Teenage Pregnancy Pilot Project Research

Freetown
Sierra Leone

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# List of Acronyms

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<th>CWCs</th>
<th>Child Welfare Committees</th>
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<tr>
<td>DHS</td>
<td>The District Health Survey</td>
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<td>DHMT</td>
<td>District Health Team</td>
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<td>FGDs</td>
<td>focus group discussions</td>
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<td>FSUs</td>
<td>Family Support Units</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICYWP</td>
<td>Integrated Children and Youth Welfare Programme</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PAR</td>
<td>Participatory Action Research</td>
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<td>PHUs</td>
<td>Peripheral Health Units</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Fund for Children</td>
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This report contains the findings from GOALs research on teenage pregnancy in 27 operational communities in Freetown Sierra Leone in August 2010. The research aimed to answer the following questions in order to facilitate a holistic approach to teenage pregnancy in Freetown Sierra Leone.

1. What are the factors contributing to teen pregnancy in the target communities?
2. What are some of the beliefs, attitudes and practices about teenage sex, contraceptives, pregnancy and parenthood among male and female teenagers and community members
3. What are some of the social, health, educational or economic issues that teenager’s who become pregnant experience?
4. What social, health or economic services currently exist for teenagers who are pregnant, at risk of becoming pregnant or have already had children?
5. What are the barriers to SRH service utilization?

Methodology
This was an exploratory study that sought to gather information on the health, education and socio-economic impact of teenage pregnancy on the teenage mother, the family and community and to assess the current provision and utilisation of SRH services for teenagers in order to inform the design of a project to assist in reducing the risk of teenage pregnancy and advocate for the needs of teenage mothers. Qualitative research methodologies were utilized to address the research questions. A combination of semi structured interviews, focus group discussions (FGDs) and key informant interviews were administered to the research participants.

Participants were drawn from GOAL’s 27 operational communities; these communities were grouped into six clusters. The study targeted representatives from the community, potential direct beneficiaries of the project, education providers and health providers/policy makers:

- Sexually active teenage girls (Aged 13 – 19 years)
- Teenage mothers (Aged 13 – 19 years)
- Sexually active teenage boys (Aged 13 – 19 years)
- Community members
- Heads of schools
8

- Family Support Units (FSU’s)
- District Health Team (DHMT)
- Peripheral Health Units (PHU’s)
- SRH clinics

Excel spreadsheets were used to analyze demographic indicators of the participants. Themes were then recognized and coded in line with the research question and FGD and interview topics and sorted using a copy and paste method under the research questions and instruments. Concepts were ranked according to occurrence.

**Key Findings**

- All 216 teenage research participants had engaged in sexual intercourse at one point in their lives.
- The average age of sexual debut for all of the participants was 14 years old with a range of 10 years to 18 years.
- The average age of pregnancy was 15.7 years old with a range of 12 years to 18 years.
- 40% of all teenage participants have never used any form of contraceptive.
- The most popular method of contraceptives among teenagers who use contraceptives is condoms followed by the contraceptive pill, other lesser used forms of contraceptives used by the teenagers are, withdrawal, implants, Injections, the rhythm method and the traditional rope (a rope with herbs that is tied around a women’s waist).
- Teenagers that do use some form of contraceptive do not use it regularly.
- 100% of teenage girl FGD participants said they know of someone aborting their pregnancy.
- Going to a clinic for abortion was rarely mentioned, methods of abortion that were described by the teenage girls were: Inserting stick in the cervix, Alum mixture with salt, solutions of native herbs, solution of blue dye, tobacco, coca cola drinks and English salts and chewing of bathing soap.
- Peer behavior can have a significant and negative impact on teenage sexual behavior. For teenage boys the peer pressure is linked with discourse of masculinity. The discourse of masculinity contributes to teenage boys exerting pressure on their female peers to then also become sexually active.
• Gender power relations have a major role in sexual activity and teenage pregnancy. Abuse of positions of power to obtain sexual favours from teenagers within communities already crippled with poverty highlighted a lack of child protection mechanisms and information for the teenagers.

• A culture of silence surrounding abuse is impeding efforts in delivering effective child protection mechanisms and efficient service delivery of FSU.

• It was demonstrated that a substantial number of teenage girls were misinformed about effective methods to prevent pregnancy and STIs/HIV.

• The teenage girls had significantly less knowledge than the teenage boys conversely; this high level of knowledge from the teenage boys does not translate into safe sex practices.

• Teenage participants expressed mostly negative attitudes towards pregnancy and parenthood, this is not reflected in the teenager’s early sexual debut and lack of consistent contraceptive use.

• The community members highlighted that discussions on sex and contraceptives are not taking place with teenagers in the community.

• Community members are against the use of contraceptives among teenagers and as they stated they lack the education to initiate these discussions.

• Teenage girls are being driven from their home, deprived of basic needs and being stigmatized by the community on becoming pregnant.

• 100% of the teenage mothers within this research are no longer in school.

• It is a popular belief that there is an actual government policy that disallows teenage mothers to return to education. This was found to be untrue and seems to be a policy that is decided by individual schools.

• There are no mechanisms to support teenage mothers (socially, economically, psychologically), even at the community level.

• The health centers which were interviewed provide sufficient SRH services in combination. However, in terms of SRH there is a worrying under utilization of services.

• There is a shortage of relevant SRH IEC material for teenagers.

• The health centers reported that an average of 221 teenage girls give birth over all the health centers every month.

• The health centers reported that an average of 916 teenagers a month seek SRH services and information.

• The health centre Marie Stopes is very popular with teenagers because of the quality of services they provide however, this feeling was not shared with
teenage boys who felt there is more emphasis on girls and SRH while they are sidelined in the context of SRH.

- Issues with heath centers interpretation of youth friendly. While 100% label themselves as youth friendly, this is not the case for those that oppose contraceptive use among teenagers.

**Key Recommendations**

- Work with schools which are hesitant to conduct SRH education, emphasize on certain ideals such as abstinence and fidelity that fit into religious ideals.

- SRH education needs to be integrated into schools – there are numerous SRH schools curriculums available to delay the onset of sex and to ensure that those who are sexually active are able to adequately protect themselves through sensitization and training of both teachers and students.

- Examine a more community based approach to caring for young mothers who have been abandoned or intervening when a teenager has been abandoned. There are community structures already in existence in the operational communities (e.g. CWCs) and can assist in family reunification and livelihood support through skills training referrals.

- Sensitization efforts towards community and family members to re evaluate the driving factors of how a girl became pregnant and thus create an awareness of the communities role in teenage pregnancy

- Formation of teenage mother groups to increase the teenage mothers support network, both in providing proper care for their children and also psychological support.

- Teaching parents and guardians life skills to improve the monitoring and care provided to their children in addition to providing training on SRH information delivery and the positive aspects of contraceptives use among teenagers this can be achieved through community workshops and working with the CWCs.

- Train youth peer educators based in clinics and the community, to generate a demand, refer teenagers to SRH services, ensure that health services are youth friendly and provide information that is tailored to teenager’s specific SRH needs.

- Establishment of a minimum standard of youth friendly service delivery in operational community’s health centers in addition to creating an understanding of what it means to be youth friendly.
Under-age pregnancy refers to pregnancy in children under the age of 18. Sierra Leone has a startling problem with teenage pregnancy. The District Health Survey (DHS) in Sierra Leone in 2008 found that there are 94 births per 1000 women annually among urban women aged 15-19. Just over 40% of women in their late twenties had their first baby by the time they were 18, and 12% of them by age 15. It also showed that only 1.2% of married women in this age group are using contraception.

The most obvious impact of underage pregnancy is on the health of the mother and child. Complications from pregnancy and childbirth are the leading cause of death in young women aged 15 to 19 in developing countries (State of the Worlds Mothers, 2007). Teenage mothers have a higher risk of obstructed labour, premature labour, low birth weight, fistula and sexually-transmitted infections, including HIV. An estimated 70 000 adolescent mothers worldwide die each year because they have children before they are physically ready for parenthood. Their children are 50% more likely to die than those born to women in their twenties. Due to stigma and fear, it is also likely that teenagers may seek to terminate a pregnancy. Abortion is illegal in Sierra Leone and unsafe abortion carries a high health risk. Underage pregnancy is a major contributor to Sierra Leone’s appalling maternal and infant mortality rates: a woman has a one in eight lifetime risk of dying due to pregnancy or childbirth and 155 out of 1000 babies die before their first birthday (UNICEF, factsheet). Teenage mothers often lack the resources and support from role models needed to take care of their children’s health. The children of teenage sex workers within GOAL’s Integrated Children and Youth Welfare Programme (ICYWP) in Freetown have higher rates of malnutrition than the general population, where malnutrition is already common.

Teenage mothers often drop out of school. This contributes to the low levels of girls attending secondary school in Sierra Leone. Just 17% of girls attended secondary school from 2000-2007, according to the UNICEF’s 2009 State of the World’s Children report. A survey conducted in 2000 states that 65% of school dropouts are girls who got pregnant whilst in school (Awareness Times Newspaper 31st March 2008). Limited education and the responsibility of caring for a child reduce a girl’s access to paid employment, completing a cycle of poverty for mother and child.
Respondents in GOAL’s annual community survey in Freetown have repeatedly identified teenage pregnancy as a problem affecting their communities.

The factors contributing to this situation are complex and poorly understood. These pregnancies may be caused by voluntary sexual relations among school-children, early marriage, transactional sex with adults and other forms of sexual abuse.

Child marriage, a traditional practice that denies girls their right to a better future, including education is rife in Sierra Leone, where 56% of girls are married by the age of 18 (mostly in rural areas). Sierra Leone’s high levels of poverty leads some young girls to look outside the family for resources to meet their needs, going out with men they believe can provide for them. If pregnancy occurs, they may be abandoned, increasing the financial burden on the family.

This research seeks to understand the driving factors of teenage pregnancy in Freetown and explore the unmet needs teenage mothers and sexually active teenagers in terms of Sexual and Reproductive Health (SRH) information and services, education and livelihoods.

**Overall Goal of Teenage Pregnancy Pilot Project:**
The overall goal of the Teenage pregnancy project is to identify and implement effective strategies to reduce the risks of teenage pregnancy in disadvantaged urban communities in Freetown.

**Project Objective(s):**

1. To gain deeper understanding of knowledge, attitudes, beliefs and practices relating to teenage pregnancy through qualitative research, in GOAL’s operational communities in Freetown in order to make recommendations to inform project design.

2. To design, implement and evaluate integrated community-based strategies to address the intricate health, education and livelihood issues associated with teenage pregnancy.

3. To facilitate access to confidential and youth-friendly family planning services at the community level.

1. 2 Research Questions
6. What are the factors contributing to teenage pregnancy in the target communities?
7. What are some of the beliefs, attitudes and practices about teenage sex, contraceptives, pregnancy and parenthood among male and female teenagers and community members
8. What are some of the social, health, educational or economic issues that teenager’s who become pregnant experience?
9. What social, health or economic services currently exist for teenagers who are pregnant, at risk of becoming pregnant or have already had children?
10. What are the barriers to SRH service utilization?

2. Research Methodology

This is an exploratory study that sought to gather information on the health, education and socio-economic impact of teenage pregnancy on the teenage mother, the family and community and to assess the current provision and utilisation of SRH services for teenagers in order to inform the design of a project to assist in reducing the risk of teenage pregnancy and advocate for the needs of teenage mothers. Qualitative research methodologies were utilized to address the research questions.

A combination of semi structured interviews, focus group discussions (FGDs) and key informant interviews were administered to the research participants. Additionally, extra interviews with teenage mothers added more value and detail to the FGDs.

2.1 Sampling and Recruitment of Participants

The target population for the study was wide and inclusive to obtain information that will inform a holistic and community centered project approach. The study targets representatives from the community, potential direct beneficiaries of the project, education providers and health providers/policy makers:

- Teenage girls without children (Aged 13 – 19 years)
- Teenage mothers (Aged 13 – 19 years)
- Teenage boys (Aged 13 – 19 years)
- Community members
- Heads of schools
• Family Support Units (FSU’s)
• District Health Team (DHMT)
• Peripheral Health Units (PHU’s)
• SRH clinics

Due to the exploratory nature of the research, purposive and snowball sampling were used. Participants were drawn from GOAL’s 27 operational communities, these communities were grouped into six clusters based on their proximity to each other (see table 1 below). Participants were identified during community mobilization events that took place during the preparatory stage of the project to ensure key stakeholder buy in. Participants for teenage FGD participants were recruited from learning spaces and were identified through GOALs community partners and projects such as the Child Welfare Committees (CWCs), mother 2 mother groups, and previous participants of GOAL’s Disadvantaged Child and Youth Programme (DCYP) Participatory Action Research (PAR) workshops. Interviews were requested and scheduled with the DHMT, PHUs, FSUs, SRH clinics and schools. Participants for the interviews with teenage mothers were selected from the FGD with teenage mothers.
Table 1: Map of Goal 27 operation communities clustered in to 6 groups

<table>
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<td>1</td>
<td>Brook Fields</td>
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<td>Magazine Cut</td>
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<td>Sorie Town</td>
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<td>Susan Bay</td>
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<td>Tower HillSumailia Town</td>
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<td>Fullah Town</td>
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<td>Mount Aureol</td>
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<td>Robis</td>
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<td>Cline Town</td>
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<td>Bombay</td>
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<td>Congo water 2</td>
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<td></td>
<td>Coconut Farm</td>
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<td>Bottom Oku</td>
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<td></td>
<td>Quarry</td>
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<td>Industrial Estate</td>
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<td>3</td>
<td>Ferry ( Kissy Bye Pass)</td>
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<td>Rokupa</td>
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<td>Kissy Mess Mess</td>
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<td>Kuntorlloh</td>
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<td>Kissy Brooke 1</td>
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<td>Grass field</td>
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<td>Kissy Brooke 2</td>
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<td>Portee</td>
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<td>Jalloh Terrace</td>
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2.2 Focus Group Discussions

FGDs were conducted with the following; 1) sexually active teenage boys and girls 2) teenage mothers and 3) community members in all 6 clusters.

Teenage Mothers: There was 6 FGDs with teenage mothers (one per cluster, 72 participants). Teenage mothers were chosen as targets for the FGDs as they can provide in-depth knowledge through their personal experience on the social, health,
economic or educational challenges they encountered while pregnant and following birth. In addition to the availability and the use of SRH, socio-economic or educational services. Before the FGD a brief key information question sheet was distributed. This obtained data on age, age of sexual debut, age when pregnant, age of child and regularity of use of contraceptives. The FGDs with teenage mothers elicited information on: factors that led to early sexual debut, knowledge and utilisation of family planning (past and present), knowledge of HIV/STIs and perception of risk, challenges faced by teenage mothers (social, educational, economic, health), current and desired support services for self and for children and also lessons learnt from their experience as a teenage mother.

**Sexually Active Teenage Boys and Girls:** There was 12 FGDs (two per cluster with 144 participants) with sexually active teenage boys and girls. Sexually active teenage girls were chosen to participate in the FGDs as they are an ‘at risk’ population for teenage pregnancy and understanding their sexual behaviour and factors that contribute to early sexual debut is essential to designing a project to lower that risk. Sexually active teenage boys have also been chosen to participate as discourses of masculinity may be influencing factors in their behaviour towards girls. It is imperative to then understand the boy’s behaviour towards sex and the factors that lead them to engage in sex and their attitudes towards teenage pregnancy. Thus, considering teenage boys attitudes and practices is essential as they can be engaged as partners for change within the project design. FGDs were disaggregated by gender. Before a FGD a brief key information question sheet was distributed, that obtained data on age, age of sexual debut, number of sexual partners and regularity of use of contraceptives. These FGD discussions facilitated a dialogue with teenage boys and girls that looked into the factors that lead to teenage sex/pregnancy, knowledge and utilisation of family planning methods, perception of risk to STIs, source and utilisation of SRH information and services, barriers to SRH information and services, and their attitudes and experiences on gender roles, power relations and GBV. For teenage boys, a discussion on attitudes of responsibility towards pregnancy was also facilitated.

**Community Members:** FGDs were conducted with community members (one per cluster with 72 participants). Community members were chosen to participate as their attitudes and views and buy in are essential in formulating strategies to reduce the risk of teenage pregnancy and in advocating for services for teenage mothers. The FGDs focused on understanding the communities perception of the extent of teenage
pregnancy in their respective communities, factors they believe are contributing to teenage sex/pregnancy, Impact of teenage pregnancy on the teenager (boy and girl), family and the community, openness of discussion on family planning in the community, and opinions on effective strategies to deal with the issues and the role of community within those strategies.

FGD guides were developed and tailored for the FGDs with each of the target groups. The FGD moderators and observers were trained in conducting these FGDs in a professional, sensitive and appropriate manner.

### 2.3 Semi Structured/Key Informant Interviews

Semi structured interviews were conducted with 1) teenage mothers and a number of identified key informants. The identified key informants were 2) School heads, 3) PHUs, 4) FSUs, 5) DHMT and 6) SRH clinics.

**Teenage Mothers:** Six semi structured interviews were held with teenage mothers (one from each cluster, six participants). Interviews with teenage mothers facilitated a triangulation of the information gathered from the FGDs. Furthermore, as teenage mothers are among the projects anticipated beneficiaries, their input into their current and desired support systems and services to both prevent teenage pregnancy and assist teenage mothers is crucial to the project design. The semi structured interview collected basic demographic data along with information on the overall impact of teenage pregnancy (social, health, educational, economic etc) on the mother, level of access to and utilisation of support services/information for mother and child, barriers to access of support services/information and types of support services desired.

**Key informants** were identified in sectors or institutions’ that can provide important information and insight in to the intricate factors leading to and challenges with teenage pregnancy, in addition to being potential partners for limiting the risk of teenage pregnancy and providing service to teenage mothers in the project design. These key informants were 1) School heads, 2) In charges at the PHU;s, 3) Officers in charge at the FSU’s, 4) DHMT District medical officer and 5) in charges at SRH clinics.

**School Heads:** Semi structured interviews took place with school heads of both primary and secondary schools in each of the six clusters (two per cluster, 12
School heads were chosen as key informants due to their role as educators and frequent contact with teenagers and their potential role as partners within the project. The interview with school heads gathered information on the extent of teenage pregnancy, perceived causes, school policy on pregnancy and resumption of education following birth and also on the possibility of school based interventions.

**PHU In Charges:** Within GOALs operational community there are 12 PHUs. Semi structured interviews took place with each of these PHUs. Interviews assessed the current health services that are currently provided particularly SRH and peri-natal care, staff attitudes toward teenage clients, services most used by teenager’s, youth friendliness of the services and ability and willingness to provide specific SRH services to teenagers.

**FSU In Charges:** There are 3 FSU’s operating within police stations in GOALs operational communities, Kissy police station, Ross road station and Eastern police station. FSUs were included in this research to understand the extent of reported sexual violence against teenagers and the number of these cases brought to court and possible collaboration for the project.

**DHMT District Medical Officer:** There was one semi structured interview with the DHMT in Freetown. The interview elicited information on government policies on teenage contraceptive use, SRH service provision to teenagers, current gaps within these services, future plans for teenage SRH provision/information dissemination and possible collaboration within the project framework.

**SRH Clinic In Charges:** There are presently two exclusive SRH providers working in the GOAL operational communities. These are Marie Stopes and PPASL. Two semi structured interviews were conducted with the SRH providers. The interviews assessed current SRH services (Including peri-natal care), staff attitudes toward teenage clients, services most used/requested by teenagers and ability and willingness to provide specific SRH services to teenagers, youth friendliness of services provided and possible interventions and collaboration with the project.

**2.4 Ethical Considerations**
The main goal of this research was to gain insight while ensuring that individual involvement is voluntary. To that end, participants had the study aims and objectives explained to them, including information on how the findings will be used. They were given an information sheet to read or have read to them and any questions were answered before their written consent was given. Participants were not allowed to participate without first signing a consent form. Community sensitization was also carried out among communities to raise awareness of the upcoming research. Another goal is to ensure the anonymity and comfort of teenage interviewees and FGD participants. Anonymity in the research report was guaranteed to all teenage participants. Participants were informed that if they did not wish to answer a question or do not wish to continue that they were under no obligation to do so. The FGDs and interviews with the teenage mothers took place in a safe and private space. The interview was pilot tested before research commenced, to note if there are incidences of discomfort with any questions. None were recorded.

Considering the extreme sensitivity of the subject, teenage participants for this study were selected from GOAL’s current beneficiaries who have previously participated in PAR exercises. PAR workshops also explore issues of sex and sexuality among children and youth. The assumption is that since they have previously participated in these GOAL events, they will be more likely to be comfortable talking about their own sexual behaviors and experiences.

FGDs and interviews with girls were moderated by female GOAL facilitators who are already known to the potential participants and have an established rapport with the girls. All moderators received training on conducting the FGD and interviews with the highest standard of sensitivity in addition to training on ethics and child protection. The research also has the support and guidance of GOAL’s child protection officer who will be on hand to help minimize risk and respond to any issue’s the participants require assistance on.

2.5 Data Analysis

Excel spreadsheets were used to analyze demographic indicators of the participants (age, gender age of sexual debut, contraceptive use). Following the FGDs and interviews the notes were transcribed for manual thematic analysis. A brief summary of each interview/FGD content and themes will be initially written to aid final analysis.
Themes were then recognized and coded in line with the research question and FGD and interview topics and sorted using a copy and paste method under the research questions and instruments. Indirect concepts may also play a significant part in the analysis. Concepts were ranked according to occurrence. Some excerpts from the in-depth interviews and FGDs were presented verbatim to give a more detailed picture of the circumstances and consequences of teenage pregnancies in target communities.

2.6 Study Limitations

The sample size is small and this limits generalisability and representation of attitudes between the groups of participants. However, as this is an exploratory research on a particular sensitive topic with a very specific research population it was agreed that FGDs and semi structured interviews was the most appropriate method to obtain sufficient data to inform the project design.
3. Findings

The findings have been analyzed based on the research questions. Findings on Barriers to SRH Access were minimal so the limited findings have now been integrated into the other question areas.

3.1 What are the factors contributing to teen pregnancy in the target communities?

All research participants felt that teenage pregnancy was both a common occurrence and a serious issue within their communities. Perspectives on what factors contribute to teenage pregnancy were taken from, teenage mothers, teenage boys and girls, community members and heads of primary and secondary schools. There were 6 themes arising from the multitude of factors provided by the research participants (See table 2 below).

Table 2: Themes

<table>
<thead>
<tr>
<th>Factors</th>
<th>Concepts</th>
<th>Categories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>Lack of support, abuse, Maltreatment, Low</td>
<td>Shifting family structure, Increasing</td>
<td>Parental Care, Economics and Sex</td>
</tr>
<tr>
<td></td>
<td>education, imitation, Low monitoring,</td>
<td>vulnerability, Low social status, Limited</td>
<td></td>
</tr>
<tr>
<td></td>
<td>imitation, Low monitoring, imitation</td>
<td>choices</td>
<td></td>
</tr>
<tr>
<td>Chores</td>
<td>Vulnerable situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty,</td>
<td>Vulnerability, sex work, education, breadwinner, Materialism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materialism</td>
<td>Poverty, Desiring what others have, peer pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peers</td>
<td>Desiring what others have, Masculinity, Conforming, mocking</td>
<td>Reaffirming masculinity Negative, Low decision making power of women</td>
<td>Negative Peer Pressure</td>
</tr>
<tr>
<td>Rape</td>
<td>Dress code, power relations, older men</td>
<td>Gender relations, power abuse, subordination of women, culture</td>
<td>Gender Norms and Power Dynamics</td>
</tr>
<tr>
<td>Female Enticement</td>
<td>Seduction, dress code of females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday lessons</td>
<td>Dress code, older men power relations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural</td>
<td>Enticement, curiosity, sexual maturity</td>
<td>Maturity, risk, enticement, paradox</td>
<td>Enticement and Natural Curiosity</td>
</tr>
<tr>
<td>Pornography</td>
<td>Enticement, power relations, peer pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.1.2 Parental Care, Economics and Sex

Inadequate parental care and poverty were the most mentioned factors by the research participants and are quite interrelated, there is an underlying theme of sex work also incorporated into this. The community members felt that parents do not monitor their children and in other cases parents from poor households encourage the female teenagers to go out and make money for the family, thus placing them in vulnerable situations. The research participants stated that parents often can not provide for their households alone and thus the teenage girl is either forced to look after herself or encouraged into sex work to supplement the household income. The teenage girl participants quoted their parents inability to pay their school fees and meet their basic needs, these teenage girl participants felt that they were the household breadwinners and this was seconded by the heads of schools who also felt that the teenage girl is often bringing in the family income. Again, the underlying theme is that these girls are using sex work to meet their own and families' needs. In other cases, teenage girl's needs were not just basic, teenage girls also mentioned wanting clothes and other fashionable goods and sex was again seen as a method to obtain such items, mostly in the form of gifts. Abuse and maltreatment of teenage girls by guardians or parents was seen as another driver of early sexual debut for survival.

“At age nine, I was sent away from home by my aunt because I lost the sum of eight thousand Leones while I was selling for her. Even when I asked people to beg her for me, she could not let me stay in the house. So I was left to fend for myself on the street until the intervention of GOAL.” Teenage Girl Participant

Chores, dictated by parents were claimed to increase early sexual debut, fetching water at night was the only chore mentioned by the research participants. This was seen as an opportunity for teenage girls to meet boys in secrecy. However, it was unclear if this was wanted or unwanted sexual attention.

Additionally, parental imitation was an influencing factor for some teenage boys. The teenage boys stated that they share the same room as their parents and learned about sex from their parents this way.
Parents were often faulted by the heads of school for not providing appropriate care and guidance to their children and this causes children to be unprepared and ignorant in terms of sexual activities. They felt that the parents themselves have a low education and do not value education and due to this they will put their children in vulnerable situations due to their own lack of ability to communicate on sexual matters.

3.1.3. Negative Peer Pressure

Peer pressure was mentioned often by the research participants. The teenage boy participants stated that many of their peers talk about sex and how it makes them feel, in such a way that the boys want to try it too. Additionally, they do not want to be seen by their peers as “cold pap” i.e. not manly enough by their peers. Peer pressure was also cited often in the context of male peers provoking the girls who have not had sex through heckling such as “You’re missing a lot of enjoyment”. Peer pressure was also discussed, not in the conventional sense, but in terms of wanting what other peers may have. This was cited for teenage girls exclusively. For example, peers may have certain clothes or other desirable material goods and the teenage girl feels
Peer pressure has been identified as a key challenge. As children make the transition from childhood to adolescence their dependence on parents as the singular source of influence and decision making begins to change. Teenager’s sphere of influence is expanded. From the findings above we see that peer behavior can have a significant and negative impact on teenage sexual behavior. For teenage boys the peer pressure is linked with discourse of masculinity. Sexual activity has come to define what it means to be seen as a man, and teenage boys received social pressure and support from peers to be sexually active. The discourse of masculinity contributes to teenage boys exerting pressure on their female peers to then also become sexual active. Shifting peer attitudes and their methods of communication is critical to address the impact of negative peer pressure on teenage sexual behaviors. Peer education or a safe place for open communication on SRH between peers could be beneficial strategies.

3.1.4. Gender Norms and Power Dynamics

Gender norms and behaviors can have a significant impact on teenage sexual activity, particularly if one gender is in a position of subordination then often the choice on sex may not be their own to make. This is a similar situation with power relationships, adults in positions of power such as teachers, parents, guardians or those in a higher economic strata can manipulate teenagers into engaging in sexual activities. FSUs were visited in order to obtain data on actual abuse cases reported but the figures were scant and not organized enough to conduct a small quantitative analysis. All the teenage girl participants felt there were challenges for girls in their communities that lead to early sexual debut. The most cited challenge was sexual harassment and violence persecuted by their male peers, older men and men in positions of power (e.g. teachers). The factor of sexual harassment and violence was mentioned 13 times throughout the 6 FGDs held with the teenage girls. This became an emotional subject area with many girls narrating their own personal stories of abuse.
“I was raped at age ten by my cousin who was then twenty-five years old. Later, the family concluded that they would settle the issue at home since we are all family.” Teenage Girl Participant

Another participant gave anecdotal evidence of another incident:

“Quite recently, a forty years old man was caught raping a girl who was only eight years.” Teenage Girl Participant

4 of the teenage girl participants stated out right that they themselves had been raped. Other teenage girl participants gave examples of rape at the hands of their step fathers and care givers and others of step mothers leading the girls into sex work. Saturday lessons (Christian school) were mentioned by the girls, they stated that when they attend Saturday lessons, they dress nicely and men “as old as their parents” will want to date them. Saturday school teachers were stated to have tried to seduce the girls. The Bondo Society exposes girls to “fanciful dresses” that boost the girls self esteem. Once they begin to get admiration from men they feel they are old enough to then have sex with them. Female Genital Mutilation (FGM) was also stated as an early initiation into sexual activity.

The girls also spoke of cases where teachers purposively give low marks when a girl would refuse to have sex with him. It was also stated that the teachers have exposed some of the girls to pornographic movies to entice them into having sex.

Domestic work load and significant household responsibility was a factor mentioned 5 times throughout the FGDs. The girls felt a high pressure to perform, they felt that unlike boys, who only do simple duties and go to school, girls are expected to go to school, do household chores, and take care of younger ones while also performing well in school. Another participant claimed that she was not allowed to attend school because she is the only girl in her family and therefore expected to help her mother with her business.

“My mother gives me a lot of work to do and if fail to do them she will mercilessly deal with me” Teenage Girl Participant

The expectation of girls to help out in the household went further for some girls who were expected to bring men into the household and use it as a means to raise funds.
“At times when things are difficult, you are expected to bring a boyfriend so he can help the family both financially and materially.” Teenage Girl Participant

A number of issues emerged when the teenage boys were asked about the challenges they faced in their communities. Boys felt they have many unwelcome advances by teenage girls who try to entice them, as well as harassment from teenage girl’s parents. The teenage boys cited that the way in which women dress contributes to their early sexual debut. One participant stated that “girls deliberately dress almost half-naked in order to seduce us”. Peer pressure was evident in the FGDs, there is a pressure to join certain boys clubs and if one is not a member they will have to endure humiliation and have their movements restricted by club members. The boys also told of peer pressure to engage in dubious activities like stealing in shops and factories, as one participant stated:

“Living in such environments means you have to really stand for what you believe.”
Teenage Boy participant

Other boys said that they feel discriminated against because they are boys, they felt that girls get preferential treatment in school and at the home. The boys felt this was particularly true in the school setting where they felt girls get better marks from the teachers “when they don’t deserve it”

The teenage boys felt that they have a heavy domestic workload from their parents. Others said that their parents want them to work in factories and their parents do not place any value on education. They said for their parents, once they have known how to read and interpret basic things they can as well engage in activities that will bring fast revenue for themselves and the family.

Understanding views on gender based violence can be used as an indicator of gender norms within communities. The majority of teenage boys (58%) felt that it is ok to beat a woman. Some of their reasons are that women are the cause of so many problems in the world (see figure 1).

“Some women are so quarrelsome. However hard you try to avoid them, they still do things that will provoke your anger. In fact when they offend you and you don’t react in any way, they see you as weakling. Some of them are unfaithful so one has to
beat them before they come to their senses. Moreover, some women like men that beat them. If you don’t beat them, they will say you do not like them”. Teenage Boy Participant

Figure 1: Is it Acceptable to Beat a Woman?

![Pie chart showing responses to the question: Is it Acceptable to Beat a Woman? 58% Yes, 31% No, 3% Depends on the Woman, 8% No answer.]

Others felt that from a religious point of view, men are the heads of households and women should subdue, additionally it was stated that because of gender equality women no longer respect their husbands so they should be beaten. 31% of teenage boys felt that is not acceptable to beat a woman.

“Women should be seen as very precious and fragile. They should not for any reason be beaten by men. They should be respected because they are mothers and sometimes the bread-winner of their families”. Teenage Boy Participant

When it comes to differences in teenage boys and girls engagement of sex it was found that the vast majority of participants felt that the rational is different. The general opinion is that girls mostly engage in sex for “survival” and boys engage in sex to reaffirm their masculinity among peers.
3.1.5. Enticing Natural Curiosity

Teenager’s lifestyles were the most mentioned factor that contributes to early sexual début and pregnancy by community members. This includes watching romantic or pornographic movies and dressing in a way that entices men to make sexual advances. Exposure to pornography (movies) was also mentioned as a driving factor by heads of schools and teenagers. Natural sexual urges were quoted only by a selection of teenagers; however the participants also incorporated pornographic movies and magazines as supplements of these natural urges. Furthermore, the teenagers felt that their natural urges were linked to their sexual maturity and ability to decide themselves when to engage in sex. Within this theme, seduction was also cited as a tool to entice men into having sex. For teenage boys natural urges meant asserting their masculinity, having fun and experimenting with sex. Natural feelings including love and attraction were only mentioned by teenage girls.

Discussion

Gender power relations have a significant role in sexual activity and teenage pregnancy. Abuse of positions of power to obtain sexual favours from teenagers within communities already crippled with poverty highlights a lack of child protection mechanisms and information for the teenagers. What is also necessary to point to is, when a teenager is placed in such an unfavourable and vulnerable situation their negotiation power is severely hampered when it comes to using contraceptives and protecting themselves from pregnancy and STIs/HIV. The ‘culture of silence’ was referred to by participants who feel unable to report abuse (More details in section 3.4.2. Child Protection Services). This culture of silence is impeding efforts in delivering effective child protection mechanisms and needs to be considered carefully and addressed through efficient service delivery of FSU and awareness raising of the negative consequences of child abuse with community members, parents, and in the educational system. With the issue of gender norms, teaching mutual respect and consideration all through schools via the life cycle approach can assist in facilitating a positive dialogue on removal of negative gender norms.
3.2.1. Sexual Debut

All 216 teenage research participants had engaged in sexual intercourse at one point in their lives. The average age of sexual debut for all of the participants was 14 years old with a range of 10 years to 18 years. The average age of pregnancy was 15.7 years old with a range of 12 years to 18 years. The teenage girls and boys gave their perspective on what they felt is an appropriate age group for sexual debut (see figure 2).
Overall, the majority of teenagers felt that 16-18 is an appropriate age to engage in sex and this was followed by the age group of 22-24, this is at least 8-10 years older than the average age which the participants themselves engaged in sex. The majority of teenage girls (n=36) felt that 16 – 18 is an appropriate age group to initiate sex, following this, 18 participants felt 19 – 21 years is an appropriate age. This is interesting as the average age of sexual début among the teenage girl participants was 14 years old but they feel that 16 – 18 is a more appropriate age to have sex. Teenage boys felt that the age group 16-18 (n=21) and 22-24 (n=19) is the most appropriate age groups in which to engage with sex. The minority felt that age 13 – 15 was an appropriate age. Again this is a belief and not a practice as the average of sexual début for the teenage boy participant was 14 years old.

**3.2.2 Teenage Contraceptive Use**

Discussion

Early exposure of teenagers to sexual activity represents a complex social, cultural and economic problem both on a personal and societal level. Teenagers who engage in early sexual activity have a higher chance of having unplanned pregnancies and an increased potential for negative health and economic indicators. As we will see throughout this report, the teenagers are lacking in sex education and rarely use dual protection contraceptives and for the minority that does, it is not regular utilization.
Overall contraceptive use is alarmingly low among the sexually active teenage research participants (see figure 3). A total of 40% of all teenage participants have never used any form of contraceptive. The most popular method is condoms (25.4%, n= 56), followed by the contraceptive pill (11.8%, n= 26), other lesser used forms of contraceptives used by the teenagers are, withdrawal, implants, Injections, the rhythm method and the traditional rope (a rope with herbs that is tied around a women’s waist). 11.8% (n= 26) of the participants did not respond to the questions on use of contraceptive (mostly teenage boys, n= 17).

Figure 3: Contraceptive Use – all Teenagers’ Perspective

Contraceptive use varied between male and female participants and the teenage mothers.

Among teenage mothers 51.3% (n=37) still do not use any form of contraceptive. The most popular method of contraceptive is the contraceptive pill, with 22.2% (n=16) using this method, however only 3 participants use it regularly. Without regular use of the pill, its effectiveness is severely compromised. Condoms are used by 11.1% (n=4) however, only 1 participant claimed that she regularly uses them. The minority who use the implant (n=5) and injection (n=4) claimed to all use them regularly – this is simpler to do as they last a number of months but they do not protect against any STIs. The rope and rhythm methods are used by a minority and are not scientifically proven to prevent pregnancy and can not protect against STIs (see figure 4).
The teenage boys were the most reluctant to share information on contraceptive use and 23.2% (n=17) did not answer this question. A worrying percentage (26%) has never used any contraception. However, condoms, (which are the only dual method of protection against pregnancy and STIs) are the most popular choice (41%) and utilized more with teenage boys than with teenage girls and mothers. Although, it must be noted that only 10 participants used condoms regularly. The second most utilized method of contraceptive is withdrawal (withdrawing the penis before ejaculation), this is used by 8.2% (n=6) of teenage boys, this method can not protect against STIs nor is it always effective against pregnancy, furthermore only 2 participants stated that they regularly withdraw. 1 participant stated the he used the pill, it is presumed that their partner uses the pill (see figure 5).
12% (n=9) of teenage girls did not answer the question on contraceptive use. Again, the concerning issue here is that 42.6% of the teenage girls have never used any method of contraceptive (see figure 6). The most popular form of contraceptives with teenage girls is condoms, with 24% (n= 18) using them. This is in contrast to the teenage mothers where the contraceptive pill is the most utilized. Conversely, only 5 participants stated that they regularly use condoms with their sexual partners. The contraceptive pill is the second most utilized method of contraceptive among teenage girls with 12% (n= 9) using this method, yet only 3 claimed that they regularly use the contraceptive pill. Lesser utilized methods include withdrawal (1.3%), implants (2.6%), injection (2.6%) and the traditional rope (2.6%).

Figure 6: Contraceptive Use–Teenage Girls

1 participant picked two contraceptive options
3.2.3. Awareness of Preventing Pregnancy and STIs/HIV

All teenage girls stated that they are aware of methods in which to prevent pregnancy and STIs/HIV. Some methods mentioned by the participants were, faithfulness, condoms, contraceptives pills and abstinence. However, some incorrect and concerning methods to prevent pregnancy or STIs/HIV were also mentioned, such as drinking salt water after sex, traditional ropes, squatting after sex, withdrawal and drinking a mixture of blue dye, aluminum sulphate and native bicarbonate after sex. This type of misinformation is an urgent concern.

88.8% (n=64) of teenage mother stated that they know how to prevent pregnancy and STIs/HIV and 11.1% (n=4) said they still do not know how to prevent pregnancy and STIs/HIV. However of the 88.8% who stated that they know how to prevent pregnancy and STIs/HIV some incorrect methods were given when asked how, such as traditional rope, squatting after sex and withdrawing before ejaculation\(^3\). Thus, it is clear that these participants have not received adequate sensitization/advice at their health centers.

All teenage boys stated that they are aware of methods to prevent pregnancy and STIs/HIV. Additionally, only correct methods of preventing pregnancy and STIs/HIV such as, condoms, abstinence and remaining faithful were provided by the participants. No incorrect information was recorded. The teenage boys demonstrated

\(^3\) Number of participants stating the incorrect methods was not noted in the FGDs
an impressive knowledge regarding the prevention of pregnancy and STIs/HIV and recited STIs/HIV key prevention messages.

“We use condoms and sensitized others on dangers of risk sexual behaviors”

100% of the teenage boys claimed that they all feel at risk of impregnating a girl or contracting STIs or HIV. They stated that they can minimize their risk by consistently using condoms and staying faithful to one partner.

Discussion
Almost all participants were confident that they are aware of correct methods to prevent pregnancy and STIs/HIV. However, it was demonstrated that a substantial number of teenage girls were misinformed about effective methods to prevent pregnancy and STIs/HIV, as a variety of responses highlighted incorrect methods. Other responses such as the blue dye, aluminum sulphate and native bicarbonate mix is grossly inaccurate and if utilized could pose a health risk to teenage girls. The teenage girls had significantly less knowledge than the teenage boys who only named correct methods to prevent pregnancy and STIs/HIV. Conversely, this high level of knowledge from the teenage boys does not translate into safe sex practices. It is likely that when young people perceive themselves to be at risk for pregnancy or HIV, they are more likely to adopt protective behaviours. Although adolescents may have the competency to accurately identify the presence of risk, they do not always have the required capability to sufficiently evaluate the consequences or costs of the risk prior to taking action. This underlines the consistent concern of obtaining consistent and accurate SRH information coupled with behavioral change interventions.

3.2.4. Abortion

100% of teenage girl FGD participants said they know of someone aborting their pregnancy. They stated that it is very common in the community and they also know of girls who have died because of medically unsupervised self abortions. Going to a clinic for abortion was rarely mentioned, but the clinics that perform the abortions were, Marie Stopes, Rokupa hospital and Karkalla community health center. More alarmingly the methods of abortion were described by the teenage girls, these were: Inserting stick in the cervix, Alum mixture with salt, solutions of native herbs, solution
of blue dye, tobacco, coco cola drinks and English salts and chewing of bathing soap.

**Discussion**

Abortion is legal in Sierra Leone only where it is necessary to save a woman’s life or preserve her physical and mental state. The findings highlight the how common the practice of abortion is and also the dangerous methods which are employed to induce an abortion. These ‘back street’ abortions represent the cheaper option for pregnant teenagers who can not afford to go to a clinic for a safe abortion. Knowledge of the safer options may not be known among the teenage girls and the community. It is essential, that teenage girls know what services are available and the extreme risk of using such dangerous methods.

### 3.2.5. Attitudes Towards Teenage Pregnancy and Parenthood

Out of the 72 teenage mother FGD participants only 3 participants stated that their friends have been a good support to them since their pregnancy. The remainder cited numerous negative attitudes and practice directed at them from both their peers and fellow community members. The teenage mothers felt they were the focal point of all community gossip, name calling (*loose, useless, bad example*), friendships with friends have deteriorated, they have purposively isolated and sometimes interaction with teenage mothers by other mothers was forbidden.

“As for the community members, most of them see them as useless and unfocused. They do not want us to interact with their children” Teenage mother Participant

The teenage mothers overwhelmingly claimed to feel ashamed, inferior and humiliated by their peers and community.

When the teenage girls were asked what happened when a teenage girl gets pregnant the responses were again overwhelmingly negative. The girls described how the pregnant girls can be driven from home, beaten, deprived of food and are stigmatized and disowned by the communities. There was scant responses on any positive treatment of pregnant teenagers, it was described by a participant that “some parents have sympathetic feelings towards their children so they take care of both
Teenage boys claimed many reactions if they impregnated a girl. They would either, take responsibility, deny the pregnancy, and try to get an abortion or runway. A few would hope that their own parents would look after the child. It was roughly, evenly split between those who would take responsibility and those who would deny the pregnancy.

**Discussion**
Ambivalent attitudes toward early pregnancy may increase the risk of teenage pregnancy. While the teenage participants expressed mostly negative attitudes towards pregnancy and parenthood, this is not reflected in the teenager’s early sexual debut and lack of consistent contraceptive use. Such attitudes are common among teenagers from disadvantaged backgrounds such as GOAL’s operational communities. For such teenagers, the desire to avoid pregnancy coupled with a lack of knowledge and services to do so is not strong enough to motivate action against early sexual debut or consistent contraceptive use.

### 3.2.6. Openness on SRH Discussion and Contraceptives

The overall majority of community members do not freely discuss issues related to sexual and reproductive health, sexual relationships with young people in their community. Reasons for this stance was that it is culturally inappropriate (age differences, respect), religiously inappropriate and that community members are lacking the knowledge themselves to initiate any discussion on issues of sexual and reproductive health, sexual relationships with young people in their community. For the few community members who stated that such discussion were held through Child Welfare Committees (CWCs), mother to mother support groups and through sensitization in the community e.g. by GOAL and ACTION AID. However, these discussions/sensitizations are not deriving from the community.

Additionally, the majority of community members were against the use of family planning among teenagers. They felt that it will encourage girls to become promiscuous; they feared that drugs would make the girls infertile and a few
incorrectly stated that using family planning would cause HIV and STIs. The community members only spoke of family planning in the context of girls and did not consider boys in this discussion. The minority that did support family planning use among teenagers stated that it would prevent unwanted pregnancies and would allow teenagers to continue their education.

**Discussion**
Open and frequent adult to teenager communication about sex (knowledge and attitudes) is linked to postponement of sexual activity, increased contraceptive use, fewer sexual partners and a decrease in teenage pregnancy. The community members highlighted that that such discussions are not taking place with teenagers in the community, additionally the community members are against the use of contraceptive among teenagers and as they stated they lack the education to initiate these discussions. This is a concerning issue as while the community members see teenage pregnancy as an urgent issue to be addressed they do not have the information to do so and they wish to approach the issue in a selected context where contraceptives are not promoted. This has underlined the need for the community members themselves to be trained on SRH information and communities along with the positive benefits of contraceptives use among teenagers rather than dealing with the problematic outcomes of non use of contraceptives among teenagers.

**3.3 What are some of the social, health, educational or economic issues that teenager’s who become pregnant experience?**

The teenage mothers spoke of many challenges they now face. 5 major challenges were cited, 1) Financial constraints/poverty, 2) community and family stigmatization, 3) health issues, 4) livelihoods and 5) education. It is interesting to note that participants only spoke of the teenage girls and the impact of pregnancy on them. When prompted about teenage fathers, there was a general consensus that the teenage father’s life will most often continue as it was with little repercussion.

**3.3.1. Community stigmatization**
The teenage mothers were strongly affected by their families and the communities' reaction to their pregnancy. The teenage mothers felt despised and isolated. They said community members often cite them as an example of girls who have ruined their future and their lives are now worthless.

“When my parents knew I was pregnant, they sent me out of the house and ordered my younger sisters not to have any dealings with me since I have chosen to ruin myself.” Teenage Mother Participant.

Community members also seconded that teenage mothers are isolated and stigmatized by the community, friends and family.

### Discussion

Teenage girls are being driven from their home deprived of basic needs and being stigmatized by the community on becoming pregnant. Teenage mothers provided their own testimony to the reality of community and family stigmatization and isolation. Yet it is these groups (community family and peers) that can facilitate a situation where a teenage girl becomes pregnant through negative peer pressure, inadequate communication on SRH and lack of parental monitoring and guidance.

Efforts to allow community and family members to re-evaluate how a girl became pregnant through sensitization on the multifaceted factors that contribute to an teenage pregnancy could allow for a more positive and open dialogue and reduce stigmatization.

### 3.3.2. Livelihoods

Financial constraints was the second most cited challenge by the teenage mothers, they claimed that they are having great difficulties in providing food, clothing and education for their child/children. Shelter is also a real concern for these teenage mothers, often when they were driven from home they can only find inadequate shelter, often they look to their friends who have not turned against them.

“It is always good for one to have babies when one is financially, materially and mentally capable to have them.” Teenage Mother Participant
for shelter. There are examples of a lucky few whose partners have been persuaded to allow the teenage mother back into the home. Although, reunification is not without its problems.

“Even though I am now living at my parents’ house, after much persuasion by elderly people in our community, I am facing a lot of challenges in raising my child in terms of accommodation, and feeding for my child. My parents constantly remind me of my past mistakes. It is really not easy fending for yourself and child.” Teenage Mother Participant.

**Discussion**

As all of the teenage mothers within this research are no longer in school and often without a place to go they rely on petty trading and poor shelter (if prohibited from parent’s house). One teenager mother stated that after the baby is four months old she will go back to sex work to provide for her child. Without skills or an education many of the teenager’s mothers have limited options. The community and families themselves need to address this issue via a community based approach to caring for young mothers who have been abandoned or intervening when a teenager has been abandoned. Community structures already exist in the operational communities (CWCs) and can assist in reunification and support through skills training referrals.

### 3.3.3. Education

74% (n= 53) of teenage mothers were attending school before their pregnancy and 26% (n= 19) were not in school. None of the teenage mothers are now attending school (see figure 7).
6 heads of secondary schools or senior teachers were interviewed across GOALs 27 operational communities. The total student population of these secondary schools interviewed is 5,305 of which 37% are girls and 63% are boys. Female attendance in secondary school is significantly reduced from primary school. Of this student population the schools had an average since 2009 until time of data collection, 279 drop outs. Girls account for a much larger percentage of drop outs, with 63% of the drop outs being girls. On average there have been 156 cases of pregnancy across 5 secondary schools (one school refused to answer this question, stating that it was a secret) from 2009 to present. Pregnancy thus accounts for approximately 15% of all female drop outs (see figure 8).
6 heads of primary school or senior teachers were also interviewed across GOALs 27 operational communities. The total student population of primary schools interviewed is 3,097, of which 51% are girls and 49% are boys. Of this student population the schools had an average since 2009 until time of data collection, 223 drop outs. Girls account for slightly more drop outs than boys, with 56% of the drop outs being girls. Drops out due to pregnancy was cited by all school heads, and based on the number of pregnancies at the schools, (n=100) since 2009, 79% of all girls leave school solely due to pregnancy (see figure 9).

Figure 9: Gender Disaggregation of Primary School Drop Outs

Discussion
The finding on the educational impact of teenage pregnancy has been re emphasized here. Out of the total drop outs, primary schools lose 15% of girls to pregnancy related drop outs and secondary schools lose 79%. None of the teenage mothers involved in this research has returned to education, although, many who are still quite young would like to return to education. Schools are in a position to play a significant role in reducing the incidence of teenage pregnancy and thus reducing the drop out rates among females. Most young people who attend school have not initiated sexual activity (average age sexual début is 14 years). The high populations of teenagers in the school setting provides an imperative advantage point to delay the onset of sex and to ensure that those who are sexually active are able to adequately protect themselves through sensitization of both teachers and students.
3.3.4. Health

Health care was cited as a concern to some of the mothers who are unable to access adequate health care. This is also linked with limited income. However, the services for pregnant and lactating women and children under 5 are free in Sierra Leone though the service delivery is not regarded highly by the teenage mothers.

“If you wanted to get adequate medical treatment for your child, you have to go to a private hospital like Urban Centre where you pay for the services you receive.” Teenage Mother Participant

82% of teenage mothers received child care and 18% of mothers did not receive any care. Of the care received, the most common were immunizations, growth monitoring, supplementary feeding and medical advice. However, the majority of teenage mothers felt that the care and drugs they and their child received in local PHUs was inadequate.

“Sometimes, I ask the nurse in charge to prescribe drugs for me so that I can buy from a local drug store instead of just depending on the one or two drugs they supply.” Teenage Mother Participant

Other participants complained that some of the nurses are very rude to them. One participant described an incident where she was humiliated loudly by a nurse in the waiting room and sent away because the girl wore old and worn-out pants.

Discussion

Although health care is free to pregnant and lactating women and children under 5 from government clinics, the teenage mothers did not mention ANC as part of services received. Considering the possible health risk associated with early pregnancy (risk of obstructed labour, premature labour, low birth weight and fistula) ANC is an important service, yet it is under utilized. From the reports above, the teenage mothers express dissatisfaction with the services for their children. Clinics are seen as under stocked and poor service delivery. The efficient management and stocking of the clinics is the responsibility of the government and the free health care scheme is rather recent event. However, the nurses should become more courteous to their patients and especially to teenage mothers who are already isolated and vulnerable. Youth friendly components should be integrated into all health care providers’ services (Discussed in detail in section: 3.4.1.3 Youth Friendly Health Care).
3.3.5. Current Support Received by Teen Mothers

Very few teenage mothers feel that the support they receive is adequate. Support can be financial, social, emotional or the provision of basic needs. In terms of who provides the support to teenage mothers, it often falls on the family of the teenage girl. Sometimes, the teenage mother may receive support from a number of sources, while others rely on no one (see figure 10).

**Figure 10: Who Supports Teenage Mothers?**

![Pie chart showing support sources](image)

The support that is provided to the teenage mothers is very minimal and was said to be some soap or a little food, friends may provide some shelter. 40% of the teenage mothers receive no support from the father of the child and there were cases where they father refused the child was his. The mothers said that often the fathers of their child are irresponsible or still in school. Another described a story of betrayal.

“We were very close. Each day, he gave me the sum of five thousand Leones for my feeding which I told my friend about. She then forced herself to the guy and they became lovers. Coincidentally, we became pregnant at the same time, but no sooner did my boyfriend notice I was pregnant than he abandoned me with my pregnancy.”

Eight of the teenage mother FGD participants said they have regret getting pregnant as they do not have financial support and worry about their own and their child’s survival.
Box 1: Teenage Mother’s story

“When I became pregnant, my parents sent me out of our house. So I stayed with my boyfriend in their family house. Unfortunately for me, he had another girlfriend who was also staying in his apartment. However, his mother managed to accommodate me in her house since I was pregnant and had nowhere to go. There were four of us living in the same room. Meanwhile, everything I had was gradually being stolen by my boyfriend’s sisters but if I dared say a word, they would spring at me like wild cats. The situation became aggravated when I complained to my boyfriend. After they have humiliated me with so many demoralizing words, they practically deprived me of food. Four months after the arrival of my child, I became very seriously sick. The neighbors had told my parents about my present condition and warned them that if they fail to take me out of that house immediately, they would have to collect my corpse. So my parents forgave me. By the time I was rushed to the hospital, my condition was now very severe. I was diagnosed with acute typhoid which had badly damaged my intestine. During the operation, my womb was tampered with which has rendered me barren for life. I thank God that I have a child now.”

Discussion

The teenage mothers did not describe any support mechanisms outside their family and friends (and even the family support is intermittent). There are no actual mechanisms to support teenage mothers, even at the community level. Considering this in the context of dire poverty where parents have problems meeting the basic needs of their own children without an extra child in the household. Fathers of the children need to take up more responsibility for their children, only 32% teenage mothers mentioned fathers as a means of support. Thus in this context, it is not unexpected that the mother has to become self sufficient. Support mechanisms at the immediate family level and the community level are required in order to reduce the negative social, educational and financial impact on teenage mothers.
3.4.1. Health Care

12 PHUs and 2 private SRH clinics were interviewed across GOALs 27 operational communities to assess the SRH services and information provided to young people.

Box 2. List of Health Centers Interviewed

1. Ginger Hall community hospital
2. Moyiba health centre
3. Wesleyan health centre
4. Grassfield health centre
5. Wellington Estate health centre
6. Calaba town health centre
7. Kuntorllor health centre
8. Susan’s bay post health centre
9. George brook health centre
10. Approved School Maternal Child Health Post
11. Ross Road health centre
12. Mabella Health Centre

_Private SRH Clinics:_

13. Marie Stopes - Kissy
14. PPASL
All 14 health centre’s provide ANC and 13 provide family planning services (See figure 11). The health centers stated that family planning services were targeted at teenagers and mothers (most often the health centre’s refer explicitly to females and none stated males, others stated teenagers in general). Immunization and growth monitoring were provided by 9 of the health centers. While HIV counseling and testing (C&T) was provided by 7 of the health centers only 2 stated that they provide services for STIs. A concerning number of health centers provide delivery (n=5) and post natal care (n= 2). All services are free for pregnant/lactating women and children under 5 with the exception of PPSAL and Marie Stopes which are private clinics. George brook health centre stated that they charge 5,000Le for family planning services and tower hill health centre changes 15,000 for under 5 and ANC services. As PHUs they should not administer a charge for these services.

**Figure 11: Health Centers Services**

Immunization for under 5s is the most frequented service, followed by ANC. However, there is an under utilization of family planning services, considering that family planning is available at 13 health centers. Delivery services are also severely under utilized but there are only 5 health centers providing this service. Postnatal service provision and use is an area of concern (see figure 12).


Figure 12: Daily Number of Clients per Service

Discussion

The health centers which were interviewed provide sufficient services in combination. However, in terms of SRH there is a worrying under utilization of services. There is an under utilization of family planning services, considering that family planning is available at 13 health centers. Delivery services are also severely under utilized but there are only 5 health centers providing this service. A lack of postnatal service provision and utilization is concerning. Under 5 care is utilized heavily as is general child care. Mothers also need to improve their health seeking behavior when it comes to their own health needs. It is known that pregnancy in teenagers can cause more complications for the mother than in women over 20 years. Thus addressing the low health seeking behavior of pregnant teenagers must be a priority.

3.4.1.1 IEC material provision

8 out of 14 health centers do not provide clients with any IEC materials to take home. The reasons given were that there was not enough to give out and many of the clients are illiterate. The 6 centre’s that do provide IEC material, provide it on the following topics: Immunization, malaria, child abuse, family planning, breastfeeding, HIV, nutrition and sanitation. Only one health centre said they have IEC material on
teenage pregnancy. 50% of the health centers stated that they do not often get teenagers requesting information on SRH. The reasons these health centers gave was that the teenagers could be very shy or unaware that they offered such services. For the other 50% of clinics that do get teenagers asking for SRH information that stated that the most requested information is on family planning.

### Discussion
There is a shortage of relevant SRH IEC material for teenagers. Making leaflets on family planning available and accessible in clinic waiting rooms may help teenagers avoid their uncomfort with discussing family planning issues.

### 3.4.1.2 Utilization of SRH Health Care

Between the 14 health centers they claimed that a total of 916 teenagers come into the clinic on a monthly basis (reasons unknown). That is an average of 65 teenagers a month per health centre. The health workers felt that it was on the increase. When probed about this increase in teenagers coming for SRH services it was clear that they were referring to already pregnant teenagers. They gave a number of reasons for the increase such as lack of sex education, poverty and the issues with teenagers never asking about contraceptives. A few also felt that the free health care was a driving factor for the increase in teenage pregnancy.

"It's the free health care declared for pregnant and lactating mothers" Health Centre in Charge

"Poverty makes mostly teenage girls to engage themselves into sexual activities and become pregnant" Health Centre in Charge

"Poverty is the major cause because many women give up themselves for daily food and material needs" Health Centre in Charge

"They never ask for information and service at clinics" Health Centre in Charge

Only one clinic stated they did not provide delivery services. This is in contradiction to the results on the services offered by the health centres were only 5 stated that they provide delivery services. It is possible that the health centers interoperated ANC to
also include delivery services. When asked how many deliveries have occurred since January 2010 with women under 20, the average was 90 with a range of 30 – 220. This means that approximately 221 teenagers are giving birth every month across all health centers. This number does not include any home births, which would probably increase the number significantly.

Of the teenage girls who answered the discussion questions on where they obtain their SRH information and services the greater majority favor Maire Stopes health centre, followed then by PHUs and Traditional Birth Attendants (TBAs). When asked where they would choose if they could go to any health centre they wanted, the majority stated that they would go to Maire Stopes due to the quality service provided and also education on sexual risk behaviors, family planning and STIs and HIV/AIDS. A few teenage girl participants stated that there are some barriers to obtaining these services and these were mostly financial. In some cases the teenage girls felt ashamed to ask the staff at the PHUs for information.

Teenage mothers were aware that pregnant, lactating women and children under 5 should have free health care; however, they still claim that they have to pay for some services. Other means in which teenage girls obtain SRH information is from school, television, peers, radio discussions, leaflets and their parents.

Teenage boys listed various sources of information on SRH information and services. The most popular source of SRH information and services were PHUs, media (TV, radio), pharmacists, their peers, Maire Stopes and schools. However, most of the boys stated that the prefer to get information from the media and information and services from the pharmacist. The boys gave the reasons that the pharmacists are simple as they give drugs and advice whereas in PHUs and Maire Stopes in particular the boys feel uncomfortable as they feel the staff prefers to treat girls and not boys.
3.4.1.3 Youth Friendly Health Care

A good indicator of a health centre’s *youth friendliness* is the health worker’s opinion on contraceptive use among teenagers. The overall majority of health centers (12/14) representatives interviewed claimed that they view contraceptive use among teenagers as positive. The reasons for their positive views were that it can reduce unwanted pregnancies and the incidences of STIs. One clinic was supported of contraceptive use but felt that parents should also be informed of the teenager’s decision to use contraceptive. The two health centers which did not agree with teenagers using contraceptive were Moyiba community health centre and Tower Hill health centre. The reasons given by the opposing health centre’s against contraceptive was due to a preference for abstinence and also that contraceptives are unchristian.

13 out of 14 health centers interviewed stated that they do not believe a health worker would ever withhold SRH information from a teenager. Interestingly, the two health centers who opposed the use of contraceptives among teenagers also did not believe that a health worker would withhold SRH information. The health centre representative who felt that health workers could withhold information stated it was for the simple fact that they are teenagers.

100% of the health centers classified themselves as youth friendly, the majority of the rational for this statement was because the centre’s provide family planning services,
one health centre representative pointed to a room with toys and, another few
pointed to their records of attendance by youths and the fact that they provide
counseling services. 13 out of 14 health centers stated that there are no barriers to
teenagers accessing any SRH care. The one health centre stated that the barrier for
accessing their clinic was that it was a Christian clinic.

### Discussion

Teenage pregnancy is considered a major issue by the DHMT; the district medical
officer stated that they have a number of services in place to deal with the issue,
such as school health education and sensitizations on the use of contraceptives.
The DHMT stated that there is no current policy on adolescent SRH. The DHMT
felt they and the PHUs could do more in terms of health sensitization, provision of
various types of contraceptives, counseling, and treatment for sexually transmitted
infection. The DHMT said that PHUs need more IEC materials and social
amenities in order to create a youth friendly environment. However, the issue is in
the clinics interpretation of youth friendly. While 100% label themselves as youth
friendly, this is not the case for those that oppose contraceptive use among
teenagers. Being youth friendly is more than service provision of family planning
but also relates to health workers attitudes and sense of confidentiality when
dealing with teenage clients. Strategies could utilise peer educators, with some
based in clinics and others in the community, to generate a demand, refer
teenagers to SRH services, ensure that health services were friendly and provide
information that is tailored to teenager’s specific SRH needs.

#### 3.4.2. Child Protection Services

3 FSUs line managers were interviewed in Kissy Police Station, Eastern police and
Ross Road. The FSUs stated that they handle a variety of cases, the most common
being sexual offences, domestic violence (physical, emotional, psychological), cruelty
to children and child abandonment. All FSUs stated that they often have cases
reported by teenagers. The teenagers most often report child cruelty, teenage
pregnancy, sexual harassment/abuse and abandonment.

Besides prosecution of the perpetrators, the FSUs also provide referrals for the
victims of abuse for free treatment and counseling at the Rainbow centre at PCMC
hospital. All FSUs said that their services are utilized by the victims, in particular the
services which offer counseling and free treatment and tracing of parents and relatives. The FSUs claimed that a major barrier to teenagers utilizing their services was the culture of silence and family members interfering with the process and try to withdraw the case from the FSU. The FSU feel themselves that they are limited in the services they provide due to insufficient logistics.

Discussion
The FSUs reemphasize the culture of silence that was first described in section 3.1.4 ‘Gender Norms and Power Dynamics’. It is a positive point that teenagers are actually utilizing the services provided by the FSU. However, if cases never get a resolution due to interfering family members or crippling bureaucracy then there may come a time when teenagers will lose their trust in FSUs and they will be sidelined as an ineffective service. Addressing inefficient service delivery of FSUs is a government concern but at the community level the impact of sexual violence or abuse of teenagers must be understood by the family and community in order to provide emotional support to the victim and sanction for the perpetrator.

3.4.3. Education Services

The primary schools were asked about their policy on school pregnancy. Overall, 4 of the primary schools stated that pregnant girls are asked to leave school; the other 2 schools stated that the girls choose to leave. 5 out of 6 primary schools state that the teenage girl is welcome back to school after she has delivered; this is contrary to popular belief that teenage girls are forbidden to return to school. The Charity Mission School in Kissy Mess Mess does not allow teenage mothers to come back to school as they feel the girl will set a bad example. However, there was only one reported case of a teenage mother returning to school and that was in 2009. All other schools reported that no teenage mothers have ever returned.

5 out of 6 secondary schools say that they allow teenage mothers to come back to school. The majority consensus however, was that while the girl is pregnant she must leave the school. This is to not distract the other pupils.

“We do not normally terminate them from school. We do call on the parents/guardian of the girl talk to them in which the guidance and counselor could be also involved. And also will be left with the girl if she thinks her pregnancy is termed and could not
be able to continue schooling, she can stay home and wait till she gave birth”
Secondary School Head Teacher

The one school that did not allow girls to be readmitted was Umuru bin Al-katab Islamic secondary school in Mayenkinhe, they stated that the teenage mothers are bad examples for the other pupils. When the secondary schools were asked if teenage mothers do continue their education after delivery, the responses were mixed; some stated that many do while others stated it’s very uncommon.

Discussion
From the above findings it is noted that teenage mothers very rarely come back to school after delivery. It is a popular belief that there is an actual government policy that disallows teenage mothers to return to education. This was found to be untrue and seems to be a policy that is decided by individual schools. Although, 2 schools (1 primary and 1 secondary) state that they will not allow teenage mothers back into school following delivery, the remaining 10 schools are open to this. This is an opportunity for information dissemination to teenage mothers and community members in combination with schools to ensure that the schools policy on readmitting teenage mothers is well known. As it has already been noted schools provide an ideal space for reaching teenagers on the issues of SRH. However, one school (Umuru bin Al-katab) stated that they do not want to teach SRH education as it is inappropriate in Islam tradition. Work with schools which are hesitant to conduct SRH education can still be conducted. Emphasis on certain religious values can be addressed, such as abstinence and fidelity. 100% of schools said that they are willing to work with GOAL to reduce the incidence of teenage pregnancy.

4. Support to the Project/Recommendations

Following all discussions, the community members along with school heads, teenage boys, girls and mothers were asked to offer suggestions on how to reduce the incidence of teenage pregnancy, support teenage mothers and ensure teenagers access to SRH information and services. GOAL staff also then examined the
recommendations and inputted additional recommendations where they felt there was still gaps.

4.1 School Recommendations

- Create a platform in schools for teenagers to have quality SRH education so that girls in particular are empowered to protect themselves from pregnancy and unwanted sexual advances.
- Accommodate any teenage mother who is ready to continue schooling through following up with teenage mothers after delivery. Do follow-up on those that got pregnant if they could be ready to continue school when they give birth.
- Sensitization around the communities and to parents during parent teacher (PTA) meetings for them to take care of their children and advice them on SRH.
- Embark on effective counseling for school children. We will also incorporate sensitive issues like sex and reproductive health during these sessions so that teenagers will be in the position to make informed decisions. In addition, invite specialists on these issues for effective education.

GOAL Additional Recommendations

- Disseminate Information to teenage mothers and community members in combination with schools to ensure that the schools policy on readmitting teenage mothers is well known.
- Work with schools which are hesitant to conduct SRH education, emphasize on certain ideals such as abstinence and fidelity.
- SRH education integrated into schools – there are numerous SRH schools curriculums available to delay the onset of sex and to ensure that those who are sexually active are able to adequately protect themselves through sensitization and training of both teachers and students. There is also evaluation literature on most effective SRH school curriculums.

“My whole feeling towards such kind of project is really good and acceptable to me because I have stated hearing about projects I have never heard of such it is interesting. If it is successful I think this can help us and other community members to be able to minimize or control the rate at which teenage pregnancy is now in all communities. I hope GOAL will make it all possible for this project to stand/achievable”. Head of School
• With the issue of gender norms, teaching mutual respect and consideration all through schools via the life cycle approach can assist in facilitating a positive dialogue on removal of negative gender norms. This could be conducted through school based peer education programmes.
• Linking schools with local health centre’s for referrals on SRH services.
• Investigating religious sanctioned SRH youth materials for utilization.

4.2 Teenage Mothers Recommendations

• For teenage mothers to actually talk to other teenagers “to prevent themselves when ever having sex so that they can not fall victims like us”.
• Training on how to raise their children with limited resources
• Skills training so that they can have a livelihood and provide for their children
• Scholarships to return to education

GOAL Additional Recommendations

• Sensitization efforts towards community and family members to re evaluate the driving factors of how a girl became pregnant
• Initiate a positive and open dialogue to reduce stigmatization of teenage mothers
• Examine a more community based approach to caring for young mothers who have been abandoned or intervening when a teenager has been abandoned.
• Community structures already exist in the operational communities (CWCs) and can assist in reunification and support through skills training referrals.
• Bring the father of the children to account – too much blame is on the females and many teenage boys’ side step the responsibility and negative impacts and can contribute to the negative impact in cases of abandonment.
• Addressing the low health seeking behavior of pregnant teenagers through media and community outreach, partner with traditional birth attendants in encouraging clinic delivery.
• Formation of teenage pregnancy groups to increase teenage mother support network.

4.3 Community Members Recommendations

• Community sensitization – public meeting on the effects and dangers of teenage pregnancies
- Radio messages
- Counseling units on teenage pregnancy should be created in schools
- Loan facilities should be open to parents to enable them support their children
- Improve interaction, sharing of experience and relationship with teenagers.
- Encourage the pregnant teenager to access medical facilities
- Help them with ways of getting income for their own and child’s needs
- Help them to go back to school
- Learn skill training
- Teach men self control
- Proper monitoring of the girl child
- Present role models to young boys and girls.
- House to house sensitisation campaign
- Create drama groups in school and community on SRH information

**GOAL Additional Recommendations**

- Parents and guardians should be equipped with an understanding of the importance of a longer term outlook and the negative impact of using a child as a main breadwinner, either through petty trading or encouraging sexual activities for money/food
- Sensitization on the negative consequences of child abuse with community members, parents, and guardians
- Teaching parents and guardians life skills to improve the monitoring and care provided to their children.
- Community members, parents and guardians to be trained on SRH information delivery and the positive benefits of contraceptives use among teenagers

**4.4 Teenage Boys and Girls Recommendations**

- Parents should reduce reliance on children to supplement household income
- Guidance and counseling are incorporated in schools.
- Encourage to join family planning
- Government should provide safe drinking water in communities to avoid getting water at night.
• Parents should intensified monitoring and supervision of children both at home and at schools.
• Minimize lessons for children at night (avoiding walking home in the dark)
• Sensitization on family planning methods and proper sexual behavior need to be done in schools and communities in order to minimize the risk of getting pregnant and contracting HIV/AIDS.
• Young girls should be taught the importance of education in their future development
• Parents should be sensitized on the importance of education.
• Set up peer educator clubs in the communities
• Introduce SRH as a subject in schools and more education on contraceptive use.

GOAL Additional Recommendations

• Accurate SRH information coupled with behavioral change interventions.
• SRH clinics trained on youth friendly service delivery
• Establishment of a minimum standard of youth friendly service delivery
• Youth friendly components should be integrated into all health care providers’ services
• Media is a method in which to conduct this as is sensitizing the health workers themselves on encouraging SRH seeking behavior among both genders.
• Peer educators based in clinics and the community, to generate a demand, refer teenagers to SRH services, ensure that health services were friendly and provide information that is tailored to teenager’s specific SRH needs.

4.5 Summary of Recommendations

The teenage pilot project objectives are to:

• Design, implement and evaluate integrated community-based strategies to address the intricate health, education and livelihood issues associated with teenage pregnancy.
• Facilitate access to confidential and youth-friendly family planning services at the community level

These substantial research findings have provided an invaluable understanding of the initial research questions posed. The process of also asking key stakeholders in the communities for their own recommendations to address the issues of teenage
mothers and teenagers in general, requirements for SRH services and information provided the team with information that is truly from the communities. The community recommendations are supplemented with additional recommendations that have been missed out and once the research findings were all collated and the overall view obtained. The project should utilize key recommendations in the sectors of health, livelihoods and education. Initial phase should begin with ensuring stakeholders are knowledgeable on SRH information and services and all misinformation is addressed. Important partners in the community, education and health sector should also be approached to understand the role that they need to play in addressing the intricate issues that lead to teenage pregnancy and the following negative educational, health, social and livelihood consequences of teenage mothers.
Good morning / Good afternoon Sir / Madam. My name is (insert) I am working with GOAL Sierra Leone. We carrying out a study on teenage pregnancy in the communities we work in and are interested in knowing the sexual and reproductive services/information your health facility provides to young people. I would like to ask you a few questions regarding services provided at this clinic if you agree to participate. The information you provide will be used for purposes of the study and in the design of appropriate interventions for adolescents. Please feel free to stop me at any point in the course of the interview if you feel uncomfortable or wish to discontinue the interview.

**General information**

Name of Health Facility:
Location/community:
Date of Interview:
Interviewer Name:

Designation of Health Facility personnel being interviewed

How long have you worked in this Health Facility?

**1) Service Provision**

What services are provided in this facility? (Ask questions to fill in the table – ask to see records to back up the information)

<table>
<thead>
<tr>
<th>Type of service (e.g growth monitoring, FP, antenatal counseling and testing)</th>
<th>Frequency of service daily, weekly, biweekly, monthly</th>
<th>Type of clientele served (infants, elderly, mothers, teenagers etc)</th>
<th>Average no of Clients served per day</th>
<th>Cost of service (if free, indicate so)</th>
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Where any records seen? Yes  No

If yes what was seen?
If no what was the reason given?

2) SRH IEC Material

Do you provide clients with any take home literature or IEC materials? Yes  No

If yes, on what subject?

If no, why not?

[Observe type of posters and other IEC in the clinic and record content of messages]

Do you often get teenagers here requesting particular information on SRH? Yes  No

If yes, what is their most requested information?

If no, why do you think that is?

3) Antenatal services

[Ask this question If antenatal services are mentioned as a service] What is the average monthly number of clients the clinic serves that are aged below 20 years?

In your opinion, has this number been increasing, decreasing or remained the same since 2009?

What do you think are the reasons for the observed trend above?

Since January 2010, how many mothers aged below 20 years have delivered in this facility?

(Did you see records to prove the figures? Yes  No)

4) Contraceptive use

As a health worker in this community, what is your opinion regarding young people using contraceptives?

Do you think there are cases where health workers may withhold SRH information or contraceptives from young people? Yes  No

If yes, why do you think that happens?

5) Youth friendly services

Does this Health facility provide health services that are tailor made for young people aged between 13-19? Yes  No

If yes, List them:

If No, Is this facility in a position to provide the following services to young people aged 13-19 years? What support will you require to provide these services?
## Type of Support Required

<table>
<thead>
<tr>
<th>Service</th>
<th>Type of support required to provide service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Facility/Equipment</td>
</tr>
<tr>
<td></td>
<td>Human Resource, Training</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
</tr>
<tr>
<td>Counseling and Testing</td>
<td></td>
</tr>
<tr>
<td>SRH Information</td>
<td></td>
</tr>
<tr>
<td>Teen mothers support services</td>
<td></td>
</tr>
</tbody>
</table>

Do you think there may be barriers to young people accessing sexual and reproductive health information and services at this clinic? Yes, No

If yes, what do you think these barriers are and why?

Would you classify this clinic as ‘youth friendly’? Yes No

If yes, what makes it youth friendly?

If no, please give information on why this is not a youth friendly facility?

### 6) Support received

Besides Government support, are there any other organizations supporting this health facility? [List them in the table below and indicate type of support]

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Support rendered to Health Facility (drugs, equipment, training etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Closing the interview:** In general you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (Wait for response).

Have you anything else to add?

Thank you very much for your time, it has been extremely valuable.
Good morning / Good afternoon Sir / Madam. My name is (insert) I am working with GOAL Sierra Leone. We are carrying out a study on teenage pregnancy in the communities we work in and are interested in understanding the schools perspective on the matter. I would like to ask you a few questions on the extent of teenage pregnancy in your school, the impact of teenage pregnancy and the factors that lead to early sexual debut in addition to understanding school policy on teenage pregnancy. The information you provide will be used for purposes of the study and in the design of appropriate interventions for adolescents. Please feel free to stop me at any point in the course of the interview if you feel uncomfortable or wish to discontinue the interview.

1) General Information

Name of School:
Primary or secondary school:
Location/community:
Date of Interview:
Interviewer Name:
Designation of personnel being interviewed:
How long have you worked in this School?
What is the current school enrolment (Boys________Girls________)

2) Drop Out Rates

How many drop outs do you get on average in a year? (students who leave before completing studies). Boys___ Girls___

What are the average ages of students who drop out?

What do you think are the reasons for the dropouts?

How many cases of teenage pregnancy has your school had this year 2010 and last year 2009? (Ask to records to back up the answer)

(Were records seen? Yes No)

What were the average ages of teenagers who became pregnant?

3) Factors Leading to Teenage Pregnancy

In your opinion, what are the factors contributing to teenage sex/pregnancy?

Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?

4) School Policy on Pregnancy

In your school, what happens to a teenage girl when she becomes pregnant?
What is the school's official policy on teenage pregnancy?

Does your school allow back teen girls who have delivered and are willing to continue with their studies? Yes No

If yes, do/how many come back?

If not why not?

5) Support for Interventions

In your opinion can schools do to prevent teenage pregnancy and support teenage mothers willing to return and complete studies?

If we were to start a programme for teenagers in your school, would you be willing to be part of it? Yes No

If yes, in what capacity?

If no, can you give a reason?

Closing the interview: In general you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (Wait for response).

Have you anything else to add?

Thank you very much for your time, it has been extremely valuable.
Good morning / Good afternoon Sir / Madam. My name is (insert) I am working with GOAL Sierra Leone. We carrying out a study on teenage pregnancy in the communities we work in and are interested in understanding the service offered by the FSU, the utilization of the services and the extent of GBV among teenagers. The information you provide will be used for purposes of the study and in the design of appropriate interventions for adolescents. Please feel free to stop me at any point in the course of the interview if you feel uncomfortable or wish to discontinue the interview.

1) General Information

Name of FSU: 
Location: 
Date of Interview: 
Interviewer Name: 
Designation of personnel being interviewed: 
How long have you worked in this FSU: 

2) Cases reported/handled

What kind cases do you mostly handle/are reported here? 

Do you often have cases reported by teenagers? Yes   No 

If yes, what is the common complaint? 

If no, what are group of people mostly report here? Elderly/married women/men etc 

In the past one year, how many cases of sexual abuse, physical abuse/assault, early marriage etc were reported? [Enter in table below] How many of these were prosecuted? Who were the perpetrators/Complainant? [Enter in table below] 

<table>
<thead>
<tr>
<th>GBV</th>
<th>Number of Cases Reported</th>
<th>Perpetrators (stranger, husband, boyfriend, family etc)</th>
<th>Complainant (age group)</th>
<th>Number of Cases Prosecuted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Marriage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse, assault</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) Service Provision and Utilization
What services do you provide to those who have been sexually abused/assaulted/early marriages?

Are the services (listed above) often utilized by the Complainant? Yes No

If yes, which services in particular?

If no, why do you think they are not utilized?

What challenges are you facing in providing services to victims of gender based violence?

What do you think are the barriers to people (particularly teenagers) utilizing the FSU services?

Closing the interview: In general you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (Wait for response).

Have you anything else to add?

Thank you very much for your time, it has been extremely valuable.
Good morning / Good afternoon Sir / Madam. My name is (insert) I am working with GOAL Sierra Leone. We carrying out a study on teenage pregnancy in the communities we work in and are interested in understanding the service offered by the FSU, the utilization of the services and the extent of GBV among teenagers The information you provide will be used for purposes of the study and in the design of appropriate interventions for adolescents. Please feel free to stop me at any point in the course of the interview if you feel uncomfortable or wish to discontinue the interview

1) General Information

Location/community:
Date of Interview:
Interviewer name:
Designation of personnel being interviewed:
How long have you worked with DHMT?

2) SRH Service Provision

How many PHUs are under you management? (List)

How many of these provide Maternal Child Health, Family Planning services VCCT, Adolescent SRH services [enter in table below and tick service provided]

<table>
<thead>
<tr>
<th>Name of PHU</th>
<th>MCH</th>
<th>FP</th>
<th>ASRH</th>
<th>VCCT</th>
<th>Other</th>
</tr>
</thead>
</table>

3) Service Provision (current & planned) on Teenage Pregnancy

Is teenage pregnancy considered a big problem by DHMT?
Has the DHMT any systems/activities in place to address the problem? Yes  No
If yes, please describe them:
If no, does the DHMT have any future plans to address this problem?

4) Policy

What is the government policy in regards to contraceptive use by adolescents?
What is the policy on provision of SRH services to adolescents?

5) Support and Interventions

What can PHUs and the DHMT do to meet the SRH needs of adolescents?
What kind of support is needed by the PHU's to include youth friendly SRH services With which PHUs and why?

Closing the interview: In general you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (Wait for response). Have you anything else to add?
**ANNEX 5: GOAL SIERRA LEONE TEENAGE PREGNANCY STUDY**

**SEMI STRUCTURED INTERVIEW GUIDE FOR TEENAGE MOTHERS**

Good morning / good afternoon Ma’am. My name is (insert) and I am working for Goal Sierra Leone. Goal is interested in understanding the current situation of teenagers and teenage pregnancy in the eastern and central parts of Freetown. To do this, Goal enumerators are carrying out interviews with individuals and institutions, to understand the situation in order to design an informed and appropriate intervention. I will ask you a few questions related to your pregnancy and role as a mother. The information you provide will be used for purposes of the study and in the design of appropriate interventions for adolescents. Please feel free to stop me at any point in the course of the interview if you feel uncomfortable or wish to discontinue the interview.

Name of Community: 
Interviewer Name: 
Date of Interview: 

<table>
<thead>
<tr>
<th>Demographic data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
</tr>
<tr>
<td><strong>Religion:</strong></td>
</tr>
<tr>
<td><strong>Educational level:</strong></td>
</tr>
</tbody>
</table>

**Occupation:** [probe for main source of income] ____________

**How old is your child?** (Enter age in months) __________

1) **Child Care and support**

On a day today basis, who takes care of your child?

What support are you receiving in caring for the child from:

- The father of the child?
- Your family?
- Friends/peers?

What are the main challenges you are facing in bringing up this child?

2) **Health Care**

Did you receive health care (ante natal/post natal) when you were pregnant/in labour? Yes No

If no, why not? Where there barriers to accessing care?

If yes, where did you go and did you think the care was adequate?

Where did you deliver your child?

Do you take your child to a health facility? Yes No
If yes, for what reasons/services do you take the child there?
If no, why not? What are the barriers?

How can young pregnant women and mothers be best supported within the health care system? What should be provided?

3) Education

Were you attending school when you became pregnant?   Yes   No
Do you intend to continue your education or get further training?   Yes   No
If yes, who will support you?
If no, what is preventing you from education or training?
How do you think young mothers can be best supported within the educational system?

4) Livelihoods

Is your current source of income enough to provide for you and your child? Yes  No
If no, how do you cope?
What would you need in order to be able to provide adequately for and your child?
What plans do you have for the future, for yourself
For your child?

5) Family Planning

Are you now aware of various family planning methods? Yes No
If yes, then please list them:
Do you know where to go to obtain family planning or SRH services and information? Yes No
If yes, where would you go for services/get information?
Do you currently use family planning? Yes No
If yes, what do you use?
If no, why not
Do you know how to protect yourself from STI’s/HIV?  Yes No
If yes, how?

6) Community attitudes
At present, what is the attitude of your peers and the community towards you?
Positive  negative

Why do you think they act that way?

7) Lessons learnt

How do you feel having a child at this time?

Would you change anything about the situation?

What message would you give to sexually active teenage boys and girls so that they may avoid pregnancy?

Closing the interview: In general you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (Wait for response).

Have you anything else to add?
Thank you very much for your time, it has been extremely valuable
Good morning/afternoon/evening, my name is [insert] and I am working on this research based at GOAL Sierra Leone. We are conducting some focus group discussions on selection of teenager mothers in the communities GOAL has been working in to obtain your views and opinions on the topic of teenage pregnancy, family planning, SRH services and gender issues. The results of these FGDs will be used to inform a project to reduce teenage pregnancy the negative consequences that it may cause the individual and the community. Is it ok if we take some notes (Wait for response)…thank you very much.

There are six topics for discussion in this session in the areas of 1) Factors that led to early sexual debut/pregnancy, 2) Challenges for teenage mothers, 3) Current and desired support systems for self and child, 4) Knowledge and utilisation of family planning methods, 5) Sources and utilisation of SRH information and services, 6) lessons learnt/intervention strategies

I will begin by asking a general question on that topic and you can then respond. All your opinions are equally valuable and I would encourage discussion among the group rather than simply answering to me. If you are uncomfortable with any questions you do not have to answer them. Please respect the opinions of all the other participants.

**Topic 1: Factors that led to early sexual debut/pregnancy**

- What do you think are the reasons young girls engage in sex?
  
  Possible probes: is it because of money, peer pressure, or…
  Possible probes: is this the same as your reason for engaging in sex young?

- Did you ever use any family planning methods?
  
  Possible probes: (If yes) which ones? How often?
  Possible probes: (If no) why not? Were there barriers to you obtaining them or information about them?

**Topic 2: Challenges for teenage mothers**

- What are the challenges of being teenage mothers in your community?
- What challenges are you facing in bringing up your child/children?

Possible probes: any issues with health, education or money?

- At present, what is the attitude of your peers and the community towards you?
Possible probes: Are they supportive or not?

**Topic 3: Current and desired support service for self and child?**

- What support are you receiving from the father of the child? Your family/friends/peers?

Possible probe: is this support adequate?

- Were you attending school when you became pregnant?

Possible probe: Do you intend to continue your education or gain further training?

- Did you receive antenatal care when you were pregnant? Did your child receive care?

Possible probe: (If no) why? Were there barriers to you or your child accessing care?

Possible probe: (If yes) what kind of care did you both receive? Where? Were you satisfied?

  - Where did you deliver your child?
  - What plans do you have for the future, for yourselves/child/children?

Possible probe: What support would you need to achieve this plan?

**Topic 4: Knowledge and utilization of Family Planning Methods**

- Are you now aware of how to prevent pregnancy/SI/HIV?

Possible probe: what can you use to prevent pregnancy/SI/HIV?

- Are you currently using/would use family planning?

Possible probes: what do/would you use?

**Topic 5: Sources and utilization of SRH information and services**

- In your community, where can teen mothers like yourselves go to get family planning services and information?

Possible probes: Have you ever obtained family planning services or information?

Possible probes: are there any barriers to seeking family planning services or information?

  - If today you wanted to get information on family planning where would you go and why?

Possible probe: what information or services can you get there?
• Have you ever heard of teenage girls in community terminating their pregnancy?

Possible probe: (if yes) where and how do they do it?

**Topic 6: Lessons learnt/intervention strategies**

• What lessons have you learnt from being teen mothers? What would you change?

• How best can young mothers like yourselves be supported

Possible probe: any other suggestions?

**Closing the FGD**

Ok thank you very much we are going to finish up soon, let’s just go over a few things……

[Summarize the main points that were brought up in FGD, identify areas of agreement and areas of different perspectives]

Does any one have any final comments or questions?

...thank you very much for your time, it has been extremely valuable.
Good morning/afternoon/evening, my name is [insert] and I am working on this research based at GOAL Sierra Leone. We are conducting some focus group discussions on selection of teenagers in the communities GOAL has been working in to obtain your views and opinions on the topic of teenage pregnancy, family planning, SRH services and gender issues. The results of these FGDs will be used to inform a project to reduce teenage pregnancy the consequences that it may cause the individual and the community. Is it ok if we take some notes (Wait for response)…thank you very much.

There are six topics for discussion in this session in the areas of 1) Factors contributing to teenage sex/pregnancy, 2) Knowledge and utilisation of family planning methods, 3) Risk perception 4) Sources and utilisation of SRH information and services, 5) Gender norms and 6) intervention strategies

I will begin by asking a general question on that topic and you can then respond. All your opinions are equally valuable and I would encourage discussion among the group rather than simply answering to me. If you are uncomfortable with any questions you do not have to answer them. Please respect the opinions of all the other participants.

**Topic 1: Factors contributing to teenage sex/pregnancy**

- What are some of the reasons why young people engage in sex in your community?

Possible Probes: Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?

- Which age do you consider appropriate for one to start having sex?

Possible probe: In your community, at what age do most young people start having sexual relationships

- Sometimes, girls become pregnant before they are twenty years old. Does this happen in your community?

Possible probes: (If yes) what happens to them when they become pregnant? (i.e. are any driven from home, stigmatized, beaten, deprived of food etc)

**Topic 2: Knowledge and utilization of family planning methods**

- Where do young people like yourself get information about the following:
  - Sex and reproductive health
  - HIV/AIDS and STIs
  - Condoms
  - Other contraceptives
Possible probe: From the sources you mentioned, which one do you prefer and why? Possible probe: are there any barriers to getting this information?

- Do you use any family planning methods?

Possible probe: (if do use family planning) which methods and why? Possible probe: (if do use family planning) do you regularly use this method? How often? Possible probe: (if do not use family planning) what prevents you from using family planning?

**Topic 3: Risk perception**

- Some people use various ways to prevent themselves from becoming pregnant, from contracting HIV and STIs. Which ones are you aware of?

- [of the listed methods]Which ones are mostly used by young people like yourselves?

- Do you feel at risk of getting pregnant/getting a girl pregnant or contracting an STI or HIV?

Possible probes: (If yes) what can you do to minimize that risk?

**Topic 4: SRH service knowledge and utilization**

- In your community where can young people like yourselves go if they needed SRH services?

Possible probes: Have you ever obtained SRH services? Possible probes: Are there any barriers to seeking SRH services?

- If today you wanted to get information on family planning where would you go and why?

Possible probe: what information or services can you get there?

**Topic 5: Gender norms among teenagers**

- (If with girls) What are some of the challenges of being a girl in your community?

Possible Probe: are there any issues like harassment, peer pressure, violence, and work load?

- (If with girls) If a girl becomes pregnant in this community, does the boy often take the responsibility of the child?

- (If with boys)What are some of the challenges of being a boy in your community?
Possible Probe: are there any issues like harassment, peer pressure, violence, and work load?

- (If with boys) Do you think it is acceptable for a man to punish his wife if he thinks she has made a mistake?

Possible probe: Do you think physical punishment may be acceptable

- (If with boys) What would be your reaction if you impregnated a girl?

Possible probes: would you take on the responsibility of the child?

**Topic 6: Intervention strategies**

- What do young people need so that they can minimize their risk of getting pregnant or contracting STI/HIV?

Possible probes: Does any one have any more suggestions?

**Closing the FGD**

Ok thank you very much we are going to finish up soon, let’s just go over a few things……
[Summarize the main points that were brought up in FGD, identify areas of agreement and areas of different perspectives]
Does any one have any final comments or questions?
...thank you very much for your time, it has been extremely valuable.
Good morning/afternoon/evening, my name is [insert] and I am working on this research based at GOAL Sierra Leone. We are conducting some focus group discussions on selection of Community Members in the communities GOAL has been working in to comprehend the communities perception of the extent of teenage pregnancy, your views on what the major factors are contributing to teenage pregnancy, opinions on family planning, the impact teenage pregnancy has on your community and methods to reduce teenage pregnancy. The results of these FGDs will be used to inform a project to reduce the risk of teenage pregnancy and support teenage mothers. Is it ok if we take some notes (Wait for response)…thank you very much.

There are four topics for discussion in this session in the areas of 1) factors contributing to teenage pregnancy, 2) Social impact of teenage pregnancy 3) Community openness on family planning discussions and 4) Methods to reduce the risk of teenage pregnancy

I will begin by asking a general question on that topic and you can then respond. All your opinions are equally valuable and I would encourage discussion among the group rather than simply answering to me. If you are uncomfortable with any questions you do not have to answer them. Please respect the opinions of all the other participants.

**Topic one: factors contributing to teenage pregnancy**

- How prevalent do you think teenage pregnancy is in your community?
  
  Possible probes: If teen pregnancy is considered a problem or not by participants and why?
  
  Possible probes: do you think it is increasing or decreasing or has remained the same?
  
- What do you think are the reasons teenagers engage in early sex and sometimes become pregnant?
  
  Possible probes: Do you think it is because of money or peer pressure?
  
  Possible probes: Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?

**Topic 2: Social impact of teenage pregnancy**

- If a teenage girl becomes pregnant or a teenage boy impregnates a teenage girl what do you think is the impact for them (i.e. in terms of social support systems, family/community relationships, education, health livelihoods)

  Possible probes: Do you think the possible impacts are different for boys and girls? If so, in what ways?

**Topic 3: Community openness on family planning**
• Do young people and adults in your community, discuss freely issues related to sexual and reproductive health, sexual relationships, HIV, STIs?

Possible probes: If yes how are these discussions conducted?

Possible probes: If no, how can adults in your community help/support young people to avoid risky sexual behaviour?

• What is your opinion regarding teenagers using family planning methods

Possible probes: are there any barriers to teenagers using family planning methods?

**Topic 4: Community methods in reducing risk to teenage pregnancy**

What do you think your community can do to help prevent teenage pregnancies, support pregnant teens and teen mothers?

Possible probes: are there any other suggestions?

**Closing the FGD**

Ok thank you very much we are going to finish up soon, let's just go over a few things……

[Summarize the main points that were brought up in FGD, identify areas of agreement and areas of different perspectives]

Does any one have any final comments or questions?

...thank you very much for your time, it has been extremely valuable.
ANNEX 9: Key Information Questionnaire for Teenage Mothers

*Give out before FGD commences

Date of Birth:

Age:

Religion:

Age when you first had sex:

Age when pregnant:

Age of child:

Do you use any of the following contraceptives/family planning? (Circle all that apply)
- Male condoms
- Contraceptive pill
- Female condom
- Rope
- IDU
- Coil
- Injections
- Implant
- Withdrawal method
- Other, please specify: ____________/
- I do not use any family planning/contraceptives

How often do you use them? (Please circle)
- Always
- Regularly
- Not regularly
- Never
ANNEX 10: Key Information Questionnaire for Teenage Boys and Girls

*Give out before FGD commences

Are you: Male or Female (please circle one)

Date of Birth:

Religion:

Age:

Age when you first had sex:

Do you use any of the following contraceptives/family planning? (Circle all that apply)
- Male condoms
- Contraceptive pill
- Female condom
- Rope
- IDU
- Coil
- Injections
- Implant
- Withdrawal method
- Other, please specify:____________/
- I do not use any family planning/contraceptives

How often do you use them? (Please circle)

Always          Regularly          Not regularly          Never
ANNEX 11: FGD Note Taker Observations Sheet

*Attach FGD notes this form

Name of moderator:
Name of Note Taker:

Date:

Venue:

Community:

Cluster Number:

Participants (circle one): community/teenage boys/teenage girls/teenage mothers

Number of participants:

Non-verbal cues and their context:

Group dynamics/interaction:
Name of researching organisation: GOAL Sierra Leone

Description of study: This is an exploratory study to gather information on the health, education and socio-economic impact of teenage pregnancy on the teenage mother, the family and community and to assess the current provision and utilisation of SRH services for teenagers in order to inform the design of a project to assist in reducing the risk of teenage pregnancy and advocate for the needs of teenage mothers. A combination of semi structured interviews, focus group discussions (FGD’s) will be administered to the research sample. Participants for the FGDs and interviews include male and female teenagers, teenager mothers, community members, health clinics, SRH clinics, DHMT, FSU’s and school heads.

Procedures: You have asked to participate in this study because your personal views and experience as teenagers/teenage mothers/community members/health providers/educational providers are extremely important and necessary to facilitate a appropriate and well informed pilot project on teenage pregnancy. Your contribution would be to attend a focus group discussion or interviews to discuss your views and experiences. The focus group discussion or interview will last no longer than an hour and will take. If you wish you may have access to the notes of this discussion or interview. The results of the study will be used to design a pilot project to help reduce the risk of teenage pregnancy and support teenage mothers.

Benefits: The benefits from this study will be the opportunity to share your experiences and to be able to contribute to knowledge. In time this information will be used in order to inform a pilot project to reduce the risks to teenage pregnancy and support teenage mothers.

Risks: There are no risks involved in being part of this study.

Confidentiality: Your identity will remain confidential. Your name will not be taken or published and will not be disclosed to anyone outside the study group.

Voluntary Participation: You have volunteered to participate in this study. You may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

Stopping the study: You understand that the investigators may withdraw your participation in the study at any time without your consent.
Name of researching organisation: GOAL Sierra Leone

Description of study: This is an exploratory study to gather information on the health, education and socio-economic impact of teenage pregnancy on the teenage mother, the family and community and to assess the current provision and utilisation of SRH services for teenagers in order to inform the design of a project to assist in reducing the risk of teenage pregnancy and advocate for the needs of teenage mothers. A combination of semi-structured interviews, focus group discussions (FGD’s) will be administered to the research sample. Participants for the FGDs and interviews include male and female teenagers, teenager mothers, community members, health clinics, SRH clinics, DHMT, FSU’s and school heads.

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Declaration: I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study. I consent to possible publication of results or use of data in other future studies without the need for additional consent. I understand I may withdraw from the study at any time.

I have received a copy of this agreement.

Participants signature/fingerprint: ............................................................

Date: .............................................................

Statement of investigator’s responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Interviewers signature:.......................................................... Date:.............