the medicine to the mother to drink and will tell the mother, you will not stay with your husband for a year.*
>
> (Cynthia, 62, Tafea)

Many of the older women cited a tradition of physical separation of husband and wife as being the traditional method of family spacing. According to Cynthia, isolation during menstruation was important to self-care as well as for family spacing. She contrasted this with modern practices of fertility limitation:

> *Now when the two of them have kids and have had enough they go to the doctor. The doctor cuts her or operates on her to stop the child. I cannot tell if this is good or not good.*
>
> (Cynthia, 62, Tafea)

Cynthia also explicitly associated modern contraception with a lack of self-care and consequently with weakness and illness:

> *We had our ways of stopping having kids and we spoke with our husband and he'd keep away from me. Today young girls using family planning have stomach ache and they are not fit and strong enough with only one or two kids. If they look after their body they won't get sick, because before we looked after our bodies.*
>
> (Cynthia, 62, Tafea)

Donna, a grandmother from Shefa, also advised against modern contraceptives based on similar beliefs that they undermine women's health:

> *I didn't do anything like family planning 'cause from how I saw it, I was afraid of family planning, it spoils my health … I used to look at my brothers' wives and I think … they use those things [contraceptives] and they feel too weak to do anything.*
>
> (Donna, 67, Shefa)

Yolanda, on the other hand, believed that modern contraception is safe and reliable. She warned that people should take great care about how they use kastom leaf medicines:

> *I squeeze the herbs too, I boil the good ones, to make people feel good but, the one I go to, if I don't feel better I stop. But people drink it, drink it, drink it … sometimes they kill a person with the leaf. They scratch the tree, the backs of the tree they squeeze it and sometimes they kill the people. Kill a man or a woman.*
>
> (Yolanda, 60, Tafea)

Yolanda, who has 13 children, said:

> *I don't use the kastom medicine to stop, not to have the babies, because I tried it. It doesn't work. That is why I have 13, see. So no point. I didn't take the bad one – I took the good one. I know the bad one. I said this one will cause a problem. So um, many have, many die. They died already.*
>
> (Yolanda, 60, Tafea)

Yolanda is also disparaging of kastom medicine for ending pregnancy, claiming that it usually does not work – and that, when it is strong enough to work, it is very dangerous:

> *They drink ah, like something very salty. Ok what they do is they put, I asked, they said that leaf, and another one? Lemon, and another one? Vinegar, make it hot hot and burn that baby … I said, you are killing the lady, not the baby. You are killing this woman, she will have no future.*
>
> (Yolanda, 60, Tafea)

Kastom medicine was frequently resorted to by pregnant adolescents. In some instances, it was effective, but most of the participants who bought such a preparation from a kastom medicine man found that what they bought did not work. Aside from those cases in which a miscarriage was brought on, none of the participants complained of lasting negative effects from the use of kastom medicine. Some of the other methods to end pregnancy reported by young participants appear to have a long history and might also be considered traditional. In 1883, medical ethnographers listed eating ironwood, drinking hot green coconut juice, jumping from heights, thumping the stomach, and having another woman step on the stomach or back as ways used in Vanuatu to bring on miscarriages (Jolly, 2002a, p. 149).

None of the participants could provide local names for the herbs that might bring about a miscarriage, but the women were insistent that they were easily accessible as they grew everywhere. Most women claimed that they could identify, even if they couldn't name, the plants. Opinion was divided as to whether women generally knew how to prepare them safely.

Cambie and Brewis offer a long list of known anti-fertility plants that grow across Vanuatu and their local names. These include[5] the ferns *aspleniacae*, 'tampal tampal imelwo' and 'natali nin nanui', which are used as contraceptives, and 'wutubo', which is eaten to induce sterility; the leaves of the flowering plant *cordyline terminalis* is used as an abortifacient; in Malekula, the coconut milk of the 'nimit' is said to be an abortifacient when served hot; the leaf buds of *Flagellaria indica L.* have a reputation as a contraceptive; the stem bark of *Pandanus pyriformis (Martelli) St John* is used to induce sterility; the leaf buds of 'noyon gengen'

5 Local names for the plants are given here. Where no Vanuatu local name was listed, the botanical name is given.

are said to act as a contraceptive; the leaf buds of 'netredteeng' or 'nietetel' are used with a *Glochidion* species to induce sterility in young girls; 'somu' is used as a contraceptive; 'butsu vel' is said to induce abortion; the green fruit of the 'popo' is used as an abortifacient; the bark and leaves of 'niyar' or 'yorset' are said to induce sterility and to act as a contraceptive; the young leaves and the young fronds of 'nornomp i navlag', together with the leaves and the bark of an undetermined *Acalypha* species, are eaten as a contraceptive; the bark of *Bischofia javanica Blume* is used as an abortifacient; 'inloptahow' or 'tangalao' is used as an abortifacient; 'fonfati' or 'ekame' is used to prevent conception; the ground bark of 'kamtsi' is used as an abortifacient; 'yatrong rong' or 'butsu nana' is chewed as a contraceptive; 'lowinga tebungu' or 'watatmer' leaves are used as an abortifacient; 'nasake' is used as an abortifacient; the hibiscus known as 'rropol', 'warin isos', 'tutachatch' or 'nakelop' is prepared as either a contraceptive or an abortifacient; 'burao' or 'var' is used for anti-fertility; 'eamopul' or 'nakau poa' is used as an abortifacient; 'vilivil' is used to induce abortion; 'labalaba' is used to induce sterility; 'map loa panoi' is used as an abortifacient; 'naghulu na' is used as a contraceptive; 'rawe mandisi' is used as an abortifacient; the grated inner bark of 'dame' is eaten with coconut flesh as a contraceptive; and the raw fruit of 'nagamat nding-nding' is said to act as a contraceptive.

Stories of the participants indicate that some of these plants may be effective, but more research is necessary to understand the efficacy and any risks. Medical-anthropological and clinical research into the uses of kastom herbs for fertility limitation is needed.

4.4 Limitations and other considerations arising from data collection

Access to, and for, remote and rural populations remains an issue for service providers, as well as for those who wish to gather necessary local evidence for policy development and service delivery planning. The 80-plus islands that make up Vanuatu are spread over 1,300 kilometres of the South Pacific Ocean. Three-quarters of the population live in rural areas and on remote islands. Local languages and particularities of contexts are diverse.

For these reasons, a study that has collected data from three sites in Vanuatu is limited with regard to how well it can represent the experience of, and make recommendations for, girls all over Vanuatu. This study has, however, documented significant, if somewhat predictable, issues. Moreover, it has shown the need to increase and expand efforts to improve educational opportunities for young mothers and to reduce community acceptance of destructive gender norms, as well as to increase contraceptive knowledge and access for early adolescent girls. While this study indicates a need to ensure that community gatekeepers do not impede access, service providers and researchers who can remain embedded in the communities are best placed to develop and refine specific programs to further those ends.

Interviews were conducted in Bislama by local research assistants engaged and trained for the purpose. In rural areas in particular, Bislama is often a second language only and participants may have been more comfortable expressing themselves in their first language.

The methodology of this study was premised on centring the girls' own views and priorities. Consequently, their narratives did not always facilitate full exploration of all the topics and agendas set in the Terms of Reference for the study. For example, as there were few cases among the interviewees of being pressured to marry the baby's father, little could be said about this excepting that girls did appear to have some ability to discontinue a relationship. In addition, the experiences and events of unplanned pregnancy have been explored in more detail than has motherhood. Most participants were new mothers and simply had less to say about motherhood itself. To collect more focused data on issues around young motherhood, it is recommended that the upper age limit of interviewees be extended to around 25 years. Older participants would have gained some 'distance' from what were often very traumatic experiences of their unplanned pregnancy and are likely to be more focused on their lives as mothers.

The topic areas that are highlighted in this report are the ones that were most prominent in interviewee stories. The degree of self-reflection required of participants in order to address certain topics (for example, around sexual consent and negotiation) sometimes proved to be an unreasonable expectation. To press young people, who may already feel 'shamed', on such topics would have risked alienating them and causing discomfort.

The research team found that while young participants were sometimes quite tentative and shy, they were happier to engage with the research team when they could come with a friend. In telling their interview stories too, the girls usually described having one friend with whom they shared secrets and who tried to help them deal with the pregnancy. It may also be that young girls are more circumspect in regard to what they will share with an older woman, and only one of our interviewers was of a similar age to the participants. Yet, there was no noticeable difference in the type or detail of the information given to the older and the younger interviewers.

5 Conclusions

A number of the findings presented here are consistent with those of earlier reports and studies. Studies have long shown that early adolescent fertility in particular is associated with low levels of sexual and reproductive and contraceptive knowledge (see, for example, Okonofua, 1995); that being too embarrassed to ask for condoms is a factor in unprotected sex among young people in the Pacific (O'Connor, 2018; McMillan, 2008); and that while experiences of guilt and fear during pregnancy are common, family members are generally accepting once the baby is born (White, Mann, & Larkin, 2018). These data also reflect conditions identified in service needs research findings that barriers to adolescent access to sexual health services include shame, cost, geographical access, concerns about confidentiality, and judgemental attitudes of health workers (Kennedy et al., 2014; McMillan, 2008). While not particularly surprising or novel, the recurrence of these findings here indicates that although these factors are well known, efforts to date have not managed to effect significant change in many parts of the Pacific.

As well as highlighting the persistence of recognised access barriers to adolescent reproductive and sexual health services, this investigation into experiences of adolescent unplanned pregnancy in Vanuatu highlights the dangerous nature of the reported common methods to end pregnancies. The study also points to the burden that adolescent unplanned pregnancy puts on older women, who may end up caring for unplanned babies of young family members. The data also suggest that although the Gender Equity in Education Policy of the Vanuatu Ministry of Education and Training specifically allows pregnant young women and young mothers to continue schooling, the policy is not consistently implemented at the school level.

There were few reliable sources of sexual and reproductive health and contraceptive knowledge easily accessible to the adolescent girls in this study. This resulted in low levels of sexual and reproductive health and contraceptive knowledge. The young participants knew that hospital clinics provided contraceptive, maternity and other sexual and reproductive health services. However, few felt comfortable or safe in accessing those services. Expectation or past experience of poor treatment was an active deterrent to future utilisation of services. Cultural proscriptions around sex talk restrict to whom young women can speak about sex and contraception, resulting in young women having limited information about sexual and reproductive health, including pregnancy. Such proscriptions also discourage them from accessing contraceptive and sexual health services. In some cases, community mores and adult gatekeepers appear to have actively excluded early adolescent girls from sex and contraceptive education provided by NGOs in a community arena.

These findings are consistent with other studies that have cited cultural taboos inhibiting the discussion of sex, negative attitudes of community leaders, and religious beliefs as barriers to the provision of adolescent sexual and reproductive health information in community settings and that, where parents themselves lack knowledge, parents may also be a significant barrier to accessing information (see Kennedy et al., 2014). Therefore, community-based activities that address the social and cultural norms and taboos hindering the provision of adolescent sexual and reproductive health information should target parents, leaders and other gatekeepers. The need for scale-up of sex education in schools in Vanuatu has also been identified in an earlier study (see Kennedy et al., 2014).

Access to adequate sexual and reproductive health information is important for adolescents, and in some settings appropriate efforts may include text messaging information and support, and the use of social and mass-media (Nair et al., 2015). Language is a key barrier to effective communication and information provision, especially for minority population groups (Nair et al., 2015). In Vanuatu, adolescents would prefer to get sexual and reproductive health information through peer educators (Kennedy et al., 2014). However, the attitudes of nurses are also crucial as nurses are the next preferred and the most trusted source of sexual and reproductive health information for adolescents (Kennedy et al., 2014).

Judgemental, uncaring and disrespectful attitudes of health care service providers shape the perceptions of adolescents about the quality of care and create distrust of the service (Nair et al., 2015). Confidentiality in care provision, trust in providers, and comfort and support from providers are key to improving adolescent use of health services more generally and sexual health services in particular, and interventions need to focus on improving these aspects of care (Nair et al., 2015).

Health care providers and outreach workers can provide information about the value of providing sexual and reproductive health services to adolescents to parents visiting the health facility, parents and teachers during school meetings, and youth and other community organisations. It is essential that service provider staff have been trained and sensitised on the importance of respecting the rights of adolescents to information, privacy and confidentiality, and respectful, non-judgemental and non-discriminatory health care. Only then can community understanding of the importance of providing sexual and reproductive health services and information for adolescents be fostered by health care providers.

This study reported experiences of discrimination from health care workers to adolescent women during pregnancy, during childbirth and in the postpartum period. Discrimination and judgemental treatment are likely to contribute to poorer access to health services and to poorer outcomes for mother and baby. Moreover, given the data, it is crucial that young women are encouraged to seek clinical follow-up care after pregnancy loss from any cause.

The World Health Organization defines unsafe abortion as procedures for terminating unwanted pregnancy that are either conducted by someone who lacks the necessary skills or conducted in an environment that lacks minimal medical standards, or both (Ahman & Shah, 2010). Unsafe abortions put women's lives at risk and are associated with incomplete evacuation, haemorrhage and septicaemia, but also with chronic pain, infertility and pelvic inflammatory disease in the longer term (Butta, Aziz, & Korejo, 2003). Generally, women will only seek medical attention following an unsafe abortion if the complications are severe, and they often delay seeking help even then (Butta, Aziz & Korejo, 2003).

Even with improved access to contraceptive services and resources, women and adolescent girls in particular are often unable to control or determine conditions of their relationships and other circumstances of their lives and their needs for fertility limitation can be expected to continue. When abortion is legal, associated mortality and morbidity declines significantly (Singh & Ratnam, 1998).

Most of the young participants in this sample had felt so desperate at finding themselves pregnant that they felt their only option was to have a miscarriage. There was a greater emphasis on fertility limitation attempts in the narratives of this group of participants than among the Chuukese and Tongan interviewees, which may indicate both that it is more common and that girls know that it is common. Some of the practices reported as common to ''spoilem baby' were very dangerous.

Purchasing kastom medicine was reportedly commonly used to bring on a miscarriage. When the participants purchased kastom medicine from a local provider, the preparations did not have the intended effect. Kastom medicines prepared by a female family member, which were usually still charged for, brought about miscarriages in our sample. This failure of kastom medicine bought from men may be due to a 'commercial' provider's tendency to err on the side of caution and a reluctance to sell a strong preparation to a young girl, or it may reflect a simple refusal to allow the fertility limitation. There is no medical literature on the effectiveness of, or risks associated with, kastom herbal medicine for fertility limitation, however, there is a range of risks associated with not seeking medical care following pregnancy loss is well documented. Participants' stories suggest that kastom herbs may be effective abortifacients. However, clinical research would be necessary to confirm this and to assess the level and nature of any risks, benefits or other collateral effects that are associated with the use of kastom herbs for fertility limitation.

The desire to abort a pregnancy was mostly driven by fear of parental anger and of social exclusion. As well as fearing a violent or abusive reaction from family and community, participants feared the isolation of having to leave school or stay home with a baby and not go out with friends. These fears of family anger and social exclusion appear largely justified on the basis of their consequent experiences. Negative family responses reflect the financial burden of supporting an unmarried mother and her child. On Tafea the burden of care often fell on older women in the family.

Despite having become pregnant within an ongoing rather than casual sexual relationship, it was the young women in this study who overwhelmingly bore the financial and social burden of the unplanned pregnancy. Once the young women in this study became pregnant, their agency and life choices were more restricted: fertilility limitation is illegal, they receive poor treatment from family, and it is difficult to continue education and pursue good employment. Attitudes of school authorities varied in regard to allowing pregnant students to remain in or return to school. Despite the fact that there should now be no school fees before Year 10, the payment of school fees – both their own and those of their children – was a concern to young mothers. The Gender Equity in Education Policy of the Vanuatu Ministry of Education and Training specifically allows pregnant young women and young mothers to continue schooling, but much of this data would suggest that the policy is not consistently implemented at the school level.

A Vanuatu National Survey on Women's Lives and Family Relationships found high rates of partner violence against women and also that 15 per cent of women said that they had been sexually abused as children (VWC & VNSO, 2011). That same survey found that women tended to downplay the violence directed against them by their partners as being part of a normal relationship. Furthermore, nearly half of those who were living with violence had not told anyone about it, or asked for help – nor had they received help from others (VWC & VNSO, 2011). This current study prioritised interviewees' own subjective understandings and framing of their relationships, and partner violence did not emerge from the narratives. However, statistics around women's

experiences of violence in Vanuatu suggest that this issue may have been under-represented in the girls' own accounts.

It is known that women are at an increased risk of experiencing violence from an intimate partner during pregnancy (Sarkar, 2008) and poor birth outcomes (such as low birth weight and premature birth) and post-natal depression are associated with domestic and family violence during pregnancy (Jasinski, 2004; Gazmarian et al., 2000). Australian studies have found that young women, aged 18–24 years, are more likely to experience domestic and family violence during pregnancy than other age groups (Quinlivan & Evans, 2001) and unintended pregnancy is often an outcome of an existing abusive relationship (Campbell et al., 2000). Pregnancy and early parenthood are opportune times for early intervention, as women are more likely to have contact with health and other professionals. As a consequence, antenatal and maternity services, as well as domestic violence support services, need to have policies in place to support adolescent pregnant women and to understand that they and their babies are at high risk of harm. It is important that pregnant girls are made aware of the available gender-based violence support and where they might turn for help.

Interviewees in this study were asked about how they began their relationship with the boy or man to whom they became pregnant. Most interviewees said they had sex because they liked the boy or described him as a good friend. None could describe any sort of negotiation and many interviewees were confused by the notion when asked. In the few cases where interviewees could describe it at all, they said they thought that the boy took the lead or asked, or sometimes simply took her to his house. The participants appeared to take for granted that friendships and relationships with boys they liked would involve sex. A few interviewees did say that condom use had been discussed, but again in most cases a girl's compliance with a boy's lead appeared to be taken for granted. Much has been reported in international literature over the years on the manner in which boys and men determine condom use within a sexual relationship (Hendriksen et al, 2007; MacPhail & Campbell, 2001; Tschann et al., 2002).

Similarly, the participants had problems thinking or talking about consent. When trying to answer questions around consent, they tended to talk about 'liking' him. In this way, 'liking' was conflated with consent to sex. Indeed, definitions of sexual consent are contested within the literature on adolescent sexuality. Legal definitions of sexual consent also vary. Scholars differ on whether consent requires demonstration through an explicit external, physical action or whether consent can be defined by an internal state of desire, or wanting. This later definition of consent appears to best fit with the study participants' understandings of consent. The expectation that girls will 'say no' to sex – even if they desire it – can also confuse the issue of consent (Wood, 2006).

Research has found that young women are themselves usually ambivalent about the 'wantedness' of first sex in particular (see Houts, 2005). In 1988, a classic paper on adolescent sex education highlighted the absence of adolescent desire in the discourse and described adolescent women as having a divided consciousness 'at once taken with the excitement of actual/anticipated sexuality and consumed with anxiety and worry' (Fine, 1988, p. 35). Many studies have since noted the ambivalence that girls feel about sex and sexual debut. Despite this, adolescent sex still tends to be conceptualised as necessarily either wanted or unwanted, with no acknowledgement of, or allowance for, ambivalence (Muehlenhard & Peterson, 2005).

Although adolescents themselves may not be able to articulate this ambivalence clearly, the desire for more information about sexuality and relationships indicates an awareness of the difficulties they face. In their investigation into adolescent sexual and reproductive health information needs in Vanuatu, Kennedy et al. (2014) found that information about sexuality and relationships was the most commonly identified need and that girls in particular wanted more information about negotiating sex and relationships.

While interviewees themselves did not express any feelings of being coerced, in a number of cases interviewees' sexual partners were at least five years older. It might be expected that relationship power differentials would favour the older partner and that there would be imbalances in levels of sexual knowledge and experience. However, young women's ability to influence the course of sexual encounters differs vastly between individuals and between locations (Wood, 2006) and the nature of the relationship both affects and is determined by the girl's relative agency.

The experiences of those who become pregnant in early adolescence are likely to differ in significant ways from the experiences of those who become pregnant in late adolescence. The few participants whose pregnancies were well accepted by their families, partners and themselves, and who had maintained a domestic and supportive relationship with the father of their baby, were at the upper age limit of adolescence when they became pregnant. Participants who had managed to resume their studies after having a baby had similarly been older at pregnancy, and a pregnancy at 18 and 19 years old compromised educational prospects less severely than at 13 or even 16 years old. Pregnant teenagers are among the most marginalised high school attenders and require specialised policy attention in order to protect their rights (Onyeka et al., 2012). Retention of young mothers and pregnant adolescents in education is important, as studies indicate that education is key to better health outcomes in both women and their children (Ngabaza & Shefer, 2013).

There is a need to understand more about pregnancy in early adolescence. However, our study did not permit the interviewing of those under the age of 16 because of issues around 'consent'. At least three mothers under the age of 16 presented themselves to interviewers but had to be declined. In addition, our recruiting method tended to result in participants who had recent pregnancies because many of the introductions were made through providers of services to these young women and their babies. Other introductions were made through community members. As the babies get older, a young mother's reliance on or engagement with services is likely to decrease. Similarly, over time, an adolescent pregnancy is more likely to be forgotten, or at least less remarked upon, than a recent one.

In 2013, over 20 per cent of women in Vanuatu had been married by the time they were 18 years old. Where it is common to marry young, high rates of adolescent pregnancy will be unsurprising. This is also likely to be reflected in a wider community acceptance of adolescent pregnancy. The focus group discussions with older women indicated that their primary concerns around adolescent unplanned pregnancy were those regarding how the baby would be supported financially and cared for, rather than the age of the mother per se.

The population of Vanuatu is spread out over a vast area and a large number of islands. Even on the most populous of those islands, transport is difficult and expensive for service providers and especially for adolescent girls. Outreach services are a necessity, but transport costs will continue to be a problem for service providers and funders.

5.1 Regional themes

The research in Vanuatu was conducted as part of a larger study called Adolescent Unplanned Pregnancy in the Pacific, which also collected data in Tonga and Chuuk State. Due to the diversity of the social, cultural, economic and political contexts that constitute key differences that cannot be adequately measured in this study, we do not attempt comparisons between the country findings. This section does, however, identify some of the shared themes and issues that emerged from the wider set of data. While we point to common threads, the findings highlight the distinctiveness of each country's data and the importance of attention to local specificity in attempts to address the issues raised.

The need to make sexual and reproductive health service and related resources and information more accessible to adolescent girls, including through the improvement of some health worker attitudes, was common in all three countries. A lack of skills – particularly counselling skills – among service providers was a significant barrier to young people's access to sexual and reproductive health services in Vanuatu (Kennedy et al., 2013a). To varying degrees, the issues of service confidentiality arose in all three countries. In studies undertaken across the Pacific region, concerns about systematic violations of confidentiality, and a variety of reasons for this, have been flagged (see Butt, 2011). However, a lack of confidentiality has been repeatedly identified as a deterrent to sexual and reproductive health service uptake (Jenkins & Buchanan-Aruwafu, 2006; McMillan, 2008; Kennedy et al., 2013a; O'Connor, 2018).

Data in these reports also highlighted the need to improve access to reliable sources of reproductive and sexual health information for adolescent girls in all three countries. The data also indicated that different means of providing information are indicated at each site. For example, the research found that social media was used heavily by the Tongan interviewees. The reliance of young Tongan participants on social media, as well as the manner in which it was integrated into their daily lives, highlights its potential as a platform from which to make locally specific and reliable reproductive health, sexuality and service provider information available to Tongan girls. However, while social media was used in Vanuatu, it was not accessed to the same extent by our participants. For them, internet and talk time on mobile and other devices was limited due to cost. The participants in Chuuk accessed internet services less frequently and often could not even be contacted by text. Therefore, it would be a mistake to overemphasise the importance and potential of social-media-based resources for those areas.

In Tonga, most of the young participants had met the father of their baby through social media platforms such as Facebook. The ways that young people embark upon, and establish, sexual relationships appeared to be quite different in the three study countries, with young Tongans connecting in virtual space; young Ni-Vanuatu meeting partners through regular activities, such as work or travel (for example, on the bus or walking); and young Chuukese women appearing particularly vulnerable when staying home alone.

The age at which a woman can legally consent to sex with a male is 16 years in Tonga, 15 years in Vanuatu (UNESCO, 2013), and 18 years in Chuuk (UNHRC, 2015). This study suggests that in all three countries, it is not uncommon for girls to become pregnant prior to the legal age of consent. Although the interviewees themselves understood their relationships as being consensual, this indicates a need for improved understanding of the dynamics of, and motivations for, relationships between adolescent girls and older males in the Pacific.

Babies are highly valued in all three societies and motherhood may offer girls not only a respected social role, but also validation as an adult woman. Other Pacific research has shown that having a baby means leaving the group of girls and joining the adult women (Salomon, 2002). Issues of feminine identity are deeply imbricated in discourses around motherhood among all societies and may be particularly so in Pacific societies. White and colleagues contended that motherhood is central to feminine identity and culturally signals becoming a woman in the Pacific (White, Mann, & Larkan, 2018). Salomon (2002) used the term 'obligatory motherhood' to describe how motherhood in Kanak societies is women's preeminent role. Pacific women's organisations have sought to challenge restrictive notions of Pacific motherhood in their advocacy work by drawing attention to the diverse and changing ideals of women as mothers (George, 2010).

Education appears to be deeply implicated in feminine aspirations and ideals. Gendered access to, and average standards of, education differ between Pacific countries (Clarke & Azzopardi, 2019) for a range of historical reasons. Evidence from Tonga suggested a relationship between high general standards of education and girls' expectations of their own lives: the distinctiveness of the Tongan girls' aspirational narratives suggests that raising the educational level of all girls works to expand and raise girls' expectations of self-determination, as well as of attaining good employment, and of continuing to train and study despite pregnancy and young motherhood.

The participants' narratives show that traditional gender roles are implicated in experiences of unplanned pregnancy in a wide variety of ways. Attention to expectations and norms around adolescent sexual relationships and the resultant impact on adolescent girls will also require attention to young men and to dominant notions of masculinity (Ricardo, Barker, Pulerwitz, & Rocha, 2006).

Even among the apparently more straightforward cross-cutting issues, such as access to information, there will be no one strategy (such as the use of social media) that will be best for all Pacific Island countries. In this set of reports, we have discussed the most relevant factors that have emerged from each specific country data. Programs and responses must be locally and context specific, and must take into account an often uneven distribution of resources across the region, as well as within the countries, if they are to be effective and acceptable.

6 Recommendations

The recommendations are aimed at policy-makers and government ministries with portfolios that include health, education, women's affairs, youth and child welfare, social services and justice; civil society organisations working in the areas of women and children's wellbeing, family and child welfare, gender equality, youth, and sexual and reproductive health; and donors and regional organisations that all have a role to play in improving young women's and girls' agency in relation to sexual and reproductive health. These recommendations represent the evidence-based views of the researchers and not the views of research participants or partners.

- **The continued development and expansion of adolescent girl programs.** Programs based on a girls' buddy system (where girls are encouraged to attend with a friend or in small groups) to provide access to sexual and reproductive health information and service referrals, and to promote the empowerment of young girls to make decisions about their social and sexual wellbeing and to challenge harmful gender norms.

- **Provision of sexuality education for early adolescents in schools.** Sex education ought to be provided as part of the curriculum for all students from age 11. Sexuality education in schools should be reviewed and strengthened to ensure that these topics are covered adequately in the curriculum and taught in class. Education around the rights of women and girls needs to be part of the education curriculum. Teachers may require training in how to teach these topics.

- **Ensure implementation of policy and processes to retain girls in education.** Recent progress in Vanuatu has made school free up to Year 10 and it is scheduled to be completely free in 2020. However, it is necessary to ensure that policies are implemented at the school level. The Gender Equity in Education Policy of the Vanuatu Ministry of Education and Training specifically allows pregnant young women and young mothers to continue schooling but, as much of this data would suggest that the policy is not consistently implemented at the school level, steps are necessary to ensure implementation. Further measures to improve educational opportunities would include programs to assist young mothers to return to higher education, as well as technical skills courses. In other settings, the provision of menstrual hygiene services in schools has been known to improve attendance rates of adolescent girls. CARE has provided improved toilet and handwashing facilities in schools on Tafea offering a model for remote areas.

- **Workshops for health workers to remove access barriers and disincentives to service use created by discriminatory and judgemental attitudes.** All hospital maternity service staff need to be aware of the special needs and vulnerability of young single mothers. Up-to-date guidelines and protocols need to be in place. Of particular importance are policies and procedures to protect adolescents' rights to information, privacy and confidentiality, and non-judgemental care. This should be backed up by training to ensure that health care providers and support staff follow policies and procedures, understand the guidelines and the reasons for them, and know their own roles and responsibilities. Professional education and training on up-to-date protocols and guidelines should be ongoing and recurring. Providers' obligations and adolescents' rights should be clearly displayed in the health facility.

- **Efforts to ensure that girls seek clinical follow-up after any pregnancy loss.** Upscaling of efforts to ensure that girls and women are encouraged to seek medical attention following miscarriage or pregnancy loss from any cause are required. In particular, it will be essential to ensure that girls who present will receive safe and supportive treatment following pregnancy loss or termination. Data collected from those who present for care following any miscarriage should include enquiries into the use of herbs and custom medicines, as well as any unsafe abortion practices.

- **Antenatal and postnatal services targeting young single women and their babies.** These services would include postnatal contraceptive and well-baby services. Resourcing should take account of the need to provide periodic provision of transport for people from remote areas to attend their nearest health service.

- **Community education programs to continue to address issues of gender violence and gendered inequality.** There is an ongoing need for community education around domestic and relationship violence and the (continued) implementation of whole-family-based programs that promote the understanding of gender equity/gender relations, especially within the family (the authors note that CARE Vanuatu already conducts some of these programs on Tafea). There is a need for programs that specifically focus on adolescents as they are embarking on their first relationships and setting patterns and expectations. It may be necessary to identify and work with gatekeepers specific to each community in order to remove barriers to young people accessing the programs.

- **Domestic violence response services to be maintained and expanded.** Women-friendly and safe domestic violence services including counselling and legal services. The provision of safe accommodation should be expanded to increase coverage and accessibility. Policing of domestic violence needs to be enhanced, and police themselves may need training in how to respond. The multiple vulnerabilities and low resources of pregnant adolescents should be understood within these services. Information on gender-based violence protection services should be provided through medical centres and at schools.

- **Advocacy for all women's rights to fertility control.** Unsafe abortion practices are common. There should be evidence-based lobbying for the repeal of laws criminalising abortion and for safe low-cost abortion (both pharmaceutical and surgical) to be made available to all women in Vanuatu. Women's health services should provide contraception free or at minimal charge to all women, including young girls. The availability of the emergency contraceptive pill should be better understood and promoted.

- **Further research into impacts of unsafe abortion practices.** The findings of this study indicate a need for further research documenting the extent and understanding the nature of abortion complications (including morbidity and mortality data from hospitals) in Vanuatu. The collection of data on harms resulting from unsafe abortion practices would assist in determining a culturally appropriate way forward in responding to unsafe abortion practices in Vanuatu. The data show that the use of local herbs for fertility limitation is still a common practice. There is a need for clinical research into traditional anti-fertility herbs and their efficacy, including the risks or advantages of use.

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