RECOVERING FROM THE EBOLA VIRUS DISEASE:
RAPID ASSESSMENT OF PREGNANT ADOLESCENT GIRLS IN SIERRA LEONE

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Abbreviations

ANC	Antenatal care
CBO	Community Based Organizations
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
DAFP	District Assessment Focal Point
EVD	Ebola Virus Disease
FP	Family Planning
FSU	Family Support Unit
GBV	Gender Based Violence
HRH	Human Resources for Health
IUD	Intrauterine device
MEST	Ministry of Education, Science and Technology
MICS	Multiple Indicator Cluster Survey
MoHS	Ministry of Health and Sanitation
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
NSRTP	National Secretariat for the Reduction of Teenage Pregnancy
PHU	Peripheral Health Unit
PNC	Postnatal care
SBA	Skilled Birth Attendant
SLDHS	Sierra Leone Demographic and Health Survey
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive summary

The assessment of adolescent pregnancy in Sierra Leone was undertaken in order to map and identify adolescent girls (aged 10-19 years) who got pregnant during the Ebola crisis, to enable an understanding of the reproductive health needs and well-being of adolescent girls in order to inform programming. Pregnancy is one of the leading causes of adolescent deaths in sub-Saharan Africa, where adolescents bear the greatest burden of pregnancy-related morbidity and mortality. The adolescent birth rate in Sierra Leone is higher than average for sub-Saharan Africa. Key factors associated with adolescent pregnancy are age at first sex, early marriage, contraceptive use and education. It is believed that the Ebola crisis that led to the closure of schools and degradation of health systems (Oyedele et al., 2015; Loaiza & Liang, 2013) further led to the increase in teenage pregnancies.

The study surveyed adolescent girls who were pregnant or had recently delivered in the 14 districts of Sierra Leone to assess their health, education and social welfare contexts. Data collection was conducted in July and August 2015 in 12 districts — Bo, Bombali, Bonthe, Kailahun, Kenema, Kono, Koinadugu, Moyamba, Pujehun, Tonkolili, Western Area Urban, Western Area Rural — and in two districts (Kambia and Port Loko) in November and December 2015.

A total of 18,119 adolescent girls were included in the final analysis, the majority (58 per cent) were between the ages of 18–19 years, not married (77 per cent) and who had attended formal schooling (at least 80 per cent); however only 9 per cent were currently attending school. Money was cited as the most common barrier to returning to school by 51 per cent of the adolescents whereas only 5 per cent cited the stigma of pregnancy. Among the adolescents who dropped out as a result of the pregnancy, the majority (76 per cent) would have liked to return to school but money was cited as the main hindrance. More than half (57 per cent) of the adolescent girls were pregnant at the time of the survey with most (88 per cent) reporting first-time pregnancies and in their third trimester. A high percentage of 15–17-year-old girls had a first-time pregnancy during the Ebola outbreak period (42 per cent).

The ever use of any kind of family planning was reported by less than a third (31 per cent) of the girls. The overall proportion of antenatal care (ANC) – at least one visit for adolescent girls that were pregnant or had delivered – was 15 per cent. The majority (80 per cent) that had delivered did so in a health facility. With regard to care and financial support of the child, the majority (45 per cent) expected financial support and care from the father of the child.

This report is divided into four substantive chapters: chapter one provides the context of adolescent well-being in Sierra Leone in which this assessment is undertaken. It assesses health, social welfare and education as it relates to adolescent pregnancy in the context of Ebola, and explains the rationale for the assessment.

Chapter two details the quantitative data sources and methods of data analysis adopted in the study. It defines the sampling technique, including the research tool and the data analysis. Chapter three presents the results from the data analysed on health as it relates to pregnancy (ANC and postnatal care, site of delivery and family planning), social welfare (marital status, care and financial support of children and the experience of violence) and education (current school enrolment, barriers to schooling, and awareness of and access to learning facilities).

Chapter four is a discussion of the general findings as they relate to adolescent health, social welfare and education among adolescent girls in Sierra Leone, and includes the limitations of the data and recommendations for future studies and actions.

1. Background and introduction

Pregnancy is one of the leading causes of death for adolescents in sub-Saharan Africa (SSA), where adolescents bear the greatest burden of pregnancy-related morbidity and mortality (Das Gupta et al., 2014). Globally, adolescent mothers are twice as likely

to die from pregnancy-related complications compared to their counterparts aged 20 years or older (WHO, 2012). Adolescent pregnancy and childbearing have severe effects on the health, education and social well-being of adolescent girls and their children.

Sierra Leone is one of the countries in SSA with poor reproductive health outcomes, particularly among adolescents. The 2013 Sierra Leone Demographic and Health Survey (SLDHS) shows a high adolescent birth rate of 125 births per 1,000 women, despite a modest decline from 146 births per 1,000 women in 2008. The modest decline in the adolescent birth rate is insufficient for the improvement of the overall well-being of adolescents including maternal health (Nove et al., 2014).

This is a higher than average rate for the sub-Sahara African region. As of 2013, Sierra Leone was ranked one of the top 10 countries with the highest percentage of adolescent pregnancies, where 38 per cent of women aged 20–24 years had given birth by the age of 18 (UNFPA, 2013). Furthermore, according to the 2013 SLDHS, the proportion of adolescent girls who had begun childbearing ranges from 5.6 per cent at age 15 to nearly 60 per cent by age 19 (SSL and ICF International, 2014).

Adolescent pregnancy has been receiving much attention in Sierra Leone, particularly in recent years following the establishment of the National Secretariat for the Reduction of Teenage Pregnancy. Sierra Leone is now developing a new Strategy for the Reduction of Teenage Pregnancy in 2016 to replace the preceding 2013–2015 strategy, entitled *Let Girls be Girls, not Mothers* (GoSL, 2013). The strategy is a multi-sectoral approach to early childbearing involving five ministries in health, education, social protection, gender and youth employment and empowerment. However, since the Ebola outbreak was declared a national emergency in July 2014, many of these developmental programmes were reduced or immobilized entirely. This assessment provides information that enables the identification of appropriate interventions and appropriation of resources for adolescent girls. Key recommendations are made at the end of this report to guide such planning and interventions.

1.1. Reproductive health of adolescents

Access to family planning (FP) is imperative to prevent adolescent pregnancy. In Sierra Leone, less than a third of women aged 15–19 years use modern contraceptives (21 per cent). There are disparities by marital status, whereby the uptake of modern contraceptives among currently married 15–19 year olds is considerably lower (8 per cent) than that of their unmarried counterparts (54 per cent). Adolescents have the highest unmet need for FP, where the majority of the unmet need is for spacing births (30 per cent) rather than for limiting them (1 per cent) (SSL and ICF International, 2014).

Adolescent mothers in SSA comprise 20 per cent of maternal deaths, most of which are due to complications from unsafe abortions (Ganchimeg et al., 2014). Nearly 20 million women have an unsafe abortion in SSA and adolescent girls account for the largest proportion of them (57 per cent) (Sedgh et al., 2015; Prata, Weidert and Srinivas, 2013). Although there is no adolescent specific data on abortion in Sierra Leone, 40 per cent of maternal deaths occur as a result of teenage pregnancy in the country (SSL and UNICEF, 2011). Adolescent girls are particularly vulnerable due to their incomplete physiological development, increasing the risk for pregnancy-related complications, such as premature delivery, stillbirth, foetal distress, birth asphyxia, low birth weight and miscarriage (Chandra-Mouli et al., 2014). Children born to adolescent mothers have higher mortality rates than those born to women aged 20 or older. Babies born to adolescents are 50 per cent more likely to be stillborn or die in the first week of life compared with babies born to older women (WHO, 2012).

The risk of newborn death is reduced when delivery takes place in a health facility or the labour is supervised by a skilled birth attendant (SBA) and takes place under sanitary conditions. For pregnant adolescents who choose to carry the pregnancy to term, antenatal care (ANC) is an important entry point to the continuum of care, providing an avenue for encouraging facility delivery and subsequent postnatal care (PNC). Prevention and early detection of potential complications by a trained physician or midwife can greatly improve the chances of mother and child survival. While there is no age specific data on ANC 1 and ANC 4 visits in Sierra Leone, about 68

per cent of women under 20 years received at least one ANC visit from a nurse or midwife, and about 25 per cent from a Maternal and Child Health Aide in 2013. A very small proportion (0.4 percent) received ANC from a traditional birth attendant (TBA) (SSL and ICF International, 2014).

Children of adolescent mothers start their lives at a disadvantage, thus perpetuating a cycle of poverty and relative deprivation (Masikwa et al., 2015). Often, adolescent mothers are hypothesized to have poorer care practices due to their lack of experience. A mixed methods study of adolescent mothers' care practices in Sierra Leone found that some care practices, including exclusive breastfeeding suffered due to the adolescent's lack of experience and knowledge of child rearing (Lai and Towriss, 2014).

1.2. Social welfare and adolescent pregnancy

Poverty has been found to motivate early marriages and teenage pregnancies due to lack of employment and job opportunities (Juma et al., 2014; Mchunu et al., 2012). The majority of adolescents in Sierra Leone grow up in poverty, where they face challenges of education and inadequate health systems, have limited access to sexual and reproductive health services and a paucity of jobs or income-earning opportunities. With limited resources and opportunities, adolescents in poverty engage in desperate survival strategies, such as exchanging sex for basic necessities, including access to housing, food, education and health care (Kamndaya et al., 2015; Miller et al., 2015). However, transactional sex as such generally involves intergenerational partnerships (partners >10 years), which increases the vulnerability of adolescent girls to victimization (Jewkes and Morrell, 2012). Several studies have highlighted age differentials in young women's relationships and the problem of coerced and transactional sex, and observed that young women are unable to negotiate safe sex because of the way gender inequality plays out in the realm of intimacy (Van Decraen et al., 2012; Nobelius et al., 2011).

There is a strong association between repeat pregnancy and having a partner who is much older, where females who engage in age-disparate relationships are more than

twice as likely to have a repeat pregnancy (Mphatswe, Maise and Sebitloane, 2016; Toska, Cluver and Boyes, 2015). Child marriage, defined as marriage or cohabitation before age 18, undermines a girl's right to autonomy, to live a life free from violence and coercion, and to attain an education (UNICEF, 2014). Early marriage exposes adolescents to a range of risks including high-risk pregnancy and births, intimate partner violence and low decision-making power (Santhya et al., 2010). Compared with those who marry at or after age 18, girls who marry before age 18 have higher rates of repeated unwanted pregnancies, obstetric fistula and intimate partner violence (Erulkar, 2013; Santhya et al., 2010).

The context of unequal partnerships, particularly in intergenerational relationships, means that male partners often strongly influence females' contraceptive and other health choices (Mphatswe et al., 2016). About 22 per cent of adolescent girls in Sierra Leone who had sexual intercourse in 2013 reported having a partner who was 10 years or older than them (SSL and ICF International, 2014). The subjection to intense gender-based violence (GBV) disproportionately affects females, giving them little negotiating power over safe sex, such as the use of contraceptives to prevent unwanted or unintended pregnancies. A qualitative study conducted by UNICEF (2010) in Sierra Leone indicated that nearly 80 percent of pregnancies amongst adolescent girls are unwanted pregnancies. This study also revealed that almost all girls reported not feeling ready for sex at the time of sexual debut, with many feeling "forced."

In 2003, the Sierra Leone Police established the Family Support Unit (FSU) to deal specifically with gender-based violence as well as domestic violence. There are 34 FSUs throughout the country; however, the low reporting of violence reflects a norm in Sierra Leone, whereby issues around violence against girls are dealt with between families, rather than through formal structures. Traditional leaders are also often called upon as arbitrators in resolving conflicts around GBV (Farzaneh, 2013).

Early or forced marriage is a risk factor for pregnancy amongst adolescent girls based on the likelihood that frequency of sexual activity is higher among married women or women in union (WHO, 2012; SSL and ICF International, 2014). In Sierra Leone, 38.9

percent of women age 20–24 are married before age 18 (SSL and ICF International, 2014). Furthermore, married adolescent girls have significantly less access to education than their unmarried counterparts (Coinco, 2008).

Child marriage has decreased steadily in Sierra Leone over the last decade. In 2013, the SLDHS reported that about 13 percent of women aged 20–24 are married by age 18, a six-percentage point decrease from the 2008 SLDHS (SSL and ICF International, 2014; 2009). It is thought that the high incidence of school dropouts between primary school classes four and six is attributed to early or forced marriage, particularly customary marriages, which are linked to secret society initiation ceremonies (Coinco, 2008).

1.3. Education and adolescent pregnancy

Staying in school has been found to be a protective factor in terms of delaying sexual activity and teenage pregnancy. In a retrospective study among young people (18–24 years) in urban Kenya, women who had dropped out of school were more likely to initiate sexual activity compared to their counterparts (Clark and Mathur, 2012; Kabiru et al., 2010). Similarly, a longitudinal study among adolescents aged 12–18 years in rural South Africa found schooling to be a protective effect against pregnancy, with those out of school more likely to have higher pregnancy rates compared to their counterparts in school (Rosenberg et al., 2015). Not having formal education can have serious socioeconomic consequences for adolescent girls that will not only affect them directly, but also their children and the overall community, making poverty a hard cycle to break.

Financial barriers are the biggest obstacle to the re-entry of young mothers back into formal school. A cross-sectional study in Freetown, Koinadugu and Pujehun districts in Sierra Leone on the care practices of adolescent mothers showed that the lack of financial support reduced the probability of young mothers who dropped out of school resuming their education (Lai and Towriss, 2014). Furthermore, the arrival of a baby into a family affects the school support received from the family due to limited resources at the household level (Coinco, 2010).

1.4. Adolescent pregnancy in the context of Ebola

In May 2014, Sierra Leone recorded its first Ebola case, and in July 2014, the Government of Sierra Leone declared a state of emergency due to the rapid spread of the Ebola virus disease (EVD). Various aspects of the economy including health service delivery and social well-being were drastically affected during this period.

With the near collapse of the non-Ebola health care system, health service utilization rates saw a remarkable decline. This decrease was symptomatic of increasing distrust and fear of the health system, as well as the insufficient numbers of health care workers in facilities (UNFPA, 2015). By October 2014, Sierra Leone had recorded a 23 per cent drop in institutional child deliveries compared with previous years (UNDP, 2015). Human resources for health (HRH) shortages have been a long-standing challenge for Sierra Leone's health system. This was compounded by the Ebola epidemic, which saw the loss of about 7 per cent of the national stock of health workers (Evans, 2015).

Nearly a year and a half after the first confirmed Ebola case, a cumulative total of 8,704 confirmed cases were reported, with 3,589 deaths. Throughout the outbreak, in an attempt to curb the spread of the virus, the Government of Sierra Leone enforced national restrictions on movement and trade, which saw an adverse effect on the economic situation in nearly every district in the country (SSL and World Bank, 2015). The Government of Sierra Leone also closed all schools, with the aim of protecting school children from contracting the virus. This led to the loss of almost a whole academic year, and perhaps more significantly, jeopardized the continuation of education for many, particularly adolescent girls.

Before the Ebola outbreak in Sierra Leone, the primary school attendance rate was 73 per cent for boys and 76 per cent for girls, and secondary school attendance was 40 per cent for boys and 33 per cent for girls.

Before the Ebola Outbreak in Sierra Leone, the national gender parity index was 1.02 at primary level and 0.84 at secondary school, where the gap in enrollment began once female students reached child-bearing age (World Bank, 2014). As the number of new EVD cases fell, approximately 1.8 million children in Sierra Leone started returning to school on 14 April 2015 after an eight-month break. On 2 April 2015, the Ministry of Education, Science and Technology (MEST) published a position paper stating that visibly pregnant girls were not allowed in the school setting. The Government of Sierra Leone (GoSL), however, expressed commitment that the special needs of adolescent girls who had become pregnant during the Ebola crisis needed to be taken into account and responded to, and took action to provide services to pregnant school girls including:

- setting up special modalities for pregnant girls to continue their education on core subjects so that they could be reintegrated into formal education after delivery;
- providing health information and access to maternal and neonatal health services, GBV and psychosocial support.

1.5. Rationale for the assessment

The EVD epidemic was associated with an anecdotal increase in adolescent pregnancy. There was an urgent need to estimate the number of adolescent pregnant girls who may have conceived and delivered during the Ebola outbreak, in order to inform health, social welfare and educational programming to reduce the ongoing impact of the Ebola outbreak on the lives of these girls.

This quantitative assessment was therefore conducted in the context of this crisis, in order to respond to the urgent need for data to assess adolescent well-being in relation to teenage pregnancies in order to inform programming needs. The national teenage pregnancy assessment therefore had the following objectives:

i. To determine the number of adolescent girls (in school and out of school) who got pregnant or delivered during the Ebola virus epidemic;

ii. To determine the areas where adolescent girls (in school and out of school) got pregnant or delivered during the Ebola virus epidemic;
iii. To identify the health care, education support and social welfare needs of pregnant and recently delivered adolescent girls;
iv. To inform the strategic plans of the MEST, the Ministry of Health and Sanitation (MoHS) and the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA) for pregnant adolescent girls (≤19 years) in Sierra Leone.

2. Methodology

2.1. Study design and data collection

The assessment was conducted in two phases using a cross-sectional quantitative survey. The same methodology and design (questionnaire, eligibility criteria and category of enumerators) was used in both phases:

Phase I: Data was collected from 12 districts: Bo, Bombali, Bonthe, Kailahun, Kenema, Koinadugu, Kono, Moyamba, Pujehun, Tonkolili, Western Area Rural and Western Area Urban, between July and August 2015.

Phase II: Data was collected from two districts: Kambia and Port Loko, between November and December 2015.

2.1.1. Data collection tool

The survey used a simple questionnaire for data collection, consisting a total of 27 questions, divided into three sections: (i) health (ii) education and (iii) social welfare. The questionnaire was slightly revised after Phase I. Whereas the Phase I version of the questionnaire asked the respondents whether there were learning facilities and materials available, the Phase II questionnaire was updated to include the kind of facilities and materials accessible to the girls. (See Annex I for Phase I questionnaire and Annex II for Phase II questionnaire).

The questionnaire was pre-tested on a small sample of the target population in Freetown, in July 2015. Questionnaires were verbally translated into the local languages by the enumerators for each chiefdom/ward, which took approximately 30 minutes. Upon review of the results from the pilot test, the questionnaire was slightly revised in the education section to include specific questions on learning materials (including exercise books, pens, core text books and radio education programs) available in the communities.

2.1.2. Consultations with stakeholders

The questions were formulated in collaboration with the relevant line ministries (MEST, MoHS, MSWGCA and ministries constituting the Teenage Pregnancy Secretariat) to ensure that the survey captured data that would be relevant for future programming.

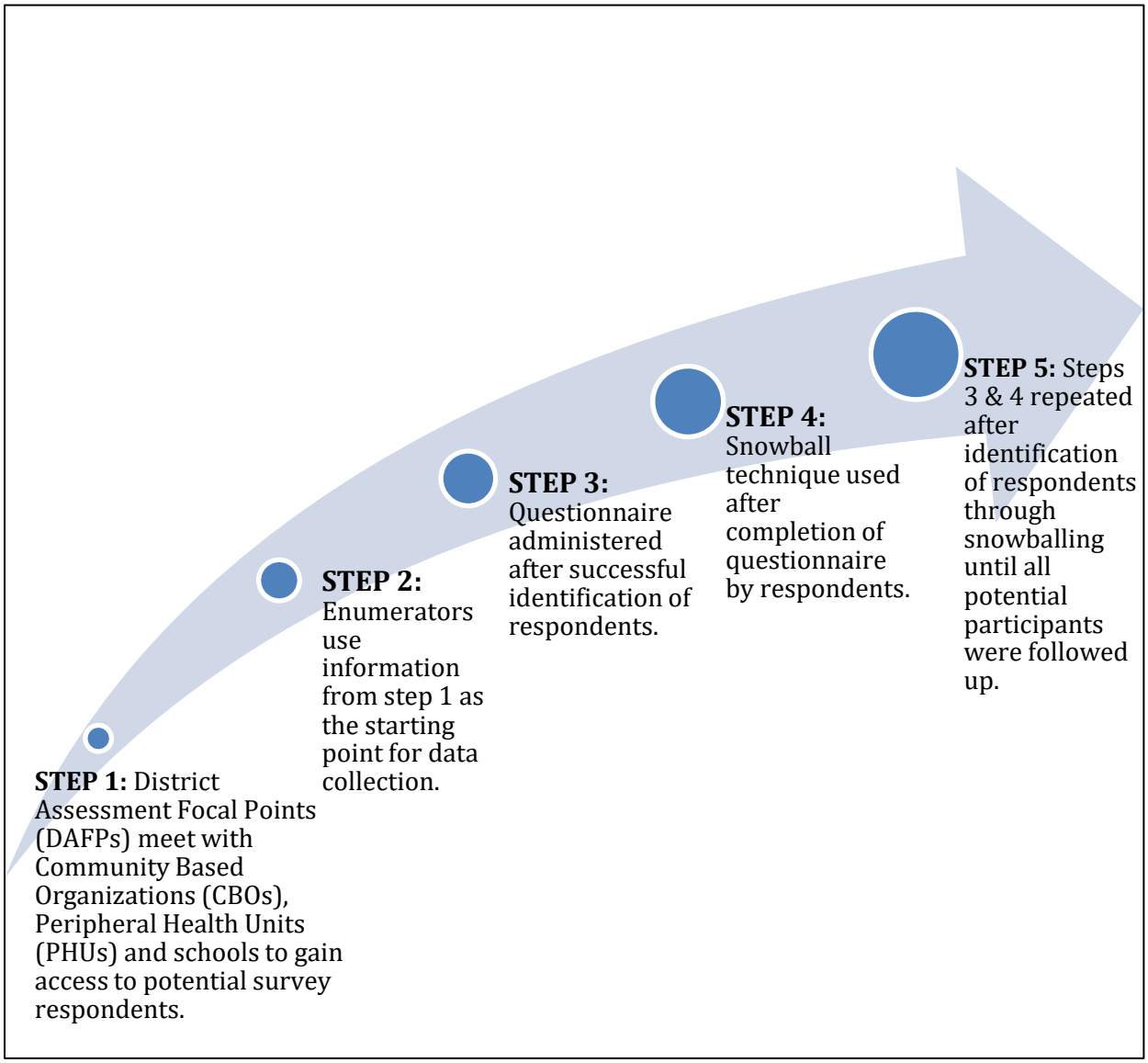
The methodology, including the questionnaire, was presented to key stakeholders for the endorsement of the assessment protocol and questionnaire.[1] Based on feedback from the meeting, the methodology (including the questionnaire) was refined. The involved institutions that contributed to the validation of the assessment protocol and methodology is available in Annex IV.

2.2. Sampling technique

District Assessment Focal Points (DAFP) were deployed from the District Surveillance teams and were tasked with taking the initial steps in locating respondents, which included meeting with Community Based Organizations (CBOs), staff from Peripheral Health Units (PHUs) and schools.[2] After respondents were located, the snowball sampling approach was used until each area was exhausted. The snowball sampling approach, which included recruiting potential adolescents referred by recruits from PHUs, CBOs or schools, was deemed particularly appropriate in reaching adolescent girls who may have been missed in places of recruitment. Figure 2.1 illustrates the steps undertaken to identify survey respondents.

1. Stakeholders were consulted at the Special Needs meeting on the 3 July 2015. The Special Needs group is chaired by the MEST and is tasked with ensuring the educational needs of special populations are met. The group mainly focuses on pregnant teenagers and the visually impaired.
2. The District Assessment Focal Points were UNFPA staff who were posted in each district and embedded within the surveillance team of the district health management teams. For the purpose of the assessment they oversaw training and data collection in the districts.

Figure 2.1: Steps used in identifying potential survey respondents



2.2.1. Inclusion criteria

Respondents were selected if they fitted the following study criteria:

- Females aged 10 to 19 years (adolescents);
- Became pregnant between September 2014 and the time of data collection; or
- Had delivered between May 2015 and the time of data collection.

Girls who met the above criteria and were willing to self-report as pregnant or delivered were included. Three screening questions were formulated to ensure that the adolescent girls interviewed matched the case definition. Parental/guardian consent was sought for girls aged 17 years or younger (see Annex I).

2.2.2. Training and data collection

DAFPs received a two-day training in order to cascade training to enumerators (contact tracers) at the chiefdom or ward levels. The training included role plays and participatory learning to ensure the proper administration of the questionnaire, as well as consent procedures and handling of sensitive data. DAFPs collected completed questionnaires in at least three chiefdoms/wards in their district each day. They were charged with ensuring quality data collection and addressing ambiguities in completed questionnaires.

Training was then cascaded by DAFPs to the district level. District-level trainings covered 432 enumerators in one-day training sessions in each district capital. The district trainings were conducted by 18 facilitators and supported by 56 representatives from partnering institutions and organizations (MEST, MoHS/District Health Management Team, MSWGCA, Statistics Sierra Leone and various Non-Governmental Organizations in the districts).

In Phase I, 402 enumerators collected data for the 24 July to 6 August 2015 period. In Phase II, data collection was conducted by 44 enumerators over a 14-day period in November 2015. Monitoring teams comprising of the DAFP, UNFPA Technical Specialists, District Statisticians and at least one staff from the involved line ministries were in the field for the entirety of the data collection period to supervise the enumerators. Interviews were conducted in chiefdoms and wards across all districts by at least two enumerators per chiefdom and ward.

2.3. Data entry and analysis

The data from completed questionnaires were inputted into a simple Excel spreadsheet on a daily basis by DAFPs. Data entry clerks, district statistics officers or monitoring and evaluation managers also assisted with data entry. DAFPs sent the compiled raw data to a UNFPA consultant at the end of every data collection day. Data was compiled centrally by the consultant into an Excel spreadsheet and exported to STATA (statistical analysis software) for analysis providing descriptive statistics on

each indicator. An independent UNFPA consultant performed a reanalysis of the data and contributed to the write-up of this report.

3. Results

This section highlights the results from the assessment of teenage pregnancy in the 14 districts in Sierra Leone during the Ebola outbreak period. A total of 18,160 girls were interviewed, 41 of whom were then excluded as they didn't match the inclusion criteria. Thus, a total of 18,119 adolescent girls (10–19 years) were included in the final analysis.

3.1. Socio demographic characteristics of adolescent girls

Table 3.1 presents the distribution of adolescent girls aged 10–19 years by selected characteristics. The distribution of adolescents shows that over 50 per cent of girls were aged 18–19 years, the majority were not married (71 per cent) and at least 80 per cent had attended school at some point. The distribution of adolescent girls in each district is evenly distributed, but the majority were from Port Loko (12 per cent) and Western Urban (13 per cent). At least 57 per cent of girls interviewed were pregnant at the time of the survey.

Table 3.1: Characteristics of adolescent girls interviewed

Characteristics	Percentage	Number
Age		
10–14	2.5	451
15–17	39.0	7,072
18–19	57.8	10,473
Missing	0.7	123
Marital status		
Married	28.2	5,109
Unmarried	71.1	12,881
Missing	0.7	129
Pregnancy status		
Pregnant	56.6	10,252
Delivered	43.1	7,804
Missing	0.3	63
Education		
Ever attended	80.0	14,488
Never attended	19.3	3,502
Missing	0.7	129
District		
Bo	6.5	1,185
Bombali	6.4	1,162
Bonthe	4.9	883
Kailahun	5.4	980
Kambia	8.8	1,591
Kenema	8.4	1,522
Koinadugu	4.6	832
Kono	4.6	829
Moyamba	5.4	980
Port Loko	12.0	2,183
Pujehun	6.7	1,208
Tonkolili	8.0	1,450
Western Rural	5.3	953
Western Urban	12.7	2,302
Missing	0.3	59

Of the adolescent girls that were pregnant, the district with the highest proportion was Western Urban (12 per cent), whereas the district with the highest proportion of adolescent girls that had delivered was Port Loko (16 per cent) (Figure 3.1).

Figure 3.1: Proportion of adolescent girls aged 10–19 years by pregnancy status and district

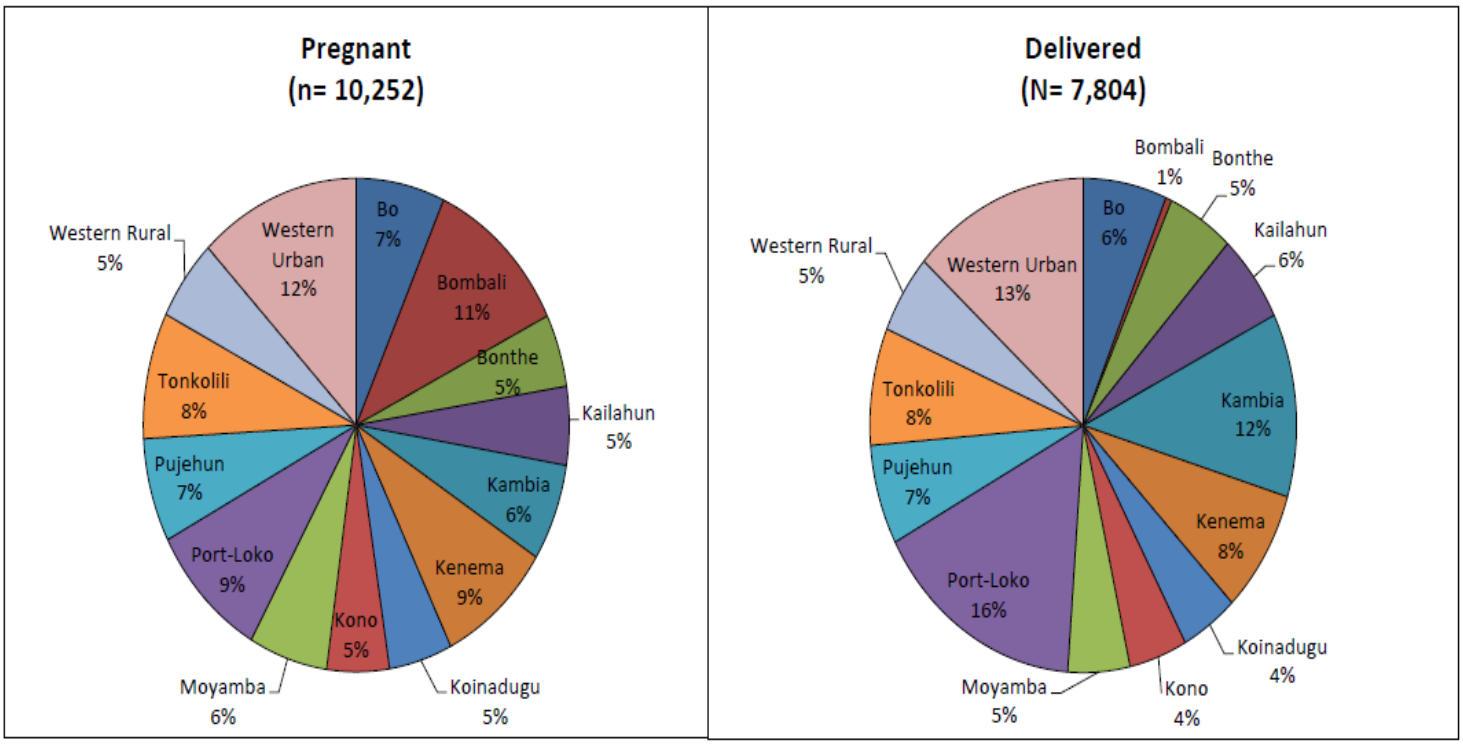
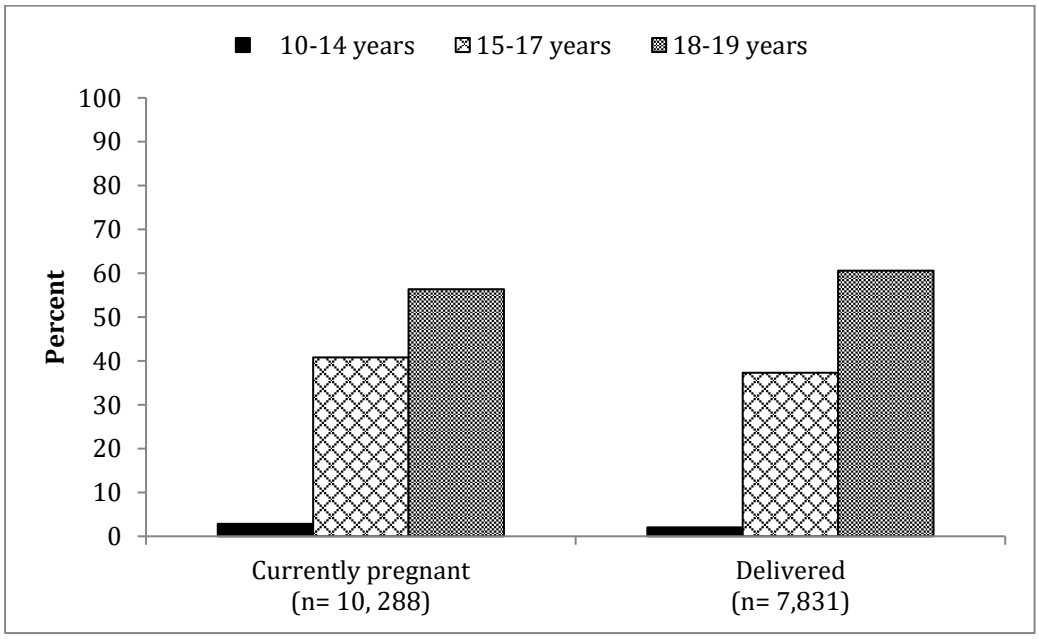


Figure 3.2 shows the percent distribution of adolescent girls by pregnancy status and age. Over half of the girls between the ages of 18–19 years (56 per cent) were pregnant or (60 per cent) had delivered.

Figure 3.2: Proportion of adolescent girls aged 10–19 years by pregnancy status and age

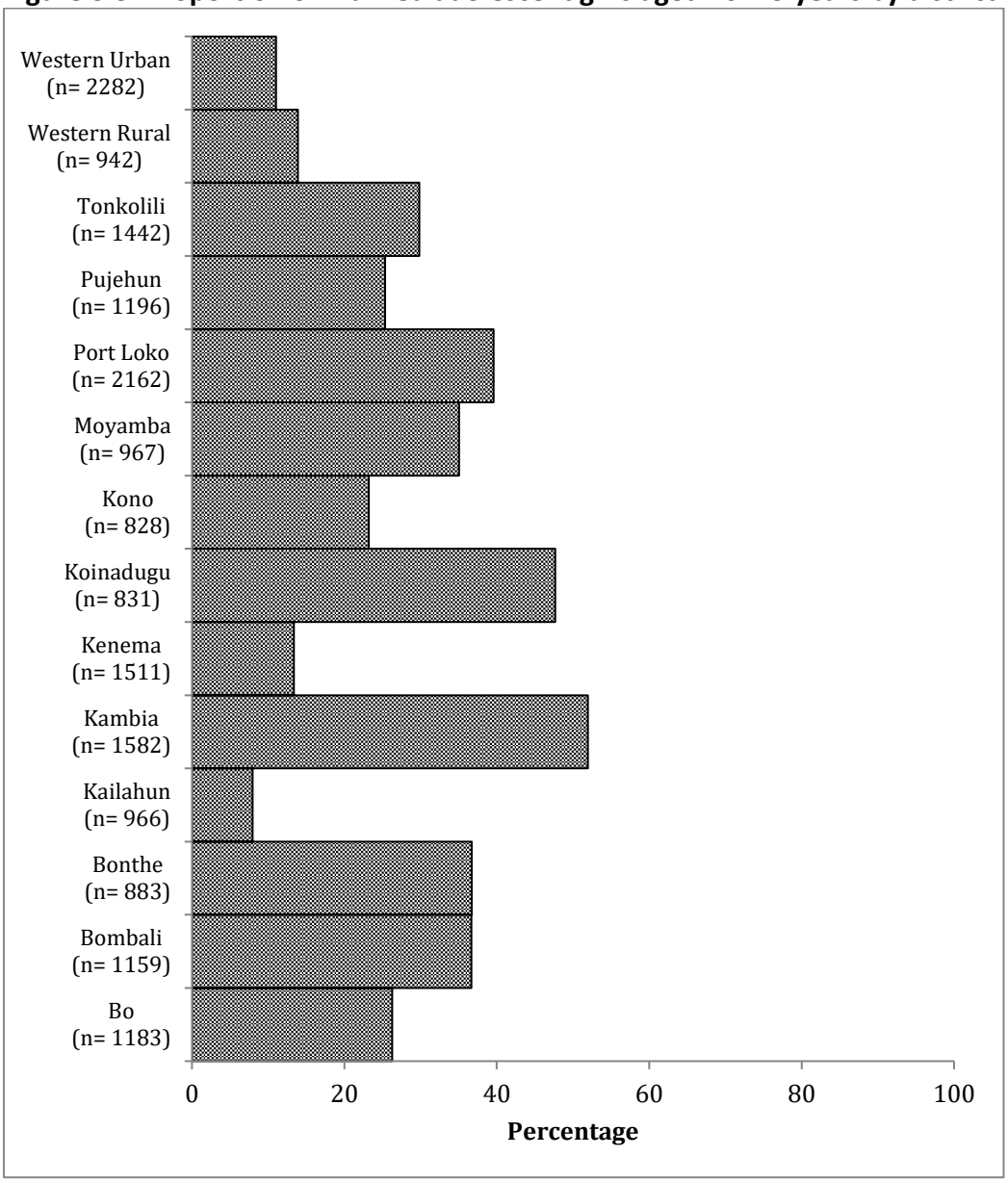


Marital status

Data on marital status was available for 17, 871 adolescent girls. The overall majority of adolescent girls were not married at the time of the survey (72 per cent). The majority of married adolescents were between the ages of 18–19 years (65 per cent) [n= 3,303]. Two per cent of the very young adolescents were married [n=88].

Figure 3.3 shows the proportion of married adolescent girls by district. Over half of the married respondents were from Kambia district (52 per cent), while Kailahun district had the lowest proportion of married adolescent girls (8 per cent).

Figure 3.3: Proportion of married adolescent girls aged 10–19 years by district



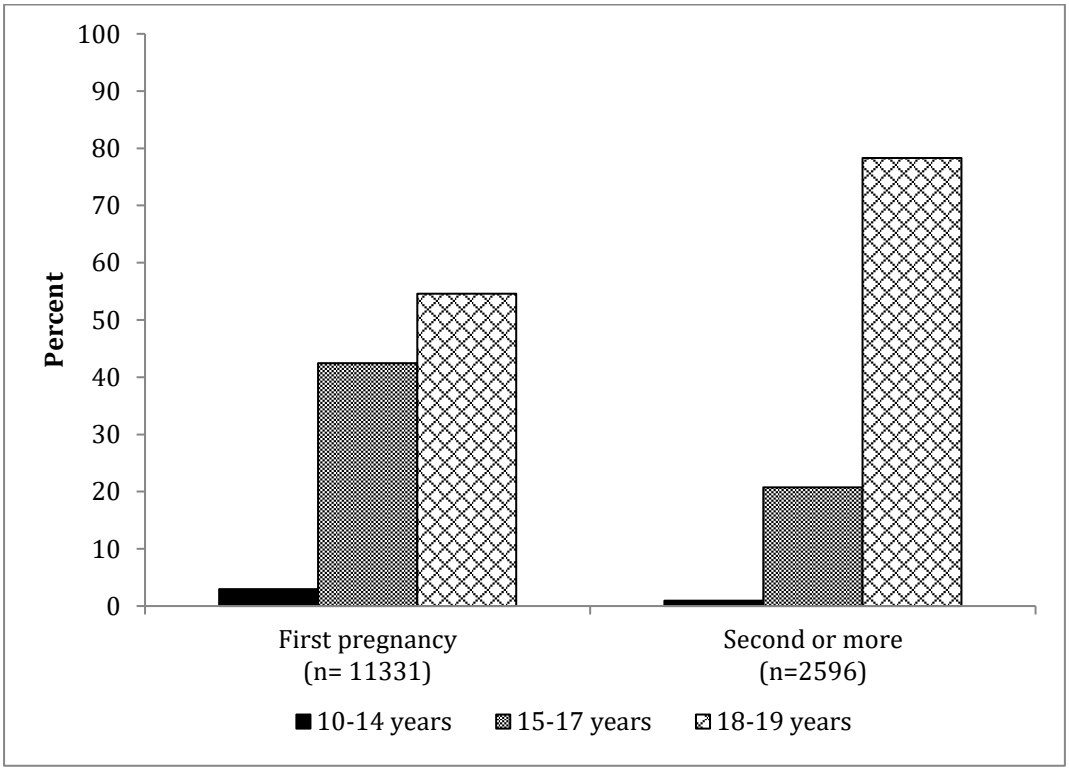
3.2. Adolescent health

This section presents the results of the assessment of adolescent girls' health as it relates to pregnancy (including number of pregnancies, pregnancy trimester and complications in pregnancy/stillbirths), ANC and PNC, site of delivery (whether facility or home-based, presence of an SBA and FP.

3.2.1. Pregnancy

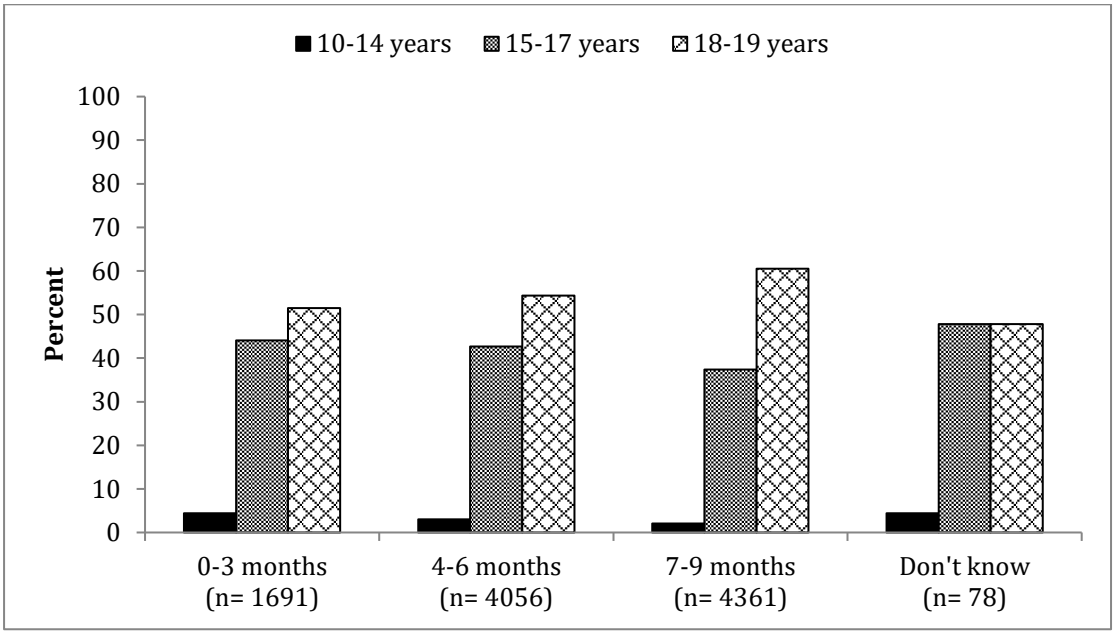
Overall, about 88 per cent (11,331) of the respondents reported a first-time pregnancy and about 12 per cent (1,604) reported a repeat pregnancy. Figures 3.4 show the proportion of adolescents by number of pregnancies and age respectively. Over three-quarters of the 18–19-year-old girls had repeat pregnancies (78 per cent), although information on the specific number of repeat pregnancies was not available. It is worth noting as well that a high percentage of 15–17-year-old girls had a first-time pregnancy during the Ebola outbreak period (42 per cent).

Figure 3.4: Proportion of adolescent girls aged 10–19 years by number of pregnancies



Data for the pregnancy trimester was available for 10,359 adolescent girls. A big proportion (42 per cent [n=4,378]) were in their third trimester, the majority of whom were 18–19-year-olds (61 per cent) (see figure 3.5).

Figure 3.5: Proportion of adolescent girls aged 10–19 years by pregnancy trimester and age



Of the 12,692 adolescent girls who were pregnant or had delivered, about 27 per cent (3,464) reported a complication in their pregnancy. Details on the nature of complications were not collected; however, the majority of girls reporting a complication were between the ages of 18 and 19 (59 per cent). Additionally, of the 8,138 adolescent girls who had delivered, 10 per cent had stillbirths. The proportion of stillbirths was higher among 18–19-year-olds and 15–17-year-olds (56 per cent and 42 per cent respectively).

3.1.2. Antenatal and postnatal care

ANC and PNC are important for preventive care and treatment as well as opportunities for education and counselling. Overall out of 10, 653 adolescent girls (10-19 years) the proportion who had at least one ANC visit was 15 per cent (n= 1624). Figure 3.6 shows the proportion of pregnant adolescents by ANC visit and disaggregated by trimester

status. Of the 783 girls in their first trimester (0-3 months), over half (58.2%) had at least one ANC visit.

Of those who reported that they had at least one ANC visit, over half (55 per cent) were in their second trimester whereas surprisingly only 15 per cent of those in their third trimester reported having had at least one ANC visit.

Figure 3.6: Proportion of pregnant adolescents (10–19 years) with at least one ANC visit by trimester status

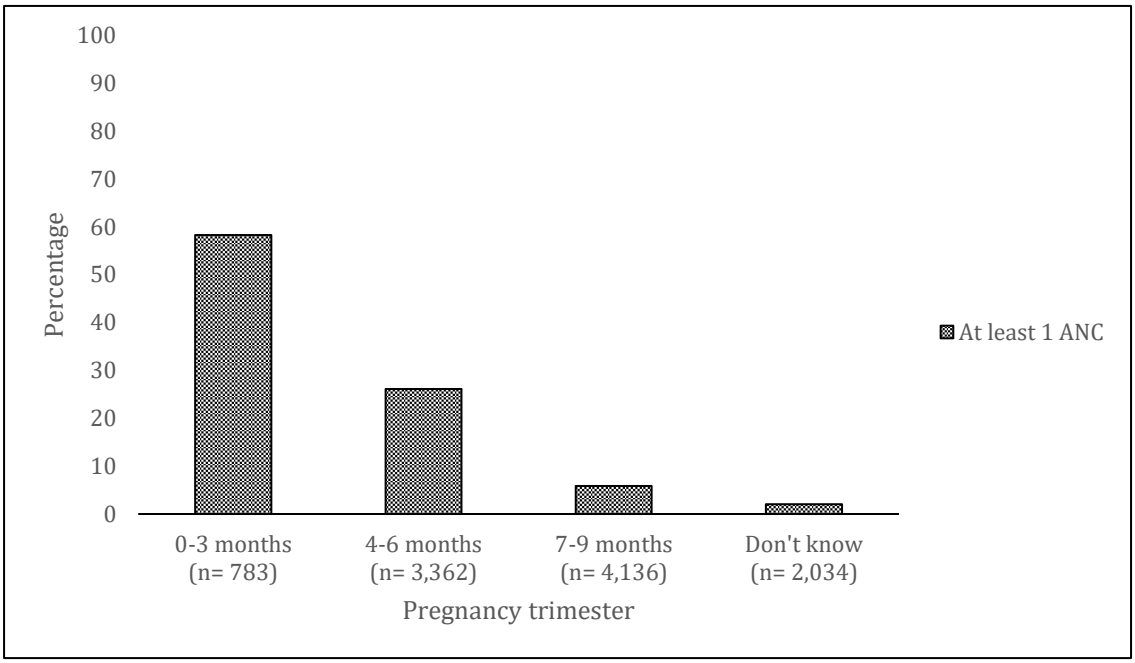
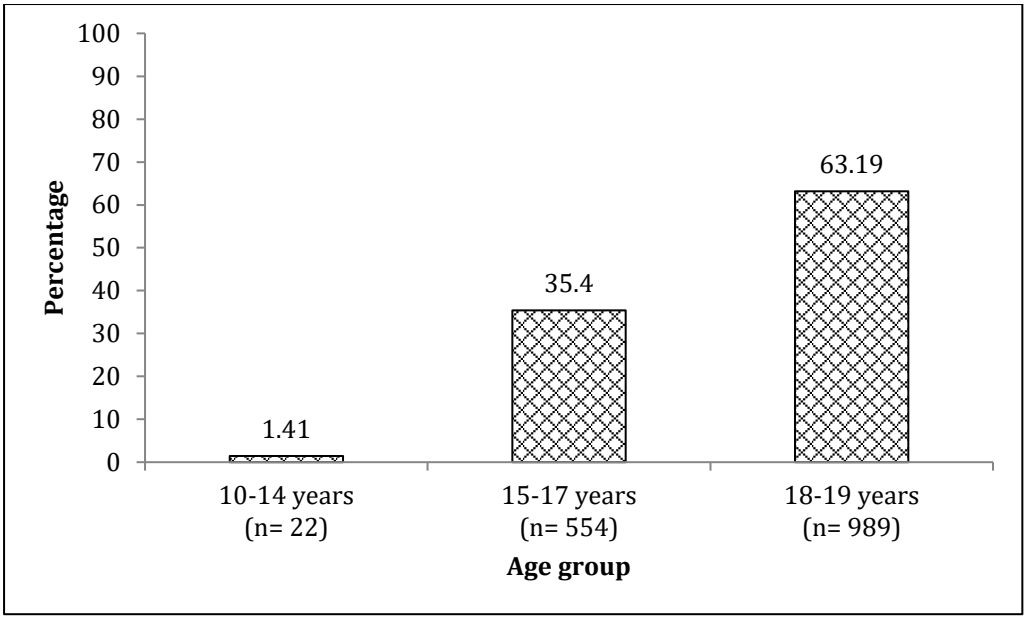


Figure 3.7 shows the proportion of adolescents who delivered and had at least four ANC visits, by age group. Overall, out of a total of 2,368 girls that had delivered, over half had four of more ANC visits (66%, n=1,566). Only a very small proportion (1.4 per cent) of very young adolescents had at least four ANC visits before they delivered. Overall among the 2,320 adolescents (15-19 year), who had delivered and had at least four ANC visits, this proportion was about 67% [results not shown]. However, only 35 per cent of 15-17 year olds attended four or more ANC visits compared to 63 per cent of the 18-19 year olds.

Figure 3.7: Proportion of adolescents aged 10–19 years who delivered and had at least four ANC visits, by age group



Regarding PNC, of the 7,627 adolescent girls that had delivered, almost all had attended a PNC service (92 per cent), irrespective of whether they had a complication during pregnancy (86 per cent) or no complications at all (92 per cent). However, it is not possible to decipher the timing of the PNC visits from the available data.

3.1.3. Site of delivery

Births that occur in health facilities or in the presence of an SBA, community health worker (CHW) or midwife can ensure the safe delivery of newborns as well as the management of pregnancy complications in a timely manner. Data about the actual place of delivery was available for 7,634 adolescent girls, whereas data for the preferred place of delivery was available for 9,989 pregnant girls. Overall, the majority of adolescent girls who had delivered reported doing so in a health facility (80 per cent) (see Table 3.2). However, 1,413 girls (19 per cent) delivered with a TBA or CHW and 98 girls said that they had delivered at home unassisted. A slightly higher proportion of those who were currently pregnant were planning to give birth in a health facility (88 per cent).

Table 3.2: Comparison of adolescent girls' intended and actual place of child delivery

Actual site of delivery	Percentage	Number
Health facility	80.0	6,110
Home, with assistance of CHW/TBA	17.5	1,413
Home, non-assisted	1.3	98
Don't know	0.04	3
Other	0.1	10
Intended site of delivery		
Health facility	87.9	8,777
Home, with assistance of CHW/TBA	5.83	582
Home, non-assisted	0.37	37
Don't know	2.35	235
Other	3.58	358

A higher proportion of girls had a home delivery with the assistance of a CHW or TBA (18 per cent) compared with those who had intended to have a home non-assisted delivery (8 per cent).

3.1.4. Family planning

This section presents the findings for ever use of FP methods among adolescent girls. Data for FP was available for 12,962 adolescent girls. Nearly a third (31 per cent [n= 3,989]) of all adolescent girls reported having ever used any FP method before. Table 3.3 provides an overview of those who ever used of FP methods by selected characteristics. Most of the adolescent girls who had ever used FP were between the ages of 18–19 (67 per cent), not married (76 per cent) and had attended school (87 per cent).

Table 3.3: Ever use of family planning by selected characteristics among adolescent girls aged 10–19 years

Characteristics	Percentage	Number
Age		
10–14	1.4	349
15–17	31.6	5115
18–19	67.0	7443
Marital status		
Married	24.2	4129
Unmarried	75.8	8774
Education		
Ever attended	86.6	10,195
Never attended	13.4	2,685

Among the 4,063 adolescent girls that reported using any form of FP, the most common was the injectable (47 per cent) followed by the implant (21 per cent) and contraceptive pill (21 per cent). Condoms were the least used (2 per cent) (See Table 3.4).

Table 3.4: Most recently used contraceptive method among adolescent girls aged 10–19 years (n= 4,063)

Type of contraceptive recently used	Percentage	Number
Implant	20.9	849
Intrauterine device (IUD)	3.3	134
Condom	1.8	72
Contraceptive pill	20.7	842
Injectable	47.2	1,919
Traditional methods	4.8	193
Don't know	1.0	40
Other	0.3	14

Figure 3.8 shows the most recently used family planning by marital status and age. Across all age groups, the unmarried adolescents have the highest proportion reporting use of FP compared to their married counterparts. Among unmarried girls, the use of FP is highest (80 per cent) among very young adolescent girls (10−14 years). Among married adolescents use of FP is highest (32 per cent) among those aged 18–19 years.

Figure 3.8: Most recent use of family planning by adolescent girls aged 10–19 years by marital status

3.3. Social welfare

This section presents the results of the assessment of social welfare for adolescent girls as it relates to the care and financial support of their children, and their experience of violence (verbal, physical or abandonment).

3.3.1. Care and financial support of the child

Ensuring adolescents have sufficient support such as child support in the event of extenuating circumstances is imperative to ensuring little to no disruption of their education. This section assesses the perceived care and support that adolescent girls have available when pregnant or after delivery. Data for expected care and financial support for the child after delivery was available for 16,638 adolescent girls for care of child and 17,096 for financial support.

Table 3.5 shows sources that adolescent girls indicated would take care of or provide financial support for the child. The adolescent girls frequently mentioned the father of the baby for both care and financial support of the baby (24 per cent and 45 per cent respectively), followed by the parent of the baby's mother (37 per cent and 27 per cent respectively). Only a small proportion mentioned the family of the baby's father for both child care and financial support (18.5 per cent and 16.3 per cent

respectively). Based on these results it seems that the responsibility for the child in the perception of the adolescent lies primarily with the father of the baby rather than the mother.

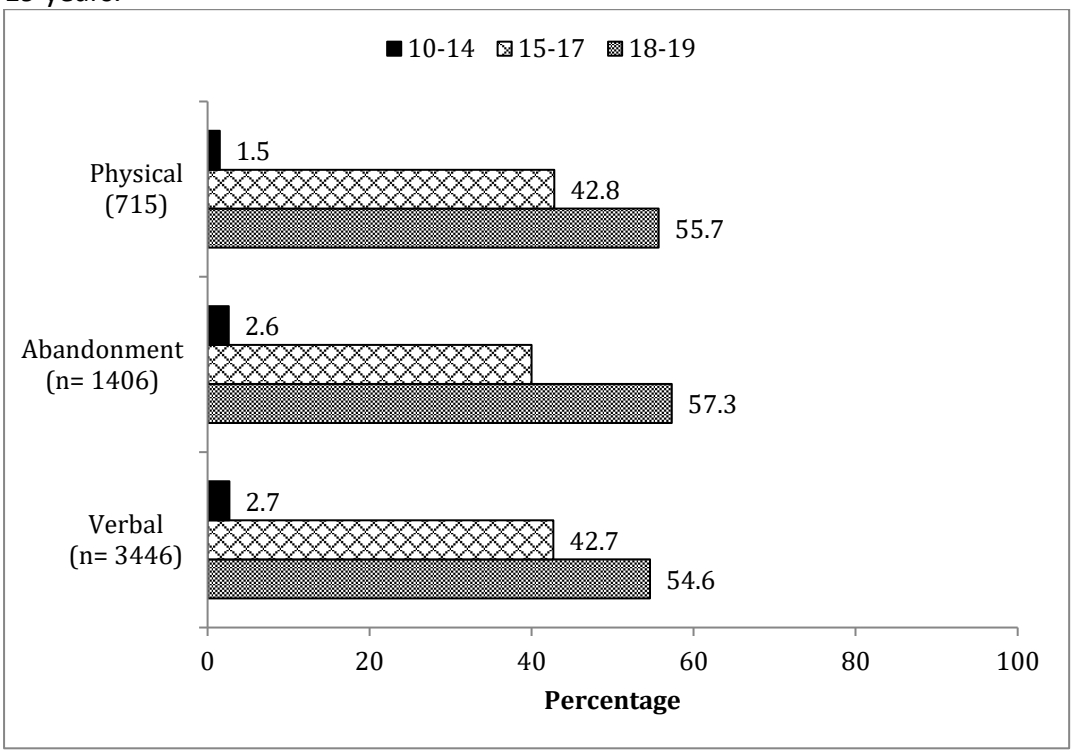
Table 3.5: Adolescent girls' perceived source of care and financial support for the child after delivery

Care of child	**Percentage**	**Number**
Mother of baby	13.4	2,223
Father of baby	24.4	4,053
Parent of baby's mother	37.0	6,157
Other family of the baby's mother	4.7	777
Parents of the baby's father	18.5	3,076
Other family of the bay's father	1.3	216
Don't know	0.7	115
Other	0.1	21
Financial support of child		
Mother of baby	5.1	868
Father of baby	44.8	7,650
Parent of baby's mother	26.6	4,553
Other family of the baby's mother	3.8	648
Parents of the baby's father	16.3	2,778
Other family of the bay's father	1.3	225
Don't know	2.0	340
Other	0.2	34

3.2.3. Experience of violence

Although the specific nature of violence (such as the perpetrators of the violence) was not available, at least 26 per cent of adolescent girls (4,632) experienced some form of violence. The most common type of abuse reported was verbal and physical (96 per cent), followed by abandonment (89 per cent). Figure 3.9 shows the proportion of adolescent girls experiencing any form of violence in relation to their pregnancy.

Figure 3.9: Experience of any form of abuse by age among adolescent girls aged 10-19 years.



The pattern on the type of abuse reported is higher among 15–19 year olds. Only 27 per cent of the adolescent girls that experienced any form of violence reported the incident and majority did so to a traditional leader (61 per cent).

3.3. Education

This section presents the results of adolescent girls' education, highlighting current enrolment, barriers to schooling (including returning to school after child delivery) and awareness of and access to learning facilities in the respective districts.

3.3.1. School attendance

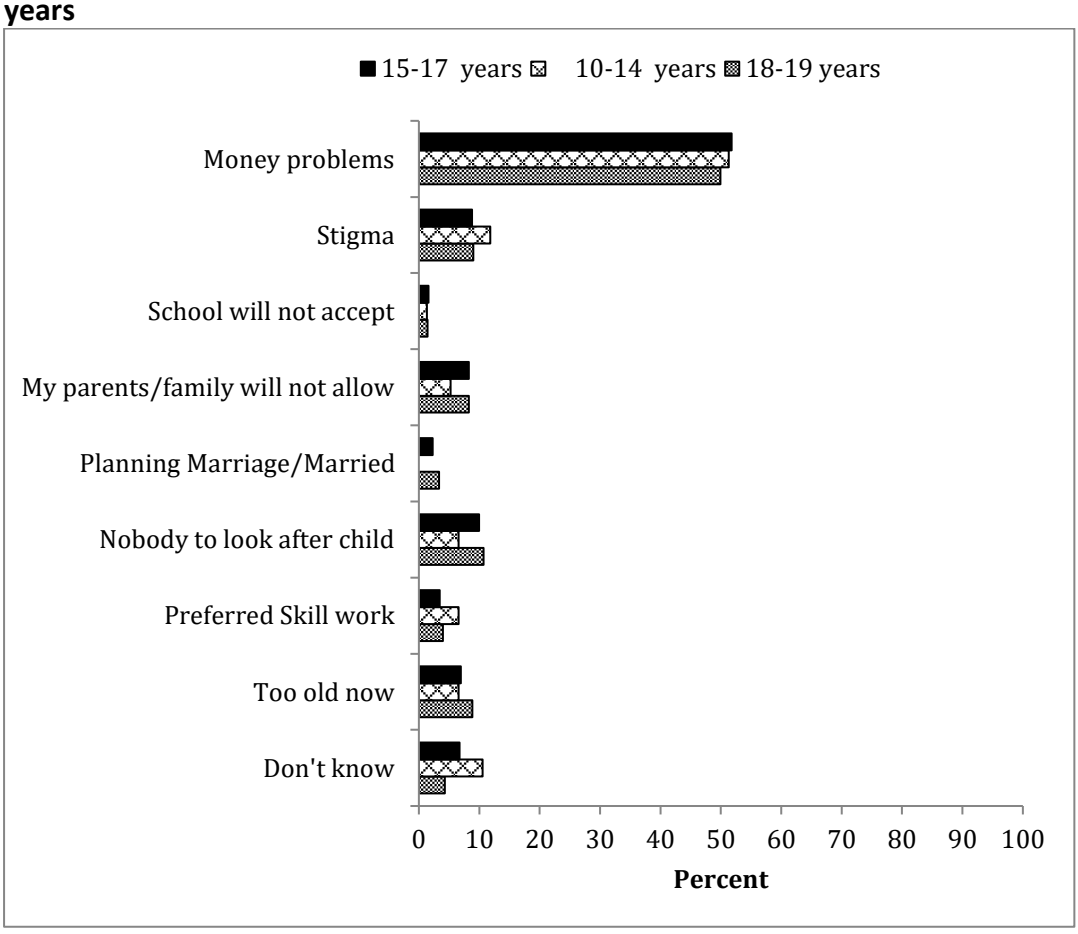
Girls were asked if they had ever attended school and their current enrolment status. It was found that about 6 per cent of the 14,431 girls that were asked were currently attending school. The proportion of those currently attending school was about the same irrespective of whether the adolescent girl had recently delivered or was currently pregnant.

At least 81 per cent (n=14,488) had attended school at some point and of the 13,382 adolescent girls asked about their intention to return to school, three quarters of them (76 per cent) indicated that they would return to school. Less than a third of the adolescent girls (22 per cent) indicated that they would not be returning to school.

3.3.2. Barriers to schooling

Various reasons were stated by adolescent girls who had attended school (n= 14,474) as to why they would not return to school. Slightly over half cited money as the main barrier (51 per cent) followed by concerns about having someone to look after the child (10 per cent) and stigma (9 per cent). Only a small proportion (<5 per cent) cited being rejected for readmission into school due to their pregnancy status or planning marriage or being married. Figure 3.10 shows the reasons for not going back to school by age group, and it shows little variation by age group.

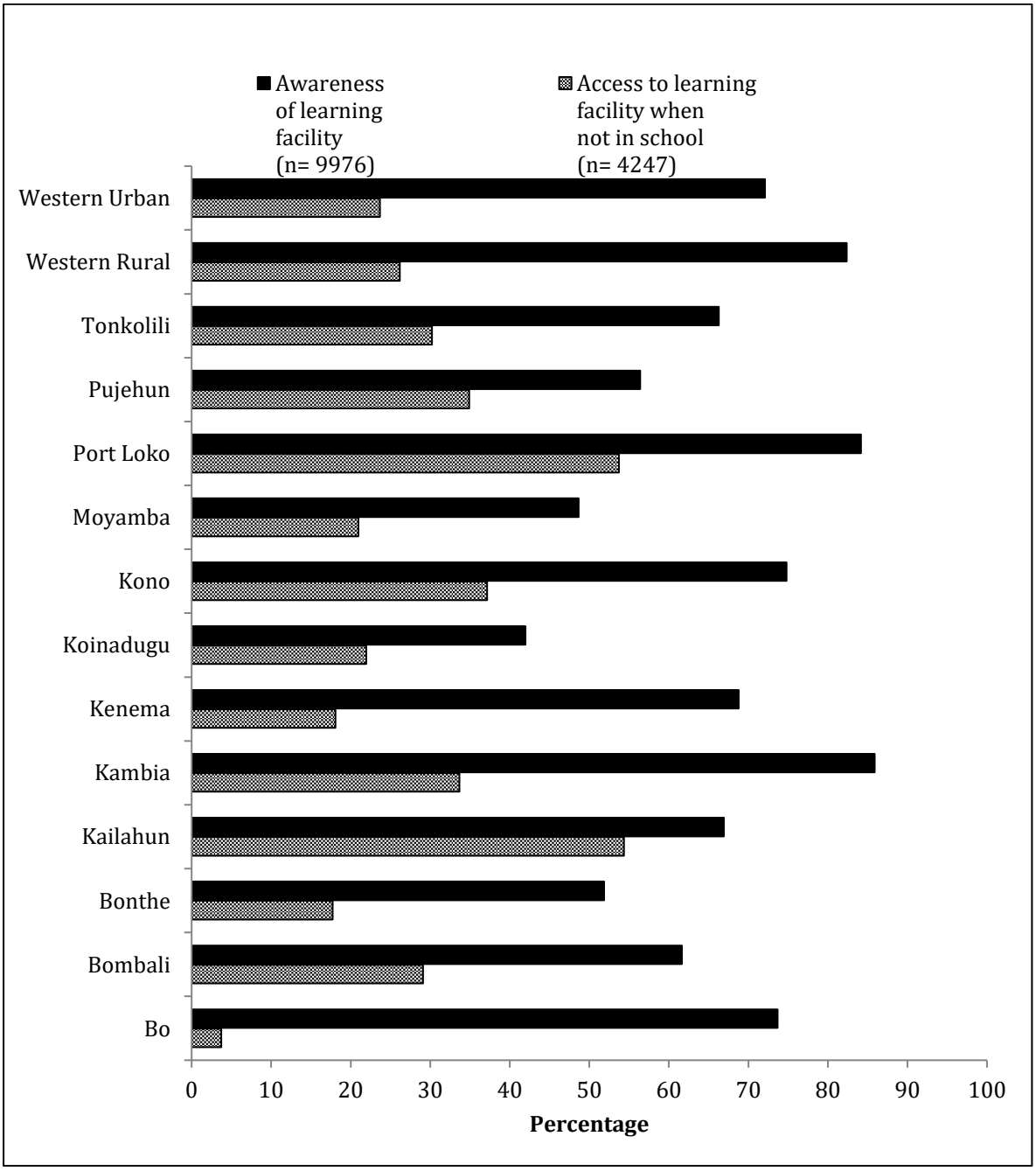
Figure 3.10: Reasons for not returning to school among adolescent girls aged 10-19 years



3.3.3. Awareness of and access to learning facilities

A total of 14,407 adolescent girls responded to the question about their awareness of learning facilities in their respective districts. The respondents were asked whether there was a learning facility in their community. The overall majority (69 per cent) were aware of such facilities; however, only about 30 per cent of the 14,234 adolescent girls indicated that they were able to access the learning materials when not in school. Figure 3.11 shows the distribution of access to learning materials and awareness of learning facilities by district, and shows sharp disparities in all districts between awareness about learning facilities and access to them.

Figure 3.11: Distribution of awareness of and access to learning facilities among adolescent girls aged 10–19 years by district



4. Discussion

This rapid assessment of teenage pregnancy in Sierra Leone indicates that approximately 18,119 adolescent girls were pregnant or had delivered between May and December 2015. This clearly implies that these girls became pregnant in 2014 and 2015, during the peak of the Ebola virus outbreak despite the information education campaigns calling on the population to 'Avoid Body Contact' (ABC) to prevent spread of the virus.

Overall, over half (56 per cent) of the respondents were pregnant at the time of the survey, with about 8 in 10 having first-time pregnancies and 12 per cent with repeat pregnancies. Most of the respondents that reported a higher number of pregnancies or deliveries were in the 18–19 age group; this could be because they constituted the largest group in the sampled population. In Sierra Leone, the median age at first marriage is 18 years for women (SSL and ICF International, 2014) and, as illustrated in the results of this assessment, adolescents aged 18–19 years had the highest proportion of married individuals compared to their younger counterparts.

It is worth noting however, that the vast majority (80 per cent) of adolescents that had recently given birth gave birth in a health facility – this much higher than the national average of skilled birth attendance at birth which is 60 per cent for mothers under 20 years old (SSL and ICF International, 2014). However, 1,558 girls (18 per cent) had delivered at home with the assistance of a CHW or a TBA and, sadly, about 109 girls said they delivered without any assistance. Although some studies show that the EVD outbreak created distrust in the health system (Streifel, 2015), the findings in this assessment show that a large proportion of adolescents still trusted the health system enough to give birth in a health facility. Our findings also indicated the majority of those still pregnant indicated a preference to deliver in a health facility. In 2013, the proportion of 15-19 year olds delivering in a health facility was just 61 per cent (SSL and ICF International, 2014); however, 80 per cent of adolescent girls (10–19 years) delivered in a health facility during this assessment. This increase could be somewhat biased by the majority of respondents being recruited from references from the PHUs.

Access to ANC and PNC services are particularly important, especially for such a vulnerable group as adolescent girls. They provide preventive care and treatment by monitoring pregnancy-related complications and the delivery of mother and child, and providing education and counselling. The WHO guidelines recommend a minimum of eight ANC visits and one PNC visit two days after delivery for mother and child (WHO, 2016).

Only 15 per cent of the pregnant girls had at least one ANC visit, with a little over half (55 per cent) reporting their visit on their second trimester. However, a cross-sectional study employing a mixed method approach in Sierra Leone amongst pregnant adolescent girls found 56 per cent of the adolescents had at least one ANC visit that mostly occurred during their second or third trimester (Coinco, 2010).

This study focused on adolescent girls between the ages of 10–19 years, and found four or more ANC visits remains low (39 per cent) compared to women of reproductive age (15–49) in Sierra Leone (76 per cent) (SSL and ICF International, 2014). This could suggest that the stigma related to premarital sexual activity as well as providers' attitudes towards very young adolescents becoming pregnant might play a role in accessibility. As noted earlier, most of the 10–14 year old adolescent girls were not married at the time of their pregnancy or delivery, hence were more likely to experience negative attitudes from service providers regarding premarital sexual intercourse.

Although there is a paucity of studies that examine access to sexual and reproductive health services amongst adolescents, particularly very young adolescents, a qualitative study on teenage mother care practices in Freetown, Koinadugu and Pujehun Districts in Sierra Leone found that providers' attitudes and costs were indeed barriers to accessing services by this vulnerable group (Lai and Towriss, 2014).

The overall ever use of FP was quite low among married adolescents compared with their unmarried counterparts, with only 20 per cent of very young married adolescent girls (10–14 years) reporting to have ever used any form of FP compared to 80 per

cent for the unmarried girls (10-14 years). Marital status therefore could be an inhibitor to the uptake of FP, especially where adolescents have neither the self-efficacy to negotiate nor the financial means to obtain FP products. The differentials in FP uptake by marital status could be due to the expectations of childbearing soon after marriage. A population-based study among sexually active female adolescents in Ghana also found that being married was associated with almost a fourfold reduction in contraceptive use due to married adolescents wanting to conceive, whereas unmarried adolescents wanted to delay pregnancy (Marrone et al., 2014).

Among those who reported use of any FP methods, the majority reported injectables (47 per cent), contraceptive pills (21 per cent) or the implant (21 per cent). Very few reported use of condoms, especially among very young adolescents (10–14 years); this may indicate a lack of self-efficacy and empowerment among this group in suggesting condom use. Furthermore, it may indicate a power imbalance in the relationships, such as a partner who is reluctant to use condoms, or condoms being associated with promiscuity. This is an issue of concern because although Sierra Leone has a relatively low HIV prevalence at 1.5 per cent (among 15-49 year olds), there is the potential for a surge in the epidemic in a country where such a large proportion of young people are sexually active (SSL and ICF International, 2014).

The large proportion of adolescents using injectables, contraceptive pills or implants may be due to the discreet nature of these types of FP methods. For instance, condoms require a mutual decision by both parties, whereas injectables can be used for three to five months and can be used discretely. Being in an age-disparate relationship can hinder the use of FP and even result in intimate partner violence (Gomez, 2011).

Although this assessment did not particularly examine intimate partner violence, it assessed experience of violence as a result of the pregnancy. While information about the age of the partner or the father of the child is lacking, at least 26 per cent of adolescents experienced some form of violence. Verbal and physical abuse was the most common type of abuse reported followed by abandonment, across all age

groups. Violence whether physical or non-physical highlights the little power that adolescents have overall as a result of their pregnancy, as they are often still dependent financially on the father of the child or their family. Furthermore, the very low reporting of such incidents by adolescents highlights the normalization of this abuse in a given community.

A substantial proportion of adolescent girls expected the source of financial support for their child to be the father of their child (45 per cent). This large number could indicate that the potential father may be of working age and mature enough to be able to offer financial support. Although information on the fathers' ages was not available, this could indicate the low level of financial autonomy that adolescent girls have. Male partners who provide financial support as seen in other studies among adolescents and young people are often older, where age differences, together with the desire for economic return likely increases the female's vulnerability, particularly if financial support creates sexual obligations where many women are locked into a relationship of dependency on violent men (Bingenheimer and Reed, 2014; Kamndaya et al., 2015).

Although information on the father of the baby was not available, the results presented in this assessment provide an understanding of reliance on the father of the child by adolescent mothers for financial support, indicating that the father of the child may be more financially stable than the adolescent mother. Further qualitative studies can provide insight into the nature of pregnancies and the age difference between adolescent girls and their partners, especially as it relates to discordant intergenerational partnerships and empowerment among adolescents.

The EVD outbreak may have left many adolescents orphaned, resulting in further cost barriers to continuing formal education. The findings that show money as the major impediment to continuing schooling is echoed in other qualitative studies, where a review of interventions related to adolescent pregnancy found that while new mothers had a great desire to continue with their education in Pujehun District, they were not capable of amassing enough funds to do so (Farzaneh, 2013).

4.1. Limitations

Limitations included a large proportion of respondents being recruited from the PHUs and through the snowballing technique. This could risk not identifying all pregnant girls or those recently delivered who may not have visited PHUs. It also biases the results to those adolescents who had consciously made an effort to seek health care. However, the information collected provides a general understanding of adolescents' access to pregnancy-related services at health facilities during the EVD outbreak Regarding data collection on PNC, there may have been some confusion among survey administrators about PNC, as many respondents in the assessment who were still pregnant reported PNC attendance.

The questionnaire was pre-tested only once with a small sample in Freetown.

Sensitive questions such as the experience of violence or first-time or repeat pregnancies may have resulted in some degree of bias in the respondents. For instance, the questions related to violence were quite broad, and the definition of violence by the adolescents may not necessarily have been the conventional definition that was in the questionnaire. However, the quantitative nature of this assessment and the data collected provides an overview of the most common violence generally experienced by adolescents, and by their marital status. Thus, further qualitative studies can expand on the findings of this assessment to elicit more details on the nature and perpetrators of violence.

Due to the cross-sectional nature of the data collection, it is difficult to ascertain the temporal relationship between adolescent pregnancy and school enrolment in the light of the Ebola outbreak. However, this rapid assessment provides a socio-ecological snapshot of the issues related to the SRH of adolescent girls, both at the micro and macro level.

4.2. Recommendations

Based on the key findings from the rapid assessment of adolescent pregnancy, the following recommendations are being made to ensure that adolescents in Sierra Leone are able to access SRH services and have the opportunities needed to keep in good health.

4.2.1. Adolescent health

The assessment revealed that less than a third of the respondents had ever used a method of family planning, despite the fact that they had been sexually active (as indicated by their pregnancy) and high numbers of teenage pregnancies. Comprehensive sexuality education (CSE) has been shown to delay age at first sex, reduce teenage pregnancies and increase use of contraception including condoms (UNESCO, 2009). CSE could be provided in schools for those in school, and in safe spaces for those out of school Age-appropriate CSE could be targeted to the very young adolescents to enable better decision-making processes as they reach puberty or when they become sexually active.

This research indicates a very low use of condoms; condoms serve a dual purpose in preventing both pregnancy and HIV and AIDS. Ensuring that both males and females are comfortable in using contraceptives, including condoms, is imperative to curbing the spread of HIV and AIDS as well as reducing the high teenage pregnancy rates.

The assessment reveals a high number of teenage pregnancies and low uptake of ANC, especially among young adolescents; training of SRH health care personnel who provide adolescent- and youth-friendly services is imperative. The availability of non-judgmental and skilled service providers may increase the uptake of services and in turn prevent pregnancy. As it relates to pregnancy, refresher courses to remove stigma, particularly during ANC or PNC, can encourage adolescents, especially very young adolescents to go to health centres early during their pregnancy to prevent complications.

4.2.2. Social welfare

Findings indicate high rates of violence towards respondents and a reluctance of victims to report such incidents. Laws already in place should be enforced in order to protect underage children. Particular attention should be given to the role of communities, specifically the role traditions play in shaping behaviours and accepted gender attitudes and norms. Key stakeholders that engage gatekeepers such as traditional leaders, parents, service providers need to be engaged in order to raise awareness and sensitize issues of adolescent SRH.

4.2.3. Education: Addressing the problem of dropouts

Due to the high discontinuation of schooling resulting from the closure of schools, the increase in adolescent pregnancy as well as financial barriers to resuming schooling, as the findings in this assessment highlight, it is vital to address these issues to ensure uninterrupted schooling for adolescent girls, particularly those who are mothers.

The Government and development partners should actively work to ensure that education modalities are strengthened through existing learning facilities, ensuring that pregnant girls have access to such facilities during pregnancy for full reintegration to formal schools after delivery. Learning facilities can work in collaboration with private and public centres to ensure wider access to all girls, adapting and tailoring interventions adequately at the right geographic locations and delivery platforms.

The Government of Sierra Leone and its partners need to deploy a strategy that is sensitive to the financial constraints faced by adolescent girls and their return to formal school. Ideally, these strategies should seek the involvement of young fathers, and the families of both parents, providing skill development courses if it is difficult to return to school.

The establishment of day care facilities, though ad hoc, has proven successful in some districts in Sierra Leone, and could be an intervention that can be scaled up throughout the country. Given the predominant financial barrier, providing subsidized

or no-cost services to adolescents and their families would help adolescents access such services. The school fee waiver enacted by the Government of Sierra Leone that ended in September 2016 should be extended to include not only the poor, but also teenage mothers.

4.2.4. Further research

Qualitative research will enrich understanding on the dynamics and context in which adolescents get pregnant, including an understanding of the context of their relationships with their partners; whether partners are older or the same age; and the motivations for sexual initiation (transactional, survival or emotional sex).

Further research is needed on the perceptions of parents, teachers and health providers regarding teenage pregnancy, and their attitudes towards providing support for teenage mothers, to enable an understanding of which adolescents access certain SRH services and why, and to what extent adolescents are able to seek help or information from the community.

Existing mechanisms that deal with GBV need to be assessed. Case reporting systems need to be strengthened to curb the incidence of violence among adolescents. This should include behaviour change communications campaigns that could reduce stigma and the marginalization of pregnant adolescents and adolescent mothers.

Additional areas worth researching which could positively impact education are:

- Types of support that ensure adolescent mothers can return to the formal education system. Crucial to this is an examination of the roles of government, community actors and stakeholders in facilitating the reintegration of pregnant adolescent girls.
- The types of support that would ensure proper care for the children of adolescent mothers when the mothers return to school, and that would be accessible by the most vulnerable groups.

- Pilot testing of a cash transfer intervention to enable girls to stay in school, alleviating the issue of financial barriers even after pregnancy.

4.3. Conclusion

The findings in this assessment suggest that adolescent SRH is still a concerning issue, as evidenced by the low use of FP and high pregnancy rates, especially among the very young adolescents. The barriers to returning to formal education can be alleviated through sensitizing communities to the unique challenges that pregnant adolescents face. This will as a whole benefit the community as a large proportion of the population is young. It is encouraging that health services are still accessed by adolescents for child delivery; however, the timing of ANC needs to be improved by strengthening existing youth-friendly services, and routine training of the health personnel who provide these services. Important gatekeepers such as traditional leaders who can play a clear role in GBV need to be included in all interventions and programmes that target adolescents; this will also be an opportunity to engage the community and lead to a better understanding and open discussion in the community about adolescent SRH.

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ANNEXES

Annex I: Questionnaire Tool (Phase I: 12 Districts)

Date	_____ July 2015
Interviewer	Name: Number:
Chiefdom	
District	
How did you find this respondent?	1. CBO/centre name: _____ 2. PHU name: _____ 3. School name: _____ 4. Snowball technique _____
Survey code	

Section 1: Health Questions		
#	**Question**	**Record answer here**
101	Is this your first pregnancy?	1. Yes 2. No 3. Don't know
102	How many months have you been pregnant?	1. 0 – 3 months 2. 4 – 6 months 3. 7 – 9 months 4. Don't know
103	Have you attended ANC (antenatal care) during this pregnancy?	1. Yes → ASK Q104 2. No → ASK Q105 3. Don't know → ASK Q105
104	How many times?	1. 1 2. 2 3. 3 4. 4 or more 5. Don't know
105	Have you had any complications with your pregnancy?	1. Yes 2. No 3. Don't know
106	Have you used any family planning methods before?	1. Yes → ASK Q107 2. No → ASK Q108 3. Don't know → ASK Q108
107	What kind of family planning have you most recently used?	1. Implant 2. IUD 3. Condom 4. Contraceptive pill 5. Injectable 6. Traditional methods 7. Don't know 8. Other _____
108	Where do you plan on delivering your baby?	1. Health facility 2. Home with assistance of CHW/TBA 3. Home non-assisted 4. Don't know 5. Other _____
ONLY FOR GIRLS WHO HAVE ALREADY DELIVERED (ANSWERED 'YES' TO Q003):		
109	Where did you deliver your baby?	1. Health facility 2. Home with assistance of CHW/TBA 3. Home non-assisted 4. Don't know 5. Other _____
110	Have you attended PNC (post natal care)?	1. Yes 2. No 3. Don't know

111	How was your baby when you delivered?	1. Alive and well 2. Still birth

Section 2: Education Questions		
#	**Question**	**Record answer here**
201	Have you ever attended school?	1. Yes → ASK Q202 2. No → GO TO SECTION 3
202	Are you currently attending school?	1. Yes → ASK Q204 2. No → ASK Q203
203	What year and month did you stop going to school?	Month: _____ Year: _____
204	What was the last form you completed?	Class: ____ OR JSS: _____ OR SSS: _____
205	What school were/are you attending?	Name of school: _____
206	After you give birth, will you return to school?	1. Yes → ASK Q208 2. No → ASK Q207 3. Don't know → ASK Q207
207	Why?	1. My parents/family will not allow 2. Nobody to look after child 3. School will not accept 4. Money problems 5. Stigma 6. Too old now 7. Don't know 8. Other _____
208	Is there a learning facility in your community?	1. Yes 2. No 3. Don't know
209	Do you have access to learning materials while you are not attending school?	1. Yes 2. No 3. Don't know

Section 3: Social Welfare Questions		
#	**Question**	**Record answer here**
301	Are you married?	1. Yes 2. No
302	Who will care for the baby when he or she is born?	1. Mother of baby 2. Father of baby 3. Parents of baby's mother 4. Other family of the baby's mother 5. Parents of the baby's father 6. Other family of the baby's father 7. Don't know 8. Other _____
303	How do you plan on financially supporting your child?	1. Mother of baby 2. Father of baby 3. Parents of baby's mother 4. Other family of the baby's mother 5. Parents of the baby's father 6. Other family of the baby's father 7. Don't know Other _____
304	Have you experienced violence in response to your pregnancy?	1. Yes → ASK Q305 2. No → END INTERVIEW 3. Don't know

305	What kind of violence?	TICK ALL APPLICABLE 1. Verbal 2. Abandonment 3. Physical 4. Don't know 5. Other _____
306	Have you ever reported a violent incident?	6. Yes → ASK Q307 7. No → END INTERVIEW 8. Don't know → END INTERVIEW
307	Who did you report this incident to?	1. FSU 2. Health facility 3. Police 4. Traditional Leader 5. Don't know 6. Other _____

Thank the respondent for her time, and the information. Ask if she has any questions for you about the survey.

Annex II: Questionnaire Tool (Phase II : Kambia and Port Loko)

Date of interview	_____(DD/MM/YYYY)
Respondent	Name: Phone Number:
Address of respondent	
Village/Town	
Section	
Chiefdom	
District	
How did you find this respondent?	1. CBO/centre name: _____ 2. PHU name: _____ 3. School name: _____ 4. Snowball technique _____

Section 1: Health Questions		
#	Question	Record answer here
101	Is this your first pregnancy?	1. Yes 2. No 3. Don't know
102	How many months have you been pregnant?	1. 0 – 3 months 2. 4 – 6 months 3. 7 – 9 months 4. Don't know
103	Have you attended ANC (antenatal care) during this pregnancy?	1. Yes → ASK Q104 2. No → ASK Q105 3. Don't know → ASK Q105
104	How many times?	1. 1 2. 2 3. 3 4. 4 or more 5. Don't know
105	Have you had any complications with your pregnancy?	1. Yes 2. No 3. Don't know
106	Have you used any family planning methods before?	1. Yes → ASK Q107 2. No → ASK Q108 3. Don't know → ASK Q108
107	What kind of family planning have you **most recently** used?	1. Implant 2. IUD 3. Condom 4. Contraceptive pill 5. Injectable 6. Traditional methods 7. Don't know 8. Other _____
108	Where do you plan on delivering your baby?	1. Health facility 2. Home with assistance of CHW/TBA 3. Home non-assisted 4. Don't know 5. Other _____
ONLY FOR GIRLS WHO HAVE ALREADY DELIVERED (ANSWERED 'YES' TO Q003):		
109	Where did you deliver your baby?	1. Health facility 2. Home with assistance of CHW/TBA 3. Home non-assisted 4. Don't know 5. Other _____

110	Have you attended PNC (post natal care)?	1. Yes 2. No 3. Don't know
111	How was your baby when you delivered?	1. Alive and well 2. Still birth

Section 2: Education Questions		
#	Question	Record answer here
201	Have you ever attended school?	1. Yes → ASK Q202 2. No → GO TO SECTION 3
202	Are you currently attending school?	1. Yes → ASK Q204 2. No → ASK Q203
203	What year and month did you stop going to school?	Month: _____ Year: _____
204	What was the last form you completed?	Class: ____ OR JSS: _____ OR SSS: _____
205	What school were/are you attending?	Name of school: _____ District: _____
206	Will you return to school?	1. Yes → ASK Q208 2. No → ASK Q207 3. Don't know → ASK Q207
207	Why?	1. My parents/family will not allow 2. Nobody to look after child 3. School will not accept 4. Money problems 5. Stigma 6. Too old now 7. Don't know 8. Other _____
208	Is there a learning facility in your community?	1. Yes → ASK 209 2. No → ASK 210 3. Don't know →ASK 210
209	If yes, which of the following is in your community?	1. Community learning centre 2. Primary or secondary school 3. NGO center providing education
210	Do you have access to learning materials while you are not attending school?	1. Yes →211 2. No → GO TO SECTION 3 3. Don't know → GO TO SECTION 3
211	If yes, which of the following learning materials do you have access to?	1. Exercise books/pens 2. Core text books 3. Radio education programme

Section 3: Social Welfare Questions		
#	Question	Record answer here
301	Are you married?	1. Yes 2. No
302	Who will care for the baby when he or she is born?	1. Mother of baby 2. Father of baby 3. Parents of baby's mother 4. Other family of the baby's mother 5. Parents of the baby's father 6. Other family of the baby's father 7. Don't know

		8. Other _____
303	How do you plan on financially supporting your child?	1. Mother of baby 2. Father of baby 3. Parents of baby's mother 4. Other family of the baby's mother 5. Parents of the baby's father 6. Other family of the baby's father 7. Don't know Other _____
304	Have you experienced violence in response to your pregnancy?	1. Yes → ASK Q305 2. No → END INTERVIEW 3. Don't know
305	What kind of violence?	TICK ALL APPLICABLE 1. Verbal 2. Abandonment 3. Physical 4. Don't know 5. Other _____
306	Have you ever reported a violent incident?	6. Yes → ASK Q307 7. No → END INTERVIEW 8. Don't know → END INTERVIEW
307	Who did you report this incident to?	1. FSU 2. Health facility 3. Police 4. Traditional Leader 5. Don't know 6. Other _____
Survey code:		

Thank the respondent for her time, and the information. Ask if she has any questions for you about the survey.

Annex III: Informed Consent Form

INFORMED CONSENT FORM

SECTION 1: Introductions

- Hello, my name is_____, I work for UNFPA. We are currently doing a survey in Sierra Leone. The survey is trying to interview as many pregnant teenagers (girls aged 19 years or younger) as possible. The aim of this survey is to understand how many pregnant teenage girls there are and what issues they may be facing.
- Any information that you give us today will remain 'secret'. We will write a report and give it to government ministries and UN agencies so that they can have a better idea how to plan programmes to help you access services and information. This is not a promise, but we want you to know that stakeholders are trying to help, but they must first understand the issues you are facing.
- The survey will last about 30 minutes. You can chose whether or not you want to take part in the survey. If you decide to start the survey, and then later decide that you do not want to complete it, you can end the questions, without any consequence or penalty, but we hope you will finish because your opinion is important to us.
- Please feel free to ask any questions or clarifications either during the interview or at the end of the discussion. If you would like to speak to somebody else about this survey, please call the Principal Investigator, Krystle Lai on 076532451.

SECTION 2: SCREENING QUESTIONS

Thank you for agreeing to be part of this important survey. I am now going to ask you three simple questions to make sure you are the right person for this survey.

Screening Questions		
#	**Question**	**Record answer here**
001	How old are you?	_____ years old (must be 19 years old or younger)
002	Are you currently pregnant?	1. Yes → START SURVEY 2. No → Go to Q003
003	Have you delivered a baby in the last 2 months?	1. Yes → START SURVEY 2. No → PARTICIPANT IS NOT ELIGIBLE FOR THIS SURVEY. FIND ANOTHER RESPONDENT.

SECTION 3: INFORMED CONSENT

Would you like to take part in this short survey? *Please tick:* Yes ☐ No ☐

Respondent Name: First _____ Middle_____ Last_____

Sign OR thumbprint: _____

As the parent or guardian of the above named child/young person I hereby give permission for them to participate in the above survey.

Parent/Guardian Name: _____ Sign OR thumbprint: _____

Interviewer Name: _____ Interviewer Signature: _____

SURVEY CODE
(District/chiefdom/enumerator/respondent):

D	D	C	C	E	E	R	R	R

Annex IV: Institutions that contributed to the validation of the Assessment Methods and Tool (Validation Meeting at MEST Main Conference Hall, 3 July 2015)

1. Ministry of Education, Science and Technology
2. UNICEF
3. UNFPA
4. Ministry of Social Welfare, Gender and Children's Affairs
5. Ministry of Health and Sanitation
6. Ministry of Youth Affairs
7. Ministry of Local Government and Rural Development
8. Forum for African Women's Educationists
9. Young Women's Christian Association
10. ECM
11. National Secretariat for the Reduction of Teenage Pregnancy
12. Concern Sierra Leone
13. Initiative in Capacity Building Association International
14. Children and Women
15. Empowerment Society
16. Protect Sierra Leone

Annex IV: Composition of research team

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UNFPA Teenage Pregnancy Research Team

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