



# Realities of teenage pregnancy in Sierra Leone

Korrie de Koning, Heidi Jalloh-Vos, Maryse Kok, Alpha M. Jalloh, Kathy Herschderfer

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## List of abbreviations

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPEHS	Basic Package of Essential Health Services
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Centre
CHO	Community Health Officer
CHP	Community Health Post
CHW	Community Health Worker
EmONC	Emergency Obstetric and Neonatal Care
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FHCI	Free Health Care Initiative
FSU	Family Support unit
GBV	Gender-Based Violence
IDI	In-Depth Interview
IUD	Intra Uterine Device
KII	Key Informant Interview
KIT	Royal Tropical Institute
MCH Aide	Maternal and Child Health Aide
MCHP	Maternal and Child Health Post
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MoHS	Ministry of Health and Sanitation
MRC	Medical Research Centre
NGO	Non-Governmental Organisation
PHU	Peripheral Health Unit
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
PPP	Public Private Partnership
RCH	Reproductive and Child Health
RNCH	Reproductive, Newborn and Child Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
USL	University of Sierra Leone
VCCT	Voluntary Confidential Counseling and Testing

# Executive Summary

This research on teenage pregnancies was developed based on the findings of an earlier study on promising practices in maternal and neonatal health in Sierra Leone (Herschderfer et al., 2012), and the development of a comprehensive package of interventions proposed by a working group consisting of experts from the Ministry of Health and Sanitation (MoHS) and representatives of Non-Governmental Organisations (NGOs) working in the field of maternal and neonatal health (MNH) in Sierra Leone. The working group identified empowering community-based education to address traditional beliefs and practices as an important gap in the country's efforts to achieving better health outcomes for women and newborns (Working group MNH package of interventions, 2011).

Teenage pregnancy and early marriage emerged as a focus for community education interventions to be piloted for a number of reasons. Firstly, empowering community education for the improvement of Maternal and Newborn Health (MNH) needs to address underlying gender and cultural norms and values as an important factor influencing MNH. These norms and values also influence early marriage and teenage pregnancy. Secondly the severe consequences for young girls as the result of an increasing teenage pregnancy rate was identified as needing urgent attention.

The Maternal Mortality Rate (MMR) in Sierra Leone is 857 per 100,000 live births; the under-five mortality rate is 140 per 1,000 live births; the neonatal mortality is 36 per 1,000 live births; and the infant mortality is 89 per 1,000 live births (Statistics Sierra Leone and ICF Macro 2009: Sierra Leone Demographic Health Survey 2008).

Sierra Leone has a population of 6.1 million (UNFPA 2012) and has a young population with 48% under the age of 18. The total fertility rate of women between ages 15-49 years is 5.1. The adolescent fertility rate is 146 per 1,000 girls aged between 15 and 19 years. Teenage pregnancies are common in Sierra Leone with 34% of adolescent girls (between 15-19 years old) having had at least one birth or being pregnant in 2008. Of these adolescent girls, 44% live in rural areas and 23% in urban areas. More than half of the 19 year old girls (54.2%) have started childbearing and more than one in 10 girls aged 15 have started childbearing (11.3%).

This report presents the findings of a qualitative study conducted in 4 districts investigating the reasons for and consequences of teenage pregnancies. The research formed the input for the development of a community education intervention in Bo district in the second half of 2012. The intervention will be described and evaluated separately and is not part of this report.

The aim of this formative research was to develop an insight in how decisions to have sex, get pregnant and marriage are reached and what the consequences are, with an intent

to inform the interventions that would direct the participative community education component. Our data are complementary to other research initiatives looking at teenage pregnancies in Sierra Leone. The value added is the qualitative data obtained that contextualise girls' choices and experiences regarding sexuality, life stories of teenage mothers, and circumstances and consequences for the teenage girl who becomes pregnant.

## **Methodology**

This is an exploratory and descriptive study that used qualitative research methods. A research table containing a complete overview of objectives, issues, methods and respondents can be found in annex 1.

The study was carried out in 2 phases each with a specific aim:

- Phase 1: To develop case studies on teenage pregnancy to inform the development of the community education programme
- Phase 2: Baseline information for the community education programme.

In-Depth Interviews (IDIs) were conducted with girls under 20 years of age; this included girls who were married and those who had become pregnant before 20 years of age. Issues explored during the interviews were views and knowledge about: marriage, life expectations, personal and sexual relationships, sexual experiences, sexual violence in the community, contraceptives and STIs, HIV/AIDS and access to health information and services.

Key Informant Interviews (SSIs) were held with *sowes*<sup>1</sup> and other influential societal women about the type of education girls receive during societal initiation, the perceptions of initiation as a road towards womanhood and the link between womanhood and the age of the girl during initiation. Other leaders and authoritative adults were interviewed about the roles, norms and values guiding the lives of boys and girls, the context of early marriage and the barriers to preventing pregnancy.

Focus Group Discussions (FGDs) with men, women and young people were conducted to explore attitudes related to SRH in the community towards early marriage, teenage pregnancy, male and female adolescent sexual and reproductive health needs, gender roles and norms and values.

### ***Study districts and sites***

In order to cover cultural, religious and geographical variations in the country, one study district was selected in 3 of the 4 regions of Sierra Leone (north, south and east). As information from the Western Area was available from a study conducted by GOAL, this region was used for field testing the study tools. The selection was based on district adolescent reproductive health indicators as reported in the validated standard tables of the Sierra Leone Multiple Indicator Cluster Survey 2010 (UNICEF Sierra Leone 2011). An overview of these indicators by district can be found in annex 2. The highest adolescent birth rate and delivery under 15 years of age is seen in Kambia, Moyamba and Kailahun and these were selected.

<sup>1</sup> A *sowe* is a title from the Bondo (female traditional) society indicating a women leader who plays a large role in girls' initiation rites into the traditional society.

The selection of the 6 study communities (2 in each district) was aimed to cover the diversity in attitudes towards early marriage, sexual violence, teenage pregnancy, traditional practices around pregnancy and childbirth and access to services. Communities in both (semi) urban and rural settings were included in the study.

### ***Data management***

Interviews and FGDs were taped, transcribed and simultaneously translated into English and checked by the field research coordinator against the original tapes.

After the development of the coding framework, the coded transcripts were entered in Atlas-ti (electronic qualitative data management and analysis software) by two researchers.

### ***Data analysis***

A coding framework was developed in two steps. Firstly, all data collectors read their own transcripts and presented the most important issues emerging from them. Secondly, all transcripts were read in small groups. During a plenary session, a coding scheme was developed based on the issues emerging from the first reading and the issues explored in the interviews and documented in the topic guides.

A second workshop was held with all stakeholders to present the data summaries from the preliminary analysis to validate the outcomes. Subsequently, analysis matrix sheets were used to analyse data across the various sites, and relevant data from various respondent groups and various data collection techniques were triangulated.

## **Results, discussion and conclusions**

### ***Age of sex initiation and marriage in Sierra Leone***

Based on our findings early marriage is the consequence of teenage pregnancy rather than early marriage being a reason for teenage pregnancy. This result shows alignment with other data sources about the initiation of early sex and teenage pregnancies in Sierra Leone.

### ***Reasons for sex and marriage***

The most common reasons for girls to have sex at an early age are poverty, the desire for material goods, coercion using psychological pressure, coercion using violence, family and peer pressure and to a much lesser extent pleasure. Results from this study show that both sex in exchange for basic needs such as food, shelter and clothing and sex in exchange for goods that improve social standing such as modern clothes, shoes etc. are reasons for sex. This distinction is important as the assessment of vulnerability of the girl and the possible incentives to change behaviour will be different.

From the FGDs and interviews in our study, it emerges that sex with influential men is something families are proud of and see as a way to get access to assets/power, as long as the girl does not get pregnant or the pregnancy is acknowledged. The underlying gendered norm that influences transactional sex emerging from this study is that the most important role of the man in marriage is to provide shelter, food, material goods and sex, to provide the woman with 'all she needs'. Girls and boys internalise these roles and expectations.

Coercion using psychological pressure emerged as one of the most common reasons for sex. Almost all girls started saying that they did not feel ready for sex, did not want sex

and felt that they were 'forced'. In most cases the stories of the girls indicate that they do not feel ready for their first sexual encounter. They agree out of 'love' and the desire to please a man. The link between sex and love emerged as a very strong concept in the interviews with the girls and the FGDs. Internalised gendered norms and roles influence this behaviour. The men and boys expect that they have to convince women to have sex with them. These expectations are linked to the culturally accepted role of a woman who is expected to care for, obey and please men and this they are taught from early childhood. Arguments of love and financial care to convince women are commonly accepted.

We did not get any direct evidence for coercion into having sex by school teachers and other influential men during the in-depth interviews with the girls. During FGDs coerced sex by teachers and other influential men was mentioned by some groups of boys. However, the increased emphasis on preventing sexual abuse through NGOs that are addressing sexual violence may have pushed the admittance of sex with older men under the carpet.

For a few girls, their first sexual encounter was through physical violence. Some girls were raped on their way to collecting water and in a few other cases girls were physically assaulted at a 'date'. The statement in the consent form that confidentiality may be broken when girls are exposed to a continued threat of abuse may have influenced the willingness of girls to speak about continued abuse but this should not have influenced reporting their experiences during their sexual debut.

Findings from the FGDs and key informant interviews suggest that the community is not noticeably concerned about girls having sex at an early age. Our results show that, having sex at an early age only becomes a problem when the girl gets pregnant and/or when the village is gossiping about a girl having sex outside marriage and family get to know about it. This is especially so if the pregnancy is not recognised by the impregnator.

At community level, teenage pregnancy is clearly seen as a problem by all groups, however, among some (age) groups, having a child has become a social desire that influences girls to get pregnant also. In addition, when girls are not performing well or are not able to continue schooling, getting married and having a baby is seen as a good alternative.

The reasons for pregnancy and marriage are also influenced by financial and increased social standing considerations by the parents and guardians. There is no support mechanism in communities for teenage mothers. Teenage mothers are mostly dependent upon help and (financial) support from their own or the impregnator's family. The impregnator or his family is also expected to cover costs for the pregnancy and later for the child. The value of the girl to the family emerges as a business investment, as derived from the findings of the FGDs and key informant interviews.

### ***Consequences of early pregnancy and marriage***

The consequences of a teenage pregnancy can be separated into health and social consequences. All communities included in this study were well aware of the mortality risk associated with early pregnancy. In fact, the risk of death is often used to scare the girl and mentioned as an important reason that a girl should not get pregnant at an early age. Abortion was a frequently mentioned option during the interviews and FGDs. Obstetric fistula as a result of very early pregnancy and sometimes rape was mentioned once.

The most frequently mentioned social consequence for girls was leaving school which affects her future opportunities in life dramatically. Many girls state that they want to go back to school but only one or two seemed to manage to do this.

Mostly, a girl who had become pregnant had to leave home to live with the impregnator's family or relatives. For some of them, this is an acceptable outcome but for some of them, this means a heavy workload and competition with family members, like sisters-in-law. Consequences in terms of gossip and shame depend on the acceptance or rejection of the pregnancy by the impregnator. The worst that can happen is that girls are seen to have sex with 'somebody from the street' and get pregnant without somebody taking the responsibility for the pregnancy. They may end up in the street trying to survive on their own and when they are lucky a relative will take them in. In most cases these girls are most vulnerable and face shame, blame and a very difficult livelihood situation.

Once a girl has had sex with a man, this man automatically becomes the girl's boyfriend and lover, irrespective of the force that was used. Society and families support this behaviour. The man who has sex with a minor (through rape or 'consent') may be brought to the police station or a local authority like a chief. The immediate next step is that the parents of the girl and the family of the man/boy negotiate the payment of compensation. Once the families agree the family of the girl will withdraw the complaint. The primary concern of parents and guardians seems to be avoiding that the girl's reputation is spoiled by making the boy/man own up to be the father of the child and pay compensation.

The consequences of a pregnancy are much more severe for the girls, but boys' and men's lives can also be shaken as a consequence of making a girl pregnant. By-laws were in place in most communities to hold men responsible for impregnating a girl. The effectiveness and equitable enforcement of these by-laws are questioned, but at the same time they signal a community concern that can be capitalised on and possibly guided to more effective prevention strategies.

#### ***Love, sex and contraceptives: information and access***

Male and female adolescents mentioned as most important sources of information about love and sex: observations through informative films, TV soaps and pornographic materials, observation of parents and siblings. Besides this, it was obtained from all interviews and FGDs that they then learned most from each other while practising sex. Information about, especially, contraceptives and HIV/ STIs was obtained through school and NGOs but this is not equally available in all communities.

Some religious leaders played an important role in promoting the use of contraceptives, when young people were sexually active. Overall, the content of information on sex was limited to technical issues about condoms, pills, implants and hormonal injections from health workers and NGOs. Social and emotional aspects of sexuality were not mentioned.

The information young people obtained from elders was mainly focused on negative messages associating sex with pregnancy and death. One girl respondent voiced the importance of open and transparent communication between parents and girls in influencing girls not to initiate early sex.

Knowledge about the type of contraceptives available among the girls in the in-depth interviews was generally good. Moreover, they received information from health workers during and after their pregnancy. The picture emerging from the interviews with elderly women shows a much greater reliance on traditional methods such as the use of a rope. Access to contraceptives is provided through Marie Stopes Sierra Leone, other NGOs and health centres. However, access is not generally made available in a non-judgemental way to adolescents. The strategies developed at the moment aiming to provide adolescent friendly services are very timely and need urgent implementation (MOHS-SL, 2012c).

### ***Gender norms, values and roles***

Gendered norms and values that are influencing teenage pregnancy have been mentioned when discussing the issues above. In summary, the most important norms and values that need to be taken into account are the emphasis on a pleasing and serving attitude towards men coupled with a norm of obedience. The general acceptance is that girls are ready for sex at an early age as long as this takes place in an acknowledged relationship, and a girl's value being related to financial gain. The expected roles of men and women in marriage in particular and society at large also play an important role in the nature of the way in which young women are coerced into having sex.

### **Recommendations**

The recommendations are based on the study results, evidence from the literature and the discussions at the end of “Realities of Teenage Pregnancy in Sierra Leone” research dissemination meeting, 8th December 2012 in Freetown, Sierra Leone.

The main recommendations emerging from all sources mentioned above are structured under *Community based approaches, sex education and providing youth with contraceptives*. Suggestions made during the dissemination meeting are taken up unless there is clear evidence that such an activity is not effective. This is the case, for example, for the forming of ‘virginity bonds’ (See Underhill, 2007). In this case the evidence from systematic reviews of sex education intervention effectiveness studies is taken. This supports an educational approach which enables boys and girls to make personal choices about when they want to become sexually active, assists them to obtain contraceptives when they want to have sex and starts before they become sexually active (Kirby, 2006).

Important considerations to keep in mind are the results of this study and others which clearly show the role that social and gendered norms and values play in coercing girls to have sex very early, when they themselves do not feel ready. Besides the need to address poverty, family and community perceptions of girls as a business investment need to shift to give girls a chance to say no to sex.

Another important aspect is the involvement of teenagers in the design of all strategies and activities. They are the ones best placed to advise on what will work and what will not. Ensure diversity of backgrounds so that strategies reach not only the ones in school but also the ones out of school and urban as well as rural boys and girls.

These recommendations link into the work already developed for a multi-faceted strategy to improve adolescent health and wellbeing, as laid out in the multi-sectoral youth programme and the teenage pregnancy strategy, as part of the poverty reduction strategy III by the Government of Sierra Leone.





# 1 Introduction

## 1.1 Context of the research

The Public Private Partnership (PPP)-Sierra Leone programme was a 4 year collaboration (2009-2012) between organisations in the Netherlands and Sierra Leone aimed to contribute to the successful implementation of the National Reproductive and Child Health Plan 2008-2010 (and the follow-up after this period), in order to reduce maternal, neonatal and child mortality in Sierra Leone. The programme was led by Cordaid (The Netherlands).

Within this programme, there was a knowledge-strengthening and dissemination component that was led by the Royal Tropical Institute (KIT, the Netherlands) in close collaboration with partners in Sierra Leone: Medical Research Centre (MRC), Ministry of Health and Sanitation (MoHS) and University of Sierra Leone (USL) and a partner in the Netherlands, TNO-Quality of Life. It aimed to strengthen health research capacity in Sierra Leone, implement (action) research in the area of MNH and build a system of information sharing on best practices.

Earlier research within the PPP programme consisted of a rapid assessment of promising practices for MNH, implemented during 2010. This research aimed to study barriers to MNH and promising interventions currently being implemented in Sierra Leone as perceived by the users and providers of care, using a mainly qualitative methodology and integrating research capacity building (Herschderfer et al. 2012).

This research on teenage pregnancies was based on the findings of the earlier study and the development of a comprehensive package of interventions proposed by a working group consisting of experts from the Ministry of Health and Sanitation (MoHS) and representatives of Non-Governmental Organisations (NGOs) working in the field of maternal and neonatal health (MNH) in Sierra Leone. The working group identified empowering community-based education to address traditional beliefs and practices as an important gap in the country's drive to achieve better health outcomes for women and newborns (Working group MNH package of interventions, 2011).

Teenage pregnancy and early marriage emerged as a focus for community education interventions which were selected to be piloted for a number of reasons. Firstly, empowering community education for the improvement of MNH needs to address underlying gender and cultural norms and values as important factors influencing MNH. These norms and values also influence the prevalence of early marriage and teenage pregnancy. Secondly teenage pregnancy was identified as an issue needing urgent attention.

This report presents the findings of a qualitative study conducted in 4 districts investigating the reasons for and consequences of teenage pregnancies. The research formed the input for the development of a community education intervention in Bo district in the second half of 2012. The intervention will be described and evaluated separately and is not part of this report.

## 1.2 Reproductive health and teenage pregnancies in Sierra Leone

Every year, about 16 million adolescent girls give birth globally, mostly (95%) in low- and middle income countries. Childbirth at an early age is associated with greater health risks for the mother. In low- and middle-income countries, complications of pregnancy and childbirth are the leading cause of death in young women aged 15–19 years. Teenage mothers have a higher risk of experiencing obstructed labour, premature labour, birth of a low birth weight baby, fistula and sexually-transmitted infections, including HIV. Stillbirths and neonatal deaths are 50% higher among infants born to adolescent mothers than among those born to mothers aged 20-29 years (WHO 2011). Due to stigma and fear, it is also likely that pregnant teenagers undergo unsafe abortion, which exposes the girl to health risk.

The Maternal Mortality Rate (MMR) in Sierra Leone is 857 per 100,000 live births, the under-five mortality rate is 140 per 1,000 live births, the neonatal mortality is 36 per 1,000 live births and the infant mortality is 89 per 1,000 live births (Statistics Sierra Leone and ICF Macro 2009: Sierra Leone Demographic Health Survey 2008).

Sierra Leone has a population of 6.1 million (UNFPA 2012) and has a young population with 48% under the age of 18. The total fertility rate of women between ages 15-49 years is 5.1. The adolescent fertility rate is 146 per 1,000 girls aged between 15 and 19 years. Teenage pregnancies are common in Sierra Leone with 34% of adolescent girls (between 15-19 years old) having had at least one birth or being pregnant in 2008. Of these adolescent girls, 44% live in rural areas and 23% in urban areas. More than half of 19-year-old girls (54.2%) have started childbearing and more than one in 10 girls aged 15 have started childbearing (11.3%). In general, adolescent childbearing is more common in rural areas, among teenagers without education and in lower wealth quintiles (Statistics Sierra Leone and ICF Macro 2009).

Early marriage and early sexual debut contribute to the problem of teenage pregnancy. Sierra Leone is among the countries with the world's highest rates of child marriage (49%) (UNFPA 2012). Twenty-four per cent of adolescent girls between 15-19 years are married (Statistics Sierra Leone and ICF Macro 2009). In addition, 6.2% of this same age group is living together with a male partner ("living in union"). Data show 27% of Sierra Leonean girls are married before the age of 15 years (UNICEF Sierra Leone 2010). The Demographic Health Survey 2008 shows that 27.4% of women aged 20-49 years had sexual intercourse by the age of 15 years; more than two-thirds were sexually active by the age of 18 years; and almost 8 in 10 women had experienced intercourse by the age of 20 years. The median age at first sexual intercourse among women aged 20-49 years is 16.1 years, which is more than one year below the median age at first marriage (17.2 years), suggesting that Sierra Leonean women generally have sexual intercourse before their

first marriage. Another study shows that 9.7% of circumcised women and 4.5% of non-circumcised women commenced sexual intercourse at ages under 14 years (Armand 2011).

Another contributing factor to teenage pregnancy is the limited knowledge about and use of contraceptives. Seventy-four per cent of Sierra Leonean women and 83% of men have ever heard about a method of contraception. For girls aged between 15-19 years, this is 58.2%. Knowledge on contraception is higher when people are better educated and in higher wealth quintiles. The current use of any method of contraception of women between 19-45 years is 10.2% and for adolescent girls aged between 15-19 years, this figure is 8.4%. Women use traditional methods, pills, male condoms and injectables most frequently. Reasons for not using contraceptives are: being opposed to family planning, a husband being opposed to family planning, fear of side effects, wanting more children, lack of knowledge on any methods and others (Statistics Sierra Leone and ICF Macro 2009). The total unmet need for family planning is 27.4% (UNICEF Multiple Indicator Cluster Survey 2010).

### 1.3 Factors influencing sexual behaviour in Sierra Leone

Other factors, apart from those mentioned above, contribute to teenage pregnancies in Sierra Leone. UNICEF Sierra Leone published a report on teenage pregnancies in Sierra Leone (2010), which revealed that teenage pregnancies are seen as a problem by the communities, but only (or mostly?) if the girl is unmarried. The teenagers included in the UNICEF Sierra Leone research had a high rate of sexual activity. Reasons for sex were 'love', receiving money or gifts, peer pressure, payment for school-related expenses, food and protection. The perception of love was often associated with material gains. The study also reported a high level of cases of sexual exploitation and abuse (58% in children 12-24 years). The study results indicated that condom use was not widespread. Only 35% of the sexually active teenagers reported ever using a condom and 80% of the unwanted pregnancies were the result of unprotected sex (UNICEF Sierra Leone 2010).

Goal (2010) undertook a study on teenage pregnancies in the Western Area district in Sierra Leone. They found some of the same factors contributing to early sexual debut as the UNICEF study: lack of support from parents, vulnerable situations, poverty, desiring what others have, peer pressure and power relations. Some adolescent girls who have no (financial) support from parents or other caretakers engage in sexual relationships with men for their upkeep. Others have sex with men or boys to gain desired material goods (Goal Sierra Leone 2010).

Gender norms and perceptions of gender roles influence how people look at (sexual) relationships, marriage and other related subjects. In Sierra Leone, the man is seen as the decision maker (Herschderfer et al, 2012). Sierra Leone historically stands in the bottom 10 of the Gender-related Development Index, ranking 177 out of 182 ranked countries in the most recent index (UNDP, 2013).

## 1.4 Reproductive health and other relevant policies in Sierra Leone

Reproductive and Child Health (RCH) is one of the priorities of the Ministry of Health and Sanitation (MoHS) in Sierra Leone as demonstrated in the Reproductive and Child Health Strategic Plan 2008-2010. In 2009, a broader National Health Sector Strategic Plan 2010-2015 was launched that provided the framework to guide the MoHS and partners to attain the health-related MDGs and focus on the needs of mothers, children and the poor. This plan focuses on strengthening the six building blocks of the health system: leadership and governance; health service delivery; human resources for health; medical products and technologies; healthcare financing; and health information systems.

As part of the implementation of the National Health Sector Strategic Plan, the Basic Package of Essential Health Services (BPEHS) was developed and launched in March 2010. It covers services that have greatest impact on the major health problems, especially MNCH problems, including interventions at community level. Recently, in November 2012, the MoHS launched the Reproductive, Newborn and Child Health (RNCH) policy 2011-2015, its corresponding RNCH Strategy 2011-2015 and a Strategic Plan for Adolescent and Young People's Health & Development 2011-2015. The RNCH Policy outlines steps to accelerate progress of the MDGs and focus on equity and reduction of disparity in RNCH care. The RNCH Strategy outlines the strategies and key activities required to achieve RNCH goals and objectives. Meanwhile, the Strategic Plan for Adolescent and Young People's Health and Development provides a framework that will guide the Ministries, particularly Health and Sanitation; Education, Science and Technology, and Youths and Sports. Implementation of the documents will give a boost to the Free Health Care Initiative (FHCI) that was launched in 2010 for pregnant women, lactating mothers and children under 5 years. They will also lead to improvement in the delivery of adolescent-friendly health services in the country.

Various acts and policies are also relevant regarding teenage pregnancies. The constitution is the overarching legal framework of the country. It recognises and protects fundamental human rights. The Human Rights Commission of Sierra Leone has the objective to protect and promote human rights, including child rights, in Sierra Leone. The Domestic Violence Act prohibits all forms of violence against individuals (including children). The Child Rights Act recognises the right of children to dignity, respect and education and stipulates the responsibilities of parents to protect their children. The act states 18 years as the minimum age for marriage and states also that no person shall force a child to early marriage. The Child Rights Act established structures at national (National Commission for Children), district (through the District Council), chiefdom (Chiefdom Child Welfare Committees) and grassroots level (Village Child Welfare Committees) and the (continuation of) Family Support Units (FSUs) in the Police, with oversight of the Ministry of Social Welfare, Gender and Children's Affairs.

The Poverty Reduction Strategy Paper II (2008-2012) makes clear links between poverty, health and violence. It mentions that early marriage is widely practised as it is often encouraged in Sierra Leonean societies for various social, cultural and economic reasons and is also associated with girls not attending schools. In the Poverty Reduction Strategy Paper III (2013-2017) there is a special focus on teenage pregnancy. A multi-sectoral teenage pregnancy strategy will be launched in May 2013.

Various sector plans are in place to address the challenge of early marriage, forced sex and unwanted pregnancies. For example, the Education Sector Plan aims to reduce Gender-Based Violence (GBV) in schools. The national teachers' code of conduct, which promotes zero tolerance to all forms of violence, contributes to this aim.

In relation to HIV, there is the Prevention and Control of HIV and AIDS Act (2007). This act provides for the prevention, management and control of HIV and AIDS, for the treatment, counselling, support and care of persons infected with, affected by or at risk of HIV and AIDS infection.

The MOHS is currently working on a revision of the laws regarding abortion in Sierra Leone. Abortion is currently illegal in Sierra Leone.

## 1.5 Reproductive health services in Sierra Leone

In Sierra Leone, health services are provided at all levels from the community to tertiary level. In the community, Community Health Workers (CHWs), including Traditional Birth Attendants (TBAs) provide preventive and curative primary health care services working closely with the three levels of Peripheral Health Units (PHUs): Maternal and Child Health Posts (MCHPs), Community Health Posts (CHPs) and Community Health Centre (CHCs). Secondary level services are provided in district hospitals and tertiary care in regional and national referral hospitals (Ministry of Health and Sanitation 2009).

In 2008, an Emergency Obstetric and Neonatal Care (EmONC) needs assessment was conducted which showed that most facilities do not qualify as Comprehensive Emergency Obstetric Care (CEmONC) services and just a few as Basic Emergency Obstetric and Neonatal Care (BEmONC) services (Ministry of Health and Sanitation Sierra Leone 2008a). A Facility Improvement Team (FIT) initiative is currently being undertaken to ensure there are 5 BEmONC and 1 CEmONC facilities functional in each district.

Access to health services has improved substantially since the launch in April 2010 of the Presidents' Free Health Care Initiative (FHCI) for pregnant and lactating women and children less than 5 years. Under this initiative, an increase of 45% was reported for institutional deliveries and a 31% increase in under-fives health facility attendance (MoHS, 2011). Antenatal care (ANC) coverage (1 visit) is high (93%) and the recommended 4 antenatal visits reported at almost 75% (SSL and UNICEF-SL 2011). Although institutional deliveries have increased, still only half of the women in the country use facilities for delivery services and 63% of all deliveries are assisted by skilled birth attendants (SBAs), the majority being Maternal and Child Health Aides (MCH Aides). Postnatal Care (PNC) coverage (first visit) coverage is encouraging with 50% within first 2 days (UNICEF 2010).

Marie Stopes Sierra Leone and the Planned Parenthood Association of Sierra Leone are increasing access to Family Planning (FP) services through outreach, with support from the UNFPA. The effort focuses on advocacy; service delivery through PHUs and various facility and community based supply of contraceptives and equipment; training for capacity building (for long-acting implants in particular); and information, education and

behaviour change communication (UNFPA 2011). Regarding reproductive health services for adolescents, these and other NGOs play a role in providing youth-friendly sexual and reproductive health services. The problem is that not all districts have these services available.

An important document describes the PHU norms and standards for adolescent health (Ministry of Health and Sanitation 2012). A basic package of interventions for adolescents and youth-friendly services should ensure that: staff members have the capacity to deliver services and show non-judgmental positive behaviour; youth are aware of the services that are available for them and the services should be at no or minimal cost; and youth-friendly health services should have special separate areas in clinics and have their own opening hours. The services, which should also be offered in outreach schemes, should include promotion of healthy growth and development, good nutrition and supervision of treatment and home-based care for HIV positive adolescents. Sexual and reproductive health (SRH) services should include education on reproductive health issues including birth spacing; family planning; promotion of condoms and oral contraceptives; referral of pregnant adolescents; ANC; promotion of abstinence if appropriate; awareness-creation and sensitisation about Voluntary Confidential Counseling and Testing (VCCT) and Prevention of Mother to Child Transmission (PMTCT) (Ministry of Health and Sanitation 2012).

## 1.6 Aim of this research

To ensure that both married and unmarried adolescents can protect themselves against pregnancy, it is important to combine the requirements for adolescent-friendly health services with interventions for the prevention of GBV in schools and the empowering community education interventions. The combination of these interventions will address the underlying factors of teenage pregnancy such as early marriage and lack of access to safe sex education and services.

This research was conducted to inform the development of an empowering community education intervention to be implemented in 4 communities in the north of Bo District, involving both young and older generation men and women. During this intervention, community members reflect on norms, values and practices regarding teenage pregnancy and maternal health needs. Norms, values and practices that the community would like to keep as they are and those that they want to be changed are identified. Conditions are discussed for making this change possible. The primary beneficiaries of the intervention are adolescents, young women and adult women of childbearing age living in rural communities with, in general, low socio-economic status, little education and limited economic opportunities. These primary beneficiaries, after going through the community education programme, will also act as agents of change within their communities. The implementation of the intervention started in September 2012 and results will be out in 2013.

The aim of this formative research was to develop an insight into how decisions are reached to have sex, get pregnant and get married and what the consequences. These insights will inform the interventions that would direct the participative community

education component. Our data are complementary to those from other research initiatives looking at teenage pregnancies in Sierra Leone. The value added is the qualitative data obtained that contextualise girls' choices and experiences regarding sexuality, life stories of teenage mothers, and circumstances and consequences for the teenage girl that becomes pregnant.





## 2 Objectives and methodology

### 2.1 Research objectives

This study had 2 specific objectives:

- Objective 1: To describe factors influencing early marriage and teenage pregnancy
- Objective 2: To document experiences of, and consequences for, girls who marry early and experience teenage pregnancy

### 2.2 Design, methods and respondents

This is an exploratory and descriptive study that used qualitative research methods. A research table containing a complete overview of objectives, issues, methods and respondents can be found in annex 1.

The study was carried out in 2 phases each with a specific aim:

- Phase 1: To develop case studies on teenage pregnancy to inform the development of the community education programme
- Phase 2: Baseline information for the community education programme

In-Depth Interviews (IDIs) were conducted with girls under 20 years of age; this included girls who were married and those who had become pregnant before 20 years of age.

Issues explored during the interviews were views and knowledge about: marriage, life expectations, personal and sexual relationships, sexual experiences, sexual violence in the community, contraceptives and STIs, HIV/AIDS and access to health information and services.

Key Informant Interviews (SSIs) were held with sowes and other influential societal women about the type of education girls receive during societal initiation, the perceptions of initiation as a road towards womanhood and the link between womanhood and the age of the girl during initiation. Other leaders and authoritative adults were interviewed about the roles, norms and values guiding the lives of boys and girls, the context of early marriage and the barriers to preventing pregnancy.

Focus Group Discussions (FGDs) with men, women and youth were conducted to explore attitudes related to SRH in the community towards early marriage, teenage pregnancy, male and female adolescent sexual and reproductive health needs, gender roles and norms and values.

## 2.3 Sampling and Recruitment

### *Selection of regions and study communities in phase 1*

In order to cover cultural, religious and geographical variations in the country, one study district was selected in 3 of the 4 regions of Sierra Leone (north, south and east). As information from the Western Area was available from a study conducted by GOAL, this region was used for field testing the study tools. The selection was based on district adolescent reproductive health indicators as reported in the validated standard tables of the Sierra Leone Multiple Indicator Cluster Survey 2010 (UNICEF Sierra Leone 2011). An overview of these indicators by district can be found in annex 2. The highest adolescent birth rate and delivery under 15 years of age is seen in Kambia, Moyamba and Kailahun and these were selected. Moyamba is geographically and culturally similar to Bo district and provided information used to develop the case studies that informed the intervention in Bo.



**Figure 1: Phase 1 study districts**  
(blue is phase 1 and red is phase 2)

The selection of the 6 study communities (2 in each district) was aimed to cover the diversity in attitudes towards early marriage, sexual violence, teenage pregnancy, traditional practices around pregnancy and childbirth, and access to services. Communities in both (semi) urban and rural settings were included in the study. In the selection of communities, adherence to and importance given to traditional values were considered. The choice of study communities was informed by knowledge obtained from project staff in primary health care units and from civil society organisations in the 3 study districts. who knew the district well.

### *Selection of communities in Bo, phase 2*

Phase 2 took place in Bo district where two chiefdoms were selected in the northern area of Bo District (Bo-North), the operational area of MRC. The selection was determined by proximity to the district headquarter town (Bo city): Chiefdom Niawa Lenga was chosen for its proximity to Bo Town and the chiefdom Komboya was chosen as a chiefdom more distant to Bo.

### *Criteria for the selection of girls for In-Depth Interviews (phase 1)*

Girls who were married and/or were pregnant before the age of 20 were purposely selected for IDIs. The intention was to ensure diversity in the following: religion, educational status, marital status, experiencing pregnancy, age of married girls, and wanted or unwanted pregnancies.

In phase 1, the purpose of the research was explained as research into the sexual and reproductive health needs of adolescents. After the girls were asked to take part in the study by a community member (mainly sows and Mummy Queens) or staff of a PHU

and agreed to be part of the study, the researchers requested individual consent from the girl. If the girl was younger than 15 years, she was asked to identify a trusted adult to give consent on her behalf, with the girl also giving assent. The IDIs were conducted at the health centre and the girls were invited by the nurse in charge.

#### ***Criteria for the selection of key informants (phases 1 and 2)***

The following types of respondents were selected for the key informant interviews (KIIs):

- Elderly (societal) women who were willing to talk about traditional education practices and norms and values guiding the lives of boys and girls
- Male and female adults (leaders and authoritative persons) who have good knowledge of existing opinions and values in the community and those who influence norms and practices in the community

Key informants included chiefs, Mammy Queens, sowes, TBAs, pastors and imams, village health/development committee or health management committee members. They were identified by health facility staff and staff of civil society organisations who know the community well.

#### ***Selection criteria for the Focus Group Discussions (FGDs)***

Boys and girls under 20 years of age were purposely selected for the youth FGDs to represent diversity in social backgrounds and current school attendance. Girls who were pregnant or had children were included in FGDs. Separate FGDs were held for girls and boys. PHU staff and community leaders purposely selected adult males and females (above 20 years) for FGDs to reflect varying views about a good age for marriage and adolescent sexual and reproductive health needs. In order to ensure that the FGD participants would speak freely, influential and powerful community members were not selected for participation. Separate FGDs were held for male and female community members.

For the FGDs and KIIs in 8 communities in Bo North (phase 2) the same criteria for selection of respondents were applied. The purpose of the research was introduced differently. The purpose was explained as a study into the perceptions, opinions and practices around needs of boys and girls related to teenage pregnancy, health, marriage and consequences of teenage pregnancy. The study would be used to inform the development of interventions to assist communities to prevent teenage pregnancy and improve maternal health.

#### ***Selection criteria for health facility staff and volunteers***

In addition, staff and volunteers from the health centre participating in FGDs and interviews were identified by the supervisors and recruited by the researchers. Older men and older women participating in the FGDs were recruited by community leaders and health workers.

Recruitment was carried out by the research team and consent was requested from all respondents.





## 2.4 Data collection and management

The data collectors were supervised in the field by the MRC Assistant Health Programme manager who functioned as field Research coordinator. A field protocol and overview forms that included all identification codes for each category of respondents per study site, names of interviewers, persons transcribing etc. were kept by the field research coordinator.

Interviews and FGDs were taped, transcribed and simultaneously translated into English. The field research coordinator checked the transcripts against the original tapes. All transcripts were checked by the MRC principal investigator and if there was doubt about some of the content the transcript was checked against the original tape-recorded interviews.

After the development of the coding framework, the coded transcripts were entered in Atlas-ti (electronic qualitative data management and analysis software) by two researchers and an inductive process of summarising the results to answer the objectives took place.

## 2.5 Data analysis

Data analysis took place during two in-country analysis workshops facilitated by 2 international facilitators experienced in qualitative analysis. Participants included most of the data collectors.

A coding framework was developed in two steps. Firstly, all data collectors read their own transcripts and presented the most important issues emerging from them. Secondly, all transcripts were read in small groups. During a plenary session, a coding scheme was developed based on the issues emerging from the first reading and the issues explored in the interviews and documented in the topic guides.

A second workshop was held with all stakeholders to present the data summaries from the preliminary analysis to validate the outcomes. Subsequently, analysis matrix sheets were used to analyse data across the various sites, and relevant data from various respondent groups and various data collection techniques were triangulated.

## 2.6 Quality assurance

The data collectors were selected based on their ability to facilitate group discussions and conduct individual interviews as well as their ability to speak Mende and/or Temne in addition to English and Krio. They received a four-day training consisting of introduction to the protocols and the techniques (including consent procedures), including role plays to simulate the various settings they would find themselves in, translation into local languages and a field trial. Topic guides were translated into local languages during one of the initial trainings, to ensure that the terminology used was focused on the intended issue.

The validity of the data was analysed using triangulation and ‘member checking’ (validation by stakeholders). The latter took place during a stakeholders’ workshop in December 2012 aimed at informing and disseminating the study’s preliminary findings.

## **2.7 Capacity strengthening and stakeholder involvement**

An important component of the research was the collaboration with researchers and research assistants from the University of Sierra Leone. Various training workshops were held to share expertise and develop skills in data collection and analysis, and on-the-job support was provided in order to carry out the field data collection and analysis. The knowledge, experience and skills of the individuals concerned provided valuable contributions during the whole research process and, at the same time, capacity building for everyone involved was done.

Three training workshops were held to:

- Develop and field-test the instruments and train data collectors
- Carry out preliminary analysis, including the introduction of the Atlas-ti analysis software
- Finalise data analysis

The following stakeholder workshops and meetings were held:

- Meetings with NGO and MOHS staff to identify priority interventions to address maternal/ reproductive health issues and gaps in research
- Dissemination and discussion of the final results and their implications

## **2.8 Ethical considerations**

Ethical approval was obtained from the Sierra Leone Ethics and Scientific Review Committee on 22 February 2012 and from the KIT Research Ethics Committee on June 5, 2012. In all cases, the data collection started after information about the study was provided. A standardised consent form was used to obtain permission/consent from the respondents.

No personal identifiers of respondents were recorded and all data were kept in a locked cupboard or on the computer that could only be accessed by the lead researchers.

The researchers arranged with the local health workers to refer respondents who needed more information and/or counselling after the interviews.

For adolescent girls below 15 years consent was obtained from their guardians combined with assent obtained from the girls.



## 2.9 Study limitations

The case studies of girls who experienced early marriage and teenage pregnancy provided in depth information from 3 different districts in the country. They can be accepted as representative for the country, within the boundaries of a qualitative research. The districts included were districts with the highest numbers of teenage pregnancy in the country. Selection included a variety of cultural, social and geographical factors. Special situations such as communities close to mining areas were not included in the selection.

Regarding the IDIs with young girls, the selection process could have led to bias. Our results show that most of the girl respondents who were married, were married because of a pregnancy. The sampling was designed to include girls who married early because they were sent into marriage by family. Despite efforts of researchers to identify these girls, most emerged as being married as a result of pregnancy.

The consent procedure included a statement that *if* during the interviews it emerged that the girl was at continued risk of abuse, she would be referred to appropriate services and confidentiality about her participation in the study may be broken. This might have affected the willingness of the girl to disclose on-going abuse. In addition the emphasis in recent years on prevention of sexually violence may have led to the ‘protection’ of teachers and other men of standing that girls had sex with, and led to under reporting. Also girls may have had a partner among their peers they attributed the pregnancy to and may have been ashamed to admit to having more than one partner.

## 3 Results

### 3.1 Presentation of findings

The results of the in-depth interviews with teenage girls are presented in case studies that illustrate common themes emerging from their experiences. The influencing factors within the wider social context were identified during FGDs and key informant interviews in their communities. During the analysis, experiences from case studies in a particular village were linked to information about norms, values and practices emerging from the FGDs and key informant interviews in that same village. Subsequently the circumstances were looked at in relation to all responses from FGDs and key informant interviews to identify how common these circumstances were. No issues emerged that were unique to only one community. The influencing factors are presented with a note on how common the emerging issues were in the study districts.

Response frequency is generally not reported, because this could be interpreted as proportions of responses which is not supported by the study's qualitative design using the following terms: 'a few' or 'some' for less than half, 'many' or 'a majority' for more than half and 'all' or 'almost all' for more than two thirds to indicate how common a response is. Numbers of responses are used illustratively to report the results of a few crosscutting issues.

The findings are presented under the following headings: number of interviews and characteristics of respondents, reasons for sex and early marriage, consequences of early pregnancy and marriage, sources and content of information on love, sex and marriage, knowledge of and access to contraceptives, gender norms and roles and other subjects.

### 3.2 Number of interviews and characteristics of respondents

In total 137 interviews and focus group discussions were conducted. Table 1 below shows the type of interviews carried by district and study phase.

During phase 1, a total of 73 interviews and focus group discussions were conducted in Kailahun, Moyamba and Kambia. In Bo-North, a total of 64 interviews and discussion groups were carried out during the second phase of the study. These interviews in Bo were conducted prior to the implementation of the community education programme.

A full overview of respondent characteristics can be found in annexes 4 and 5. In summary, almost all of the girls who were interviewed in-depth in Kailahun and Moyamba had started secondary school while only half in Kambia had done so. In general, diversity in religious affiliation was seen in Kailahun and Moyamba except for Kambia, as expected in a predominantly Fulla community all the girls reported being Muslims in Kambia.

**Table 1: Number of type of interviews by district and phase**

	PHASE 1			PHASE 2
	Kailahun	Moyamba	Kambia	Bo
IDI girls	12	12	12	0
FGD girls	2	2	2	8
FGD boys	2	2	2	8
KII elderly women	2	2	2	8
KII community members	4	2	5	8
KII health workers	2	4	2	8
FGD older women	0	0	0	8
FGD older men	0	0	0	8
FGD health workers	0	0	0	8
<b>TOTAL</b>	<b>24</b>	<b>24</b>	<b>25</b>	<b>64</b>

Most girls were or had been pregnant and reported becoming pregnant between 14 and 19 years old.

Almost all boys and girls participating in FGDs in Moyamba and Kambia had started secondary school. Kailahun and Bo had a greater diversity regarding educational level, with a majority of girls in the FGDs in Bo having none or only primary education.

### 3.3 Reasons for sex and early marriage

The reasons that young girls give for having sexual intercourse and for early marriage are discussed in this paragraph. These reasons relate to each other and they also relate to subjects discussed in sections 3.5 and 3.6 including: sources and content of information on love, sex and marriage and knowledge of and access to contraceptives.

#### 3.3.1 Reasons for having sex

As expected when interviewing girls with a teenage pregnancy as primary focus, almost all the girl respondents in the in-depth interviews were sexually active. The average age of sexual debut of the girls involved in the in-depth interviews was just short of 15 years with a range between 12-17 years (excluding one girl respondent who reported sexual abuse at the age of five).

The following case study is of a 12-year-old girl who speaks about her first sexual encounter with a 22-year-old man.

### **A 12-year-old girl who had sex because a man cared for her**

When I was 12, I was friends with a young man. This man was like a friend to me. He used to give me money every day. At that time my auntie was not taking care of me and my mother and father had died.

The man, who was not that old but older than me, he gave me money and then I ate. One day he called me to come inside the room. I had not started 'man's business' (sex) yet. He told me we were going to have sex. I said no, because I was afraid, but he said that I did not love him. I liked the man, that's why I agreed.

Afterwards I did not feel well. My body felt warm and then I started to lose weight. I did not tell my auntie. I was afraid she would beat me.

Various aspects emerge from this case study. From a human rights perspective, this young man is abusing a minor taking advantage of her vulnerable social and economic position. This case also demonstrate coercion: At first, the girl does not want to have sex but after convincing words from the man, she agrees.

### **Poverty**

Girls and boys learn at an early age the social norm that love and sex (love and sex are often seen as the same thing) are exchanged for money and care. The way a girl learns to take money from boyfriends is clearly articulated by a female key informant: '*...If I have a boyfriend then I call my daughter and tell her to go and take money from this man for me. She goes there and the man gives her the money and she will do the same in the future.*' (KII woman leader, Kambia)

The same was reported by some boys and girls during FGDs. A Muslim girl respondent who had never had sexual intercourse herself said: '*Some of them when their family does not hold (upkeep) them, they go to the street, they will go and take belle (get pregnant).*' (IDI girl, Kambia)

Money received is intended to be used for the upkeep of the girl or her family. Some school-going girls have sexual intercourse for money for food as reported by boy respondents: '*When they (teenage girls) leave here and go to X to go to school (away from the village), she will need money for lunch because she knows she is not near her parents. That gives her a reason to get involved into mami and daddy business (sex). Those girl children who go to the secondary school, they can be 10 in number in a small room without food. So some of them, when the night comes, they go out to find men.*' (FGD boys, Kailahun)

Some respondents reported that teachers ask girls to pay money for their exams and if they do not have the money, the teacher has sex with the girls so that '*they learn how to sex*'. Boys also spoke about the involvement of teachers: '*Yes sir, like in this school, if the parents cannot pay the school fees, they take the girl to the principal to take her and he will be paying*

*for her fees. The principal will impregnate the girl and he will not take care of her (the possible pregnancy).’* (FGD boys, Moyamba)

### **Coercion**

In-depth interviews with teenage girls revealed that the first sexual encounter was often a result of coercion by the man/boy. Two types of coercion were identified: 1) pressuring the girl using arguments until she finally agrees and 2) using violence (this topic is discussed later). Perceptions of gender roles could influence this cycle of pressure and agreement as the majority of respondents see the man as the decision maker whose decisions should be followed by women.

In most cases, the man/boy pressured the girl by saying that having sex was normal when there is ‘love’. In some cases when the girl disagreed, men increased pressure by referring to the girls’ physical readiness after having gone through initiation. The following quotes illustrate these reasons:

*‘It (sex) was never my own wish... I agreed because of love.’* (IDI girl, Kailahun)

*‘When I was 15 a young man forced me but I did not accept then he begged me, then I agreed.’*

*Why did you accept? ‘Because he begged me.’* (IDI girl, Moyamba)

*‘He begged me. I denied. So when he begged more, because I love him, I agreed.’* (IDI girl, Kailahun)

*‘When I was 15 a young man asked me to have sex with him. I did not want to, but he convinced me. He said I am a woman now after having gone through Bondo so I was ready.*

*He also said I will not die from sex; nobody does. He begged me and I did not want to, but said yes.’* (IDI girl, Moyamba)

Another form of coercion was mentioned in relation to the local dances that are held in most communities: *‘Like the dance which they have today, when we girls go there, and we don’t have money to enter that dance, we stand at the gate then a boy will tell us to feel free; so they buy us drinks, rum, but it’s not for free. They give us rum to drink until we are drunk then they take us to their home and have sex with us. Sometimes, some girls, it will be their first time to sex, so they learn that night how to sex.’* (FGD girls, Bo)

### **The desire for material goods**

When asked about what worries adolescents, the desire for material goods was answered most frequently. Besides sex in exchange for money (for upkeep) sex in exchange for material goods is widespread as demonstrated by the following quotes:

*‘The first thing that worries girls are the new fashion dresses, more so when you want new shoes and you can’t afford it, and you have seen your friend has bought one, you will go for it, and that will lead one to sex for it and buy the desired shoes you want.’* (FGD girls, Kambia)

*‘If we are now having sports, my mother cannot buy slippers for me, I will go to a man (to have sex) so he buys it for me. If my companion has dirty jeans, and I also want to have it, I will go to a man who can buy it for me.’* (FGD girls, Kailahun)

*‘When I was 12 years old I had sex for the first time. My parents were not close to me and I was hungry. So one day I thought I go to this man who has money and he gave me 2,000 Leones for food and a drink. There are other men too and sometimes they will even buy a dress for me.’* (IDI girl, Kambia).

<sup>2</sup> This refers to initiation rites in the traditional Bondo society

*'It's for dressing, when girls see their friends who dress fashionably, or has cosmetic skin or eat good food. The girl too will want it at the end she will go and have a boyfriend, which leads to early pregnancy.'* (FGD girls, Bo)

*'Why we get sexual intercourse is because he gives me anything I want.'* (FGD girls, Moyamba)

In relation to receiving material goods, girls spoke about older men as well as boys. Boys sometimes mentioned this competition between themselves and older men who generally had more money to spend on the girl: *'I had a girlfriend, but because I do not have money someone took her away from me.... When you do not have money they will not like you.'* (FGD boys, Kambia)

Some boys saw this as a reason to work hard to find money somewhere.

### **Peer pressure**

Peer pressure was mentioned by key informants as a factor leading to sex between young people. Boys and girls themselves also mention peer pressure as an important factor leading to sex. The peer pressure can be connected with the desire for material goods, but also with the 'image' of having a boyfriend or girlfriend.

*'Well, like girls make friends with their fellow girls who are involved in love with men. If the other is not involved in any relationship with a man and sees her friend who is in love with a man, and that man buys mobile phone for her that will influence the other girl to enter love relationship with men.'* (FGD male adults, Bo)

Many girls reported that peer pressure is playing a role in the decision to get pregnant:

*'I get information about pregnancy from my friends, because when my friend gets pregnant, she will come to tell me. Then when I see her with the pregnancy I also fall for it then I go to X (a boy) and so he will impregnate me.'* (FGD girls, Moyamba)

*'For me, I was having a friend, she got pregnant and gave birth to a beautiful child, and then I said I want to get pregnant and give birth to a beautiful child. Then at night I used to go to men until I got pregnant.'* (FGD girls, Moyamba)

*'Some boys when they see their companion, they bluff with their child... Like we women, as I am sitting now, this one has a child and I do not have, when we sit together, she bluffs with the child.'*

During an FGD, girls reported that peer pressure regarding impregnating a girl can be a factor playing a role for boys: *'When he sees his companion impregnated a woman, he too will go and impregnate a woman.'* (FGD girls, Kailahun)

### **Family involvement**

Family may play a role for a girl to have sex and marry. Some women encourage their daughters to have a boyfriend often for the extra income this brings with it. A number of girls related stories about their own family members playing a large role in convincing them to have sexual intercourse. It is not clear if the family members receive something from the men to do this.

*'It is the same. Some women encourage their daughter to keep boyfriends. They even collect money like, one thousand Leones from the men. This they will do until the girl gets pregnant and they send her in to marriage.'* (FGD male adults, Bo)

*'We met in town and he told me that he wants me, but I said I don't want him. The other day again, he came and told my sister.. then my sister told me that he said he wants you and I told my sister that I don't want him. Then my sister told me to agree and I agreed.'* (IDI girl, Kailahun)

Family may also play a role in influencing girls not to initiate sex at an early age. Some girls told of how their mothers openly advise them and encourage the girls to come to their mothers for help (financial) instead of engaging in sex: *'My mother tells me to ask her for money any time I am going to school. She will tell me not to go to men for money or have sex.'* (FDG girls, Bo); *'My mother tells me not to sex and if I need money let me ask her, she will give it to me.'* (FGD girls, Bo)

### **Sexual violence**

Sexual violence was reported as the reason for sexual intercourse by some girls. The following quote is from one girl who openly spoke about her experience with sexual violence:

*'When I was 15 years old I was going to fetch water. This boy was watching me and came after me. I was fighting with him but he got on top of me and he had his way with me... He forced me... because he was matured and I was not.'* (IDI girl, Kailahun)

As previously mentioned, most girl respondents interchange the words love and sex and this is also the case after sexual violence. *'That time I went to fetch water, then he pushed me down the hill. When I fell he came on top of me and sexed me. I shouted, but he held my mouth.'* *'Were both of you in love? I did not just love, except when he did that then we loved.'* (IDI girl, Moyamba)

During FGDs girls were very vocal about cases of rape in their communities:

*'One Pa, his case was at the Barry he went and raped one five (5) years old child... the child's mother left her with the man to take care until he is back from the bush. So when she returned now she was crying, and bleeding. Then she asked the girl who did that to her. Then the child said is that Pa who fingered me. The child, the mother, the father and the Pa were brought here they are in court.'* (FGD girls, Kailahun)

*'Yes it (rape) is happening... Like how a big man forces the girl and tell them let go and sex with force... Some when they went to fetch fire wood in the bush there they rape them.'* (FDG girls, Kambia)

### **Pleasure**

A few girls spoke openly about their own sexuality and needs, although these were exceptions.

*'It's the man who first told me to have sex, but now some days even if I have the feeling I will tell him that I need him and I will call him and say let us meet and get sex.'* (IDI girl, Kambia)

### **3.3.2 Reasons for early marriage**

Less than a quarter of the girl respondents were reported as being 'officially' married but many more were in some sort of union and living with the families of the impregnators. This study found two major reasons for early marriage: pregnancy and poverty. The parents or family members play a big role. In the case of pregnancy, they send the daughter to the family of the impregnator who take on the financial responsibility for the girl. In the case of marriage because of poverty, the marriage is arranged by the parents.

### Pregnancy as a reason for marriage<sup>3</sup>

Of the total number of girls in this study, 82% were pregnant or had been pregnant (N=31). In almost all cases, the pregnancy was a reason for marriage. Only 2 girls reported a marriage before they were pregnant.

The following case study is about an 18 years old Christian girl who became pregnant when she was 16 years old.

#### Pregnancy as a reason for marriage

At that time, I was going to school and staying with my aunt. A business boy used to visit us at home. After a while, a friend of him told me that the boy loved me, but I answered I didn't want him.

He kept on asking to have sexual intercourse, but I said no, I have never done it, and then he convinced me till we had sex. He promised me to pay my school fees till I finish school.

When I got pregnant I told him and he told me not to abort it, but to give birth to the baby. So my parents called him and asked him, then he answered for the pregnancy. So he was responsible for the pregnancy till I gave birth and until now I'm staying with him.

When I was four months pregnant, we got married (Calabash marriage). My mother, aunt and uncle arranged the marriage and my husband paid them all school fees that they have spent for my education so far.

Pregnancy as a reason for marriage is also illustrated by the following quotes:

- *In this town, a child will not get married until she gets pregnant. When she gets pregnant, her mother pushes her saying: go to your husband.*' (FGD girls, Kailahun)
- *At what age do girls marry? 'Some if they see that they have got pregnant now.'* (KII, female leader, Kambia)
- *'It's sex that makes them to marry at a small age.'* (SII community leader, Kambia)
- *'.. When they go to X (chiefdom headquarter town) to attend school when coming back we just see them coming with a protruded stomach, pregnancy. If I don't have money to send her to clinic, I will ask her to show the man. Then they can push her to the man. That is how marriage comes about.'* (FGD female adults, Bo)

When a girl becomes pregnant, this can result in a marriage or living in union (with or without formal or traditional ceremonies) but this is not always the case. Girls consider themselves married when the man recognises the pregnancy as his.

*'The marriages now are not real marriage because we give ourselves to men and this is as a marriage (because they have sex and get pregnant).'*' (FGD girls, Moyamba)

<sup>3</sup> The term marriage could refer to an official ceremony (civil or religious) or living in union with or without a traditional ceremony ('calabash marriage'). In this study, girls consider themselves married and use this term when the impregnator recognises the pregnancy.



### Poverty as a reason for marriage

Many respondents reported that a girl can be ‘married off’, because the family wants to generate money. An unmarried girl costs money (school fees/ food). If a girl is married, all expenses will be borne by the husband. In addition a girl who does not go to school may also not contribute to the household. One girl described her own situation as: *‘I was sitting without doing anything to my parents so I decided to marry.’* (IDI girl, Moyamba)

The following case study is a story of a 16-year-old Muslim girl in Kambia who married when she was 15 years old and became pregnant when she was 16 years old.

### Marriage as a ‘financial relief’ for parents

I was in school but couldn’t pay my lunch. There was this man that was doing everything for me and I told my parents that I’m leaving school and get married to this man. My parents couldn’t help me; the man was the only one standing by me.

So the parents of the man asked my parents. My parents were happy about it. They said that they agreed, because they cannot afford to do anything for me so if you are going to care for my daughter, you can go ahead.

There was another case of a girl who got married (before getting pregnant) to end the family quarrel between her mother and her stepfather who did not want to pay for her education because her cleverness would only reflect on her birth father and not on him. In order to leave home, her only option was to get married: *‘My mother’s husband was not my real father when I came from school he punishes me because he did not give birth to me. If I educate I will only benefit my own father, so in the evening when my mother comes he shouted at her so I decided to leave school and get married. This is why I left school. So because he shouted at my mother that is why I left school.’* (IDI girl, Moyamba).

Girls have an economic value to families and this is often a motivation for families to marry their girl children off as demonstrated by the following:

*‘All depends on the poverty in the family when a girl has grown up and fully matured, the father of the girl will say let me give my child to a man so that there will be money in the house. Again most of the girls when their parents sent them in school they will not learn, but to involve in sex life. So when their fathers hear that report, sooner the girl comes on holiday the father will say before you waste my money and strain my effort, I am going to give you to a man.’* (FGD boys, Bo)

*‘It’s for poverty, if a man has come to the parent and say I want this your child because this man is doing some good to them, then they will agree and force their child to the man without getting the consent of the girl.’* (FGD girls, Bo)

For some parents, power and influence are reasons for sending daughters into marriage: *'For example, this Paramount Chief here, the parents will marry a girl to him because they want to have a saying in that house; they want power even if the girls do not want the chief. So as a result, this is how they marry. Sometimes it's because of land issue, some will marry their daughters to land owners, they force those girls to get married into those families to get land.'* (SSI health worker, Moyamba)

There seems to be a perception that a young girl is ready for sex and marriage at a young age, *'The ages some girls marry in this community are 13, 14, 15'* (FGD girls, Kambia)  
*'According to this town a girl will be 13, 12 years when her parents give them to marry... I have known one of 10 years... Before they get an early pregnancy, we prefer to send them to their married homes'* (FGD boys, Kambia)  
*'The least age they marry is 12... If the parents of the girl do not have money and the girl has a boyfriend who gives her two thousand for a day, every day... The girl will go there... then the man impregnates her' ... The parent will not be annoyed because they have the feeling he will marry the child'* (FGD boys, Kambia)

The social norm that husbands are financially responsible for their wives is widespread. In answer to the question: When you get married what will the woman expect from you? The boys in a FGD stated:

*'The woman will expect that you give her anything she needs like money.'* (FGD boys, Kambia)

### 3.4 Consequences of early pregnancy and marriage

In all communities, teenage pregnancy was associated with negative consequences for the girls themselves and for the boys and their families who assume responsibility for her.

#### 3.4.1 Consequences for the girl

##### **Pregnancy as a risk to the health of young girls**

The consequence most mentioned (by all respondents) was the health risk to the young pregnant girl, especially the risk of complications during delivery which could result in her death:

*'It will affect them (pregnant young girls) in many ways, at times the girl will not be able to deliver for herself. If her parent does not have money to do operation the girl will die.'* (KII community leader, Bo)

*'If a woman has not reached the age to marry and gets married, when she gets pregnant she would not be able to deliver all by herself except they have to undergo operation.'* (FGD boys, Bo)

*'Yes, when a girl is small then enters into marriage, most times when it is time for them to give birth they can't survive it. Or even if she gives birth, it will leave her with a problem.'* (FGD male adults, Bo)

*'.. If she is not yet mature her hips will be small and that makes it difficult for her to deliver.'* (FGD female adults, Bo)

*'The reason why we don't allow our child to remain small and get marriage is that when a child is small and give her to a man it becomes a big problem. When she gets pregnant, even to deliver for herself she cannot, except they take her to the hospital to be operated upon. So that is why we do not allow our child to remain small and gets marriage.'* (FGD male adults, Bo)

One girl even mentioned the risk of fistula:

*'I heard that when you marry early and get pregnant you will not deliver safely. This will affect the vagina and they will get this sickness where the faeces and urine out through the vagina (meaning fistula).'* (FGD girls, Bo)

### **Abortion**

One health worker revealed that there was a risk that young girls would seek to terminate the pregnancy and put themselves at risk:

*'For some they will not want their parent to know so they will decide to abort it in the process the girl will die.'* (FGD health workers, Bo)

*'Some can be discouraged, some can even attempt to abort it, and when she attempts to abort it they die in the process. It has happened in this town, two of the girls died.'* (FGD boys, Kailahun)

*'How do you call them? The traditional healers. They give the girl traditional medicine to drink to destroy the pregnancy. But at times some die in the process.'* (FDG boys, Moyamba)

Some of the girls in the in-depth interviews shared their experience with abortion or attempts at abortion. Out of the 31 girl respondents who had experienced a pregnancy, 4 reported having attempted an abortion, of whom one was successful. Friends and/or relatives often advise girls to undergo abortion. Many of the impregnators advised against abortion and tell the girls not to do it. Abortion was an issue talked about in almost all communities.

*'When I met them at the corner when they talked about me...they (my fellow school girls) said if it was them they will abort the pregnancy; they tempted me but I said I will not do it.'* (IDI girl, Moyamba)

*'Some they do abortion .... when their friends get pregnant they will called them and say if you want to do abortion this is what you should do.'* (FGD girls, Kambia)

*'When I tell him (father of the baby) that I am pregnant from him, then he said okay, he wanted to go and see my parents but I have stopped him saying that let him wait till my parent know about it....'* Interviewer: But did you want this pregnancy? *'Well I tried but it did not abort.... I drank those traditional medicines ... They sell it in the market and tell you how to take them. .. but nothing happened to me.'* (IDI girl, Kambia)

*'So I went and told him (father of the baby) that I am pregnant, and then he asked me how many months then I said two months. So he advised me not to abort it and that when my parents ask me to tell them that he will answer. So I said ok.'* (IDI, Girl Kailahun)

One community leader was clearly aware of the dangers of abortion: *'the dangerous part is that it can lead them to early death'..... 'Because some commit abortion, you know.'* (KII community leader, Kailahun)

### **Social consequences for the girl**

When a young girl gets pregnant, the social and other consequences reported in the interviews and FDGs differed from case to case. Consequences depended on the reaction of the impregnator: he can accept the pregnancy and he can deny the pregnancy. In the case of acceptance, the impregnator can take responsibility for the care and upkeep of the girl (and later the child) or not, which also has a big influence on the girl. In addition, reactions of family, friends and others also influence the well-being of the girl. The diagram in figure 2 on page 71 visualises the various scenarios identified.

#### **Social consequence scenario 1: School drop-out**

All the school-going girl respondents who became pregnant had left school. Almost all of them voiced the intention of returning to school and counted on support from the impregnator or family, as promised. A chief in Moyamba reported that only 5% of the girls are able to return to school and the rest dropped out.

The following case study from Kailahun shows the determination some girls have about going back to school and the support to do this.

#### **An 18-year-old girl, pregnant for the second time**

When I was 16 years old, I got pregnant for the first time. I attempted to abort it, because of the words my companions were telling me. I tried, but I was unable. It was the country medicine that they gave me, the yellow one. The parents of the impregnator begged us not to take it into court, they promised to be responsible and they were. After delivery, I got back to school.

Right now, I'm pregnant for the second time from the same man. I dropped out of school. I was in form 2. In the beginning of my pregnancy, the man had another girlfriend who I was beating up, so she went away. I summoned the man Le 5,000 for not feeding me. I'm staying with my mother now and the man is taking care of me and the child. He gives money from the work at the palm oil farm where he works, he also left school. I expect to go back to school when this baby walks. My father won't pay my school fees anymore. I expect my man to pay, as he also sent me back to school the first time.

All respondents see education for girls as very important. *'Because when the girl child learns, she will remember the family. But the boy child, he will not remember his family. He will just go to another side.'* (IDI girl, Kambia)

*'... they always say boys when they grow up they take away money, but when the girl educated, she helps the family.'* (FGD boys, Moyamba)

*'I will continue with school, so that tomorrow nobody will bluff me with education.'* (IDI girl, Kambia)

#### **Social consequence: scenario 2: fatherhood acknowledged**

In many cases, when a girl becomes pregnant, the family of the girl discusses with the family of the impregnator (either with or without intervening of police or a chief or another authority, which was always initiated by the family of the girl) with the aim

that the care and upkeep of the girl and later the child becomes the responsibility of the impregnator or the family of the impregnator. In the majority of cases, the girl is moved out of the parental house to live with the family of the impregnator and be cared for. An official or unofficial marriage can take place, but this was not always the case. Some girls return to their parental home after they have delivered.

### **A 17-year-old girl with her child living with ‘the family-in-law’**

I met my boyfriend in Freetown. When I became pregnant, we came to the village and told the parents of the man. Then the parents of the man had to go to my parents to say they are here to marry me. Then they had to give some money. And they agreed that I had to transfer up there.

Now, I’m living there (at the house of the man’s family) and I get support from my own mother, the grandmother of the child (the mother-in-law) and my husband. They treat me well. Sometimes I do the cooking and at times my mother-in-law does it. I don’t want to go back to school again. My husband left for the city when I was four months pregnant. Since I delivered he didn’t come back.

This case study shows the way how people treat young girls who get pregnant while they are not married. In some cases, the girl will go back to live with her own family, but there is most of the cases an agreement between families on the upkeep of the girl and her (future) child.

One girl from a FGD (Kambia) summarised it in this way:

‘The boy child, if he impregnates, his parents have to do the spending, like to pay the girl’s school fees and other things and when the girl child gets pregnant, she had to go out.’

An imam said:

*‘... The family of the girl will take money from him (the impregnator). After that they will say just as you impregnate you have to put money for her and come and marry her.’* (KII community leader, Kambia)

If the (family of) the impregnator didn’t give any money, the girl’s family sometimes went to the police and the Family Support Unit (FSU) that is part of the police services:

*‘Say the man who impregnated my child he did not take care, if they did not give them anything, then it’s the chiefs who will say to go to the police.’* (KII elderly woman, Kambia)

When boys deny paternity (some of them even run away to Liberia or Guinea, or to a town far away to be able to attend school there), the parents of the girl will have to take care of the girl and bear the extra financial burden:

*‘It is difficult for us parents because the boy who impregnates will deny and we take up the responsibility of the child.’* (FGD female adults, Bo)

Sometimes, the family takes the girl back:

*‘Some of them (the family of the girl), when they like their child, they will say they would not want their child to suffer. After the family (of the boy) has taken care of the girl till she delivered, some of the parents of the girl will make a case with the boy’s family. If at all they did not take care, the girl’s parents will take care of their child.’* (SSI health worker, Kambia)

From the interviews in this study, it appears that most of the boys (impregnators) ‘answer’ to the pregnancy (recognise it). This was confirmed during a FGD with girls in Moyamba: *‘Some will take care, some will not, those who answer are in the majority.’*

### **Maltreatment and low social position**

Boys recognised poor treatment of young married girls by the following quote:

*‘It affects some (young pregnant girls) when some of them (husbands) they maltreat them when they marry.’ (FGD boys, Bo)*

Another consequence noted was that girls would suffer if the husband would not take care of her properly and she could suffer hunger, poor living conditions (a low position and serving the family- in-law) and even have her husband leaving or beating her:

*‘When she gets pregnant it affects them, as they don’t have a man to be responsible, then they strain. Like when she is pregnant she goes to the farm and carries heavy load which is not good for her.’ (FGD boys, Moyamba)*

### **Shame and gossip**

The issue of money and upkeep of the pregnant girl played a role everywhere, but sometimes shame was also a reason for driving a pregnant girl from the parental home:

*‘(When a girl is pregnant and not married) results in disrespect to your family and you will be driven from home, because you have brought shame and disgrace to the family.’ (FGD girls, Kambia)*

Some key informants said that said families can abandon a girl to the street but more common to the man:

*‘The one that is common is when a child is pregnant you send her to the street.’ (KII, elderly woman, Western Area). When a girl is pregnant and not married ‘They abandon the girl to the man’ (SSI health worker, Moyamba)*

The following quotes and case study show that the community can have a large effect on the girl’s feelings, because of gossip.

The shame and gossip seems to be less when a boy answers for the pregnancy, because then the financial and support issues are solved (at least by agreement).

*‘It is disgraceful, because she is not married and perhaps the man will not answer for the pregnancy. If the man doesn’t answer, then the girl will suffer and everybody will talk about her. That’s what happens in this community. Again it is not good, because there should be a man who is responsible for the pregnancy. If not, the girl will suffer.’ (FGD girls, Moyamba)*

*‘Some (people from the community) will come to see you when you are in labour. They want to know if your husband bought things for the baby or not. Instead of helping you they will go out and start talking about you.’ (FGD girls, Moyamba)*

### **An 18-year-old girl driven away from the parental home after the case was settled**

When I got pregnant, my family wanted to take the impregnator to court. Then the family of the boy begged, because his father just died when I got pregnant. Then my grandmother (I stay with her) told them when I deliver and the baby walks, they will be responsible for my schooling. They said yes.

The people were talking about me. They said 'look at that child who is pregnant'. I felt very bad. My friend advised to abort the pregnancy. My mother wanted to drive me away, she shouted at me. My father said he is not the one that gave birth to me this world and next world; if he dies I should not go there, if I go there his sin will be on me.

People didn't say any bad things about my man. They only said his father has just died and he has impregnated. As long as he answered, he is the one that is taking the responsibility, not them, so they stopped to talk about him.

People were talking about my grandmother. They said it's for Le 5,000 some old women have allowed her child to get pregnant. My grandmother stood up and said she will not give her child out for Le 5,000.

### **Scenario 3: Fatherhood is not acknowledged**

The following case study from Kailahun demonstrates the stigma that girls experience when the pregnancy is not recognised.

### **A 19-year-old pregnant girl, sent away from the parental home with no support from impregnator**

My first pregnancy was at 14 years, but I aborted it, because of the age and the class I was in. Now I'm pregnant again and my parents told me to abort it, but I said no because of the first one, I don't know which problem it can give me again in my life. I decided to come and stay to my grandma, because my parents were so vexed with me.

Since I have come here, the man hasn't come yet, there is no communication. My grandmother provides food for me. I have support from an organisation from Freetown, I don't know how they call them. They give us business to do so that we can forget about too much of boys and girls business and go back to school later.

It is clear from the data in this study, that there is generally a negative connotation towards young girls becoming pregnant without being married. Respondents mentioned that it is not good to 'go roaming around' and 'become pregnant from the street' (FGD girls, Bo) and the young girl's future is spoiled (with school drop-out and poverty and a low social position at household level).

*'They will say she did not listen to her parents, that is why she is pregnant and we will call her a kolonko (prostitute).'* (FGD girls, Bo)

The reaction of the impregnator can also be based on this view on girls 'roaming around': *'Some will admit, others will come with all sorts of excuses that he had seen you with another man and therefore he can't accept that he is the father of the child, I have seen that happening in our community.'* (FGD girls Kambia)

Girls admitted this problem themselves, For example, one girl of a FGD recognised this: *'... Right now if your mother continues talking to you should not go after men, but you fail to listen and you do not go out with one person but when you see this one, you go with him, and when you see the other one, you want to love him. When you get pregnant and you point one of them (as the impregnator), he will say I'm not the one and his father and mother can force him to agree.'* (FGD girls Kailahun)

In Kailahun, one girl noted how happy her mother was when she became pregnant because it gave her a goal in life. *'They were happy, because at that time I was just roaming, not going to school, not doing any work. I was not married, so when my mother heard that I was pregnant, she became happy, saying that my daughter is serious now.'* (IDI girl, Kailahun)

Community respondents as well as girl respondents mention that besides talking about the girl (who becomes pregnant) the community has strong views about her parents:

*'The family of the child will be very much disrespected, because they will tell you that you don't even know how to take care of a child.'* (FGD male adults Bo)

*'Some people will say the parents did not take care of the girl properly, because they allowed her to go to disco dance.'* (FGD girls, Bo)

The economic value of girls was previously mentioned in relation to pregnancy. In some cases, girls are also seen as having a degree of economic value when they are given to a (financially) good marriage. This is lost when the girl becomes pregnant and a reason for lament by some parents.

*'Well, when a woman gets pregnant and we are not the ones who gave her to a man we can just bear it but it breaks our hearts so much..., because a girl child when she grows up if you want to a rich man to come for her hand in marriage, is like a business you are doing, so if another man come and grip her, it will just appear like when you are passing with your market and then someone comes and take it and tear it apart, that is tantamount to stealing. You can never be happy for such a person, so anybody who tampers with our girl child when it is not an arrangement between us and him when he impregnate her it causes a broken heart for us.'* (FGD male adults, Bo)

There is a clear difference in how respondents view pregnancy for married and unmarried girls:

*'Except if the child is not married, then she becomes a laughing stock. But if she is married and gets pregnant it brings happiness to the husband and the family because they are starting their own family.'* (FGD male adults, Bo)

### **3.4.2 Social consequence: Consequences for the impregnator**

From the above, it is clear that a girl's pregnancy can have large consequences for the impregnator.



### **Financial consequences for the (family of) the impregnator**

From all interviews and FGDs, it emerged that there were almost always (financial) consequences for the impregnator or the family of the impregnator (when the impregnator is young and can't take the responsibility). There are several scenarios identified for the families of the impregnator, depending on agreements between the 2 families:

Some will have to pay an agreed amount of money to the family of the pregnant girl

Some will have to pay money for upkeep of the girl (during pregnancy and for the first years of the child)

Some will have to pay back the costs made for all years that the girl has been in school

Some will have to pay the continuation of the girl's education after delivery

Some boys will have to marry the girl

Some boys or families of the boys will take the girl up in their homes

There are (local) laws in place that determine who should care for the pregnant girl until she delivers and which penalties or sanctions are enforced. This is particularly the case when the impregnator does not accept the pregnancy as his responsibility.

*'We will ask the girl about the man who impregnated you, if the girl shows, we will report the man... to the chiefs, then the chief will ask the girl's family to go to Bo... the police will ask the man and gives the girl to him till the girl deliver.'* (FGD female adults, Bo)

*'That law was there but for now we have another law, a by-law, which shows a stipulated amount of money for the man to pay and is that money the girl will use till she deliver.'* (FGD boys, Bo)

### **School interruption**

As already stated, a schoolboy who impregnates a girl can face problems in continuing his education.

*'Some of the parents become annoyed, sometimes they go to the school and report to the principal. The school itself will take action: the boy will sit (=leave school) till the girl delivers. Then, the relative of the boy will have to take responsibility to put the girl back in school.'* (SSI health worker, Kambia)

*'The boy will seat till the time the girl delivers and the girl begins to go to school, then the boy will begin to go to school.'* (SSI community leader, Kambia)

*'... When we come back home, our parents tell us that they cannot send us back to school because of the money they have spent on you. That they have spent the money in the case.'* (FGD boys, Kailahun)

*'Well, at some times some elders and the chief will take action against the boy. There is a law that if a young boy impregnates a girl, both will sit until the girl gives birth, before they both return to school.'* (FGD boys, Moyamba)

*'The girl's parents will report to the chiefs. So the boy will be responsible or he will be asked to stay out of school until the girl gives birth before he continues his education.'* (FGD female adults)

Respondents noted that the law is not always enforced equally or not enforced at all:

*'There was a case when a boy impregnated a girl and was taken out of school and even rusticated from this town, but when the chief's son impregnated a woman, he was not taken out of school and he is still here attending school.'* (FGD health workers, Bo)

When asked by the moderator, if these laws were effective, one boy responded 'no sir' while laughing, implying that boys did not seem intimidated by this law. (FDG boys, Bo)

### **Social consequence: pressure to take responsibility, but no blame**

Boys who impregnate a young girl, and who are often still in school themselves, are sometimes ‘punished’ (having to pay or leaving school) and are talked about by the community. From the interviews, it appears that comparison to the girls, the boys are blamed less for the ‘roaming around’ and impregnating before marriage. Boys generally said that it was not good to impregnate girls but referred to the consequences for themselves more than to the actual deed. Although the shame seems to be less, there is a social consequence for the impregnating boy: the pressure to take responsibility (accepting the pregnancy and taking financially care of it).

### **Social consequence: perceptions about the impregnators**

Some boys were proud about impregnating a girl. *‘He (the impregnator) will be happy and tell his friends at school that he will soon have a child.’* (FGD boys, Moyamba)

Some girls in the FGDs observe that boys can be proud of impregnating a girl: *‘Like for some man they will happy and say they too have impregnated a woman.’* (FGD girls, Kambia)

According to the respondents, the true impregnator is not always the impregnator that assumes the responsibility for the pregnancy. This does not seem to be a problem as long as someone assumes the responsibility.

*‘... The girl gets pregnant, the teacher will tell her to show the student. The teachers will give false evidence against you that you impregnated the girl, and the burden will be on your parents.’* (FGD boys, Moyamba)

*‘... Boys impregnate girls and they deny, then you sit at home. Except another man comes and accepts that he impregnated you and then he marries you.’* (FGD girls, Moyamba)

### **Judicial consequences for the impregnator**

Although in most of the cases, the family of the pregnant girl and the family of the impregnator negotiate a compromise solution, in some cases, there are judicial consequences for older men who impregnate girls (often a money fine, see above) or for young boys who do not answer to a pregnancy. One boy reported that boys can be misled and forced to answer to a pregnancy:

*‘The parents come with the case to the police at the family Support Unit... When they notice that you impregnate a girl, they lock you up or even if you deny that you are not the one, they will lock you up again and after some time they take you out and interview you again, until you agree. As long as the child has named you, even if you are not the one who impregnated her, if it’s you that she wants and has shown you, they are going to treat you.’* (FGD boys, Kailahun)

## **3.5 Sources and content of information on love, sex and marriage**

### **3.5.1 Sources of information on love, sex and marriage**

Many sources of information on love, sex and marriage were identified by respondents.

#### **Film and dance**

In most communities, respondents reported that girls and boys get information on love and sex from (pornographic, love, blue) films / videos.

*'Most times they learn about it (sex) through the video. When there is a video show they (boys and girls) pay and watch. There are some films that show sexual intercourse, when they see it, that is what they practise when they return home.'* (KII imam, Bo)

*'When a girl child begins to have sex, she gets the information from the film. When a film is playing a lot of things are exposed. When a man says he want her she is going to agree because she has seen it in a film she too is going to practise it.'* (FGD adult women Bo)

*'... If fact this town likes much enjoyment. When the principal came here, he stipulated a law that no girl should go on a disco dance or show. As a result of this, the parents and whole community rose against him. So, meaning the parents are the ones encouraging their girl child to enter in such a life.'* (SSI Health Worker, Moyamba)

### **Observation and 'learning by doing'**

Observation and imitation were reported to be important for young people regarding learning about love and sex. Mainly key informants and older men and women and some boys in FDGs commented on parents and family members that are watched and serve as (un)intended example for young people. Especially the parents are mentioned as a source of information about sex:

*'It's through our parents, when they all sleep in the same room. They see their parents at night what they do so they copy from them.'* (FGD boys, Bo)

*'Teenagers learn about sex when they sleep in the same room with their parents. They see them at night when having sex, so they learn.'* (FGD adult women, Bo)

Brothers and sisters can also be important sources of observation and information:

*'For instance you are a small boy and your brother has a lover, he sends you to go and call the woman, from there you too can learn.'* (FGD male adults, Bo)

Girls and other respondents report that girls learn about sex from boys and men. This was described by various respondents as the experience between boys and girls 'in the room'.

*'Yes, when we enter the room and have sex with boys that is how we learn about love.'*

*'When we are in love we have sex with men. We get pregnant the man will come and marry us.'* (FGD girls, Bo)

*'Some women when you keep them as friends they will teach you how to go about sex while some men to teach a woman how to take care of herself.'* (FGD girls, Moyamba)

*'I got to know about sex from the man who deflowered me. He is the same man to whom I am married.'* (FGD girls, Bo)

Some boys reported that they learned about sex from girls. *'It is particularly from girls that we learn about sex, when they gather and discuss about it. So we meet them to teach us about sex, when they lay down we do sex that is how we get used to it.'* (FGD boys, Bo)

*'According to me when I sit with the girl child we play and they tell me about love when they want a man how will you capture him, how to get a woman's feeling.'* (FGD boys, Kambia)

### **School, NGOs and the health centre**

School and NGOs were reported to be another important source of information. In most communities, boys and girls reported getting information from the biology teacher and from NGOs such as Restless Development (formerly Student Partnership Worldwide), CORD, MRC, Marie Stopes, Red Cross (depending on the area).

Health workers report that there are NGOs coming to the village to talk about family planning:

*'Yes, they come, display pictures to educate people on how to plan their family and give birth to few children.'* (SSI Health Worker, Bo)

### **Information from elders**

Many respondents reported that young people get information on their roles in marriage from their elders.

### **Male and female secret societies**

Secret societies exist in which girls and boys are important institutions for reproducing cultural norms and values, and boys and girls are taught about life sex and marriage: *'The way how they go through Bondo society (female secret society) is there they will learn how to become responsible parent tomorrow, there they teach them how to cook how to respect elders how to take care of the home and the family and the rest of it.'* (KII, community leader, Kambia)

Some male and female community leaders shared that the male and female societies used to be for learning about life, sex and marriage. They also showed concern about the reduced age girls are put through the society, as is illustrated by one community leader.

*'During that time, when a girl or boy joins that Society they can be able to sensitise her that you have reached the stage to marry. They can show you how marriage can go, and how to take care of your matrimonial home if you are a girl child. Then if you are a boy child again, they can be able to tell you how to take of you marriage home, if you are married how you should control your home, your woman and your children. Those were the things they used to do, but now it is not happening. Because children now join the society at a very young age. So they are not be able to get any education through that.'* KII, community leader, Kailahun

*'Like the boys they can tell them the signs and symptoms that they can reach to begin to have sex. And when they sex at that stage, they can pregnate a girl.'* (KII, community leader, Kailahun)

Some of the women involved in the female society were very clear about the importance to teach girls to avoid getting pregnant although their method may not be the most effective: *'we teach them for example, we make a rope and tell them if any man touch you by way of sex you will die. We tie the rope on their waist to put fear into them that if any man touch them they will die.'* (KII, elderly woman, Moyamba)

### **3.5.2 Content of information on love, sex and marriage**

In general, the content of the information was often focussed on what boys and girls should and should not do. The focus of almost all information that young boys and girls got in both schools and from family members or elders was that they should not have sex early. There was not much information on technical issues regarding reproductive health, prevention of pregnancy and STIs. Also, the communication seemed to be very one-sided, talking to the girls and boys, rather than listening and having a dialogue.

### **Content of information on sex from schools, health centres**

In school, the girls reported being taught about sex:

*'Now, they teach us biology in school, they show us pictures of how to sex and what they do to prevent pregnancy.'* (FDG girls, Kailahun)

*'... In our school, our teachers tell us if we have sex we will get STI.'* (FDG girls, Bo)

*'They teach us how a boy grows up till he reaches maturity thus shows out that a boy has reached sexual stage. And they also tell us that when one wants to sex with a girl, one has to get condom to avoid sickness from the women.'* (FDG boys, Moyamba)

Dropping out of school and endangering their education when a girl gets pregnant is a warning given to girls and boys. In school, they tell them *'to pay attention on our education and stay away from sex'* (FDG girls Bo).

*'When we go to school they tell us that there is a stage one reaches for you to have sex, if you do not reach the stage and you have sex you will die. That is the warning they give us that we should not have sex at an early stage.'* (FDG girls, Bo)

*'They tell you not to be promiscuous ... whatever our parents give us let us appreciate it. If one is going to learn then let our attention be there so that in the future one can stand on her own so whatever her companion has she too can get it. That is what they warn us about in school.'* (FDG girls, Bo)

Girls report that they get information in school about their menstruation.

*'They (teachers in school) say right now if we have not reached the stage to get pregnant, if we get pregnant we will have problems, we will have stomach problems, we will encounter bleeding problems when you have reached the stage to be pregnant.'* (IDI girl, Kailahun)

For boys, they reported about what they learn in school about sex and the use of condoms:

*'Like SPW (Students Partnership Worldwide), when they go to the school they teach us how to use condom, how to sex, you should not use your naked body, if you do that you are going to impregnate a woman. So those are the type of things that they advise us and we can learn from them.'* (FDG boys, Bo)

Health workers were also an important source of information and the providers of condoms. It seems that the health workers try to give sex education, but that this is not always successful:

*'We give sex education but they don't come, except when they get pregnant they come to clinic and we talk to them and educate them about sex and give them condoms.'* (FDG Health Workers, Bo)

### **Content of information on sex from family members or elders**

A boy from a FGD said that his mother tells him *'not to bring problems and that he should avoid womanising and not to impregnate girls, so that they can be educated.'* (FDG boys, Bo)

Another boy said his mother tells him *'not impregnate a girl and bring the case to her.'* (FDG boys, Bo)

Some mothers do attempt to talk to their daughters and warn them for pregnancy and STIs, as is shown in the following quote:

*'She used to say right now as I am, sexual intercourse does not fit me, she said I have to learn. She said at my age when I am 15, sexual intercourse does not good for me, if I have sexual intercourse, water will leak from me. That is why I have to abstain till I reach like 20 years before I begin to sex.'* (IDI girl, Kailahun)

Their fathers tell daughters *'not to enter love relationship with men that are not their husbands.'* (FGD girls, Bo)

The male adults responded that the traditional education for girls is *'not to come close to men and sex, otherwise they will drop out of school and suffer.'* (FGD adult men, Bo) and boys get information from their fathers: *'Like you are small the father will say do not engage in love affairs else you will become a dropout.'* (FGD adult men, Bo)

Instead of having sexual relationships, both boys and girls are advised to go to school and study hard:

*'Keep off from women, saying that it spoils our education.'* (FGD boys, Bo)

*'When they send us to school, they wouldn't want us to get pregnant; they want us to learn our books and that we should not pant after men, we should not be foolish, we should take our books serious. At night, we should study.'* (FGD girls, Bo)

In many communities the importance of education for girls and boys is emphasised. The importance that a man should not be overshadowed by his wife can be gleaned from the following quote:

*'Our parents tell us to be educated so that no woman will show off on you.'* (FGD boys, Bo)

In some communities elderly women try to scare girls with telling them that they will die if they have sex early. An elderly women report on what she is teaching to young girls:

*'If we get to know that a child has not had sex, we warn her not to do it at an early age as that will affect her. And that if she starts early, she can neither benefit herself nor her mother. But scaring them does not always work: when we scare them that if they do it they will die, they tell their friends they have done it and they have not died ... In the past when you tell a girl child that if she had sex she will die, she can be afraid but now they have no fear.'* (KII woman leader, Bo)

*'What I understand is that, in this village, we tell girls that if you are not 18 years don't have sex with men; if they do it ... we will know and they will die.'* (FGD adult men, Bo)

*'Because my mother had explained to me, by then I was small. She said that when you are small and you have sexual intercourse, you will die.'* (IDI girl, Kailahun)

The general impression is that girls and boys do not get sex education from parents or elders. An elderly woman (a sowe) also had the same kind of answer when asked if she teaches teenagers about sex:

(Hesitant to answer) *'No, we only tell them not to have sex until they grow up and marry, which will be beneficial to you and the parents. But some leave us at night to go for dance, which is very shameful to us mothers.'* (KII woman leader, Bo)

Some elders are not impressed by the sex education that people receive. They see information about sex as a reason to have sex.

*'The white people have sent people here to talk to our children about love and how to use condoms ... We teach about sex but the SPW come to schools and teach them about sex, how they use condoms, this is the reason why teenagers are involved in sex and love now.'* (FGD adult men, Bo)

In some communities parents and elders report that they tell girls to come to them for money to prevent them from having sex with men.

*'We do not give them any traditional education but when they are going to school we tell them to be serious with their books. We give them food, and sometimes cash so that they can get stranded and follow men to come back with pregnancy.'* (FGD adult females, Bo,)

### **Content of information on marriage**

In all interviews and FGDs a traditional picture emerged of a stereotyped role in which boys and girls are socialised. Boys are socialised into contributing to the household by fetching water and helping their fathers in the farm. When they grow up, they are the one responsible for the household. Girls are taught to clean, cook, help her husband and look after the children.

The following quotes show the stereotyped roles of boys:

*'Here a boy follows their fathers to the farm and will work together.'* (KII woman leader, Bo)

*'... When morning comes you urge him or her to go to school or you tell him or her to take the cutlass and go to the garden, or that after school go to the garden and brush.'* (FGD adult females, Bo)

The following quotes show the stereotyped roles of girls:

*'My mother tells me to sweep in the morning, I wash clothes and cook at home.'* (FGD girls, Bo)

*'A girl should learn how to cook, sweep the house, ..and take care of the home..... because they have to marry and stay with their husbands.'* (FGD adult males, Bo)

*'... She takes care of her husband and family.'* (KII religious leader, Bo)

*'.. Women do weeding and cleaning the farm for their husbands.'* (FGD health workers, Bo)

*'My mother tells me to go to school, in the morning I have to sweep, fetch water and tidy the house, also when I comes from school, I have to help in the kitchen.'* (FGD girls, Bo)

Girls also get to know about marriage when they join the Bondo society for the initiation. One of the girls from the FGD explained about all the things that are expected from her to do:

*'For instance, farm house work. You go to the farm, your younger brother can be sitting and the your mother will ask you to go and do weeding, because you have to go to your marriage home your brother doesn't have to go to a marriage home...'* (FGD girls, Bo)

Some changes are emerging in some communities about the perceptions of gender roles. Adult men in an FGD stated that there should be more equality in the roles of boys and girls:

*'I would like to see a gender balance, the role of sweeping should not only be assigned to girls, boys should also sweep. Also, in terms of fetching water, it should be done on equal basis between boys and girls, then they know that things are working.' ... 'Just like they are giving privilege to women to get education for them to come out fine, it does not mean that they have to do all the work or the boys always in front and the girls at the back, both should be side by side.'* (FGD adult males, Bo)

## 3.6 Knowledge of and access to contraceptives

Many respondents in the individual interviews with girls, key informants and the FGDs with boys and girls knew about family planning (even if they were not using it themselves). Of the 38 young girls that were interviewed, many used some method of family planning at the time of the interview. Among these girls, almost half used condoms, a quarter used injections, some used traditional family planning methods and a quarter used other modern methods like pills or the implant.

When asked about the reason why the girl did not use contraceptives, most of them said they did not know what to do. Some girls reported they didn't want to use a family planning method and reported that they didn't use contraceptives, because they had not yet had sexual intercourse. Other reasons that were mentioned (less often) were: fear, lack of money, waiting to start with family planning till the first child walks, wanting to give birth and the fact that Marie Stopes had not been in the community for a long time.

The following sections present information on knowledge of the respondents about family planning, different methods that are available and access to these contraceptives.

### 3.6.1 Knowledge of and beliefs about contraceptives

#### Knowledge of contraceptives

From many interviews, it was seen that amongst boys and girls, there is knowledge of the different methods to prevent pregnancy. In some cases, pregnant girls could mention different family planning methods but explained that they did not have this knowledge before they got pregnant.

When asked which methods the respondent knew to prevent pregnancy, the methods most often mentioned (and described) were:

- Abstinence
- Being faithful
- Condom (sometimes referred to as 'One foot Socks')
- Female condom
- Intra Uterine Device (IUD, called 'coil')
- Implant (called 'Captain Band')
- Injection (Depo Provera, lasting for 3 months)
- Oral contraceptives (tablets, pills, sometimes referred as PPA (Planned Parenthood Association))
- Traditional/ country rope (also referred as Mende medicine or "Loklo" (which means: 'stand a little', provided by 'moraman'/ Juju men)
- Traditional/ native medicine (boiled herbs to be drunk, sometimes referred as "Goloquae", provided by elderly women or traditional healers)

Other methods as natural rhythm and withdrawal were not often mentioned. Sterilisation was not mentioned by anyone.



A chief in Moyamba had another recommendation to avoid pregnancy:

*'... One method is to get them sustainable, involve them in some micro credit programmes. Perhaps we think it's because of material things that they get involved in sex. So if they have these small micro credit programmes, there will be no need to look up to boys and men for them to get money for personal issues. Perhaps this will help them raise money for themselves and it will divert their attention a little from men.'*

Boys mentioned most often the use of condoms. Some respondents just responded *'you should join family planning'*, but they were not able to come up with specifics. Other respondents were not able to answer about which methods exist for family planning.

Boys and girls also described the various contraceptive methods:

- *'If you don't want to get pregnant, you abstain, use condom and be faithful or you take injection.'* (FGD girls, Kambia)
- *'It's the ABC method I know. Okay, like when you and some person are in love, you have one partner and you are faithful to him and he will be faithful too. At any time you meet they will advise us in school to use condom, so you will do so.'* (IDI girl, Moyamba)
- *'If a man calls, you should not go there, you should go and sit at your house.'* (IDI girl, Kambia)
- *'If you have reached that stage, your parents will bring you to the hospital to join PPA medicine (oral contraceptives)... Every morning you drink it. If you start to drink it at night, you should not mistake. When you mistake you get pregnant.'* (IDI girl, Kailahun)
- (About the implant) *'They tear small part of the arm and put it there and sow it... You can't get pregnant. When you are ready (to become pregnant), you go and let them remove it.'* (IDI girl, Kailahun)

## **Barriers to the use of contraceptives**

### **Perceptions of effectiveness by girls**

Some girls not using contraceptives noted the reason as chance of failure of the various methods.

*'I had a friend who had taken the injection and got pregnant... I'm not wasting my money on any preventive if I'm going to get pregnant... Whether I take it or not, I will get pregnant.'* (IDI girl, Kambia)

Regarding condom use: *'They said it (a condom) gets stuck in a girl, so I said let me stop using it so that it will not happen to me. Then I said let me wait for Marie Stopes, but before they could come I was already pregnant.'* (IDI, girl, Moyamba)

### **Negative views on contraceptives**

Stories and gossips about failure, misconceptions and side effects can lead to a negative view on contraceptive use.

One woman in Bo said that parents don't want their children to use family planning methods, because of misconceptions that long-term use may cause infertility:

*'Well some of them knows here, when you talk to the parent to prevent their children, they will say they do not want to stop their children to give birth, because they think, if their children finish learning their book, they will not be able to give birth.'* (KII adult woman, Bo)

One health worker explained how boys feel about the use of condoms: *'But boys do not agree to use condom, they said they want it flesh to flesh.'* (SSI Health Worker, Bo)

### **Side effects**

Other girls reported about side effects of the various methods of family planning: *'The injection that I took caused me to bleed a lot and I came to this hospital. They could not stop it, except I had to go to Freetown. From then, I decided not to use preventive again.'* (IDI girl, Kambia)

*I want when it (her child) walks, let me be using country medicine, because this Captain Band they are talking about, they say it makes one bleed too much. And we have seen this a lot. Sometimes when they give it to a person, she won't menstruate, it is her stomach that protrudes.'* (IDI girl, Kailahun)

### **The traditional method of preventing pregnancy**

The traditional rope method was often mentioned and described by almost all types of respondents.

*Just an ordinary rope, according to the one I have seen, it is a tick stick they pile they mixed with tread, join it and roll it, than they tie it. I have seen a person who had tied it but came to the clinic when her pregnancy was four months, she said they cut it, that's why she got pregnant.'* (SSI TBA, Kambia)

*'The rope, they tie it around the waist of the woman. Some can go for four years without getting pregnant.'* (FGD boys, Kailahun)

Some girls told of failure of this method: *'The rope has disappointed me. It was on my waist and I got pregnant.'* (IDI girl, Moyamba)

One TBA noted the difference between the past and now where girls have more knowledge and do not believe in traditional methods: *'For the girls, we tell them that in our youth age, our mothers tied rope on our waist so they don't have sex. They tell us if we have sex, we will die and we believed. But now you cannot tell that to a girl, she will not listen because it will not kill them.'* (KII TBA, Bo)

### **Access to contraceptives**

Many of the young respondents spoke freely about accessing contraceptives and many health workers indicated that their services provided this. Parents and community authorities and leaders had varying opinions about the use of contraceptives by youths.

### **Barriers indicated by youth**

Some girls said that it was *'shameful to go to the hospital to ask for protection'* (FGD girls, Bo). They also suggested that boys do not go there to ask for condoms. Some girls also indicated that they would not ask a boy to use a condom.

### **Providers of contraceptives**

Many respondents mentioned the "hospital" (which was often the health centre available in the village/area) and Marie Stopes as the place to get contraceptives. For information on family planning, the school was also mentioned. In Kailahun, Save the Children was also mentioned as having a role in information on contraceptives. In Moyama and Bo (Nengbema), Restless Development was mentioned. Pepe Doctors (drug peddlers) were mentioned as suppliers of contraceptives. In Moyamba, girls reported that condoms were sometimes distributed to boys at the dances.

Health workers generally reported that distribution of contraceptives to young boys and girls is part of their standard care: *'Both boys and girls, especially the girl child who has started their menstruation, we will call them and talk to them and give them medicines to drink (contraceptive pills), to the boys too we talk to them and give them 'one foot socks' which is condom and explain to them how to use it.'* (FGD health workers, Bo)

### **Opinions that influence adolescent access to and use of contraceptives**

Although most respondents noted that condoms were easily assessable at health facilities and outreach services in the community some other views were reported for very young boys and girls. According to some boys and girls, health facility staff withheld contraceptives for young boys and girls who had not yet started menstruating.

Responding to the question if the clinic will give condoms, one girl answered: *'Yes, if you reach the stage of sex. For the pills, if you reach the stage (starting menstruation) they will give you, but if you don't reach the stage they will advise you to abstain from sex.'* (IDI girl, Moyamba)

Provision of condoms to young boys was also reported as problematic by boys themselves: *But I think boys of 15, 16 years do sex? 'Yes, (together); because they are forcing themselves to do it.'* *But does the health center not provide these services to them? 'Because they have not reached the stage to sex. That is the law at the clinic.'* (FGD boys, Moyamba)

Some parents voiced strong opinions about youth joining family planning services, feeling that this would encourage sexual activity: *'She (the mother) would tell you that you do not want to do any good work for yourself. That when you go to the nurses, they are going to give you medicine so that you can now be running after men.'* (FGD girls, Bo)

Religious leaders can also influence the health seeking behaviour of adolescents. One imam showed no preference but noted the various methods for teenagers to avoid pregnancy: *'To prevent pregnancy they should go to clinics for medicines, or you abstain from sex all together and listen to your parents.'* (KII community leader, Bo)

Another imam had a pragmatic view about contraceptives for adolescents: *'... Because some of them (youth), particularly religious people, we put fear in them that God does not want that (use of implant), and indeed. But for your child not to get pregnant early, because you want her to learn and do something for you, maybe you can join her that way if you want her to continue her school. But if she gets pregnant, she will become a drop-out and sit down.'* (KII, community leader, Bo)

One pastor interviewed was also in favour of contraceptives. *'... we therefore go to talk to them at primary school about the use of preventives as soon as you start to see your period in order to prevent them as they enter into the world.'* (KII community leader, Moyamba)

Just as religious leaders, traditional woman leaders (Sowes) can also influence health seeking behaviour of adolescents on sexual and reproductive health. Although some Sowes voiced concerns about the early age of sexual initiation, they generally were in agreement that pregnancies should be avoided and showed some knowledge of modern contraceptive methods:

*'Well, I don't know its name; but for me it is better than the other medicines that they give to girls. If your girl is having sex, you give her that thing on the arm and when she is ready to get married you remove it.'* (KII, elderly woman, Bo)

One Sowe knew about oral contraceptives: *'If a girl do not want to get pregnant if the injection do not fit her, there is groundnut (meaning brown coloured small tablet) that has now come which the girl will take every night even if a girl is having sex or not....we call it PPA.'* (KII, elderly woman, Bo)

### 3.7 Gender norms and roles

Gender norms and perceptions of gender roles influence how people look at (sexual) relationships, marriage and other related subjects. In the above presented case studies, some issues regarding gender norms are already presented. In this paragraph, we make some of the findings regarding gender norms and roles more explicit. Those gender norms and roles are taught to young boys and girls from their parental home and boys and girls are brought up in a different way, to be able to fulfil their role in the future.

Some respondents (especially female and male adults and some of the boy and girls in the FGDs) referred to the traditional society initiations as important in becoming a man/woman. For the boys circumcision was one of the things that could make a boy become a man, but this was not mentioned in all interviews.

Some respondents referred to changes in roles of men and women, that the roles are not that separate anymore as it was in the past. They mentioned role models and campaigns that are intended to promote gender equality.

#### 3.7.1 Gender norms and roles: men

##### **What makes a man a man**

Many respondents reported a real man to be strong, both physically and sexually (he should be able to reproduce).

*'(A man is) like someone who is capable during sex, who is strong in sex.'* (FGD boys, Bo)

*'(A man is a man) when a man is able to marry more than two women like five, every day he impregnates one.'* (FGD girls, Kambia)

A real man was reported to be successful (he has money), someone who solves problems and maintains a family by providing shelter and food:

*'A man who works hard and solves his own problems is a real man.'* (FGD girls, Bo)

Men themselves saw a man as someone who is successful in business and who commands respect from family, friends and community. A man was seen as a real man when he has money, has property and has a family to feed. The man must be hard working and protect his family.

*'He is respected by the entire family and they listen to him when he speaks.'* (FGD male adults, Bo)

*'You see my way of answering this question is that the word 'MAN' when you look at the acronym it means 'Make A Name'. Your companion can look at you and say you are a man when you have money, you have asset and you have a child.'* (FGD male adults, Bo)

One respondent summarised as follows:

*'When they say this is a man, you are now able to do something for yourself. You can be able to marry, you can be able to do something for that woman, you can be able to think of the family of that woman, you can be to think of your family, wherein you encounter any problem that can take you to your own people. At that time you have become a man, you have now somebody.'* (KII, community leader, Kailahun )

And another respondent said:

*'He should take care of his family, he is the family head, and at the same time he supports the children; he is the umbrella that controls the family.'* (KII community leader, Moyamba)

Education was seen as important for men:

*'When a man is educated and able to deliver in a public clearly, they will say this man is a man.'* (FDG boys, Kambia)

*'Like this boy here, when he grows up, his mother will tell him to go to school when he puts attention on his education and comes first in class and later finish his education; then they will say this is man.'* (FGD girls, Moyamba)

### **Expectations of men in marriage**

The most important role of the man that came out of almost all interviews was that a man should provide the wife with money and goods.

*'The women would want clothes, food and to provide her everything... They also want sex from us.'* (FGD boys Bo)

*'... if I am married my woman will expect me to find money.'* (FGD boys, Bo)

Some girls during FGDs expressed concern about men not providing financial support to ensure the use of health services for their children. Besides taking care of the wife, a man is often also expected to take care of the family of the wife, for example in case of a funeral by providing money, giving the family small things and (help them) building a house.

Besides money, men report that it is expected from them to have children:

*'The woman will expect to have children.'* (FGD boys, Kambia)

### **3.7.2 Gender norms and roles: women**

According to many respondents, a woman is supposed to care for the house, the children and the husband. She should listen to the husband and be able to care, also for his family or visitors.

*'A real woman is hard working and does everything for her man.'* (FGD boys, Bo)

*'We only say this is a real woman when she is able to work in the farm and generate some money to take care of her child.'* (FGD female adults, Bo)

*'When a woman marries then she is now a real woman.'* (FGD girls, Bo)

For some of the adult men and women it was important that a women *'obeys her husband and takes good care of her children to grow up well.'* (KII with an imam, Bo)

From the FGDs with girls, boys and one elderly woman, another image of a woman also emerged. They emphasised that a real woman is a woman who has a degree of independence and is respected for that:

*'When a woman goes about doing her own work like a business and can solve her own problems, then she is a real woman.'* (FGD girls, Bo)

*'We have certain women who work like men. When you see them in the bush how they work, they are physically strong, then you say this is a woman.'* (FGD boys, Bo)

The following quote shows that no matter the respect a woman gets for being strong and capable, she is still expected to obey her husband:

*'To us here when a woman works hard and builds a house, we will say this is a woman. When a woman protects her husband at the time of difficulty and obeys her husband we will say this is a woman.'* (FGD girls, Bo)

Also for women, getting children is seen as something important by many respondents:

*'I would also like to bear a child for him.'* (FGD girls, Bo)



During the FGDs with boys this expectation was also voiced: ‘... *she can give birth for you.*’ (FGD boys, Bo)

Women were seen as being a real woman when they were married and had delivered a child.

### **Expectations of women in marriage**

As already stated above, a wife contributes to the household, cares for the children and helps her husband:

*‘A real woman is the one who helps her husband to do any work or take care of the home in the absence of the husband.’* (FGD female adults, Bo)

## **3.8 Other issues reported in interviews**

This paragraph contains summaries of the findings on the following subjects: HIV/ STI knowledge, health care use during pregnancy, relationships between adolescents and adolescent concerns and needs.

### **3.8.1 HIV and STI general knowledge**

Most respondents knew about HIV and STIs. Not all of them were able to report names, corresponding symptoms and treatment, but most of them were able to mention symptoms of STIs, and in case someone experiences these symptoms to advise them to go to the hospital or health centre. The use of native (traditional) medicines was also mentioned.

One imam voiced a very strong opinion about the use of traditional medicine for STIs: *‘They do not have initiative to go to the hospital for medication, but will use traditional herbs to cure themselves, which does not work.’* (KII community leader, Bo)

Most respondents knew about HIV and knew that it can be transferred through sexual intercourse, when you have more than one partner: *‘when you the girl become infected with gonorrhoea, it is because you can’t be sexually satisfied with a single man; you may need two or three men ...’* (FGD girls, Moyamba)

The majority of the respondents knew about prevention methods (abstinence, faithfulness (mentioned often), condom use (mentioned often), not using shared razor blades. Also the importance of testing was mentioned by some of the respondents. The source of information is comparable with the source of information on contraceptives described in section 3.6.1.

The issue of faithfulness was discussed by some respondents and it appears that men having multiple partners is accepted and a reason to be concerned about health. An adult woman in Bo had a concern regarding being faithful: *‘But some men sex many women so it is not reliable to stick to one man, so it is not safe.’*

Two imams in different communities in Bo emphasised that men needed to use protection:

- *'Even the book (Bible or Quran) said it that you should not have sex with a woman that is not yours. If you want to have sex with a woman that is not yours except you use condom.'*
- *'In the first place, you have to control yourself; by have one partner or if you want to go so and so you have to use condom.'*

Various respondents showed knowledge about STI symptoms:

- *'The first person to know is your male counterpart, because when he puts his penis in the vagina he feels pleasure but after he has sex that is the time he feels the pain more so if the woman is infected. And as for the woman you can't know you have been infected so easily, it would take up to nine months before you feel the pain.'* (FGD girls, Kambia)
- *'Yes, like gonorrhoea, some women will not know about it for long period, when they discover the sickness it will be too late.'* (FGD adult men, Bo)

Some girls related STIs to having sex early

- *'When you have not reached the stage to have sex, if you do it you get vaginal discharge. When you do it every day, and you are under 10 years, and when you start to have sex, is not good, you get vaginal discharge. The water that you discharge has offensive odor.'* (FGD girls, Kailahun)
- *'Like when you are at age of 6 and start having sex, by the time you are 18 years, your vagina will be slack and water comes out of you.'* (FGD girls, Bo)

Some misconceptions were also found about the transmission of HIV:

- *'Through water you can get HIV.....Through pools, they can contain germs, if a person washes in that pool who has HIV, and you too go and washed in that same pool you can get HIV.'* (IDI girl, Kailahun)
- *'One should not walk bare-footed you can get HIV.'* (FDG girls, Bo)
- *'Some people they have bad urine, when one steps on it, it give you HIV.'* (FDG girls, Bo)
- *'When someone goes and urinates and a fly goes there and come when it touches you it injects the water in your body that causes HIV.'* (FDG girls, Bo)

Most girls who were interviewed and who had been pregnant or were pregnant at the time of interviewing visited the health centre or the hospital for antenatal care. Most of them started late, about their 6<sup>th</sup> month. Not many girls reported to have visited a TBA.

For delivery, the majority of the girls gave birth at the health centre/ hospital or were intending to do so. (This result could be biased, because interviews were taking place at the health facility). Two girls reported to have delivered at home and one wanted to deliver at home in the future.

Most respondents knew the importance of delivering at a health facility:

*'When you born at the house, sometimes you will have to born some babies who are bigger. Then your pregnancy will pain you for long but if is in the hospital your pregnancy will not pain you for long belle, they will call in (district headquarter town) they will come with the motor car, they will carry you to (district headquarter town) if they were not able to deliver you here, but in the house if they do not know what to do they will hold on you for long, when you have tied now, that one will bring problem then you will die.'* (IDI girl, Kambia)



### 3.8.2 Relationships between adolescents

On relationships between boys and girls, many of the young people did not have friendships with the opposite sex, because they or their parents thought that this would end up in a sexual relationship. Others did have friendships with the opposite sex.

Besides getting the help of a boy regarding studies, girls gave the following reason for having friendship with boys: *'It is good to make friends with boys than girls because she will expose your secret. Boys, when you make friends with them, they will advise you and they will not let your secret out and you will not tell him all your secrets. Then boys will advise you how to do things but girls when you tell them your secret they expose it when you quarrel.'* (FGD girls, Moyamba)

### 3.8.3 Adolescent concerns and needs

During the FGDs, boys and girls were invited to mention any concerns and needs that they might have. Below the most frequently mentioned concerns and needs are summarised:

- (Money for) dressing: most girls found it very important to have good dressing, especially when friends are well dressed.
- Heavy workload which is hindering school performance (both boys and girls).
- Fees for schooling (mostly boys and some girls), they are afraid to drop out of school. Girls who are pregnant sometimes have concerns about getting back to school.
- Love relationship, especially when the other is getting another boy or girlfriend. Some boys have concerns regarding money, they need money to be able to have a girlfriend.
- Young girls who have a child are sometimes worried about feeding the child.
- A fear of girls is to get pregnant and the boy is denying that the pregnancy is his.
- Lack of quality of teachers in the school. *'They do not teach fine, when we go to school we just play and we go back.'* (FGD girls, Kambia)





## 4 Discussion and conclusions

### 4.1 Age of sex initiation and marriage in Sierra Leone

Despite considerable efforts of the researchers to identify and interview girls who married before they became pregnant, only two girls who were interviewed actually married before they had sex and became pregnant. Based on our findings, early marriage is the consequence of teenage pregnancy rather than early marriage being a reason for teenage pregnancy. This result shows alignment with other data sources about the initiation of early sex and teenage pregnancies in Sierra Leone. Data from 2008 report a median age at first sexual intercourse among women aged 20–49 years as 16.1 while the median age for first marriage is one year higher at 17.2 years old (SSL 2009).

### 4.2 Reasons for sex and marriage

The most common reasons for girls to have sex at an early age are poverty, the desire for material goods, coercion using psychological pressure, coercion using violence, family and peer pressure and to a much lesser extent pleasure.

Having sex in exchange for money or goods is called transactional sex. Transactional sex happens among woman and girls from various economic strata: among the more well off and the poorest (Swidler and Watkins, 2007). The type of exchange differs in terms of poverty and the desire for material goods as a reason for sex. Results from this study show that both sex in exchange for basic needs such as food, shelter and clothing and sex in exchange for goods that improve social standing such as modern clothes, shoes etc. are reasons for sex. An extensive body of literature shows the exchange of sex for material goods inspired by a pursuit of ‘modernity’ and not just poverty in other countries (Suzanne Leclerc-Madlala, 2004). This distinction is important as the assessment of vulnerability of the girl and the possible incentives to change behaviour will be different.

Swidler and Watkins draw our attention to the complexity involved in unequal interdependencies between men and women. Transactional sex and having multiple partners is not just a simplistic desire for food, goods and sex. One important aspect that they highlight is the network that is created by longer term sexual relationships which provide access to future jobs and support in times of economic crises. From the FGDs and interviews in our study, it emerges that sex with influential men is something families are proud of and see as a way to get access to assets/power, as long as the girl does not get pregnant or the pregnancy is acknowledged. Transactional sex or ‘unequal interdependencies’ (Swidler and Watkins, 2007) in relationships between men and women in and outside marriage are a common thread in our findings. The underlying gendered norm that influences transactional sex emerging from this study is that the most important

role of the man in marriage is to provide shelter, food, material goods and sex, to provide the woman with 'all she needs'. Girls and boys internalise these roles and expectations.

In our study exchange of goods for sex is, in the rural areas we investigated, mainly focused on modern dresses, shoes and food rather than more sophisticated goods such as smart phones etc. Our findings on reasons for sex are confirmed by the reports of research recently conducted in other sites in Sierra Leone. (GOAL 2010, UNICEF 2010).

Previous studies in Sierra Leone as well as this study show that women generally defer to men for decision making. (Herschderfer, 2012, Coinco, 2008), putting young girls in a vulnerable position when it comes to negotiating about sex. Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labour market participation are associated with improved reproductive health outcomes.

Coercion using psychological pressure emerged as one of the most common reasons for sex. Almost all girls started saying that they did not feel ready for sex, did not want sex and felt that they were 'forced'. As in other studies (Goal, 2010, UNICEF, 2010), further exploration showed that in most cases girls finally agreed to have sex through a combination of pressure and the construction of love and entitlement introduced by the men. This is a discourse and experience very similar to the ones reported in the international literature (Wood et al., 1998). In most cases the stories of the girls indicate that they do not feel ready for their first sexual encounter. They agree out of 'love' and the desire to please a man. The link between sex and love emerged as a very strong concept in the interviews with the girls and the FGDs. Internalised gendered norms and roles influence this behaviour. The men and boys expect that they have to convince women to have sex with them. These expectations are linked to the culturally accepted role of a woman who is expected to care for, obey and please men and this they are taught from early childhood. Arguments of love and financial care to convince women are commonly accepted.

According to a previous study in Sierra Leone, the main perpetrators of sexual abuse and exploitation in the school settings are teachers, coercing girls to have sex in exchange for marks/grades. 'Sugar daddies', boyfriends and other unknown persons came next. One third of the victims of rape or unwanted sexual intercourse did nothing (did not talk about it at all) and 5.4% reported to the police (Concern Worldwide 2010). We did not get any direct evidence for coercion into having sex by school teachers and other influential men during the in-depth interviews with the girls. During FGDs coerced sex by teachers and other influential men was mentioned by some groups of boys. However, the increased emphasis on preventing sexual abuse by NGOs that are addressing sexual violence may have pushed the admission of sex with older men 'under the carpet'. An earlier study on teenage pregnancy (UNICEF, 2010) reported that girls were initially only referring to one partnership mostly with a peer, as we find in our study. Girls in the UNICEF study, often sub-consciously, revealed more than one partnership only after further probing (UNICEF, 2010).

For a few girls, their first sexual encounter was through physical violence. Some girls were raped on their way to collecting water and in a few other cases girls were physically

assaulted at a 'date'. The statement in the consent form that confidentiality may be broken when girls are exposed to a continued threat of abuse may have influenced the willingness of girls to speak about continued abuse but this should not have influenced reporting their experiences during their initial debut. A study of Concern Worldwide (2010) showed that sexual violence is a widespread phenomenon in Sierra Leone. About two-thirds of the girls in their study reported to have experienced at least one or more forms of sexual violence. About 18% of the girls had experienced rape and nearly half of the incidents involved physical assault, indicating the severity and seriousness of the problem. Most often it is done in the homes and the community, school-related rape contributed to 30% of the cases. The most commonly cited places in connection with school-related rape include places on the way to and from school and school toilets. Although some respondents denied the existence of sexual violence, a larger number confirmed its existence in their communities and neighbouring villages.

The distinction between psychological coercion and using physical force is not so important from a legal perspective. In both cases it is legally abuse of a minor. However, to develop interventions it is important to understand the context in which very young teenagers have sex and the reasons for girls to give in to the demands of men.

Findings from the FGDs and key informant interviews suggest that the community is not appreciably concerned about girls having sex at an early age. Our results show that having sex at an early age only becomes a problem when the girl gets pregnant and/or when the village is gossiping about a girl having sex outside marriage and family get to know about it. This is especially so if the pregnancy is not recognised by the impregnator.

At community level, teenage pregnancy is clearly seen as a problem by all groups, however, among some (age) groups, having a child has become a social desire that influences girls to get pregnant also. In addition, when girls are not performing well or are not able to continue schooling, getting married and having a baby is seen as a good alternative.

The reasons for pregnancy and marriage are also influenced by financial and increased social standing considerations by the parents and guardians. There is no support mechanism in communities for teenage mothers. Teenage mothers are mostly dependent upon help and (financial) support from their own or the impregnator's family. Most of the time, both families agree upon the support that will be given. The extent and length of support provided by the teenage boy's family is dependent on the economic situation of the family (UNICEF Sierra Leone 2010). The in-depth interviews in this study show the importance given to compensation for failed investments in school fees and a spoiled reputation from the man (or his family) who impregnated the girl. The impregnator or his family is also expected to cover costs for the pregnancy and later for the child. The value of the girl to the family emerges as a business investment, as derived from the findings of the FGDs and key informant interviews.

This may also explain the pressure on girls from aunts, sisters and other family members to agree to sex with a man who shows interest. The contribution to school fees and other goods during the period before a pregnancy and the subsequent pregnancy and the negotiation for compensation and contribution to the mother and child may have motivated the pressure that is put on the girl.

### 4.3 Consequences of early pregnancy and marriage

The consequences of a teenage pregnancy can be separated into health and social consequences. Health consequences such as unsafe abortion and increased maternal mortality and disability including obstetric fistula (AbouZahr, 2003, Khan et al., 2006) are well documented. All communities included in this study were well aware of the mortality risk associated with early pregnancy. In fact, the risk of death is often used to scare the girl and mentioned as an important reason that a girl should not get pregnant at an early age. Abortion was a frequently mentioned option during the interviews and FGDs, and four out of 31 girls reported that they had an attempted abortion. This shows that the possibility of abortion is well known and that it is taking place. Our study does not give any information about the scale of abortion taking place, but the fact that abortion is illegal in Sierra Leone stresses the importance of addressing issues regarding abortion, because the abortions take place under unofficial and non-medical circumstances, which leaves women at great risk (UNICEF, 2010). Obstetric fistula as a result of very early pregnancy and sometimes rape was mentioned once.

The most frequently mentioned social consequence for girls was leaving school, which affects her future opportunities in life dramatically. For pregnant girls, an important consequence is that they drop out of school. In the Goal study, 100% of the school-going girls that became pregnant did not return to school. The UNICEF study presented a girl drop-out rate because of pregnancy of 71%. Only 27% of male teenagers dropped out of school due to impregnating a girl. According to some by-laws (community level regulations), if the impregnator is a school-going boy, he is supposed to leave school for a certain period of time. This by-law is not effective and followed everywhere.

Many girls state that they want to go back to school but only one or two seemed to manage to do this. Some community members are against allowing pregnant girls to attend school till they are ready to deliver (Goal Sierra Leone, 2010; informal communication between researchers and community members during data collection). Especially elders fear that this would encourage others also to get pregnant.

Mostly, a girl who had become pregnant had to leave home to live with the impregnator's family or relatives. For some of them, this is an acceptable outcome and for some of them, this means heavy workload and competition with family members, such as sisters-in-law. Consequences in terms of gossip and shame depend on the acceptance or rejection of the pregnancy by the impregnator. The worst that can happen is that girls are seen to have sex with 'somebody from the street' and get pregnant without somebody taking the responsibility for the pregnancy. They may end up in the street trying to survive on their own ; or if they are lucky a relative will take them in. In most cases these girls are very vulnerable and face shame, blame and a very difficult livelihood situation (see also UNICEF, 2010). Getting pregnant without being married was seen as something wrong by most of the respondents, but as soon as the impregnator took responsibility for the pregnancy, the problem was solved for many of them. See figure 2 for various consequences of teenage pregnancy.

**Figure 2: Social consequences of teenage pregnancy for girls**

Situation	Responses	Consequences
<b>Scenario 1</b>		
School girl gets pregnant	➔ Leaving school	➔ Reduced social and economic potential
<b>Scenario 2</b>		
Fatherhood is acknowledged	➔ Leave family to live with family of impregnator or ➔ Stay and live with own family	➔ Well cared for ➔ Heavy workload ➔ Competition with other family members ➔ Maltreatment by husband, family.
<b>Scenario 3</b>		
Fatherhood is not acknowledged	➔ Live on the street or ➔ Live with own family	➔ Severe blame and shame and very difficult livelihood situation

Once a girl had sex with a man, this man automatically becomes the girl’s boyfriend and lover, irrespective of the force that was used. Society and families support this behaviour. The man who has sex with a minor (through rape or ‘consent’) may be brought to the police station or a local authority like a chief. The immediate next step is that the parents of the girl and the family of the man/boy negotiate the payment of compensation. Once the families agree, the family of the girl will withdraw the complaint. The primary concern of parents and guardians seems to be avoiding the situation that the girl’s reputation is spoiled by making the boy/man own up to be the father of the child and pay compensation for the failed investment in the girl and future expenses during pregnancy and for the child. If this concern is solved, a majority will support the pregnancy. The norm that having a child for both men and women is very important could contribute to this.

The consequences of a pregnancy are much more severe for the girls, but boys’ and men’s lives can also be shaken as a consequence of making a girl pregnant. By-laws were in place in most communities to hold men responsible for impregnating a girl. The effectiveness and equitable enforcement of these by-laws are questioned, but at the same time they signal a community concern that can be capitalised on and possibly guided to more effective prevention strategies.



The consequences for some young men are that they also have to leave school to take a job and look after the girl and the child, at least till the child is old enough to walk. Some men do not want to face the consequences and leave the area or the country. In any case, the man or his family is expected to pay compensation and give money for the girl and the child.

#### **4.4 Love, sex and contraceptives: information and access**

Male and female adolescents mentioned as most important sources of information about love and sex: observations through films, TV soaps and pornographic materials, observation of parents and siblings. Besides this, it was concluded from all interviews and FGDs that they learned most from each other while practising sex. Information especially about contraceptives and HIV/STIs was obtained through school and NGOs but this is not equally available in all communities. Some religious leaders played an important role in promoting the use of contraceptives, when young people were sexually active. Overall, the content of information on sex was limited to technical issues such as condoms, pills, implants and hormonal injections from health workers and NGOs. Social and emotional aspects of sexuality were not mentioned.

The information youth obtained from elders was mainly focused on negative messages associating sex with pregnancy and death. The same was found in previous studies carried out in Sierra Leone (GOAL 2010, UNICEF, 2010). Elders were scaring adolescents rather than having a dialogue with them. One girl respondent voiced the importance of open and transparent communication between parents and girls in influencing girls not to initiate early sex. This was also found in the GOAL Sierra Leone study from 2010 and in international literature.

Knowledge about the type of contraceptives available among the girls in the in-depth interviews was generally good. However, they received information from health workers during and after their pregnancy. The picture emerging from the interviews with elderly women shows a much greater reliance on traditional methods such as the use of a rope. Access to contraceptives is provided through Marie Stopes, other NGOs and health centres. However, access is not generally made available in a non-judgemental way to adolescents. The strategies developed at the moment aiming to provide adolescent-friendly services are very timely and need urgent implementation (MOHS-SL, 2012c).

#### **Gender norms, values and roles**

Gendered norms and values that are influencing teenage pregnancy have been mentioned when discussing issues above. In summary the most important norms and values that need to be taken into account are the emphasis on a pleasing and serving attitude towards men coupled with a norm of obedience. The general acceptance that girls are ready for sex at an early age as long as this takes place in an acknowledged relationship, and a girl's value being related to financial gain. The expected roles of men and women in marriage in particular and society at large also play an important role in the nature of the way in which young women are coerced into having sex.

## **Evidence for interventions that work**

All reviews included in the following paragraphs show that addressing adolescent sexual health and prevention of teenage pregnancy is the result of multiple strategies implemented at the same time. The most important elements are sex education, providing access to contraceptives and addressing gender-based norms, values and practices.

### **Communication education, reflection and action**

Addressing norms and values, in particular gender and poverty through community-based interventions as well as in a broader institutional context, is also an important element to bring about change (Harrison, et al., 2010). Studies show that discussions and dialogue between elders and youth (parents and others close to the teenager) about condom use and sex can be important to delay sexual debut and increase the use of contraceptives when having sex. (DiClementee, 2001; Whitaker, 1999; Hutchison, 2008). The positive deviant analysis approach (Shekar et al., 1990) taken for the teenage pregnancy study carried out by UNICEF (2010) gives useful examples of positive role models that can be integrated and suggests a number of steps that can be taken to conduct such an analysis. Care needs to be taken to involve young people in the identification of role models. In addition, an adult education approach ‘the generational dialogue’ developed by Anna van Roenne working as a consultant for the German Corporation for Development (GIZ) (publication by GIZ forthcoming in 2013) is an approach already piloted in Sierra Leone to address FGM. This approach may be adapted to address gender norms, values and practices that influence teenage pregnancy and are also underlying sexual and gender based violence, such as physical and psychological coercion pressurising very young girls into sex against their wishes. The latter is irrespective of their final ‘agreement’ as this study has clearly shown that their agreement is a result of pressure and social constructs and not given freely.

### **Sex education**

Sexuality education is not integrated into the education system in Sierra Leone. The emphasis on abstinence for youth may be a supportive action for very young girls provided this is supported in the community by adults openly supporting girls to say no to sex. At the same time, there is overwhelming evidence from systematic reviews that “abstinence only” programmes have shown not to work and to actually put girls and boys in danger (Kirby, 2008, Underhill et al., 2007). The so called ‘virginity pledges’ are not effective and the ones who take part in virginity pledges are less likely to use any protection once they become sexually active (Underhill et al. 2007)

Kirby(2006) reports that sex education that includes condom access for youth who chose to be sexually active is effective in preventing HIV/AIDS and pregnancy. The factors influencing protective behaviour were knowledge, perceived risk, values and attitudes, perception of peer norms, self-efficacy and skills, and others. Most programmes increased knowledge about HIV, STIs, and pregnancy (including methods of preventing sexually transmitted infections (STIs) and HIV and pregnancy). Important elements that made the sex education programmes effective were the involvement of people from different backgrounds involved in the design of the programme, conducting formative research that includes looking at the needs of the intended beneficiaries and attention given to addressing community norms and values. The teaching style is best based on participatory ways of involving audiences and helping them to internalise information and look at

personal ways to apply information (Kirby et al. 2006, Harrison et al. 2010). In addition, sex education is most effective when started before boys and girls become sexually active. Also sex education does not promote earlier sexual debut and/or promiscuity (Kirby, 2006). In Sierra Leone this means that sex education should start at 10 years of age at the latest.

### **Providing youth with access to contraceptives**

One of the successful strategies to improve the reproductive and sexual health of adolescents is the combination of training providers in the provision of ‘youth friendly’ services combined with community based interventions (Napierala Mavedzenge, 2011). The provision of contraceptives through health providers and peers is an essential aspect of reducing the risk of pregnancy and transmission of sexually transmitted diseases in youth who are sexually active. The development of youth friendly services is already taken up by the Ministry of Health and Sanitation in Sierra Leone (MOHS-SL, 2012c).

Community based distribution of condoms and other contraceptives is already practiced in Sierra Leone as can be seen from this photograph

## 5 Recommendations

The recommendations are based on the study results, evidence from the literature and the discussions at the end of “Realities of Teenage Pregnancy in Sierra Leone” research dissemination meeting, 8th December 2012 in Freetown, Sierra Leone. The discussion was guided by the following questions on the implications of the research results that were presented:

- How can we change social norms and values in relation to family, community and services?
- How can we use peer influences to prevent teenage pregnancies?
- How can we influence communication and services to prevent teenage pregnancy at family, community and service level?
- How can we address social consequences of teenage pregnancy for girls?
- How can we address social consequences of teenage pregnancy for boys?

The main recommendations emerging from all sources mentioned above are structured under community-based approaches, sex education and providing youth with contraceptives. Suggestions made during the dissemination meeting are taken up unless there is clear evidence that such an activity is not effective. This is the case, for example, for the forming of ‘virginity bonds’ (see Underhill, 2007). In this case the evidence from systematic reviews of sex education intervention effectiveness studies is taken, supporting an educational approach that enables boys and girls to make personal choices about when they want to become sexually active, assists them to obtain contraceptives when they want to have sex and starts before they become sexually active (Kirby, 2006).

One suggestion that emerged during the meeting was to advocate for the president to get behind a campaign to reduce teenage pregnancy.

Important considerations to keep in mind are the results of this study and others which clearly show the role that social and gendered norms and values play in coercing girls to have sex very early, when they themselves do not feel ready. Besides the need to address poverty, family and community perceptions of girls as a business investment need to shift to give girls a chance to say no to sex.

Another important aspect that applies to all more detailed recommendations further in this section is the involvement of teenagers in the design of all strategies and activities. They are the ones best placed to advise on what will work and not. Ensure diversity of backgrounds so that strategies reach not only the ones in school but also the ones out of school and urban as well as rural boys and girls.

These recommendations link into the work already developed for a multi-faceted strategy to improve adolescent health and wellbeing, as set out in the multi sectorial youth



programme and the teenage pregnancy strategy, as part of the poverty reduction strategy III by the government of Sierra Leone. Under this umbrella activities need to include:

### **Community based strategies**

Develop discussion and reflection opportunities in the communities that will stimulate reflection, discussion and action about:

Ways in which elders and teenagers (10-19 years) communicate with each other in general. Reasons for teenage pregnancy including gender norms, values and roles. This reflection needs to involve boys and girls to come to a new understanding of the roles of men and women in a changing society.

Reduce coercion of girls into sex.

Investigate and reflect on the role of male and female societies in prevention of teenage pregnancy and a modernised form of sex education.

Discuss the dangers of removing girls from school when they are pregnant and explore ways in which the disruption of a girl's education through pregnancy can be avoided.

Consequences of teenage pregnancy for boys and girls and how the community can support them

Community based strategies need to be implemented by NGOs and CBOs partnering with District Health Management Teams and District Social Welfare Offices. Well known approaches such as 'Intergenerational Dialogue' for improving communication between generations have already been introduced in Sierra Leone to address maternal health and teenage pregnancy, but need further development and evaluation. This strategy involves young and older generation male and female groups, is intensive and requires a longer-

term involvement of community groups of about 3 months. A wide-scale evaluation of the lessons learned from various community-based strategies already implemented in Sierra Leone, aiming to reflect and shift norms and values, may assist in developing the most effective approach, as well as action research to scale up these strategies.

Advocacy for addressing teenage pregnancy with community leaders, including religious and traditional leaders and female/male secret societies, is important to conduct just prior to or simultaneously with implementation of the intergenerational dialogue in communities.

The development of role models is well described by UNICEF (2010). Important in the development of role models - also called 'positive deviants' - is to ensure that the positive deviants are developed together with girls and boys. Examples are older boys and girls who have successfully made choices they feel good about. For example, a girl in this study is successful in school, has a boyfriend and uses contraceptives to prevent pregnancy. Another example may be the mother who talked with her daughter about sex and told her to come for money to her rather than exchanging sex for money. An example given during the dissemination meeting is the use of university girls who visited a school where 30% of girls used to get pregnant during school holidays. The visit of the university girls who shared their life with the secondary school girls before they went on holiday reduced the number of girls that got pregnant (the story did not clarify if the girls used more contraceptives or did not have sex).

There is a need to develop support schemes for vulnerable girls. It is important to identify families and girls living in poverty who need support to avoid the need to exchange sex for money to live and to attend school but also to identify teenage girls who are pregnant and are not supported.

The formation of discussion groups including male and female elders and youth to reflect on soaps and other films shown in the community may help to place information and ideas about sex and relationships into perspective.

### **Sex education**

Based on the overwhelming evidence about sex education it is recommended to start sex education before pupils reach the age of 10. A national curriculum needs to be developed based on evidence and experience available (See Kirby, 2006; [www.guttmacher.org](http://www.guttmacher.org)).

The recommendations developed by UNICEF (2010) address comprehensively the way forward for developing information and age-based sex education which they referred to as 'family life education' in schools as well as information and education for out of school youth and parents using other media.

Now radio is the network that reaches almost everywhere in Sierra Leone and therefore the most appropriate network. However technological development goes fast so in addition, social media are an appropriate source for reaching youth with information and stimulation for discussion.

**Providing access to contraceptives**

The strategy for implementing 'youth friendly services developed by the Ministry of Health and Sanitation (MOHSSL, 2012c) makes a very good start. However, experience shows that health professionals need - beside training - supportive supervision and reflection opportunities on the conflict that often emerges between their requirement to support girls and boys with contraceptives and the personal norms and values of the professional. Debriefing and supportive supervision as well as support by NGOs will assist to implement the strategy.

This strategy is best implemented in combination with the above mentioned strategies.

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## Annex 1: Research Table

Objectives	Main research questions	Research methods	Data collection tools	Research participants
<p>1. To describe factors influencing teenage pregnancy and experiences of girls faced with early marriage and teenage pregnancy</p>	<ul style="list-style-type: none"> <li>• What are the perceptions of factors influencing early marriage and teenage pregnancy?</li> <li>• What are the gender roles, norms and values guiding sexual and reproductive health behaviour of adolescent girls and boys?</li> <li>• What traditional education do boys and girls receive and at what age(s)?</li> <li>• What is the impact of early marriage and teenage pregnancy on the teenage mother, the father and the community?</li> <li>• What are the perceptions of adolescents about their sexual and reproductive health needs?</li> <li>• What social and SRH services are available for adolescents?</li> </ul>	<p>In depth interviews girls</p> <p>Focus Group Discussions</p> <p>Semi-structured Interviews</p>	<p>IDI guide 1 and 2</p> <p>FGD 2 guide</p> <p>SSI-1 and 2 and SSI3 guide</p>	<p>20 participants age 19 or less in each of the 3 regions of which at least 10 with a teenage pregnancy</p> <p>2 FGDs with girls and boys between the ages of 15-19 in each intervention community and in the life stories communities in the 3 regions</p> <p>Minimum of 2 informants per community from among the following:  - 1 elderly woman and one from:  PHU, sexual violence clinic staff, Health Management Committee representatives e.g. local councillor, - Chiefs etc.  In each intervention community and in the life stories communities in the 3 regions.  Staff and volunteers in intervention area.</p>

Objectives	Main research questions	Research methods	Data collection tools	Research participants
<p>2. To describe changes in factors influencing teenage pregnancy before and after the interventions</p>	<ul style="list-style-type: none"> <li>• What attitudes and practices do health and other staff, volunteers and elders display towards early marriage, male and female adolescent sexual health needs, gender roles, norms and values related to SRH, harmful practices in childbirth?</li> <li>• What health and other sexual and reproductive health services are available for adolescent boys and girls?</li> <li>• What community actions are taken, what are the perceptions and examples of their effectiveness and why were they effective?</li> <li>• What are improvements in facilitation skills of facilitators?</li> </ul>	<p>Focus group discussions with young and older women and men</p>	<p>Guide FGD1 and FGD2</p>	<p>4 FGDs before and after each intervention community: 1 with girls below 19, 1 with women above 19, 1 with boys below 19 and one with men above 19</p>

## Annex 2: SHR indicators per district

Indicator (Source: MICS 2010 (validated standard tables)	Bombali District	Tonkolili District	Portloko District	Kambia District	Koinadugu district	Bo District	Bonthe District	Moyamba District	Pujehun District	Kailahun District	Kono District	Kenema District	W/A Urban	W/A Rural
Adolescent birth rate (per 1,000; 15-19 years)	122	100	142	159	91	106	129	185	99	159	158	151	98	138
% of women (15-19 yrs) who have had a live birth before 15 years	7	10	6	11	8	8	7	16	13	10	9	6	5	9
% of women (15-19 years) who begun child bearing	33	34	43	43	33	33	40	40	44	39	30	34	23	39
% of women (15-19 years) pregnant with first child	5	2	12	8	4	8	5	9	8	8	3	6	3	8
% of women (15-19 years) married or in union	20	40	35	35	32	19	24	27	34	27	24	19	9	22
% of women (15-49 years) married before 15 yrs	16	24	22	20	11	17	19	19	16	14	17	14	10	14
% of women (15-24 years) who ever had sex	82	93	89	85	71	80	86	89	80	82	77	84	67	76
% women (15-24 years) literate	53	31	36	39	45	50	32	35	33	47	37	37	65	37
% of women (15-49 years) literate*	25	19	20	20	20	34	31	20	16	19	21	21	68	57

\*Different source: SLDHSBS 2009 – characteristics of respondents

### Annex 3: Overview of study communities phases 1 and 2

Phase	District	Chiefdom	PHU village
1	Kailahun	Kissi Teng	Kangama
		Jawei	Daru
	Kambia	Samu	Bapuya
		Magbema	Rokupr
	Moyamba	Banguwa	Sembahun
		Fakuniya	Gandorhun
	Western area*	No chiefdoms, this is western area rural	Tombo
2	Bo	Komboya	Njala Komboya
			Teibor
			Nyagohun
			Small Komboya
		Niawa Lenga	Nengbema
			Sahn
			Ngogbebu
			Korbu

\* field testing area

## Annex 4: Summary of characteristics IDI/SSI respondents

Characteristics IDIs with girls, N=36												
District	Number of interviews	Age range	Average age	Secondary education	Muslim	Christian	Number ever pregnant	Age range during 1st pregnancy	average age first pregnancy	sexually active	Age range sexual debut	Use of modern contraceptives
Kambia	12	15-18	16.8	6	12	0	8	15-18	16.1	11	12-17*	5
Kailahun	12	15-19	16.8	10	4	8	10	15-19	16.1	11	12-17	3
Moyamba	12	15-19	17.5	9	4	8	11	15-18	15.9	12	14-15	4
<b>Total</b>	<b>36</b>	<b>14-19</b>		<b>28</b>	<b>21</b>	<b>17</b>	<b>32</b>	<b>14-19</b>		<b>34</b>	<b>12-17</b>	<b>12</b>

\*excluding one report of a 5 year old girl who had been sexually molested

Characteristics SSIs with elderly women, N=14					
District	Number of interviews	Age range	Average age	Education (range)	Role or position
Kambia	2	40-45	43	None	Sowe, TBA, Mama Queen
Kailahun	2	50-60	55	None	Sowe, Mama Queen
Moyamba	2	40-56	48	Primary-SSS 3	Sowe, TBA, Mama Queen
Bo	8	45-85	64	None	Sowe, TBA

Characteristics SSIs with community leaders and health workers N=35					
District	Number of interviews	Age range	Average age	Education (range)	Role or position
Kambia	7	30-70	55	None-SSS 3	MCH Aide, Imam, Chief, Pastor
Kailahun	6	43-57	53	Tertiary	CHO, Pastor, Imam
Moyamba	6	29-56	41	Tertiary	CHO, Pastor, Teacher, Chief
Bo	16	25-85	42	None-Tertiary	MCH Aide, CHO, CHA, Imam, Pastor

## Annex 5: Summary of characteristics FDG respondents

Characteristics respondents FGDs						
	Gender					
<b>District</b>	<b>male</b>	<b>female</b>	<b>Age range</b>	<b>Age average</b>	<b>Sec edu</b>	<b>Mende</b>
Kailahun	24		14-19	17.2	13	11
Kailahun		28	13-19	16.9	14	18
Moyomba	25		15-19	16.5	24	25
Moyomba		19	15-19	17.6	19	18
Kambia	20		14-19	15.7	20	
Kambia		20	14-17	15.4	16	
Bo	96		15-19	17	42	96
Bo		84	15-19	16.6	21	84
FGD boys	165		14-19	16.6	99	132
FGD girls		151	13-19	16.6	70	120



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Since the end of the civil conflict in 2002, Sierra Leone has worked hard on rebuilding its health and social system. Although progress has been made in reducing maternal mortality, the number of women who die as a result of complications during pregnancy and/or childbirth is still one of the highest in the world. The high number of pregnant girls and teenage mothers has severe health and social consequences and contributes to the problem of maternal mortality in Sierra Leone.

KIT and partners in Sierra Leone and the Netherlands have joined forces with the Government of Sierra Leone to investigate and address teenage pregnancy through knowledge sharing capacity building and the development of interventions. This work is carried out within the Public Private Partnership (PPP) Sierra Leone, one of the programmes that make up the MDG5 Meshwork for improving Maternal Health\*.

This report includes the justification, methodology, results and recommendations of a qualitative study interviewing teenage girls who were pregnant or had been pregnant, and focus group discussions with their peers, elders and leaders in various communities in Moyamba, Kailahun, Kambia and Bo. The report describes the stories of the girls who became pregnant. The reasons for their pregnancy and the consequences of their pregnancy for them, their family and the man/boy who impregnated the girl are described as well. These stories were used in the training of health workers, for the development of a community education strategy. The report formulates implications and recommendations for further policy and strategy development for adolescent sexual and reproductive health in Sierra Leone. The latter are also based on the outcomes of a discussion of implications during a dissemination meeting of the results in Sierra Leone.

\*Part of the knowledge strengthening component of the MDG5 Meshwork Public Private Partnerships Programme for the improvement of Maternal Health in Sierra Leone.



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