Introduction

Since the transition from childhood to adulthood requires series of physical, emotional, and social changes (Women & UNICEF, 2018), studies show that adolescence is often unprepared for these unavoidable changes (W.H.O., 2018). For instance, substantial numbers of girls in many countries have knowledge deficits and misconceptions about menstruation that cause fear and anxiety leading to unprepared care for the eminent menstruation (Chandra-Mouli & Patel, 2017; W.H.O., 2018). Similarly, critical knowledge gaps exist among adolescent girls, especially in Africa and Asia, about when and where to obtain and how to use a range of modern contraceptive methods (W.H.O., 2018). There is strong evidence for the positive effects of Comprehensive Sexuality Education (CSE) on increasing adolescents' knowledge and improving their attitudes related to sexual and reproductive health (SRH) (W.H.O., 2018; Women & UNICEF, 2018). Studies further indicated that curriculum-based CSE programs can contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, increased use of condoms, reduced risk-taking, and increased use of contraception (Women & UNICEF, 2018). There is no evidence suggesting that CSE increases sexual activity, sexual risk-taking behaviors, rates of HIV or other STIs (Fonner, Armstrong, Kennedy, O'Reilly, & Sweat, 2014; Shepherd et al., 2010; W.H.O., 2018). School-based CSE has also been shown to be a cost-effective intervention to contribute to HIV prevention and control (Fonner et al., 2014; Kivela, Ketting, & Baltussen, 2013; Montgomery & Knerr, 2018). Although CSE is gaining global political commitments, huge gaps remain between political frameworks and actual implementation strategies (Vanwesenbeeck, 2020).

Politicians and the legislature authorize the provision of health and social interventions to adolescents. Enabling laws and policies, such as those requiring governments, non-governmental organizations, or civil society groups to provide CSE, are in place in some countries (W.H.O., 2018). In several places, major barriers such as the absence of enabling laws, the presence of contradictory laws, norms, values, and/ or culture, as to when a law or policy requiring the ministry of health to provide contraceptive information and services to all individuals of reproductive age is undermined by another law requiring mandatory parental consent for the provision of health services to legal minors, the presence of exceptions to laws, or where age-of-marriage laws can be waived on different grounds, and the presence of restrictive laws (Vanwesenbeeck, 2020). Although Legal and policy reform takes time and effort, it needs to be given due consideration. Interventions intended to contribute to specific

health outcomes including preventing and responding to STIs or harmful traditional practices such as female genital mutilation/cutting (FGM/C) are both determinants of problems and their responses are closely linked. Laws or policies that require parental consent for legal minors to obtain health services hinder access to contraceptive information and services, for example, HIV testing and counseling. Social stigma can hinder care-seeking for STIs and intimate partner violence (IPV). Building equitable gender norms and values through CSE can contribute to preventing gender-based violence (GBV) and to promoting joint decision-making on contraception in couples and/ or singles. (W.H.O., 2018).

Health consequences, pregnancy, and childbirth complications are the leading cause of death among girls aged 15–19 years globally, with low- and middle-income countries claiming 99% of global maternal deaths of adolescents aged 15–49 years (W.H.O., 2017a, 2019). Mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis, and systemic infections (sepsis) than women aged 20–24 years (Ganchimeg et al., 2014; W.H.O., 2018). Also, about 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to an increase in maternal morbidity, lasting health problems, and mortality (Darroch, Woog, Bankole, Ashford, & Points, 2016). Early childbearing may increase risks for newborns as well as young mothers. Babies born to mothers under 20 years face higher risks of preterm delivery, low birth weight, and severe neonatal conditions (Ganchimeg et al., 2014). In other words, rapid repeat pregnancy with short birth intervals is a major concern for young mothers indicates further adverse risks for both the mother and the child (Kozuki et al., 2013; Norton, Chandra-Mouli, & Lane, 2017). On social consequences, unmarried pregnant adolescents may face stigma, rejection, or violence by partners, peers, and parents (Blum & Gates, 2015). Girls conceived before 18 years are more likely to experience violence within a marriage or partnership (Loaiza & Liang, 2013). Teenage pregnancy may also jeopardize girls' future education and employment opportunities (Blum & Gates, 2015; Merrick, 2015).

The Gambia, like many other countries in sub-Saharan Africa, has long been overburdened with sexual and reproductive health problems. Despite the progress to meet the sustainable development goal 2030 (SDGs) target, many barriers post a challenge in making the country hopeful in realizing these set targets (SDGs 2030) (Stenberg & Thorsson, 2019). Maternal mortality still remains high up to 433 deaths per 100, 000 life birth, Neonatal mortality accounts for 22 deaths per 1000 life birth, the prenatal mortality rate is 30 death per 1000 live birth (Stenberg & Thorsson, 2019), 1300 new HIV infections, and 1100 AIDS-related deaths