Research evidence to inform strengths-based policy and practice: Mapping the coping strategies of young women in Mozambique

Abstract:

Unintended pregnancy amongst young women in Mozambique is associated with many 'problems' and 'poor outcomes'; yet little is known about how young women, their family and communities actually respond to these problems. Qualitative research on the coping strategies used by young mothers under 20 years of age in response to conflictual relationships, poor material provision, poor health and poor educational access in Mozambique is presented. Data was constructed through 21 semi-structured narrative interviews with young mothers (16-19 years old) from two regions (urban/south and rural/north) on their experience of coping with unintended pregnancy. Thematic data analysis to identify coping strategies was completed using Nvivo 7. The majority of strategies identified were 'relational' in nature highlighting the importance of developing interventions which strengthen naturally occurring strategies used by women, their families and communities. The findings are used to illustrate the role of strength-based research in developing policy and practice, particularly in relation to community development and groups considered unable to 'cope' or 'get on'. It is also important to ensure strengths-based approaches are used to tackle structural inequalities and strengthen organisational resources, despite this being a strong critique levied at strength-based interventions.

Keywords: Mozambique; unintended pregnancy; coping strategies; young women; narrative interviews; strengths-based.

Subject categories: Social work approaches and methods; Reproductive and sexual health; International perspectives

Introduction

Strengths-based perspectives are a core part of social work values, practice and policy approaches, closely linked with concepts of resilience or 'coping' (Hill, 2008; Ungar, 2008; Fawcett and Reynolds, 2010; Guo and Tsui, 2010; Hutchinson, 2014; Harms Smith, 2017). Essentially strengths-focused social work rejects a deficit-focused response to the challenges faced by people and communities, believing that it is possible to overcome difficult and stressful situations, even growing and developing through them (Saleebey, 1992). A strengths-based approach involves working with individuals, families or communities to identify and build upon resources, coping strategies, exceptions and possibilities that already exist or are possible to create, even when this seems impossible (Kelly and Gates, 2011). Principles of hope, resilience, coping, opportunity, well-ness and repair replace preoccupations with injury, problems, stress, adversity, maladjustment, victimisation and learned helplessness without minimising the nature of adversity (Norman, 2000; Kelly and Gates, 2010). Concepts like 'resilience' or 'coping' are often used to operationalize strengths-based perspectives. Set in a framework of strengths, coping can be more than just 'surviving' or 'getting by' (Hutchinson, 2014). The revolution of the strengths-based approach is particularly powerful in relation to groups or social problems conceptualised as 'powerless', 'impossible to change', or 'hopeless'; such as those with long term mental health problems, those with long term drug and alcohol addiction or victims of domestic violence (Guo and Tsui, 2010; Kam, 2014). Responses to these groups, for example, are often characterised by responding to each crisis as they occur and long-term 'maintenance' which is shaped by the expectations that professionals and/or individuals and their families have for the level of well-being they can expect. This may result in individuals not pursuing educational or employment activities, for example, because of these expectations.

However, strength-based approaches and concepts like resilience have also received significant critique in recent years, sometimes considered as individualistic approaches which ignore structural inequalities (Boyden and Cooper, 2007; Guo and Tsui, 2010). Harms Smith (2017) goes so far as to say that it is paramount to '*blaming the poor*' and claims that strengths-based approaches can '*fail to address serious and oppressive structural dynamics which perpetuate poverty and inequality'* (p2). In essence, critics see strengths-based approaches as expecting individuals to use 'individual' strength in response to problems which have deep roots in structural inequalities (Hutchinson, 2013). Concerns have also been raised that inexperienced practitioners may minimise serious problems or overlook real needs by a narrow view on strengths (Ernst, 2001). A strengths-based approach could even be used to justify a reduction of services by placing all responsibility for overcoming adversity on individuals (Fawcett, 2009). Laird (2008), for example, warns that concepts of 'strength' and 'coping' in an African context, for example, need to take into account the socio-economic, rather than psycho-social, causes of social problems in the region. In addition, there are many ways to conceive of 'strengths' which are culturally determined, set within an environmental context that dictates what is appropriate and available (Ungar, 2008).These concerns are particularly pertinent in contexts of poverty and international development (Harms Smith, 2017). Yet strengths-based principles underpin many models frequently used in social development such as asset-building or capacity-building (Rapp et al, 2005). Strengths can be recognised and encouraged not only in individuals but also in households, families and communities. Individual strength is still an important part of responding to structural inequalities– indeed expressions of agency are essential for hope building which inspires collective action and social change (Gordon and Song, 2004; Fergus and Zimmerman, 2005). Yet, individuals rarely only draw on their own strength and draw on the strengths and resources of others.

The strength-based approach was initially developed in a 'western' context (Oliver and Charles, 2016) and the task of integrating strengths perspectives into different practice contexts around the world remains in its infancy (Laird, 2008). It is recognised that international social work and social development practice, particularly through processes of colonisation, imperialism and post-colonisation, has at times, destroyed rather than facilitated the resources, strengths and resilience of families and communities in the global South (Midgley, 1981; Schmid, 2007; Yellow Bird, 2013). In recognition of this, strength-based perspectives have started to influence policy and practice in 'non-western' contexts, highlighting compatibility with other approaches used in the global south such as indigenous social work, the capabilities approach, asset-focused approaches, participatory approaches and culturally sensitive practice (Roff, 2004; O'Leary et al 2015; Crawford et al 2016; Gupta et al 2016; Mafile'o and Vakalahi, 2016); all of which are usually considered as emancipatory and community-based approaches.

This article presents a piece of strength-based research on early and unintended pregnancy which was designed to inform strength-based policy and practice in Mozambique. The research is then used to open up a wider discussion on the role of strength-based research in international social work and social development.

Methodology

Background

The impending birth of any child in Mozambique is a significant life event which takes place within complex social relations (Graham, 1999). When a pregnancy comes sooner than desired, or planned, additional complexities arise which are more likely to be perceived as complications (Johnson et al, 2004). Consequently, there are a whole array of health and social problems associated with unintended pregnancy (UNFPA, 2013). Young mothers have a lot to 'cope' with during this 'unplanned' life event; and early and unintended pregnancy has therefore become a significant health and social development concern in recent years (UNFPA 2013).

Aims and objectives

The main aim of the study was to identify coping strategies used in response to 'problems' encountered during unintended pregnancy; and to use this knowledge to make recommendations which would strengthen these strategies through social development intervention. Coping strategies are defined as '*constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person'* (Lazarus and Folkman, 1984, p.141).Using strength-based principles it was theorised that knowledge of coping strategies revealed by the research would ensure social development intervention progressed in a way that reinforced capabilities; building on the strategies already used by young women and their families (Hutchinson, 2014).

Participants

Twenty one young women (16-19 years old) who had had a self-defined unintended pregnancy and live birth in the last 2 years were invited to share their experience of unintended pregnancy with a researcher and translator.

Sampling and access

All research participants were accessed through the national programme for adolescent sexual and reproductive health in Maputo City and Zambézia. These provinces were chosen to reflect the significant differences between rural and urban contexts as well as northern and southern Mozambique. Eight youth associations, four across each province, were selected from which to invite three research participants each, ensuring access to young women from different regions and socio-economic backgrounds. Youth workers from each association identified young mothers known to them who were not married when they first became pregnant, and invited them to take part. The youth associations provided a 'safe' access point to participants who are unlikely to be in education. The youth workers also guaranteed to provide follow-up and long term support as needed. Data from the narrative interviews were also complemented by data from focus groups and professionals linked to each of the eight youth associations. This resulted in a wealth of in-depth data, within the available resources, that has been triangulated in data analysis not presented as part of this paper (Taplin, 2009).

Methods

The research involved direct interaction with research participants using semi-structured narrative interviews, drawing out their experiences, understandings, views and perspectives of unintended pregnancy. The interviews were structured to elicit free flowing narratives, and follow-up questions were used to explore and reflect on the narratives given. Reflectivity on processes of coping was largely prompted by asking 'why' questions to understand intentions or 'how did you respond to that?'

Data and data analysis

Data were translated from Portuguese into English by two research assistants; young women familiar with each region and fluent in both languages. Basic research assistant training was given along with regular supervision sessions. Transcribed data was transferred into a qualitative data analysis software package, Nvivo 7, for qualitative coding, thematic and discourse analysis. The main aim of the data analysis presented here, as highlighted through the research questions, was to identify the coping strategies used by young women in response to the challenges associated with unintended pregnancy. Four main 'problems' were categorised through initial analysis of the transcripts; poor health, poor educational access, conflictual relationships and poor material provision. Coping strategies were identified by first coding the 'problem' (i.e. poor health), and linking these codes with the 'responses' made to the problem (such as seeking advice from a health professional) and finally the 'outcomes' (health problem resolved or not). Coping strategies were labelled as either 'cognitive' (internal regulation of thoughts), 'emotion focused' (internal regulation of feelings), 'problem solving' (external action) or 'relational' (used of social relationships and networks) based on the distinctions often made in the literature regarding different types of coping strategies (Lazarus and Folkman, 1984). Resources were labelled as 'personal' (use of self), 'social' (use of social relationships) and 'organisational' (use of /institutional/organisational resources) (Hutchinson, 2014).

Ethics

Central to the conduct of the research were issues of informed consent, access to participants, impact of the research on participants, sensitivity of the research, prevention of harm, use of translators, awareness of power relations and health and safety considerations. The Social Research Association (SRA) code of ethics and research guidance from the Economic and Social Research Council (ESRC) were used to underpin the research development, and

ethical approval was granted by the University of Southampton prior to fieldwork taking place. Additionally a Mozambican social worker from a well-respected African and independent women-focused organisation took on the role of onsite supervisor to ensure that the context and Mozambican interests were sufficiently represented within the research process All respondents were able to give their consent without reference to any other, and the research documents were available in both Portuguese and the regional language.

Results

Sample characteristics

In total 21 young women agreed to participate in an individual semi-structured narrative interview (anonymised characteristics available online as supplementary information). Respondents were asked to self-identify their pregnancy as unintended before the interview. Essentially all of the respondents described pregnancies that were conceived outside of marriage, being unplanned not only by the respondent, but also by the biological father and both their families. Age at conception ranged from 12-19 years and most respondents remain unmarried (14/21) living with members of their own families (13/21). The majority of respondents were still in school (16/21) which is not representative of the general population in Mozambique. It is likely that school attendance is higher in this group because they were linked in some way to youth associations that promote and facilitate educational access.

Based on the narratives described, it was clear that respondents took specific internal or external actions to manage, reduce or overcome perceived problems, which are highlighted in bold below (also see table 1). While some strategies were described as rational pre-planned

courses of action, some strategies, while specific and conscious were not necessarily pre-conceived through a rational cost-benefit type analysis (Hutchinson, 2014).

Table 1: Coping strategies identified

Strategies for reducing conflictual relationships

Each participant described at least one conflictual relationship, the majority describing more, especially when disclosing the pregnancy. Twelve experienced conflict with the biological father, 17 experienced conflicts with parental figures, and four experienced conflict with health providers. Four described episodes of physical violence while others described verbal conflict or being forced to do things they did not want to do (for example, moving to live with the father of the child).

Various strategies were identified with the aim of reducing conflict or restoring relationships. As Filoberto illustrates below, eight young women **actively delayed formal disclosure to significant parties** (such as the biological father, parents or in-laws), sometimes even denying the pregnancy, to first **seek informal support and advice** from those who would not take 'responsibility' for the pregnancy, namely friends;

> *'I only spoke to the father of the child in the second month, before that I only spoke to my friends and they were giving me advice'*

Although under time constraints, this enabled them to consider how people would react, what they were going to do and whether to have an abortion. Data showed that friends were more likely to suggest and discuss abortion than parents or older female relatives. Friends were

therefore used to help develop alternative strategies, getting advice and information they might not receive from family members. In addition, predicting the likely range of reactions from significant others enabled young women to expect and be emotionally prepared for the worst, whether this occurred or not, **basing their actions on social knowledge** (i.e. knowledge of social norms and values and 'social stories' related to unintended pregnancy in their community).

The narratives revealed that the additional strategic value of confiding in and **seeking support from older female relatives** was that they were more likely to provide some form of advocacy and support during future discussions about who would take 'responsibility' for the young women and her child (before and after birth) as Valda describes;

> *'And my aunt she came to stay with us for a period of time, she is the one who found out... Then my aunt, she was very close to me, she was a friend to me, so she said ok I will tell your parents and she arranged a day and told me 'be prepared because today I am going to tell them'.'*

While older women's attempts at advocacy were not always successful at facilitating the outcome young women wanted, ten examples were given of female relatives accompanying respondents when disclosing to the biological father, or insisting she stay at school or return home if unhappy living away. Mother figures were often described as advocates when she was excluded from key decision-making meetings often held between the two families when deciding who would take 'responsibility' for the pregnancy and if marriage will occur.

Although many of the biological fathers initially refused to validate the relationship and accept 'responsibility' for the child, the narratives show that it is possible to **engage in active discussion** to increase engagement. Ten young women described on-going dialogue, reminding him of their relationship and suggesting how they could make things work. For three respondents this resulted in his acceptance and engagement over a period of time. However, when conflict with the biological father could not be resolved several respondents directly approached his family for support as shown by Adela's example;

> *'I told him one day and he said 'ok that's not a problem' I think he already knew and he was preparing to run away to avoid the responsibility. The next day he didn't come back and I never saw him again … it is the parents who accepted responsibility because the parents always saw me there with him. He never accepted.'*

Three respondents revealed that the biological father or his family, who had previously refused responsibility, made contact after the birth, wanting to take responsibility for the child at this time. One participant refused to put the name of the father on the birth certificate unless he took responsibility, **using the value of the child** as an important element in negotiations. In three narratives, young women who had moved to live with the father of the child returned home to live with her own family after the child was born because her family were more accepting of the child after birth. There is some evidence then that engaging in active discussions and negotiations could be effective at reducing conflict, even in the context of unequal power relationships.

Conversely, across at least ten of the narratives there appeared to be few external responses to physical, verbal and emotional abuse. **Remaining passively engaged** in these relationships,

young women appeared to wait for the abuse to pass, believing it would reduce over time, particularly after the birth of the child - as Hannah said '*but it ended up being that I was able to pass through that thing and I got along'*. Two respondents who were physically abused by family members described waiting for these relationships to change, relying on others to bring an end to the violence. Others described doing what they were told even though they did not want to, such as moving to live with the biological father or having further sex without a condom; they said they had no choice but to do as they were told. While risky, when relationships with others are central to all other decisions, meeting of needs, personal and culture values and goals, it can be considered strategic to remain passively engaged in these relationships despite conflict (Kabeer, 1999).

Strategies for accessing material provision

An extra, unplanned, mouth to feed has significant financial implications for those who take responsibility for the child, especially in a country where 55% of the population live below the poverty line (UNICEF, 2011). Seventeen respondents described continuing to struggle financially, unable to meet their basic needs. Pre-marital pregnancy is likely to occur before the biological father or his family are financially able or prepared to take responsibility, evidenced by the fact that only six respondents remained in formal relationships with the biological father.

The majority of respondents (12) **continued to live with their parents,** who were by default their main providers; those with the main 'responsibility' for care and provision. However, there were several arrangements between families which included additional provision from the biological father or his family. At least four respondents also **received financial support**

from men who they were in (sexual) relationships with, but who were not the biological father of their child(ren).

Additionally, ten respondents describe **engaging in some kind of productive activity.** Almost all respondents who were not in school engaged in productive activities as did many of those still attending school. This included making biscuits, cakes, sandwiches and juice to sell from home, growing and selling fruit and vegetables, sewing, hair braiding and renting out property. Most indicated that the money earned was used by the whole household. More young women from the northern/rural region were engaged in productive activities; it being more common for them to grow and sell their own produce.

Although respondents were concerned with the immediate nature of day-to-day material provision, eight described **education as a long-term strategy** for financial security. Educational access is therefore balanced as a long-term strategy, along with other short-term strategies for immediate provision within day-to-day time limitations. However, only one respondent had graduated from school and although she had secured formal employment, her child was living with her mother because her job was located far from the family home.

Strategies for good health

According to the young women interviewed, barriers to good health during pregnancy included anxiety, lack of information, lack of adequate service provision, unsafe abortion, being inexperienced and poor support from others. Fifteen respondents described acute anxiety, vomiting, increased tiredness, headaches, stomach aches and long term impacts on menstruation. Seven also described more serious complications such as malaria, fever,

anaemia, difficulties during birth, severe weight loss and premature birth. Only six made no reference to health concerns.

All respondents had some **contact with health professionals,** at either a clinic or hospital. All of the young women confirmed their pregnancy at a hospital and attended some antenatal appointments. All but one gave birth at hospital. However, not all women were tested for HIV/AIDS or given essential information about pregnancy, and four reported conflict with health professionals, as described by Adela, pregnant at 15;

> *'when I went at first the midwifes from the hospital, they have a problem, they got angry, when I got in the room I was alone, they insulted me, I started to cry and they said I was a child, how could I have done such a thing, I didn't say anything because I was scared.'*

Respondents knew little about pregnancy and they 'coped' with this by **seeking advice, guidance and help from experienced female relatives** in the family or close neighbours and friends, particularly in relation to emotional support. More young women reported seeking and receiving help, advice and emotional support from older women in their family than they did health professionals as shown by the contrasting way Adela talks about the support her mother gave;

> *'my mum became very much my friend, she would counsel me, I would ask my mum what would happen when arrives the time for giving birth, how is it going to be, is it going to hurt a lot. She hid some details and she would say 'you must be courageous', so when the day arrived I started feeling bad and she took me to the hospital'*

When a **claim of 'responsibility'** is made, whether it be by the biological father, his family or her family, they are accountable for feeding, clothing, accommodating and providing for her and the child if unwell. However, the level of care provided through this process was variable. In general, a young woman's own family appeared more effective at preventing poor health when taking 'responsibility', and those who described sufficient provision of food, clothes and shelter also reported less health problems.

Abortion in Mozambique is illegal except in exceptional circumstances, and is largely unsafe. Clandestine abortion contributes to high levels of maternal mortality especially in young women (Singh et al, 2006). Four respondents said they **did not have an abortion** because of the associated health risks, and eight gave examples of women they had known who had died or became very ill following an abortion. The risk of death, long-term health implications, and not being able to have any more children were given as the main reasons for not having an abortion. Keeping the baby rather than having an abortion, even with the social and cultural implications, is cited as an action they took to stay healthy.

Poor educational access

Barriers to continued education mentioned by the respondents included lack of finances to pay school fees and other costs, poor health during and after pregnancy, childcare responsibilities, being moved to evening classes and lack of support from teachers. While primary school education is free in Mozambique, secondary schools charge variable fees for students over the age of 12 and for matriculation, in addition to charges for books and uniforms (Roby et al, 2009). Eight respondents missed at least a year of school due to the

pregnancy, and four had to repeat years. Eight were rescheduled to study in the evening. Yet when interviewed, fifteen respondents were still in school despite interruptions.

The **discourse of education** as being essential for future opportunities, a good job, independent provision and personal growth was highlighted by many respondents as a contributing factor when striving for educational access (also found by Roby et al 2009) as hinted by Mary;

> *'my future will be bad because I've stopped studying. If I'd continued studying, not getting married, I would have been in the 10th class by now and I would be having a better future.'*

Five young women from urban areas revealed that **parents had engaged in conversations with them about education**, giving them the choice to continue with school. Young women who were given this choice spoke passionately about continuing with school, drawing on this discourse to facilitate educational access.

Seven respondents returned to school because of **childcare provided by the family**, while three others accessed childcare from outside the family. Sisters who had unintended pregnancies 6 months apart and lived at home with little support from the biological fathers, looked after each other's child while they attended school in either the morning or the afternoon. Young women from the urban areas were more likely to receive financial support to facilitate school attendance, while families from rural areas tended to provide childcare.

The narratives show the **importance of flexibility in the education system** to facilitate school returns after a child is born. For example, while eight young women dropped out of school completely during the pregnancy, three have since returned. While this meant that education was interrupted, years repeated and return not guaranteed, young women used the acceptability of stopping, restarting and repeating to continue their education. This also enabled young women to balance multiple childrearing, household and income generating responsibilities.

Seven respondents received **support and encouragement from teachers to continue in school** helping them to make use of this flexibility. On at least two occasions this included a visit to the family home to discuss school return with parents. Of the seven who received support, five continued in school without any gaps or repeated years. In contrast, other respondents made reference to active discouragement from teachers, as this example from Louisa shows:

> *'my school didn't do anything, only my teachers they would make fun of me and say that 'oh you used to miss classes just to get pregnant.'*

Five young women **used evening classes to continue their education**. This national policy means that instead of being completely excluded from school, pregnant 'girls' are moved to study in the evening, allowing young women to care for their child or engage in productive activities during the day. However, the use of evening classes is controversial because many rural areas do not have electricity and travelling to school at night can be dangerous. At least four young women stopped studying when forced to attend evening classes.

Discussion

The aim of the research was to use knowledge of coping strategies used by young women during unintended pregnancy to make recommendations for further interventions to strengthen these strategies. Table 2 gives some examples of the recommendations made to policy makers and practitioners based on the strategies identified (more examples can be found in the supplementary material online).

Table 2: Examples of recommendations based on coping strategies identified

The research also tells us a number of things about the role of strengths-based research and how it can initiate, inform and develop strengths-based policy and practice, particularly in contexts of international social work and social development. This paper defines strengths-based research as research methodologies and/or research objectives that seek to identify, better understand, enhance or even test grassroots, community-based or 'naturally occurring' actions and processes that facilitate improved well-being in contexts of adversity.

Firstly, the research highlighted in this paper shows that strengths-based research is particularly important when it reinforces the presence of 'strengths' (and agency) in groups which are stigmatised or considered 'unable to cope' (Fawcett, 2009; Corrigan et al, 2011; Hutchinson, 2014) Professionals, such as teachers and health practitioners, working with young mothers in Mozambique were unable to identify any coping strategies used by young women in response to the challenges they face (Hutchinson, 2014). These young women were considered as 'not coping' or worse, 'unable to cope'. Yet the research described through this paper shows that young women accessed a wide range of personal, social and

organisational resources in response to the challenges they encountered. Imagine then if they were supported by social work professionals and services infused with a strengths-based perspective, accompanied by the long-term influence of strengths-perspectives on the stigma associated with unintended pregnancy (Fawcett, 2009; Corrigan et al 2011) - particularly for those who are considered deviant. This reflects the core values of social workers around the globe who work with groups considered to be unimportant or hopeless. Strengths-based research supports policy and practice approaches which challenge not only 'disease' models held by some professionals but also models of 'development' which excludes those who are considered as unable to contribute, or worse, as those who are holding countries back (Hutchinson, 2014).

Secondly, this research shows that although young women did draw on personal 'strengths' to cope with the problems associated with unintended pregnancy, largely without social investment from institutional or organisational resources, their strategies were often limited and sometimes ineffective (i.e. they were not always able to persuade the biological father to take responsibility). Many coping resources remained outside their control, influence or negotiation, highlighting the need for more social investments to strengthen coping, and strengths-orientated social policy to underpin these. Rather than place the responsibility for dealing with social problems on the shoulders of individuals, this piece of strengths-based research highlights the responsibilities of governments and organisations (see table 2 or a fuller list in supplementary online material). Most of the coping strategies identified can be strengthened by sustained investment in health, education and community services, as well as the capacity building of health, education and community professionals.

Thirdly, strength-based research can also map the resources that are currently used or available in relation to a particular challenge, to act as a foundation for policy and practice, particularly when completing community, family or individual assessments (Fawcett and Reynolds, 2010). The majority of coping strategies identified through this study, for example, were relational, involving access to social resources through relationships, social interaction and negotiation. In the context of a culture that primarily functions through kinship networks, interdependence and reciprocity (Graham 1999), the relational element of coping appears critical. Social development strategies tend to focus on the provision of services and infrastructure to enhance the availability of these resources for individuals, families and communities. Yet the research highlights that strengthening relational strategies (both formal and informal) through direct intervention and social investments are also needed.

Finally, the reliance on relational strategies and social resources seen in table 1 draws attention to the role and centrality of power relationships in responding to the challenges faced by young women (Bundy-Fazioli et al 2009; Guo and Tsui, 2010; Oliver and Charles, 2016). Strengths-based research which is rooted in an understanding of power relationships can draw attention to structural inequalities underpinning social problems, ensuring policy-makers and practitioners continue to engage critically with 'family problems' that are rooted in discrimination and inequality. The young women in this research all used internal strategies and 'waiting it out' in response to domestic violence, for example. Even strengthening the use of strategies such as getting support from other family members, removing oneself from harm, mediation or negotiation, for example, does not deal with the issue of gender inequality underpinning domestic violence. Nor does it prevent young women from being exposed to domestic violence in the first place. Strength-based research embedded with a critical perspective can also help guide policy-makers and practitioners as

to the level of intervention needed (using an ecological framework, for example). In this way strengths-based perspectives can still be used in contexts of structural inequality, such as extreme poverty, where 'overcoming adversity' seems 'out of reach' of individuals, and requires collective coordinated action for sustainable change (Hutchinson, 2014). Strengths-based research which includes a critical perspective will motivate strengths-based policy and practice to go beyond individualised responses and to challenge ingrained power structures that impact on the strengths of individuals, families and communities (Matsuoka, 2015).

Study limitations:

Qualitative interview responses do not give 'direct access' to experiences, which are reconstructed through interaction, language and interpretation. Therefore it is important to note that descriptive and analytical interpretations of coping strategies were identified through the data within methodological limitations, and only reflect what was shared by participants in relation to the challenges they described.

Generalisation about all young women in Mozambique cannot be made based on this data due to the small sample drawn from only two regions, but that data adds depth to social explanation regarding the life event of unintended pregnancy, coping strategies and the discourse of women in Mozambique and sub-Saharan Africa. It is likely that the sample includes a bias towards a positive attitude to education as this is one of the main messages communicated by the youth associations. Participants may also be more 'pro-active' than those not associated with youth associations, which could have impacted the coping strategies identified.

Finally, interviewer characteristics and the translation process may have impacted on the nature of the narratives described, recognising the impact of re-telling a narrative to both a Mozambican research assistant and white British researcher. While we initially planned to meet with each participant several times to build a rapport prior to the interview, this was not logistically possible and the narrative interview was conducted in one session. The interviews ranged in length from 30 minutes to 90 minutes, however most were about 70 minutes long, and this gave participants time to give a detailed narrative of their experience as a whole rather a day to day account. Conversation was focused on how they responded to the challenges they identified.

Conclusion

Strengths-based research is needed to inform strengths-based policy and practice in contexts of international social work and social development (Roff, 2004). Strengths-based policy and practice is not without its critiques and these are particularly important in contexts of community development, where strengths-based approaches must function at different levels of an ecological framework, and cannot ignore or minimise the roots of the challenges faced by individuals, families and communities. Connecting individuals to communities to create forms of social solidarity utilises strengths. Fundamentally social workers and other practitioners need to know more about how people 'cope', 'respond', 'survive', 'resist', and 'overcome' the challenges they face on a day to day basis, largely without the support of social welfare interventions, so that social policy and social work practice is designed to support, enhance and facilitate this strength, rather than undermine it. While strength-based assessment frameworks and scales of measurements (which draw heavily from concepts of resilience and coping) have been developed in western contexts to guide practice and policy development (Cowger and Snively 2006; Guo and Tsui 2010; Toros and LaSala 2017), there

remains a need for research evidence to shape the development of strengths-based policy and practice in other contexts (like the work of Maman et al 2009 or Skovdal et al 2009). More research needs to be developed in ways that takes into account the principles of strength-based practice, while critical engaging with cultural contexts and structural inequalities impacting the communities we work with.

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