



## Vård i olika kontexter: Kvinnohälsa i Gambias sjuksköterskeutbildning

Ett skolprojekt om hur ämnet kvinnohälsa tillämpas i  
sjuksköterskeutbildningar i Gambia

## Caring across contexts: Women's health in Gambia's nursing education

A school project about how the topic women's health is applied in nursing  
education in The Gambia

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## Abstract

**Background:** The Gambia is a developing country where women's health is impacted by inadequate access to healthcare resources. Stigmatization and cultural factors continue to affect how women's health is taught and practiced. Research on nursing students' perspective on women's health in The Gambia has been interpreted as limited. While women's health is constantly developing, several challenges remain in need to further improve.

**Aim:** The aim of this Minor Field Study was to describe the representation and teaching of women's health within nursing education in The Gambia.

**Method:** The MFS was created with qualitative methods and analysed using qualitative content analysis.

**Result:** The result describes how various factors affect nursing education in The Gambia. Several factors are highlighted as important in how the subject of women's health is integrated and applied within nursing education in the Gambia.

**Conclusion:** This MFS aimed to describe how women's health is applied within nursing education in The Gambia. The study highlights nursing students' perspectives, which can be used to develop and increase understanding of how women's health can be integrated into nursing education in The Gambia.

**Key words:** Minor field study, women's health, nursing students, nursing education, The Gambia

## Abstrakt

**Bakgrund:** Gambia är ett utvecklingsland där kvinnors hälsa påverkas av begränsade tillgångar till hälso-och sjukvårdsresurser. Stigmatisering och kulturella faktorer kvarstår som påverkar hur kvinnors hälsa lärs ut och tillämpas. Forskningen om sjuksköterskestudenters perspektiv på kvinnors hälsa i Gambia har tolkats som begränsad. Ämnet kvinnohälsa utvecklas ständigt men flera utmaningar är i fortsatt behov av förbättring.

**Syfte:** Syftet med denna Minor Field Study var att beskriva representationen och undervisningen om kvinnors hälsa inom sjuksköterskeutbildningen i Gambia.

**Metod:** Denna MFS skapades med kvalitativa metoder och analyserades med hjälp av kvalitativ innehållsanalys.

**Resultat:** Resultatet beskriver hur olika faktorer påverkar sjuksköterskeutbildningen i Gambia. Flera faktorer lyfts fram som viktiga i hur ämnet kvinnohälsa integreras och tillämpas inom sjuksköterskeutbildningen i Gambia.

**Slutsats:** Denna MFS syftade till att beskriva hur kvinnors hälsa tillämpas inom sjuksköterskeutbildningen i Gambia. Uppsatsen belyser sjuksköterskestudenters perspektiv, vilket kan användas för att utveckla och öka förståelsen för hur kvinnors hälsa kan integreras inom sjuksköterskeutbildningen i Gambia.

**Nyckelord:** Minor field study, kvinnors hälsa, sjuksköterskestudenter, sjuksköterskeutbildning, Gambia

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## Background

### Association to strategies for Swedish development cooperation

One strategy for Swedish development cooperation is the Government's strategy for sexual and reproductive health and rights (SRHR) in Africa 2022–2026. The Government of Sweden (2022) presents a regional strategy that is involved with Africa in the thematic area of human rights, democracy, the rule of law and gender equality. One goal for the project focuses on increased access to right-based interventions and strengthened conditions for increased accountability for SRHI Equal Health (The Government of Sweden, 2022).

Our Minor Study Field project is connected to this strategy with focus on women's health and SRHR for women. This school project contributes to these goals by describing nursing students' education and what nursing schools in The Gambia teach about women's health, by examining the knowledge and experience from nursing students in The Gambia.

### Healthcare in The Gambia

According to World Health Organization (WHO, n. d) The Gambia is at a low income (LIC) level in the Sub-Saharan Africa. According to WHO (2022), the life expectancy is 66,3 years for females and 62,2 years for males. The leading cause of death in The Gambia are HIV/AIDS and lower respiratory infections, the density of nurses and midwives stood at 6,9 per 10 000 population, this has increased since 2012 (WHO, n. d). The Gambia's healthcare system encounters several challenges, including staff shortages, limited infrastructure, lack of equipment and insufficient funding. The prevalence of infectious diseases such as malaria, continue to rise, while socioeconomic barriers further hinder access to necessary healthcare for many Gambians. The general goal is to enhance the quality of healthcare and improve it is financial accessibility for all Gambians (WHO, 2022).

Research has been found on nursing and midwifery education in The Gambia. However, investigating how women's health education is taught in Nursing education in The Gambia was more challenging. A study from 2018 address topics such as teaching and practicing nursing code of ethics and values in nursing education in The Gambia (Haddy & Jainaba, 2018).

## Considerations in women's health in The Gambia

In The Gambia there are challenges that could affect women's health. Women and girls are facing health challenges caused by gender significantly which may lead to discrimination (WHO, n.d).

Factors such as unequal power relationships between men and women, social norms, psychological violence, and limited education can prevent women and girls from attaining healthcare (WHO, n.d).

In sub-Saharan Africa, approximately 49% of the pregnancies are unintended, resulting in around 35 million unsafe abortions occurring per year (Tazinya et al., 2022). African health system is underfunded, leading to overworked healthcare personnel, compromised service quality, and especially shortage of resources in rural areas. The challenges met are further intensified by inadequate access to sexual and reproductive health and rights (SRHR) services. An important barrier to the incorporation of SRHR and HIV services is the lack of financial, human and structural resources (Tazinya et al., 2022).

The limited knowledge and access to sexual and reproductive health information are one of the reasons for low contraceptive prevalence among adolescents and young people. The quality of sexual and reproductive health and rights (SRHR) services for adolescents and young people is hindered by ineffective counselling and service-related issues, subsequent in weakened satisfaction (Lowe et al., 2021).

The Gambia faces a high prevalence of unintended pregnancy, requiring strengthened efforts to develop sexual education for women. Increasing access to cost-effective healthcare and family planning services hold possibility to lessen the occurrence of unplanned pregnancies (Barrow et al., 2022). Constrained accessibility of contraceptive methods among young individuals intensifies the rising pregnancy rates observed in adolescents' girls (Lowe et al., 2021). Furthermore, young people may face barriers when it comes to seeking healthcare regarding their sexual health issues due to feelings of shame and disapproving attitudes of health workers (Lowe et al., 2021)

## Barriers in women's healthcare

Access to institutional obstetric care—including antenatal, delivery, postnatal care—is inhibited by a complex interaction of barriers for women. These challenges stem from economic constraints, geographic isolation, embedded gender norms, inadequate educational opportunities, deeply held cultural beliefs, and inadequate resource allocation within healthcare facilities (Kyei-Nimakoh et al., 2017).

According to Luoga et al. (2025) female genital mutilation is a traditional practice in the sub-Saharan African countries. It can lead to long-term health issues, such as psychological trauma, malformation of the genitals, health issues and complications during delivery (Luoga et al., 2025).

The prevalence of female genital mutilation in Sub-Saharan African countries among women are 53,5% (Luoga et al., 2025).

### Nursing education in The Gambia

The first nursing school in The Gambia was developed in 1964 where nursing students was educated for three years at certificate level in general nursing. At present there are five public institutions for nursing education where there are different length of the course, orientation and qualifications for the students. There are three categories of nurses in the nation, Registered nurses, Community health nurses and Enrolled nurses (Sanyang et al., 2022).

The duration of the education for Enrolled community health nurses is two years according to World Health Organization (2016).

### Theory

Black feminist theory as shown by Collins et al. (2021) underlines the correlation of social categories—such as gender, race, class, religion, and culture—in affecting the lived experiences of individuals. These categories cooperate to define social realities and conclude access to essential resources, opportunities, and power. As a transformative approach, Black feminism challenges and seek to demolish systematic racism and discrimination within healthcare, research, and educational systems.

Black feminism wants to develop justice in the healthcare system and focus on acceptance and understanding of people's experiences. By listening to those who are excluded it can contribute to a more equitable healthcare system (De Sousa & Varcoe, 2022). Black feminist theory offers a way to get an understanding regarding black women's health using a feministic framework. It can be applied to analyze health, reproductive rights and maternal care among black females (Brantley et al., 2023).

Collins et al. (2021) emphasize the implication of lived experiences, remarkably the viewpoint of disempower populations. Understanding the connected power constructions is necessary for driving social change. Collins et al. (2021) argued that societal power demonstrates through numerous categories, involving gender, race, class, sexuality, and nationality. Power is emphasized as operating across four unified levels: *Structural* encircling law and educational system. *Disciplinary* surrounding rules, surveillance and bureaucratic

practices. *Hegemonic* containing cultural ideas, beliefs and norms that regulate inequality and *Interpersonal* that applies to everyday interactions where topics of power and inequality are actively confronted.

Collin's theory about intersectionality aids nursing students to identify how power imbalance related to race, gender, class, sexuality, and nationality impact patients' healthcare encounters. This approach is critical specifically when caring for marginalized populations, such as black women whose concerns may otherwise be neglected because of structural and interpersonal inequalities (Collins et al., 2021).

## Problem definition

How do nursing students in The Gambia perceive that their education has prepared them to care for patients with women's health-related issues?

## Aim

The aim of this Minor Field Study was to describe the representation and teaching of women's health within nursing education in The Gambia.

## Method

### Design

The minor field study was designed with a qualitative approach using Graneheim and Lundman (2004).

### Data collection

To collect data a semi structured interview guide was used. Inspired by Kallio et al. (2016) method, an interview guide was made. The finalized interview guide is included in Appendix 1.

The interviews lasted around 10 to 20 minutes. The interviews were recorded and transcribed by the authors.

### Participants

For inviting participants, we used the method of snowball sampling (Kirchheerr & Charles, 2018). The inclusion criteria were female and male studying nursing in The Gambia. In total it

was seven students participating, see table 1 for a demographic presentation of the participants. Prior to starting the interview, all participants received a informed letter of consent (Appendix 2).

The informed letter of consent contained thorough information of the school project, including the to withdraw from the study at any given time. The informed letter of consent included the authors contact information, such as e-mail and telephone numbers, if any inquiries that might appear after the interview. Verbal informed consent was obtained from the participant. All recordings were securely stored and restricted to the authors only (CODEX, n. d.).

*Table 1, Demographic table of the participants*

<b>Participant</b>	<b>Gender</b>	<b>Age</b>	<b>Program</b>	<b>Time studying</b>
1	Woman	23	Nursing	1 year
2	Woman	23	Nursing	1 year
3	Male	27	Nursing	1 year
4	Woman	21	Nursing	1 year
5	Woman	21	Nursing	1 year
6	Woman	20	Nursing	1 year
7	Male	23	Nursing	2 years

## Data analysis

The interviews were analysed according to Graneheim and Lundman (2004) qualitative content analysis. The interviews were listened to, transcribed and read through several times to get a more complex understanding. Before the analysis, quotes and keywords were selected from the interviews to give guidance. Using quotes and keywords as guidance, meaning units were selected (Granehiem and Lundman, 2004). Through a comparative analysis of the codes, similarities and differences were identified and helped the forming and development of sub-categories. See table 2 for an example on how an analysis was done.

*Table 2. Example of the analysis.*

<b>Meaning Unit</b>	<b>Condensed Meaning Unit</b>	<b>Code</b>	<b>Sub-category</b>	<b>Category</b>

“Most of the time it's information. And the practical part comes when we have clinical placements”	Lack of practical preparation in nursing education	No skills lab practice	Shortage of practical preparation	Is theoretical education good enough?
“Even if you are in school, you have to ask, ask, ask for the lecturers to open up about the female genital issues.”	Student need to ask teacher to lecture more about women health	Lack of education	Student must ask about women's health	Student initiation on difficult conversations
“They believe that if you are talking to a woman in religion aspect, you don't have to go deeper because in certain religion, they believe that you have to protect women from talking about certain aspect of a woman.”	The religious aspect can affect how much it can be discussed about women's health.	Religion's influence	Difficulties with communication about women's health	The tension between religion and gender
“Especially as a man, you go to a place, try to address them about women's health. For example reproduction or menstruation.	Difficulties for male nurse students talking about	Gender-based challenges	Gender-related difficulties addressing women's health to female patients.	

<p>Some people might think why is this person talking about our personal matters. So you find it very difficult to try and meet your needs, if you want to address an issue in a particular place.”</p>	<p>women’s health.</p>		
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## Ethical considerations

As a representative of Sweden and Örebro University, the guidelines, procedures and rules that exist was pursued. Considerations were taken to avoid unnecessary risks, and how we were perceived (Örebro University, 2021). Respect for culture, tasks and situations were considered with sensitivity to expectations and local customs. Consideration was taken due to discrimination based on religion, gender, ethnicity, disability, age, sexual orientation or gender identity. Personal data were managed according to GDPR (Örebro University, 2024).

Several ethical aspects were considered while carefully reading the guidelines specifically misconduct in research, processing personal data and ethics in research abroad. The ethical information had been discussed between the authors, which has given an increased understanding of research ethical considerations abroad (CODEX, n. d.). According to Artal et al. (2017) participants who take part in a research study need to have informed consent and the four basic ethical principles must be followed and valued, which are beneficence, autonomy, non-maleficence and justice. We are aware that women’s health can be perceived as a sensible topic. The participants received all the information about the topics before they attended.

Preconceptions were discussed and gained an understanding that there may be a different power imbalance and cultural differences between us and the participants (Broesch et al., 2020). Cross-cultural research concerns power imbalances and differences in values, expectations and norms, which should be acknowledged during the research process (Broesch et al., 2020). According to Broesch et al. (2020) engaging respectfully with local institutions,

participants and communities are fundamental to guarantee ethical and meaningful research, therefore this have been considered throughout the research process.

In creating this Minor Field Study in a different country, the study intended to maintain the same ethical standards upheld by the home institution such as respect for participants autonomy, dignity and privacy (Uppsala university, 2024).

## Results

### Cultural challenges in nursing education

All the participants were aware of the impact of cultural barriers in nursing education, with all but one having personally experienced these challenges. The participants experienced that male nurses and male nursing students often face difficulties when discussing and assisting female patients in hospitals, particularly when it is related to women's health issues. All participants expressed that culturable norms frequently state that men should not be involved in women's health issues.

Two participants expressed the challenges caused by cultural barriers, highlighting difficulty in discussing with individuals from diverse cultural backgrounds. Some participants shared experiences in which teachers were reluctant to talk about women's health, as cultural beliefs often regard it as a private matter.

*“Like when teaching this about women, like there are some individuals that will rise to start bringing issues that is adjacent to their culture. But it happens, like I've been attending workshops that have been saying it, but I've never set my eyes on it, or I've never experienced it. “- Participant 7*

*“Yeah for sure like religious rights they think like it's only your husband that you see you in that state and not let any male nurse or a male student nurse to see you in that state as well because they find it like disrespectful or they have this culture of stigma to it that you should not be all of that like in front of somebody else.” - Participant 6*

The participant mentioned that their nursing education included female genital mutilation (FGM) and the challenges associated with FGM. Some participant described that FGM is rooted in the culture beliefs in Africa, where some individuals believe it should be done, while other oppose it. A participant expressed attempts to increase awareness among women regarding the dangers of FGM, actively pushing it is rejection. It was expressed that deeply

rooted cultural norms utilize significant influence over societal practices, presenting substantial barriers to emancipation from traditional customs.

Another participant shared experience encounters with harmful cultural practices at home, such as the use of certain medications or herbs by women who believes this substance will ease childbirth. A student describes that, within some cultural beliefs, discussing sexual health within the household is disrespectful. The participant noted that discussing sexual health may be seen as inappropriate, even if the intent is solely to seek information about reproductive health.

*“There are certain cultural practices that are harmful, like certain women that are, if they know that they are pregnant, they will be doing this cultural practice. They will be giving them certain medications or certain herbs that if they use it, it's going to ease, like labor, when they're in labor, it's going to ease the pain and other stuff. Whilst that's not true, it can bring certain complications.” – Participant 2*

One of the participants described that nursing remains a female dominated profession, with only a few male nursing students per class. The participant noted that some parents can have strong opinions about their son pursuing a career in nursing and advising to seek another career because nursing is seen traditionally as a profession for women.

*“Because when you go, even if you can see the nursing sector, you have more females than male. Even sometimes when you want to do nursing, like your parents might even say, no nursing is not for you. The first mindset was like, nursing is only for female.” – Participant 3*

The result indicated that cultural challenges significantly affect nursing education and practice in The Gambia, especially in the context of women's health. Male nursing students encounter difficulties discussing with female patients regarding women's health issues. Participants also highlighted how harmful traditions such as female genital mutilation, pose substantial health risk despite awareness of these complications. Furthermore, nursing profession is often seen as a female profession and for males, which may result in familial discouragement.

### [The tension between religion and gender](#)

The participants discussed the impact of religious factor when it comes to nursing. It was expressed that the female patients were unwilling to expose themselves to any male nursing

student or male nurse than their significant other because of religious beliefs. Male nursing students described that these situations often required involvement of healthcare professionals of the female gender such as a female nursing student. All the participants were aware of how religious barriers can influence nursing education, with all the participants except one having experienced that effect personally. One participant implied that religious beliefs may impact health education related to women.

*“So it also count in the health education of women, sometimes also religious factors can influence the teaching of human health, because if you look at it some religions as I said the female genital mutilation religion will accept it and sometimes they will say religion will not accept.” – Participant 1*

Another participant acknowledged that certain religions impose restrictions on discussing female health, resulting in conversations between patients and nurses regarding women’s health may be hindered. The participants highlighted difficulties with religious restrictions regarding blood transfusion, noticing beliefs had resulted to women in childbirth declining necessary blood transfusion resulting in impacted patient care.

*“Yeah for sure like religious rights they think like it’s only your husband that you see you in that state and not let any male nurse or a male student nurse to see you in that state as well because they find it like disrespectful or they have this culture of stigma to it that you should not be all of that like in front of somebody else.” – Participant 6*

*“We do talk about it, female genital mutilation, like it’s something that affects women, like in terms of childbearing, it might lead to maternal death and stuff like that. So, we emphasize that a lot. We educate the women and we even trying to keep them away from it because it affects a lot and it’s not only in Islam like Africa in general like we believe in it so yeah, I think that’s.” – Participant 4.*

Participants emphasized religious barriers in nursing education influence the education about women’s health, particularly regarding practices such as female genital mutilation and blood transfusion. These religious factors created challenges in providing education and evidence-based healthcare. Additionally, difficulties for male nursing students were expressed when

female patients refused healthcare from men due to religious reasons, leading to difficulties for male nursing students learning patient care and communication related to women's health.

### Gendered dimension of lecturing women's health

The participants expressed opinions regarding female lecturers finding it easier educate about women's health, as they are more comfortable and willing to share more information about the subject compared to male teachers. The female participants believed that further education on women's health is necessary, although the male participants were satisfied with the currently provided theoretical education on women's health. The participants shared experiences regarding male nurses and male nursing students often encounter difficulties when assisting and communicating with female patients regarding women's health issues. One participant described nursing students need to initiate and request lecturers to address genital health topics, as male lecturers tend to avoid educating subject about genital health in detail due to cultural belief as women's health tend to be sensitive and private.

*“They [the male teacher] just talk a little bit about the topic not more because it's dealing with female so their cultural belief is like about female is so much private that they don't talk about it more they just talk about it less and you know make their way out of it and it's finished so that's the problem they have to talk about it more”-Participant 1*

*“Most of the time they [all lecturers] prefer teaching on general than particularly on women health education because they believe that if you are human you're supposed to know everything so they prefer not to go there much because you know it's about private matter and sometimes they don't feel comfortable. Especially if we are a male teacher, they prefer not to go that side more. “- Participant 1*

The results showed that participant perceived female lecturers as more comfortable than male lecturers teaching about women's health. Female nursing students expressed a desire for more education on women's health, while male nursing students were generally satisfied with the current education. In addition, male nursing students reported challenges with assisting female patients due to cultural barriers, and while some male lectures were observed to avoid discussing women's health issues in detail.

### Nursing students navigating complexity in education

The participants had varying perspectives and opinions regarding the theoretical information on nursing education. One participant shared an experience having to demand the lecture to

address female genital issues. It was observed by the participant that students often needed to proactively ask for additional information about women's health, as the education perceived insufficient. The participants felt that the coverage of women's health topics was inadequate and that nursing students lacked opportunities to discuss the subject. While the participants were satisfied with the education about reproductive health, the curriculum about women's health was not prioritized. The male participants mentioned satisfaction with the lectures about women's health, though one male participant believed the focus was limited and suggested that extra curriculums might contribute to women's education. Both male participants agreed that increased education and awareness on the topic was necessary.

*“It's actually not a lot because most of the time it's under like reproductive health that we get to learn about women's health and reproductive health and all of that but in other courses like we don't get to talk about it that much but under reproductive health it is actually well driven towards it.” - Participant 6*

The result indicated that the participants perceived women's health education insufficiently included into the curriculum in nursing education, which required nursing students to ask for additional information. While reproductive health was taught, women's health education was overlooked. Although, the male participants were generally satisfied with the nursing education, they agreed that greater education on women's health were necessary.

#### [Intersection between classroom and clinic placement](#)

The participants mentioned the subjects included in Gambian nursing education related to women health were female genital mutilation, gender-based violence, abortion, atonic pregnancy, malaria in pregnancy, family planning, fertilization, labour, reproductive health, antenatal and postpartum care. A common concern the participants emphasised was the limited practical preparation provided. While nursing schools include practical skills training such as catheterization, other aspects primarily focus on basic nursing skills practice. The participants indicated that nursing students learn practical skills about women's health mainly at clinical placement, overall that there were limited practical preparation at the nursing education.

*“We think like we need to, because it's a broad stuff, like it's broad, like we need to get more information and actually practice like in school and not just like in hospitals, like in schools*

*as well. There should be practical labs with all of that that focuses mainly on women's reproductive health.” – Participant 6*

Although most of the participants thought it was insufficient practical preparation, some participants felt it was sufficient since practical training is further learned at clinical placement.

*“No, the lecture is good, because at the end of the day, whatever we learn, we can always see in the field. So what we learn when we go to the field, we normally see it there. So it's somehow easy. It's easy. “– Participant 7*

Gambian nursing education included topics related to women’s health, however participants expressed that there was limited practical training related to women’s health, with most training mainly during clinical placement. While most participants believed further development regarding additional practical training at school was necessary, a few felt satisfied with the current system.

#### [Seeds of awareness through nursing students’ eyes](#)

The participants mentioned the importance of educational development, mentioning initiatives such as expanding the curriculum about women’s health. Participants emphasized the necessity to further develop women’s health education into the curriculum in nursing education.

*“If we are doing more of projects like health education, bringing more projects in the Gambia, going to the rural areas, help educating them, like guiding them, it's a way of helping them because Maternal mortality, it's high in the Gambia right now, and infant mortality. “-Participant 2*

*“More of education, let people know what it's like to know more about their health and not think you should be shy to talk about it and to be shy to go to the hospital. Tell them what's wrong with you and to have like informed decision making on contraceptives and like avoiding unwanted pregnancies and all of that. I feel like it should just be like let them know they're safe in hospitals and they could talk about it without it being disrespectful.” - Participant 6*

*“Maybe we still introduce some other curriculums that women might need or that might contribute to this women's education.” - Participant 7*

All participants agree that the most crucial area requiring improvement is the increase of awareness about women's health. They highlighted that significant awareness could play a fundamental role in reducing the stigma correlated with women's health issues.

## Result summary

The results describe the participants perspective on women's health education within nursing schools in The Gambia. Participants mentioned a desire for increased clinical training and further theoretical teaching regarding women's health. The participants expressed challenges associated with male lectures teaching about women's health. The results revealed that culture and religious barriers significantly influenced the healthcare for women. Male nursing students expressed challenges in teaching and acknowledge women's health issues. The nursing education were affected by religious beliefs, creating challenges in providing evidence-based healthcare and education. Stigma and cultural factors were identified as key barriers that led women from discussing women's health concerns, which led to a reluctance to seek necessary healthcare. The lack of resources was found to limit women's possibilities to access necessary healthcare and education about their health. All participants agreed on the critical need to raise awareness to further develop nursing education and to address these challenges.

## Discussion

### Method discussion

The qualitative method was chosen to address the understanding of nursing student's perspectives and experiences (DiCicco-Bloom & Crabtree, 2006). This study used a qualitative approach with Graneheim and Lundman (2004) methodology to analyze interviews on experiences, knowledge and perceptions.

Qualitative analysis method worked well since it created a more structured way to do the data analysis and was suitable for the aim of this study. This method made it possible to capture participants' meanings and experiences, thereby increasing the capability of this study to respond to the aim of this study.

The transcription and reading of the material were done independently. Afterwards, meaningful units were identified and worked together by condensing, coding and creating different categories and themes. A consequence of the data analysis process was that it is time-consuming, as the data required review from both authors independently and together, to further deepen the analysis. Other analytics approaches could have been used; the chosen methods were most appropriate for this MFS study. The qualitative approach developed by Graneheim and Lundman (2004) was selected because it enables a systematic and transparent analysis process and increases the credibility of the study by using analytical steps.

When using semi structured interview guide, understanding can be deepened with social and personal questions (DiCicco-Bloom & Crabtree, 2006). When constructing the interview questions for this MFS, a semi-structured approach was used to build a structured format (Kallio et al., 2016). The first phase was to determine what subjects and topics had to be included to align with the aim (Kallio et al., 2016). With limited experience of constructing a semi structured interview guide, a draft was developed, and a pilot was performed. We formed a preliminary interview guide with three background questions to get demographic information about the participant and eight main theme questions. Following feedback from supervisor, the interview guide was altered to make the questions more open-ended. After the third phase was completed, the fourth phase was pilot testing the interview guide (Kallio et al., 2016). It was decided that the interview guide was effective and relevant. The final version of the interview guide was sent back to the supervisor for feedback, which was reviewed.

Focus group was an initial alternative to collect data, since the discussion could have given a broader understanding. With focus group discussions the participants could talk about the subject and share experiences and knowledge with each other. However, when using a focus group discussion, there exists the potential to influence or bias individual's experience (DiCicco-Bloom & Crabtree, 2006). While the use of focus groups could have aided a broader discussion, individual interviews provide participants to express themselves freely in a private environment. This was significant given the sensitivity of the topic, since participants may be more comfortable expressing personal experiences in a private environment. Consequently, focus group discussion was not selected for this study.

During the recruitment process in finding students for an interview, initially five nursing students expressed interest in participating in an interview each. Each student was contacted

to seek permission to create a group chat on social media platform, which was approved by all the students. One student showed up for an interview, follow-up contacts were made to the other students with no response. To avoid pressure on the students, no further contact was made (Woolf and Edwards, 2021). Consequently, there was restricted variation between the participants, since all but one student was registered at the same school. Addition of students from several nursing schools might have presented a broader scale of experiences and perspectives (Shea et al., 2022). The limited variation in nursing schools may have lowered the number of perspectives, although data was regarded as rich and included different depictions of the student's experiences. The limited variation also intensified comparison among participants and aided a deeper exploration within the shared context. Therefore, the data was contemplated adequately to fulfill the aim of the study. The restricted diversity among participants stemmed from challenges in the recruiting process and to find nursing students willing to participate in this MFS study. Even though broad outreach to numerous nursing schools and educational institutions in The Gambia and on different social media platforms, there was minimum interest in in participation.

The first interview was held in a secluded quiet place, and the rest of the interviews were held at a nursing school in a secluded office. At the school during two interviews nonparticipating individuals came into the room which could have led to disturbing environment and missing information. Although distraction can disrupt the participants' tendency to give detailed answers about sensitive topics, it was not shown in the interviews (Varma et al., 2021).

The samplings size, inclusion and exclusion criteria were set before the recruitment (Gentles et al., 2015). All the participants matched the sampling criteria, such as desired sampling size which were between 6 to 10 nursing students, both female and male students. Kirchheerr and Charles (2018) describes the risk of bias and limited diversity, such as the initial "snowball" can have a strong influence. The potential limitations associated with the snowball sampling method are acknowledged. Particularly, having six out of seven participants registered at the same nursing school could reduce diversity in answers.

This minor field study has provided us with greater understanding regarding how to interview with a qualitative analysis method. Working with a qualitative analysis method helped to shape the results by discussing and comparing codes and forming categories. We gained a deeper understanding in balancing ethical responsibility with the interest to learn more about a

subject, with ethical considerations like cultural sensitivity, informed consent and confidentiality.

Consideration has been given to the potential power imbalance between the authors and participants (Karnieli-Miller et al., 2009). A discussion was conducted before the interviews between the authors regarding how we might be perceived and effort was made to make sure respectfulness and responsiveness were pursued through the interviews. Throughout all interviews, we intently examined our body language to confirm a respectful and welcoming atmosphere, thereby encouraging participants to openly share their experiences (Westland et al, 2025). Our intuition during the interviews was that the participants experienced the interview as safe and respectful. It was conveyed by several participants with positive reception for the opportunity to share their experiences. Furthermore, they appeared comfortable during the interviews, which indicates that our anticipated approach of respectfulness was attained.

In this study, artificial intelligence was employed as a language device to archive rhetorical assistance to improve transparency and to achieve further formal sentences. The device did not impact on the analysis, outcomes or conclusion, the use was exclusively for linguistic editing intentions.

## Result discussion

Collins' theory helps to highlight and understand how overlapping system of gender norms, cultural expectations, and institutional challenges influence women's health education in nursing school in The Gambia. By recognizing lived experiences and acknowledging power inequalities, nursing students can provide more person-centered healthcare (Collins et al., 2021). This result discussion will be analyzed through the four levels of power that Collins et al. (2021) describe which are *Structural*, *Disciplinary*, *Hegemonic*, *Interpersonal* and with the perspective of *Intersectionality*. While all these levels provide as a framework, the discussions acknowledge that power dynamics can intersect across multiple levels of power and cannot be fit into one single category.

Collins et al. (2021) describe the structural level of power as how laws and educational systems affect individuals' lives by shaping access, rights and societal prospects. Collins et al.

(2021) framework shows how social institutions thoroughly control and replicate inequality, allowing privilege to certain groups while disadvantaging others.

With connection to the result of our study, Zou et al. (2025) proposes silence affecting the individual discomfort but represent a socially barrier in healthcare. Using our theory (Collins et al., 2021) silence in healthcare not only cause personal discomfort but also can work as a social barrier. Collins et al. (2021) speculate that silence can be seen by institutions as a mechanism of power, especially to silencing other affected by factors such as race, gender, and professional hierarchy. Therefore, maintaining inequalities in the healthcare system.

In line with this study (Dahab et al., 2016), it demonstrates how societal inequalities inhibit women's access to necessary healthcare, especially for female residents in rural areas. This emphasizes the societal reasonability of nursing schools to prepare students to adopt larger community needs. Patterson et al. (2024) propose integrating rural placements into education might enhance students' knowledge and preparation since inadequate clinical education appears in rural areas. Combination of these challenges, economic constraints and limited access to educational and communication resources further impede rural women's ability to acquire and use basic healthcare. Collins et al. (2021) emphasize how privilege and systemic power structures control healthcare accessibility, enabling vulnerability among excluded groups. Women's health inequalities are not purely individuals' concerns but are deeply embedded in greater structural discrimination. These finding hold major consequences for nursing education in The Gambia. By incorporating an understanding of these inequalities into curriculum, nursing students can explain the dimensions to address power imbalances and advocate for equitable, available healthcare in their future practice as nurses.

Limited awareness and health literacy significantly impacted women's knowledge of women's health. This is supported by Kilfoyle et al. (2016), who argue that health literacy plays a vital role in a reproductive health for women, and healthcare personnel must acknowledge the potentially adverse consequences that limited health literacy may have on reproductive health outcomes. Mostly all participants mentioned female patients often lack basic understanding of their own reproductive health, unless they have received formal education. This absence of health knowledge is itself a substantial risk. This is supported by Binta Jallow et al. (2025), who describes most adolescents lack awareness about their rights regarding sexual and reproductive health (SRH), and the biggest contributing factors are lack of information and cultural taboos affecting SRH service.

Participants expressed that the women's health simulation lab inadequate them for clinical placement. Defining the appropriate extent of simulations-based training in nursing education in The Gambia presents a substantial challenge, especially due to the non-existence of standardized metrics for evaluating the required amount of simulations labs. While clinical placements provide practical experience, the consistency and depth of learning among nursing students may be tentative, potentially leading to inconsistencies in skill gain. Increasing simulation lab could developed nursing students' skill development, clinical judgement and self-assurance. This aligns with the study of Görücü et al., (2024), which prove simulations-based education is improving nursing student's decisions-making skills but also gaining self-confidence. Developing simulation labs in nursing education may help join the gap between theoretical knowledge and practical application, therefor preparing nursing students to provide better women-centred healthcare before participating in clinical placement. From the perspective of Collins et al. (2021) it can be revealed how insufficient simulation lab reflects greater structural imbalances in nursing education. The stated limits in simulation lab could restrict students' ability to develop confidence and competence in women's healthcare. Therefore, students are not provided with necessary occasions to practice in safe learning environment, which continues existing power imbalances in nursing education. It is demonstrated how limited practical skills-training in women health can be implied as part of broader structural inequalities influencing black women's health education (Collins et al., 2021).

Reinforcing systemic barriers within nursing education not only affects learning conditions for the students but may also impact the quality of healthcare provided to women. Bvumbwe & Mtshali, (2018) clarifies that most countries in Sub-Saharan Africa experience significant difficulties in healthcare training, attributed to increasing student charges, inadequate faculty capability, lacking infrastructures and resources. Furthermore, there is high necessity for clinical training locations. Addressing these challenges necessitates improved capability of educators and mentors, updating curricula to meet existing requirements and improving accessibility of important infrastructure and resources (Bvumbwe & Mtshali, 2018) This emphasize the need for prioritizing women's health training opportunities within nursing education in the Gambia.

Participants expressed satisfaction with female lecturers teaching about women's health, noticeable that female lectures appeared more comfortable and willing to share more information about the subject. Our theory shows personal experience and embodied

knowledge shape both teaching and learning (Collin et al., 2021). Collin's emphasize individuals from marginalized social positions often develop specialized knowledge that strengthens their credibility and relational connection with learners, for example female lecturers' comfort with women's health topics (Collins et al., 2021). Female participants trust in female lecturers suggest that knowledge rooted in personal experience holds greater authority in women's health education. This perspective is supported by Zing et al. (2024), who found female lectures place a greater importance than male lectures teaching about sex- and gender-based medicine.

Participants expressed women's health education lacking, specifically topics about female genital issues. In line with this study Tørris (2024) which emphasize knowledge gaps among nursing students regarding women's health, the topic should be involved into the curriculums to ensure equitable health for women.

Collins et al. (2021) characterize the disciplinary level of power as the use of control through institutional rules, surveillance, and bureaucratic practices rooted in everyday practice. This system of power controls by acclimatizing behaviors through standardized procedures such as routines, rules, and bureaucratic procedures, thus disciplining bodies and identities in behaviors that finely yet obstinately reinforce intersectional hierarchies (Collins et al., 2021). The participants indicated the necessity for educational development, specially building stronger foundational knowledge about women's health. Participants suggested initiatives such as projects aimed at rural areas to educate individuals about women's health and expanding the curriculum about women's health. Seidue et al. (2022) discuss that women living in urban slums require further education on sexual and reproductive health. According to Collins et al. (2021), the development of safe spaces is essential for confront the social hierarchies that silence women's voices and constraint their access to healthcare. Awareness raising and adopting supportive environments are essential to building an inclusive and reliable healthcare system. Such an approach encourages women to handle healthcare systems with greater effectiveness and manage developed health results. Our study highlights the importance of strong healthcare support system and targeted educational development. These methods are necessary for defeating structural inequities, reducing stigma, and ultimately improving health outcomes for women.

Collins et al. (2021) illustrates hegemonic level belonging to the area where dominating norms, beliefs and values are established and contained in society. These ideas often show

inequalities and power structures as justified and normal. Factors such as gender, ethnicity and class collaborate within these norms, highlighting hierarchies and shaping individuals understanding of themselves and others (Collins et al., 2021).

It was shown that religious influence affects women's health education and healthcare. In line with this study Ganle (2015), it can be described that when Muslim women seek skilled healthcare, they prefer not to receive such care from certain people, including male healthcare personnel. This suggests that interaction between health system and religious expectations can form a conflict between women's desire and service availability.

Cultural discomfort influenced female patients to avoid discussing or rejecting assistance from male nursing students, resulting in male nursing students to encounter difficulties during clinical placement, which is strengthened by Buthelezi et al. (2015). The cultural barriers described by participants confirm how gender and culture shape communication and interactions within healthcare environment (Collins et al., 2021). It could be discussed that female patients not addressing women's health issues with male nursing students are due to cultural expectations. These cultural norms may hold back male nursing students to practice and engage with female patients, therefore creating unequal learning opportunities for male nursing students in nursing education in The Gambia.

Cultural stigma appeared to limit the discussion of women's health within both nursing school and society. Beliefs about female modesty had an impact on female patients and nursing education. Tohit et al. (2024) emphasize cultural taboos around sexuality, menstruation, contraception and abortion may limit the communication and education initiatives. It was revealed an influence of cultural norms in the society, and it presented a difficulty to release deeply rooted cultural traditions such as female genital mutilation and cultural practices at home. This suggests that cultural beliefs significantly influence women's health education and highlight the need for strategies that support open dialogue and supportive learning conditions. In line with this study Kaplan et al. (2016), cultural norms in The Gambia affect prevention and healthcare when it comes to attitudes regarding female genital mutilation. This dynamic creates a tension between nursing education, the need to respect cultural beliefs, and teaching evidence-based care.

The participant discussed how certain religious beliefs can restrict women from receiving essential medical treatments, such as blood transfusion during labour. This presents ethical and practical dilemmas, particularly when patient safety is compromised. Schantz-Dunn &

Nawal (2011) discusses the necessity to discuss the possibility of blood transfusion with pregnant woman early in pregnancy to confirm they are entirely informed. And so, for clarification of any misunderstandings and enable considerations of alternative treatment options if the need for a blood transfusion will arise (Schantz-Dunn & Nawal, 2011). These ethical dilemmas emphasized tension between religious beliefs and necessary medical treatment, but also importance of communication.

Participants noted that limited discussions about women's health issues can have contributed to a norm of silence on these topics. Alomair et al. (2020) highlight in Islamic communities, conversations about sexual and reproductive health are rarely discussed and regarded as a sensitive topic which may result in limited knowledge and awareness about sexual and reproductive health.

Conversations and educating about women's health issues is there for complicated by the societal acceptance of not addressing the topic, for example, educating against female genital mutilation (FGM) despite the health risk. Such silence can be seen as both structural and epistemic boundaries that suppress women's voices and experience in healthcare. The restraint is especially when religious norms cross with patriarchal authority (Collins et al., 2021). Educating women about their health issues, including FGM, is complicated cause by this silence norm which reflects the way social structures have control over women's bodies and knowledge. The norm of silence around women's health issues can be seen as a system of social control to restricts women's ability to make informed decisions about their own health. The theory shows barriers in healthcare, such that shapes women lived experiences due to wider power relations.

Participants expressed that male lectures often express discomfort or avoid teaching topics related to women's health issues, particularly those regarding genital health, due to deeply rooted cultural beliefs. The reluctance to engage with sensitive subjects may mistakeably extend patriarchal norms that disregard women's health concerns.

Nursing students' necessity to proactively seek for more teaching about women's bodies suggests that this education is not freely accessible, highlighting how cultural taboos can restrict open conversations about women's health (Collins et al., 2019). This aligns with the theory how cultural taboos can suppress discussion and lecture about women's health issues and health. Our study underscores nursing students' responsibility to address curriculum gaps themselves, however also emphasizing the influence of structural and cultural norms on the accessibility of women's health education.

Gendered cultural norms contribute to the formation of “structural silence”, which reflects on a women’s ability to seek information and access healthcare. As a result, the limited knowledge is not purely an educational gap but also an indicator of a broader power dynamics that discourages open discussions about women’s health issues (Collins et al., 2021).

Collins et al. (2021) interpersonal level illustrates how power and inequality are exhibited in everyday interactions between people. These interactions are affected by numerous cooperative factors such as gender, class and ethnicity. The factors shape how individuals are addressed and positioned within social perspective (Collins et al., 2021).

Topics that were raised by the participants was the concern regarding vulnerability of women living in rural areas. Participants described how limited transportation from long distance to healthcare facilities could delay healthcare causing complications during labor. Dahab et al. (2016) describes how the most major contributor to maternal health includes transportation barriers to healthcare facilities, economic constrains and cultural values in African low-income countries.

The result of this MFS shows restriction limit women’s access to healthcare, while inequalities in education and communication tools reduce knowledge about women’s health, resulting in limited healthcare access and awareness.

Applying Collins et al. (2021) interpersonal framework, women health is influenced not only by gender but also by geographical barriers, poverty, limited knowledge, and resources. Women’s health cannot be fully understood by gender alone, it must also be analyzed in relation to material conditions and systemic power relations.

The results show that women’s health outcomes are not exclusively a product of individual biology or identity but are substantially influenced by the broader social and structural context in which women live. The interaction of geographic, economic, and power dynamics with gender creates varied lived realities and disparities in healthcare access. Such systematic inequalities—rooted in education, economic opportunity, and healthcare facilities—further impair inadequate health experiences for women.

With this perspective, an analysis of women’s health must be greater than gender alone. It is necessary to deliberate other factors within social systems such as power relations and material conditions; thus, these factors impact health equity.

Collins et al. (2021) define intersectionality as the interaction of several power structures, such as class, gender and ethnicity. These power structures cannot function separately but operate together in individuals’ experiences and society’s structure. It is fundamental to reflect

how these intersecting structures are experienced together in individuals' lives and within societal context (Collins et al., 2021).

Utilizing an approach regarding intersectionality, nursing education in The Gambia can develop students' awareness, therefore understanding of patients' lived experiences increase. With the use of this framework, it can enable nursing students to understand how different social factors such as socioeconomic status, gender and ethnic backgrounds cooperate to influence health access and outcomes. Described by Younas et al. (2024) intersectionality works as a tool to challenge and confront inequalities rooted in socioeconomic and cultural differences.

Additionally, applying this framework allows nursing students to develop deeper awareness about the complexities inherent in individual's experiences. Such awareness develops essential skills like cultural sensitivity, empathy and critical thinking, properties that are vital for not only clinical placements but throughout their future careers as nurses.

Increased awareness of these dynamics can contribute to more effective and person-centered healthcare which is supported by Harazneh et al. (2025) which express strong cultural competence is vital for giving effective and sensitive healthcare.

Incorporating an intersectionality framework into Swedish healthcare nursing can notably improve the professional development of future nurses, encouraging the achievement of advanced skills and empathy. By using an intersectional perspective, nurses in Sweden can better understand different background of their patient, including migrant, refugees, and ethnic minorities. A patient's identity expands further than their medical condition, it includes intersectant dimensions such as gender, cultural background, and socioeconomic status which is supported by Blackie et al. (2019) who argue about the idea that a patient's identity extends beyond their medical condition.

By identifying and adopting intersectant social factors, Swedish nurses can give healthcare that is individualized, equitable, and culturally sensitive adapted. Siira et al. (2023) support this approach, highlighting that intersectionality serves as a necessary framework to achieve a complex understanding of patient and patient experience and recognizing healthcare injustices.

Ultimately, incorporating an intersectional perspective into nursing practice, both in The Gambia and Sweden prepares nurses and nursing students with essential tools to acquire a

deeper understanding of patient needs. This perspective acknowledges the impact of social and structural factors on individuals' health and wellbeing.

For nursing students in The Gambia, intersectionality can improve empathy, cultural competence, and critical thinking, while further person-centred and sensitive care to each patient's background. By a greater understanding of patient, this approach has the potential to lighten healthcare inequalities and elevate the quality of healthcare provided.

## Conclusion

This study emphasizes how women's health and nursing education are shaped by intersecting factors. Considering using the intersectional perspective allows nursing care to be provide in a more person-centred way, therefor encouraging more understanding and respect for the patients and overall quality of healthcare. The intersectional perspective emphasizes the value of understanding how power dynamics, personal experiences and societal norms impact the caring relationship. Nursing students' education was affected by several factors such as cultural and gender norms, limited resources and religion which together affected healthcare and educational quality.

Meaningful developments in patient care and nursing educations necessitate the inclusion of intersecting challenges into practice. By doing so, arising nurses can interact with patients in ways that thoroughly recognised and respect the depth of their individual experience and cultural backgrounds.

## Clinical implications

As a nurse, it is important to have knowledge of the several cultural, religious and gendered related barriers that may affect patients' healthcare, enabling more respectful and person-centred approach.

From a clinical perspective, Collins et al. (2021) theory could support nurses in develop a greater understanding of patients beyond their medical conditions, including for example socioeconomic factors. Our theory suggests women's experience are shaped by intersecting factors such as culture, gender, and social context. By utilizing our theory, nurses in The Gambia could develop their attention to patients' lives and experience, therefor contributing to further person-centred healthcare.

Utilizing Collins et al. (2021) theory in nursing practice in The Gambia could greater nurses' awareness of the power dynamics innate in healthcare systems, therefor encourage the growth of healthcare relationships embedded in respect and dignity. Collins et al. (2021) highlight the significance of listening to women lived experience without making assumptions. Although nurses in The Gambia could not fully understand the lived experience of every woman, continuing an open and reflective approach could improve trust and communication in healthcare settings.

Using Collins et al. (2021) theory in the Swedish healthcare system could improve the providing of person-centred care. By applying an intersectional perspective, nurses –mainly in Sweden– could help deepen their knowledge of, and understanding, to the individual experiences and social backgrounds of their patient's. Healthcare professionals in Sweden could utilize an intersectional approach to understand how a patient's experience in the healthcare system is influenced by intersecting dimensions, such as gender, ethnicity, and socioeconomic factors. For nurses in Sweden, integrating an intersectional perspective is not only an academic exercise, thus a practical tool for establishing trust and preservation dignity in patient care and healthcare environments.

Overall, our theory may guide nurses in The Gambia to reflect on their roles and position in healthcare contexts. By remaining sensitive to social and cultural tones, nurses could be better prepared to establish respectful relationships that acknowledge patients as individuals beyond their medical diagnosis.

## Further research

Existing studies on women's health and nursing education often emphasize cultural beliefs, gender norms and structural barriers such as poverty. Much of the available literature are focused on female genital mutilation (FGM), limited autonomy for women, stigma around sexual and reproductive health, and religions influence on healthcare behaviours. However, most of this literature focuses on nurses' perspective, with limited searching of nursing student's experiences.

It would be beneficial to deepen the research regarding the topic of male nursing students experience, and how they face cultural and religious barriers while preserving a responsibility

to researching and requiring quality healthcare for women. A qualitative approach continues essential for this type of study, while methods such as in-depth interview or focus group discussion would allow researchers to greater understanding of these experiences. Also, utilizing a mixed-methods design may provide detailed personal perception and broader patterns, enriching the overall findings.

Another topic that still needs investigation is how the theory-practice gap impacts nursing students' competence, with the prospective for simulation lab to develop nursing students' practical skills and confidence. Research could further examine how simulations-based learning influences students' preparedness for clinical placement in The Gambia, with a specific focus on women's health environment, such as a gynaecological wards. Utilizing a longitudinal or quasi-experimental research design, where students' performance is evaluated before and after simulations labs, could provide vigorous evidence for the efficiency of curriculum strategies in linking this gap.

Furthermore, the influence of lecturer's gender and comfort levels in teaching and discussing women's health topics need further investigation to better identify how to create an applicable learning environment. A thorough study could combine student perception surveys with lecturer interview to identify the significant factors that impact creating a supportive and inclusive educational environment. By integrating culturally frameworks with educational theories, further research may provide beneficial understanding that develop both student learning outcomes and the quality of patient care.

To achieve a broader understanding of how women's health is learned in the nursing education in The Gambia, conducting a quantitative study is advised to study a larger population, which could illustrate different perceptions comparison to this MFS.

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## Appendix 1

### Background questions

- How old are you?
- How far have you come in your education?
- Can you tell us about your experience with the nursing education in Gambia?

### Main issues

- What subjects and topics in women and reproductive health are included in the nursing education?
- How much focus is placed on teaching about women health in nursing education?
- What specific women health topics are taught?
- How are the specific women health topics taught?
- What challenges do nursing students face when it comes to teaching women health?
- Do you think there are any cultural or religious factors that influence the teaching of women health?
- Do you think that there is anything to improve about women's health education?
- How do you think women's health education can be developed in the future?

## Appendix 2



### **Informed consent to participate in school project**

#### **Nursing students' education about women's health in Gambia**

We are two nursing students at Örebro University in Sweden aiming to do a school project in The Gambia. We are interested in the nursing education concerning women's health in The Gambia.

If you are a nursing student in The Gambia, we would be grateful if you would like to participate in a interview with us concerning this topic.

The interview will last between 40-60 minutes, and it will be audio recorded. Our school project will start at the end of October 2025, and we are aiming to arrange the interview in the beginning of November. The interview will take place in a for you suitable place. The interview will be recorded, and the recordings will be kept locked and only us writing this school project and our supervisor will have access to the material. The collected interviews will be used for a qualitative analysis and will be written as a school project. Your participations are voluntary, and you can at any time choose to no longer participate without giving any reason.

Your experiences are important to us, and we will be thankful if you decide to participate.

If you have any further questions, you can also contact us.

Kind regards, Elin & Sabina

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