

Preventing Teenage Pregnancy in Sierra Leone Impact Evaluation Baseline Report

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Executive Summary

The Inter-agency Learning Initiative aims to improve the protection of children by strengthening community-based child protection mechanisms (CBCPMs) and their linkages with government actors, while at the same time generating robust evidence of the impact of this approach on children's protection and well-being outcomes. The initiative was established in 2009, by a group of child protection agencies in response to the limited evidence base on what works to strengthen community response to protect children (Wessells, 2009).

The initiative is a multi-year project which involves action research in Sierra Leone and Kenya and aims specifically to strengthen the practice of child protection. The initiative includes an action component wherein communities decide how to improve their CBCPMs by strengthening their linkages with more formal, government led aspects of the child protection system and the wider national child protection system. This is complemented by an evaluation component which is measuring the impact of the action component on children's risk and well-being outcomes.

The communities selected as the first intervention groups in Sierra Leone decided to develop activities aimed at reducing the incidence of teenage pregnancy. This report presents the findings from a an intervention specific baseline study which examined attitudes, behaviours and norms related to teenage pregnancy, contraception and sexual reproductive health of 360 young people between the ages of 13 and 19. The report combines the results of this complementary baseline with some of the findings from the original baseline study for the initiative, which included some questions on sexual behaviour and pregnancy. Findings are presented for both the comparison and intervention groups as well as for the Bombali and Moyamba districts.

The findings of the study indicate that at baseline, young people in both comparison and intervention communities do have some knowledge about sexual and reproductive health, with the majority (84.7% of girls and 86.5% of boys) able to demonstrate knowledge of the risks of teenage pregnancy and more than two thirds (65%) able to list ways of avoiding pregnancy. The majority of young people also reported that they and their peers do not want girls to become pregnant.

Many teenagers demonstrated knowledge about contraception and how to avoid pregnancy but they also believed that contraception could have harmful effects such as reducing fertility at a later stage in life. Over two thirds of teenagers in both the comparison and intervention groups thought that this was the case.

Despite high rates of teenage pregnancy recorded in the original baseline study, during the intervention survey, just over half (54.8%) of sexually active teenagers in the intervention group said that they planned to use condoms compared to 43.8% of the comparison group. However less than half of young people reported that people in their village have ready access to condoms.

The findings of the intervention survey also highlight the existence of certain norms which may influence individual behaviour despite knowledge and attitudes conducive to avoiding sex and pregnancy. Over a third of teenagers said that they were fearful of ridicule or criticism when asking partners to use condoms and around 20% of the intervention and comparison groups thought that 'people expected teenage girls to have sex even if they do not want to'.

The findings of the intervention baseline survey and subsequent data collection exercises will be analysed within a social norms framework in order to track shifts in individual, as well as group attitudes and behaviour. It is expected that attitudes, intentions and social conducive to avoiding early sex and pregnancy become more pronounced in the intervention group over time.

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1. Introduction

Children in Sierra Leone, as in many other countries around the world, face significant harms to their well-being and development caused by violence, abuse, neglect and exploitation. Local people and communities are at the forefront of efforts to address and prevent these harms and are often the front line of response to protect children. Despite significant resources invested by the humanitarian community in supporting communities to protect their children, there is little evidence about what works to strengthen community responses, and furthermore about how to strengthen linkages between communities and government, as part of a more effective national child protection system.

1.1 The Inter-Agency Learning Initiative

The Inter-agency Learning Initiative aims to improve the protection of children by strengthening community-based child protection mechanisms and their linkages with government actors, while at the same time generating robust evidence of the impact of this approach on children's protection and well-being outcomes. The initiative was established in 2009, by a group of child protection agencies in response to the limited evidence base on what works to strengthen community response to protect children (Wessells, 2009).

The aim of the initiative is to learn about how communities protect children and the role of community based child protection mechanisms (CBCPMs) in this, and to generate a robust evidence base on the effectiveness of different community-driven strengthening interventions that enable CBCPM capacities to prevent and respond appropriately and effectively to child protection issues.

The initiative is a multi-year project which involves action research in Sierra Leone and Kenya and aims specifically to strengthen the practice of child protection. The initiative includes an action component wherein communities decide how to improve their CBCPMs by strengthening their linkages with more formal, government led aspects of the child protection system and the wider national child protection system. This is complemented by an evaluation component which is measuring the impact of the action component on children's risk and well-being outcomes. The baseline for the initiative was carried out in two stages (see section 2.3 for more details). The first baseline exercise collected data on a broad range of child protection risks and demographic variables, while the second baseline collected data on teenage pregnancy and related behaviour, expectations and intentions of young people. This report presents the findings from the second baseline (referred to as the intervention baseline), which are specific to the community-driven intervention work in Sierra Leone².

1.2 Action component overview

In a systematic literature review that was undertaken during an early stage of the inter-agency learning initiative, community ownership was found to be primary among seven key factors driving the effectiveness of CBCPMs (Wessells, 2009). In contexts where CBCPMs were owned and driven by local people, they were more active, appeared to have greater impact, and were more likely to be sustained once external funding and support had finished. Conversely, CBCPMs that had been established by an NGO or other external agency were less likely to be very active and often stopped working once the support was gone. A second key factor of effectiveness appeared to be the quality of linkages between communities and the available government services and structures. In many contexts, including Sierra Leone, it was found that linkages between communities and government-led systems are very weak, and that as a result local people are working virtually alone to prevent and respond to child protection issues. In contexts where linkages were

²Other reports from previous phases of the action research in Sierra Leone and Kenya are available from the Community Child Protection Exchange at www.childprotectionforum.org

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stronger, action to protect children appeared to be more effective, demonstrating a better functioning child protection system with different actors working together.

The action component of the initiative builds directly on this learning and aims to improve the protection of children through a community-driven process that strengthens community ownership and also develops the linkages between CBCPMs and formal system actors. The target group for the action component are children and adults in six rural villages in Sierra Leone.³ In each of Moyamba and Bombali Districts, three villages, which were located in the same Chiefdom, formed an intervention cluster.

The community driven action component began with a process of inclusive planning in each intervention cluster. As discussed below, the findings from the ethnographic phase were fed back to the villages, and this stimulated collective reflection and discussion about which were the priority issues for the community and what community members should do to improve the situation of children. To enable more detailed and inclusive planning, Sierra Leonean facilitators were hired to live in and work with communities and help them to choose which child protection issue they wanted to address by means of a community-driven intervention that linked community mechanisms with District level government actors. Inclusive planning was facilitated by an inter-village planning task force that included children and adults who had been elected by their communities. At village level, planning discussions occurred in open community meetings and also in discussions of sub-groups of teenage girls, teenage boys, adult women, adult men, and elders. Also, home visits enabled people who were unable to attend public meetings to give inputs into the planning. The village level discussions informed the discussions of the inter-village task force, and vice versa. This circular process continued over a period of several months until agreement was reached on a child protection issue that could be addressed through a linking intervention. In tandem with these discussions, senior Sierra Leonean advisors and the facilitators worked with various District Government and formal system actors to build interest in collaborating with the communities and take stock of the feasibility of addressing various issues under discussion.

Both intervention clusters selected teenage pregnancy as their priority issue to be addressed. Continued discussions via the inter-village task force and local villages developed an intervention model that included three elements:

- (1) family planning, including the use of contraceptives,
- (2) sexual and reproductive health education, and
- (3) life skills, including the ability to say 'No' to unwanted sex and to negotiate and plan sexual activity.

These elements are implemented through a dynamic process of community mobilization in which teenage girls and boys, parents, elders, and Chiefdom authorities all play key roles. Taking a bottom-up approach, the communities decided whether and how to link with government and NGO actors, both of whom proved to be willing partners. The District Ministry of Health provides the contraceptives and the training for local health staff to use them appropriately. Marie Stopes and Restless Development provide capacity building for community selected Peer Educators on family planning and sexual and reproductive health, respectively.

Community people drive the intervention, primarily through the Peer Educators, the inter-village task force, and the village implementation focal point, who reports regularly to local authorities. Youth Peer Educators model constructive behaviour and themselves decide how to create and communicate key messages. For example, they develop dramas (multiple vignettes) showing young couples making wise decisions about sexual activity or acting on impulse, with very different consequences. Afterwards, community members discuss the implications. The youth leaders play a key role in stimulating dialogue, reflection, and constructive problem-solving around the prevention of teenage pregnancy. Adults also play a key role.

³ As discussed below, twelve villages participated in the study. Half of them were in an early intervention condition, whereas the other half were in a delayed intervention condition.

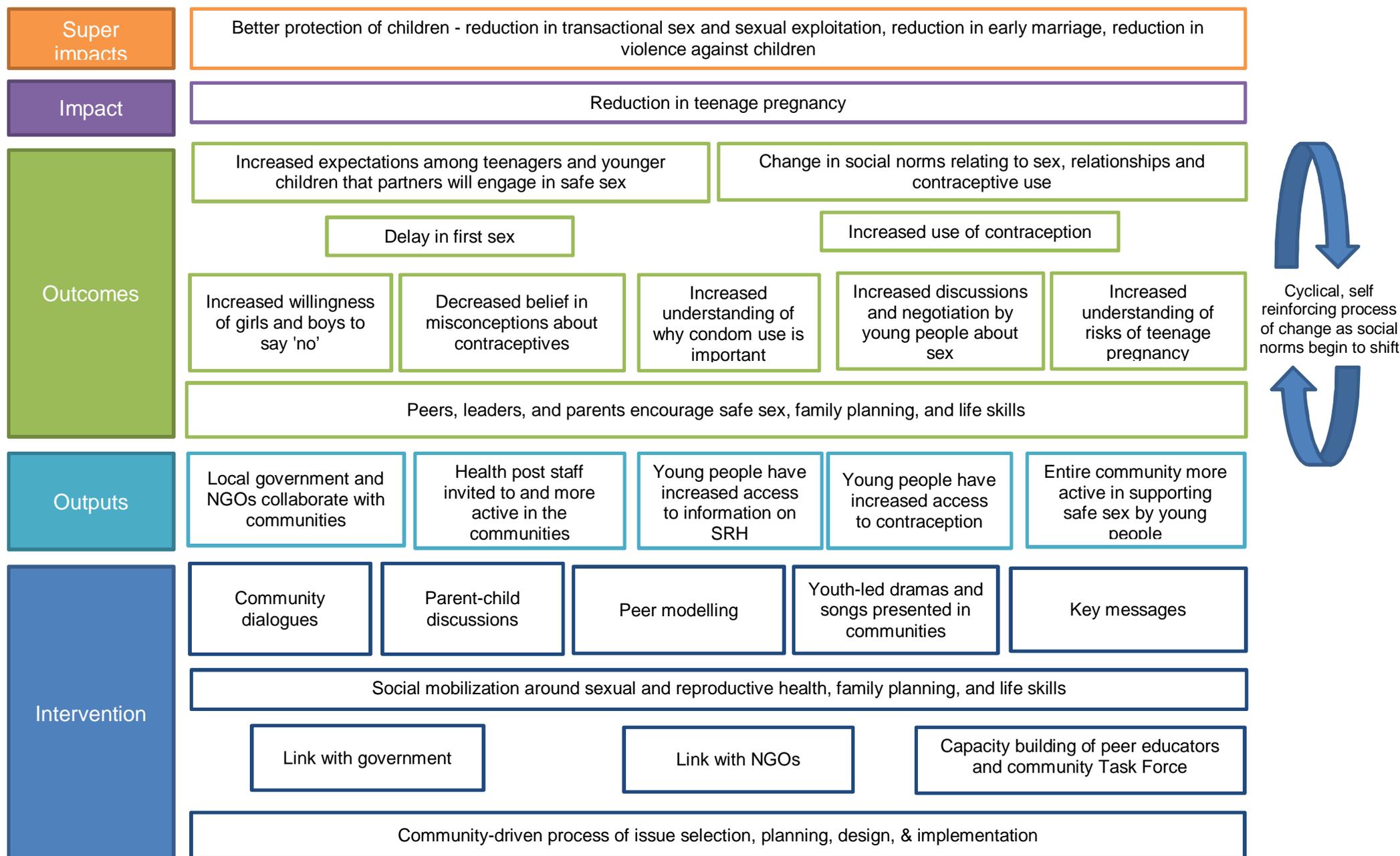
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Health staff, who are now invited regularly by communities to visit and speak at public meetings, help to educate, raise awareness, and advise on issues regarding sex, contraception, HIV and AIDS, and pregnancy prevention. Parents talk with their children about issues of puberty, sex, and pregnancy. Elders, Chiefdom authorities, and Mammy Queens, openly support the activities and encourage a spirit of collective mobilization. In essence, this is a social norms change approach that aims to reduce the rates of teenage pregnancy and unprotected sex, thereby supporting children's well-being and advancing the Sierra Leone National Strategy for the Reduction of Teenage Pregnancy 2013-2015.

The intervention theory of change is summarised in Diagram 1 below.

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Figure 1. Theory of Change for the Intervention



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1.3 Evaluation component overview

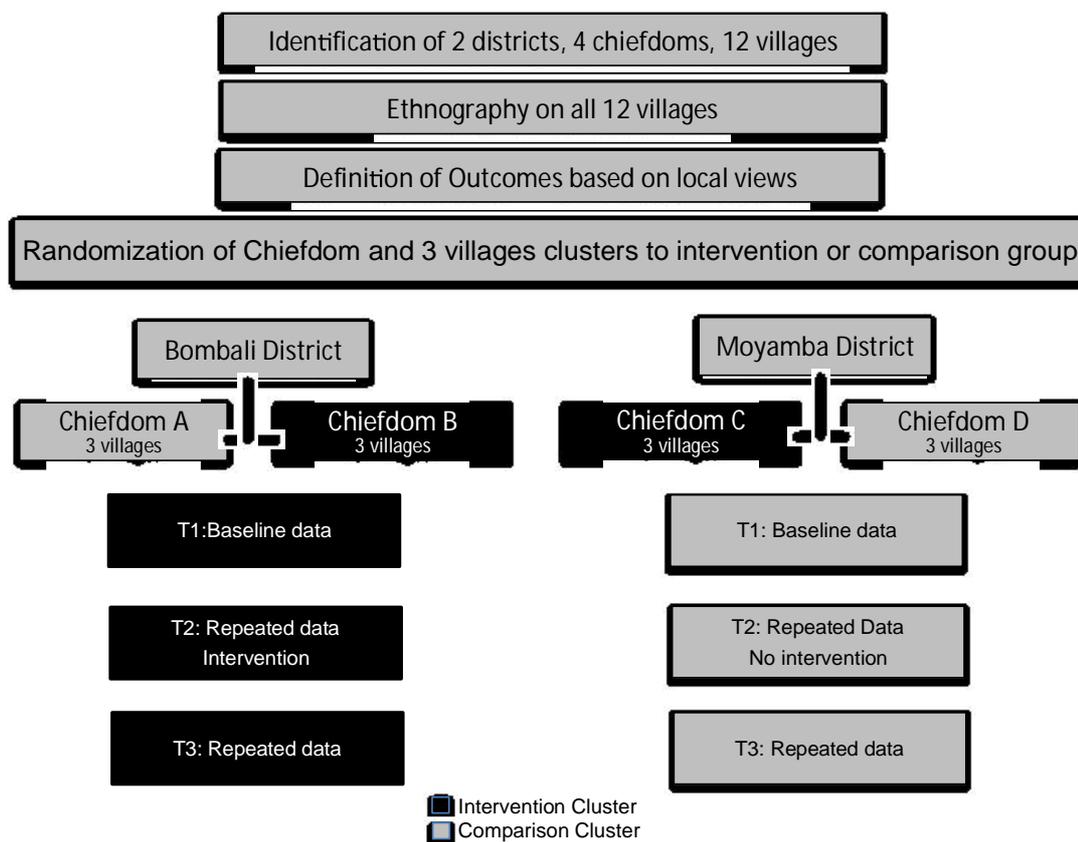
The evaluation component of the project in Sierra Leone aims to answer the following question:

- Do community-driven child protection mechanisms that have strong linkages with the formal system reduce sexual abuse, exploitation and the incidence of teenage pregnancy

To address this question, the evaluation aims to assess the impact of the community-driven interventions on the incidence of teenage pregnancy, and also on a range of immediate and medium-term outcomes including change in young people’s knowledge and attitudes towards contraception, access to and use of contraception, and social norms in the communities around sex, relationships and contraceptive use.

The evaluation has a quasi-experimental design and is part of an action research process with multiple phases, as shown in Figure 1.

Figure 2: Multi-stage action research process



The evaluation used a randomized cluster trial design. In the first phase of the research, two districts, Moyamba and Bombali, were selected through a consultative process as reflecting some of the ethno-linguistic and regional diversity within Sierra Leone. Two chiefdoms within each district which were comparable in many respects were then purposively selected and randomly assigned to be in the intervention or comparison arm of the study. Three villages from each chiefdom were selected and included in the study. This design allows

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findings from the cluster of three villages in one chiefdom to be compared to its matched cluster in chiefdom, enabling the analysis of attribution of change to the project interventions.

In order to measure change in children's outcomes the evaluation design includes a baseline (T1) and two follow up surveys with children aged 13-19 years. The first follow-up survey (T2) is undertaken 9 months after the start of the intervention and the second and final follow-up survey (T3) will take place 20 months after the start of the intervention.

2.1 Ethnographic Research

The first phase of the action research process involved rapid ethnography in each village to learn about local people's understandings of childhood, child protection risks, local pathways of response to those risks, preventive factors, and linkages between community protection mechanisms and processes with those of the formal, government led aspects of the child protection system (Wessells, Lamin, King, Kostelny, Stark, & Lilley, 2012). The process of this phase, which involved local researchers living in the villages, was important because it built trust and rapport that was essential for the subsequent work. In addition, the findings of this phase were fed back to communities in a process that enabled collective reflection. The community members said that the research had captured accurately what they themselves saw as the main child protection problems, and they began on their own initiative to reflect on what they should do to address those problems. The fact that people defined the problems themselves and discussed how they might address them was an important foundation for the community-owned process that lay at the heart of the intervention, as discussed above.

2.2 Definition of locally defined outcome areas

In the next phase, the research team developed a contextually appropriate tool for measuring the risk and well-being outcomes for children. Using ethnographic and free-listing methods with a random sample of adults and young people (Stark, Wessells, King, Lamin, & Lilley (2012), the researchers identified locally defined outcome areas in regard to harms to children and children's well-being. Outcome areas of risk and wellbeing were also identified through international child rights standards such as the African Charter on the Rights and Welfare of the Child and the UN Convention on the Rights of the Child. Using these locally and internationally identified outcome areas, the researchers developed and field tested a survey instrument for measuring children's risk and well-being outcomes.

2.3 Baseline survey

Due to the length of time that communities needed to develop an inclusive planning process, agree on a priority issue, and develop an action plan to address it, the baseline survey was undertaken in two parts. The first baseline survey was undertaken from February-March 2012 (before communities had identified teenage pregnancy as the focus issue) and collected information on the full range of child protection issues that had been identified from the ethnographic research and outcomes definition activities (Stark et al., 2013). This reflected a public health approach of collecting population based data on children's risk and well-being outcomes. The baseline survey was administered by trained national researchers across all twelve project villages. Going door to door, the research team conducted a census of 530 children between the ages of 13-17 years across the 12 villages. Because age verification proved to be operationally challenging, the upper age limit was raised to 19 years.

The second part of the baseline survey, which is the focus of this report, was undertaken from February-March 2013 (once communities had identified teenage pregnancy as the focus issue) and collected data specifically

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related to teenage pregnancy, including knowledge and attitudes towards contraception and pregnancy in line with the activities that communities had planned.

The project and evaluation timeline is presented in the table below.

Table 1: Project and evaluation timeline

Activity	Start date	End date
Ethnographic research	January 2011	April 2011
Definition of locally defined outcome areas	May 2011	July 2011
T1: Baseline survey (Baseline 1)	February 2012	March 2012
Process of community dialogue to identify priority child protection issue and develop action plan	April 2012	December 2012
T1: Intervention baseline survey (Baseline 2)	February 2013	March 2013
Community-driven activities and activities to strengthen linkages with formal system with external facilitation and support	Staggered between February and July 2013	November 2013
T2: 9 month follow-up survey	November 2013	December 2013
Continuation of community-driven activities with phasing out of external facilitation		
T3: 20 month follow up survey	November 2014	December 2014

2. Methodology

The intervention baseline study built upon the previous phases of the action research, particularly the first baseline survey. The objective was to collect additional baseline information pertaining to knowledge, attitudes, behaviours, and social norms in relation to contraception and teenage pregnancy since the communities had selected teenage pregnancy as their focus issue. This study completed the baseline dataset against which the impact of the locally developed intervention described above will be assessed.

2.1 Study population and sample

The aim was to find and interview all 530 young people across the twelve villages who participated in the original baseline survey using tracing information that had been collected at that time. For the tracing process, the two community facilitators first visited each village to hold community discussions about the purpose of the upcoming survey and to start locating children for interview using the tracing information. The facilitators shared information with the young people about when the research team would be coming to the village so that they could be available for interview. Upon arrival in each village, the research team located the young people, completed the care-giver and child consent process and then checked young people's identity using the tracing information before starting the interview. It was not possible to find all children from the original baseline survey, however, as many had moved away from the villages, in particular to larger towns to attend secondary school.

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2.2 Research Ethics

The intervention baseline survey was subject to the same ethical considerations and protocols as the original baseline survey. Consent forms for the young person and their care-giver were developed based on those used in the original baseline survey. At the time of completion, personal data on the respondents were recovered on a detachable cover sheet which was then removed, leaving only a unique identification number on each questionnaire. Questionnaires were stored separately from the identifying information and only authorised members of staff had access to this.

2.3 Survey tool

The intervention baseline survey tool built on the first baseline which had already collected information on young people's relationship status, sexual activity, incidence of teenage pregnancy and use of contraception, as well as other child protection outcomes. A survey tool for 13-19 years olds was therefore developed for the intervention baseline containing 30 questions which provided additional information specifically linked to the community intervention. The intervention baseline survey tool collected data on:

- personal demographics (age, sex, religion, ethnicity)
- respondent's sleeping location for the past two weeks
- knowledge and attitudes towards contraception, abortion and HIV and AIDS
- access to contraception and information about sex, relationships, pregnancy and contraception
- peer and community expectations and intentions regarding sex, contraceptive use, and teenage pregnancy
- experience of participating in the survey

The survey tool was translated and used in Krio and took on average 30-40 minutes to administer. The tool was piloted for one day in a neighbourhood of Freetown before being finalised and used in the project communities.

2.4 Data collection

Data collection was carried out through the administration of a seven page questionnaire by trained interviewers. Interviewers used a conversational interviewing technique, probing and providing additional explanations to interviewees when necessary. Data collection took place between 24 February and 2 March 2013 and was conducted by seven researchers, four of whom had been involved in the original baseline survey. The researchers were organised into two teams, one working in Moyamba and the other in Bombali. The Moyamba team was led by David Lamin (UNICEF) and the Bombali team was led by the Lead National Researcher, Dora King. The researchers participated in two days of training on the tool in Freetown before piloting and data collection. Data quality control procedures were established for the fieldwork. In both teams, the national lead researcher and team leader reviewed every completed survey form to check for completeness and accuracy so that any errors could be followed up and quickly corrected.

2.5 Data entry, cleaning and analysis

At the end of the data collection process, the completed paper survey forms were taken to Columbia University in the US for data entry and analysis. The data was entered into an excel spreadsheet and cleaned to remove incomplete records. Once cleaned the intervention baseline dataset was merged with the original baseline survey dataset using Stata. Individual records were merged using a unique ID code for each respondent and then the merge was checked using village, sex, age, religion and ethnicity variables.

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Data analysis was conducted using Stata and included descriptive analysis and significance testing across the intervention and comparison clusters. The study design calls for little to no significant differences between the comparison and intervention clusters within each district at baseline stage. For example, in order to assess whether the upcoming intervention affects knowledge regarding birth control, each group (intervention and comparison) should ideally have similar knowledge levels before the intervention. For this reason, this report documents any significant differences that were observed between the intervention and comparison clusters at the baseline measurement period, before the intervention had begun.

2.6 Limitations

While every effort was made to locate children from the original baseline, this was not always possible. A total of 360 teenagers were interviewed as part of the intervention baseline, of whom only 321 could be matched as original respondents. This represents just over 60% of the original cohort of 530 respondents. However, analysis comparing the demographic composition of respondents in the original baseline and the intervention baseline shows strong similarity, giving confidence that the findings of the intervention baseline are representative of the whole cohort.

There were also some differences recorded in relation to children's reported ages at original baseline compared with the intervention baseline, with some children reporting ages significantly higher than in the previous survey, over and above the one year gap to be expected between the surveys. This is perhaps unsurprising though as many teenagers in the original baseline study found it difficult to pinpoint their exact age and were not in possession of formal identity documents.

The one year gap between the original baseline survey and the intervention survey means that some degree of change in young people's knowledge, attitudes and outcomes might already have occurred, particularly in the intervention clusters where the project facilitators had been working during the year supporting community discussion and action planning. It is possible that this process of community dialogue was itself already having some impact on the young people.

Some of the results of the survey may also be influenced by the sensitive nature of the topics discussed with teenagers. While most of the questions in the intervention baseline did not ask the teenagers directly about their sexual behaviour, they were asked to report on their beliefs or perceptions in relation to sexual practices, pregnancy and contraception. The high proportion of "don't know" responses to some of these questions (up to 46%⁴ in some cases) may suggest that some of the teenagers may have felt uncomfortable answering. However this could also be interpreted as a way of expressing a lack of knowledge or a lack of a clearly defined opinion on certain issues.

3. Demographic composition

A total of 360 young people aged 13-19 years participated in the intervention baseline study. This compares to a total of 530 young people in the original baseline study. Table 1 displays the demographic characteristics of the respondents, comparing the intervention and comparison sites within and between each district. The median age of the group was 16 years. The demographic composition of the group of teenagers interviewed for the

⁴46.7% of teenagers in Moyamba responded "I don't know" to the question "Do you agree or disagree: Most teenagers in this village expect to use condoms when having sex".

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intervention specific baseline was similar to the original baseline group, despite the difficulties in locating the entire cohort, giving some confidence that the information is representative.

The gender division of the group was not equal, with 53.7% being female and 46.3% being male. The predominant reported religion was Islam (53.3%) followed by Christian (46.4%). Participants were also asked what ethnic group their family belonged to. The most common response was Mende (46.4%), followed by Loko (43.4%). As noted in the original baseline survey, ethnic group differs across districts, which is evident in the high proportion of Loko in the Bombali clusters and Mende in the Moyamba clusters. There was also a small degree of overlap between ethnicities with two teenagers classifying themselves as Loko and Temne, and five as Temne and Mende.

At the time of the original baseline, almost half of the group described themselves as single, 40% had a boyfriend or girlfriend and 10% were married. Over 20% of the group had at least one child at that time.

Table 2. Demographic Characteristics of the sample (n=360⁵), stratified by district and the intervention and comparison sites

	Bombali			Moyamba			
	Intervention	Comparison	Total	Intervention	Comparison	Total	Grand total
Sex (n=354)							
Female	54	35	89 (50.3%)	56	45	101 (57.1%)	190 (53.7%)
Male	49	39	88 (49.7%)	52	24	76 (42.9%)	164 (46.3%)
Religion (n=360)							
Christian	70	18	88 (49.4%)	63	16	79 (43.4%)	167 (46.4%)
Islam	34	56	90 (50.6%)	47	55	102 (56.0%)	192 (53.3%)
Other	0	0	0	0	1	1 (0.5%)	1 (0.3%)
Age years (median)	16	16	16	15	16	15	16 (12-20)
Ethnic Group⁶ (n=364)							
Loko	103	55	158 (87.3%)	0	0	0	158 (43.4%)
Temne	2	16	18 (9.94%)	9	1	10(5.3%)	28 (7.6%)
Mende	1	1	2 (1.1%)	98	69	167(88.8%)	169 (46.4%)
Susu	0	0	0	2	1	3(1.6%)	3 (0.8%)
Fullah	0	2	2 (1.1%)	0	0	0	2 (0.5%)
Other	0	1	1 (0.6%)	2	1	3(1.6%)	4 (1.1%)
Relationship status (n=321)							
Single	37	25	62 (40.0%)	73	24	97 (58.4%)	159 (49.5%)
Boyfriend/ Girlfriend	41	30	71 (45.8%)	28	30	58 (34.9%)	129 (40.1%)
Married	9	13	22(14.2%)	4	7	11 (6.6%)	33 (10.3%)
Children (n=320)							
Yes	21	7	28(18.2%)	20	17	37 (22.3%)	65 (20.3%)
No	65	61	126 (81.8%)	85	44	129(77.7%)	255 (79.7%)

⁵ Where responses are analysed together with the original baseline findings only the cases where a match could be established were included. This means that the number of respondents is reduced to 321.

⁶ % of responses not % of respondents (cases)

4. Findings

4.1 Relationships, sexual activity and teenage pregnancy

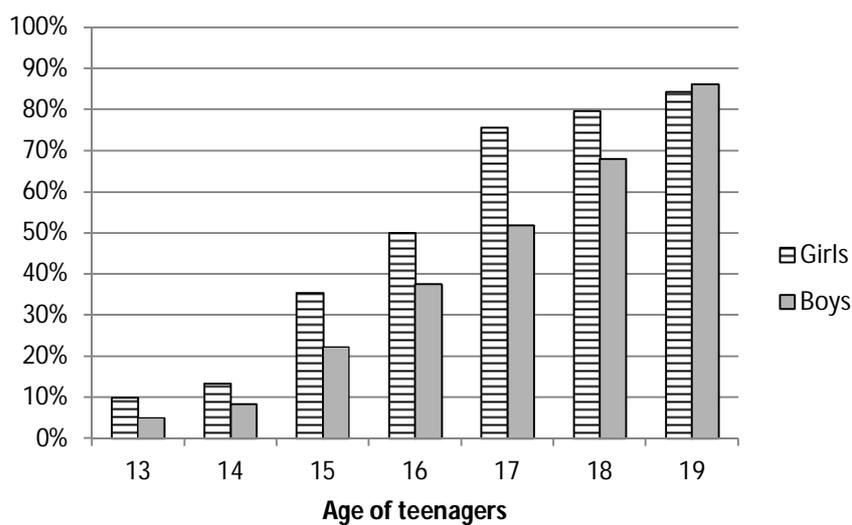
Nearly half of all young people were in relationships and sexually active

Of the 525 young people who answered questions about their current relationships in the original baseline survey, 258 (49.3%) had reported having had a girlfriend or boyfriend in the preceding year. Also, 212 (40.5%) participants had reported that they were sexually active, regardless of whether they had a current girlfriend or boyfriend. Within the sample of 212 teenagers, more girls (56.6%) were sexually active compared to boys (43.4%).

Some young people were sexually active by 13 years of age and 85% of 19 year olds were sexually active

Nearly 10% (8.6%) of 13 and 14 years olds reported being sexually active during the previous year. Figure 1 shows the proportion of sexually active boys and girls by age. With increased age, higher proportions of girls than boys report being sexually active, with the exception of 19 year olds.

Figure 3. Proportion of sexually active boys and girls by age (n=212)

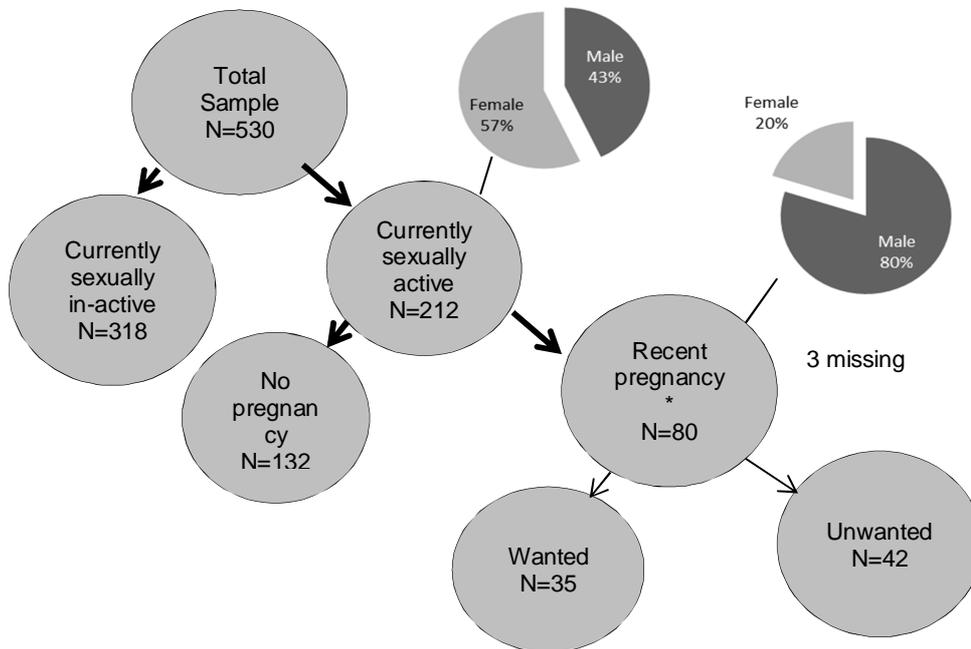


Over a third of all sexually active teenagers had become pregnant in the last year

Within the year prior to the original baseline survey, 80 respondents had reported becoming pregnant or impregnating a sexual partner, resulting in a one-year period-prevalence of 37.7%, very high for such a young population. Of interest, out of the 80 participants who reported having a recent pregnancy, 17 were male, meaning that nearly 20% of sexually active boys had a partner who became pregnant. Generally, males are also less likely to know the pregnancy status of a sexual partner, so it is likely that the 20% figure underestimates the true prevalence.

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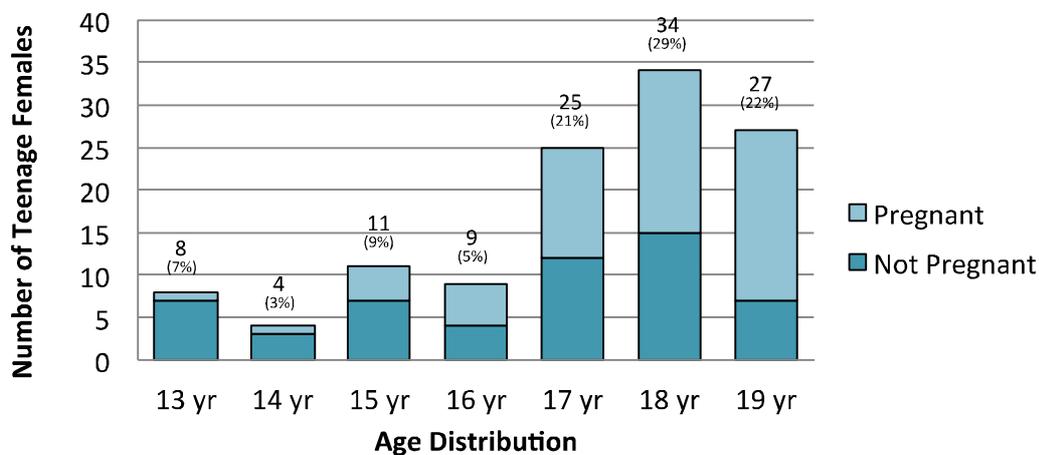
Figure 4. Recent sexual activity and pregnancy in the past 12 months



Over half of sexually active teenagers aged 17-19 years had a pregnancy in the last year

For young people in the survey aged 17, there were approximately equal numbers of sexually active girls with and without recent pregnancies. By 19 years three quarters (74%) of sexually active females in this study had been pregnant in the last 12 months. This very high percentage of teenage pregnancies among sexually active teenagers resonates with the findings of other research conducted in Sierra Leone (Government of Sierra Leone, 2013).

Figure 5. Number of sexually active female teenagers in the original baseline group, disaggregated by age and pregnancy status (first baseline)



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A logistic regression that assessed the strength of association between pregnancy and age indicated that, for every additional year following sexual debut, there was a 50% increase in the odds of having had a recent pregnancy (OR=1.48, 95% CI: 1.17-1.88). Not attending school in the preceding year was also associated with a 4-fold increase in the odds of having had a recent pregnancy (OR=4.16, 95% CI: 1.85-9.38), suggesting a strong association between teen pregnancy and school drop-out⁷.

Among the most important findings from the first baseline survey, substantiated by previous phases of this research, are the risks associated with sexual activity among teenagers. Twenty-three percent of girls, and 50% of sexually active girls in this study had been pregnant in the past 12 months, some as young as 13 years. For each additional year of age, the females in this study had a 50% increase in the odds of becoming pregnant. By the age of 19 years, more than 75% of sexually active young women had been pregnant. These findings are consistent with the data from national surveys conducted in Sierra Leone showing that 34% of all pregnancies occur among teenage girls (Statistics, 2008), and that 26% of teenage girls between the ages of 15-19 years have already had a birth (MICS, 2010), with most of the births for children in that age range coming before the age of 18 years (UNFPA, 2011). National statistics also reveal that teenage mothers start having children at ages as young as 9 years, and 40% of maternal deaths occur as a result of teenage pregnancy (Government of Sierra Leone, 2013). In light of the severity of the problem of teenage pregnancy, it is encouraging that communities in the intervention clusters have selected this as the problem they seek to address in their subsequent intervention.

An important finding in the baseline study is that living with parents appeared to be protective against early sexual debut, yet once teenagers become sexually active, the sexual risk environment over-rode the protection afforded by living with parents. This finding suggests that parental protection by itself is not sufficient for addressing the multiplicity of sexual risks in teenagers' social environments and that other supportive measures are also important.

4.2 Knowledge, attitudes and intentions relating to contraception and pregnancy

Most young people know about the risks of teenage pregnancy and report that they and their peers don't want girls to become pregnant

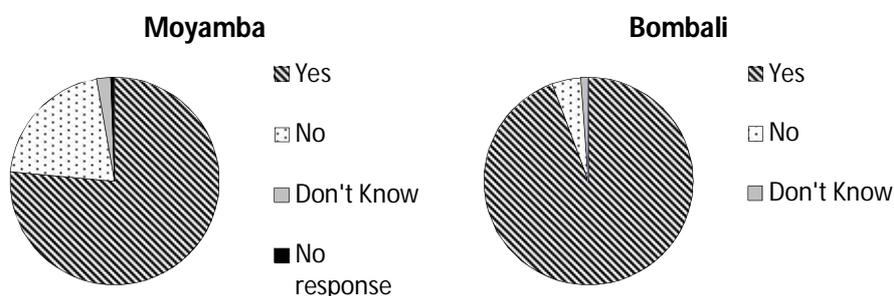
Over 85% (306) of those interviewed during the intervention survey thought that it was dangerous for a girl to get pregnant, with similar results for girls and boys (84.7% of girls and 86.5% of boys). When asked to name which specific risks or problems they were aware of in relation to teenage pregnancy, maternal death was the most frequently mentioned response, followed by still birth and a long and/or difficult labour.

A higher percentage of respondents in Bombali (93.8%) thought that it was dangerous for a girl to get pregnant compared to 76.4% in Moyamba, a difference that is statistically significant ($p=0.000$). The charts below compare answers to this question for Bombali and Moyamba.

⁷ Calculations from the original baseline study.

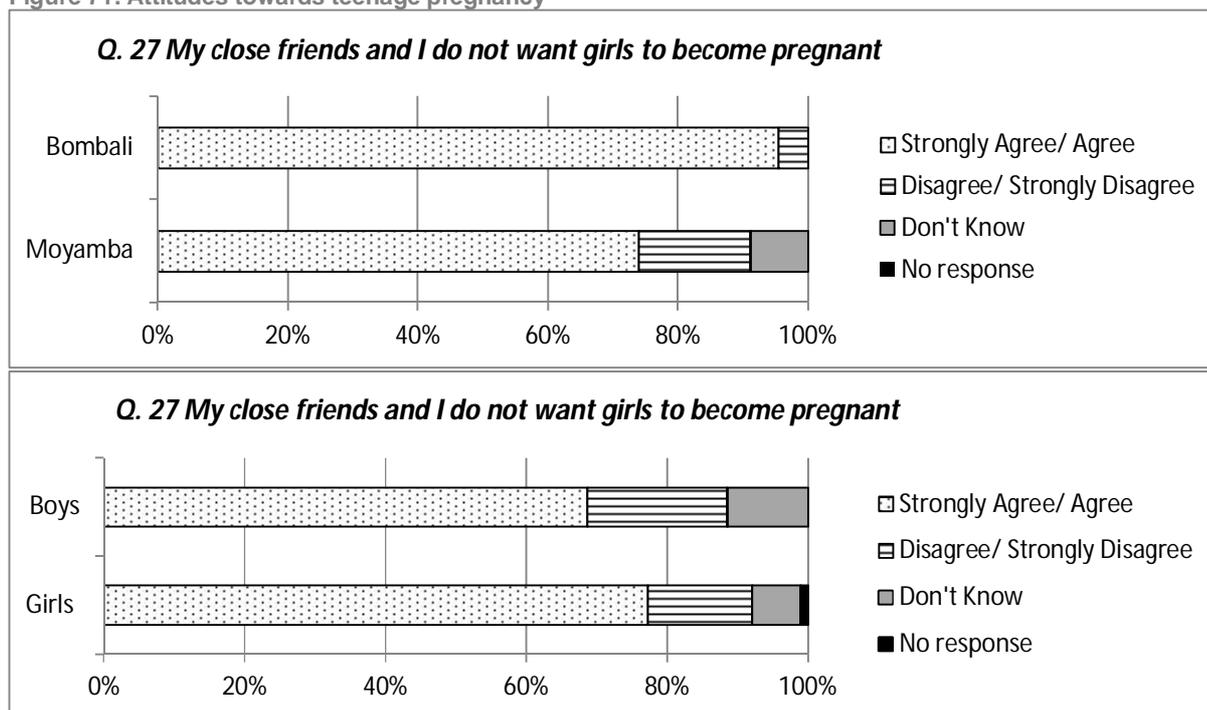
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Figure 6. Knowledge of the risks of pregnancy



When asked whether they agreed with the statement “My close friends and I do not want girls to become pregnant” results were similar with 89.3% Bombali and 68.7% in Moyamba strongly agreeing, however the difference between the two areas was found to be statistically significant (p=0.000). Differences between the intervention and comparison groups were minimal with 79.4% and 78.5% strongly agreeing respectively. There were also differences between girls and boys’ answers to the question, with 77.2% of girls strongly agreeing or agreeing compared to 68.4% of boys.

Figure 71. Attitudes towards teenage pregnancy



These findings indicate that awareness regarding the dangers of teenage pregnancy is lower in Moyamba than in Bombali and that teenagers in Moyamba are not quite as strongly opposed to the idea of teenage pregnancy as in Bombali. While overall the findings appear to indicate a relatively high level of awareness of the dangers of teenage pregnancy and a desire for girls not to get pregnant, over 50% of the teenagers who were sexually active in the intervention survey group (52 out of 119) had been pregnant in the year prior to the original baseline, suggesting that this awareness alone does not translate into behaviour. The gap between attitudes and

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behaviour has been well documented in the fields of psychology and sociology, e.g. Chaiklin (2011) and Wicker (1969). NGOs have also examined the discrepancies between expressed attitudes and observed behaviours or between knowledge and practices in behaviour change interventions, for example in hand washing (Coombes & J, 2010). The role that social norms play in affecting the relationship between attitudes and behaviour is also been examined (Liska, 1974) and sheds some light on to why attitudes are not a straightforward predictor of behaviour.

Many teenagers do know something about contraception and how to avoid pregnancy

Despite the high pregnancy rates recorded in the baseline survey, more than two thirds of (65%) of teenagers in the sample did know ways that people can avoid pregnancy. For the young people who did report knowing how to avoid pregnancy, the most commonly cited methods were the use of male condoms, injectables/ implants, contraceptive pills, and traditional medicine.

In Moyamba, significant differences between the intervention and the comparison clusters were observed for relationship status⁸ ($\chi^2=7.51$, $p=0.023$), sexual activity in the past year ($\chi^2=6.91$, $p=0.009$), and contraception knowledge ($\chi^2=6.01$, $p=0.014$). In Bombali district, no significant differences were observed between the intervention and the comparison clusters.

Many young people believe that contraception can have harmful effects

Perceptions related to the use of contraceptives were further investigated during the intervention survey. When asked why it is important to use condoms when having sex, the most frequent response from teenagers was to reduce the risk of pregnancy, followed by reducing the risks of Sexually Transmitted Infection (STIs) and reducing the risk of contracting HIV. Girls and boys had similar ideas of why it was important to use condoms but a relatively high proportion of the respondents answered that they did not know (25%).

Commonly held beliefs about the negative effects of contraceptives were also tested during the study. When asked if they agreed with the following statement *“Do you agree or disagree: If a 15-year-old girl uses contraceptives such as pills or injections, she may have a hard time getting pregnant when she is 20 years old and want to become pregnant”*, 65.7% of teenagers in Bombali and 63.7% in Moyamba strongly agreed or agreed. Results were similar across intervention and comparison groups, with 67.8% and 62.6% strongly agreeing or agreeing respectively.

Many teenagers say they plan to use condoms and believe that their peers do too

The graph below shows the distribution of responses of the intervention group in relation to key questions about the use of condoms. We can see that just over half (54.8%) of sexually active teenagers in the intervention group agree or strongly agree that they plan to use condoms, compared to (43.8%) of the comparison group. Questions relating to intentions were included in the questionnaire as planned behaviour or intentions are thought to relate more closely to behaviour.

We can also see that teenagers in both groups think that their peers are likely to behave in similar ways to themselves. In the intervention group 54.8% agreed that they intend to use condoms while 59.7% expected that others would. In the comparison group 43.9% planned to use condoms and the same percentage thought that others would. During the course of the intervention these attitudes may shift, but we would expect the contrast

⁸ Data from the original baseline survey. This question was an open question. During data analysis responses were coded as 'married', 'having a boyfriend or girlfriend' or 'single'. Further sub categories specified whether the respondent was living with their boyfriend, girlfriend or spouse.

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between these results and those of the intervention group to become more pronounced if the intervention were successful.

Figure 8. Attitudes towards the use of condoms: Intervention group (sexually active teenagers only)

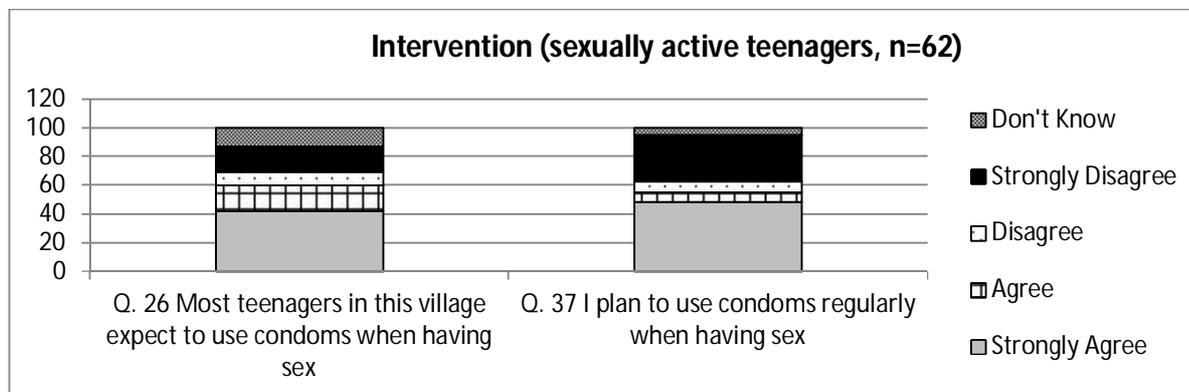
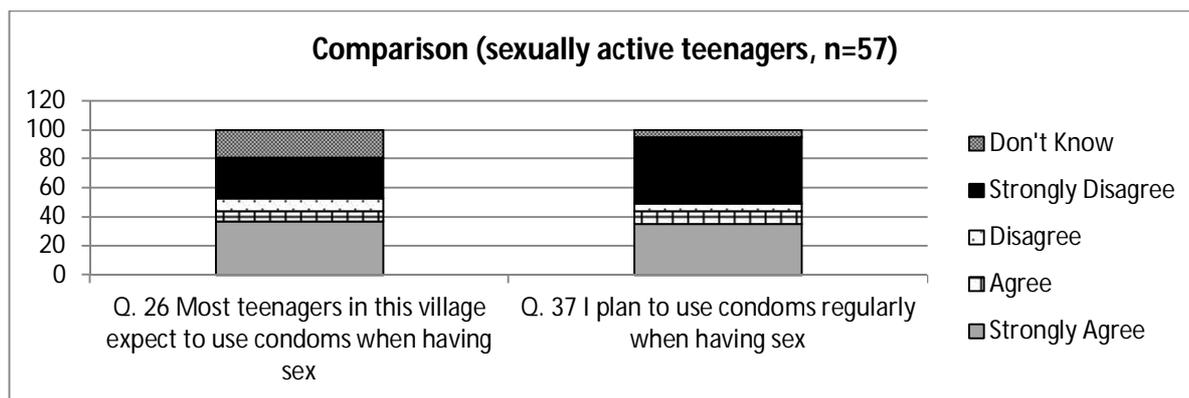


Figure 9. Attitudes towards the use of condoms: Comparison group (sexually active teenagers only)



Less than half of young people reported that people in their village have ready access to condoms

Of the 360 teenagers participating in the intervention specific survey, 44.1% (158) thought that people in their village had ready access to condoms. Higher percentages of teenagers in Bombali (56.25%) than in Moyamba (32.4%) thought that people in their village had ready access to condoms.

The results of the original baseline study indicated that teenagers seldom used contraceptives. High rates of pregnancy are also indicative of infrequent use of contraceptives. Only 34% of sexually active teenagers reported ever having used contraceptives, and only 50% of those who used contraception said they used them consistently. The most commonly used method of contraception was male condoms, the use of which frequently depends on the presence of gender norms that enable females to negotiate condom use. Of the 212 sexually active teenagers, only 77 (36%) reported using contraceptives, most commonly the male condom and injectables/ implants.

4.3 Protective behaviours and life skills

More teenagers in Bombali knew whom to go to for advice than in Moyamba

Teenagers were asked about reliance on parents or others as sources of advice and support. Differences in responses between Moyamba and Bombali were marked, with 78.7% of teenagers in Bombali (140) and only 40.7% (74) of teenagers in Moyamba saying that they knew whom to go to in order to obtain accurate information about sex, pregnancy, abortion and related issues.⁹ In contrast, there were few differences between the data when pooled for both districts across the comparison group and the intervention group (50.6% vs. 49.5%, respectively).

Protective behaviours such as the ability to say “no” to sex were also investigated. The chart below compares responses to two questions about intended and expected behaviour for the intervention and comparison groups. The ability to say ‘no’ to unwanted sex is something that only around half of each group feels comfortable with, however the majority of the group does not agree that people in general in their community expect teenage girls to engage in sexual relations even if they don’t want to.

Figure 10. Intentions and community pressures: Intervention Group

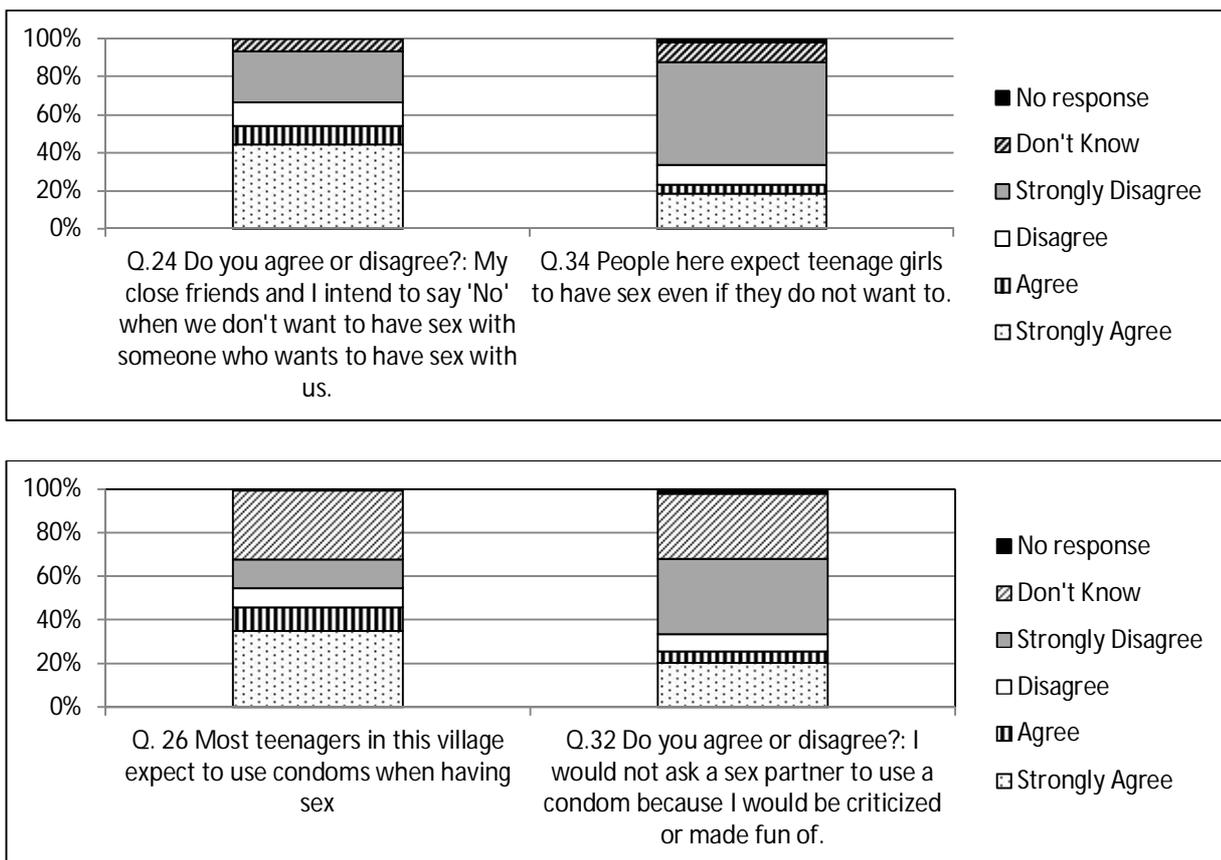
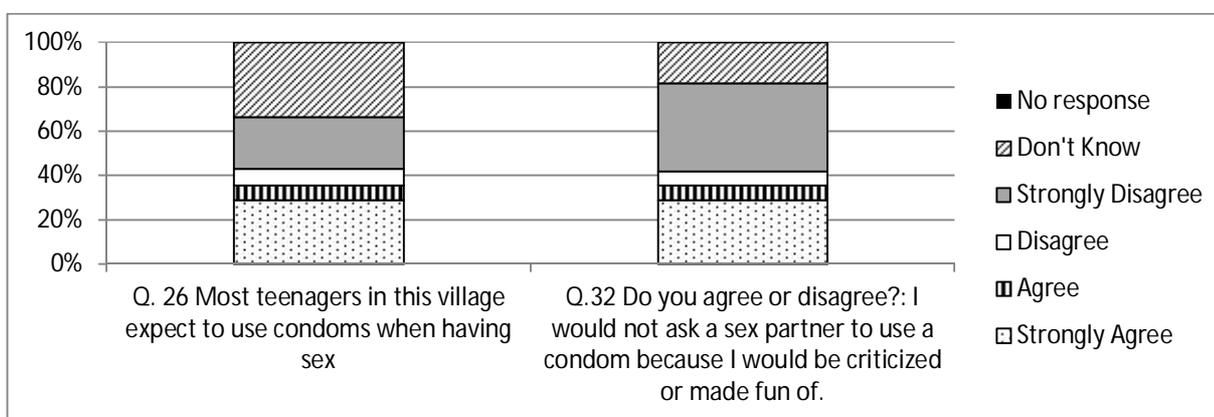
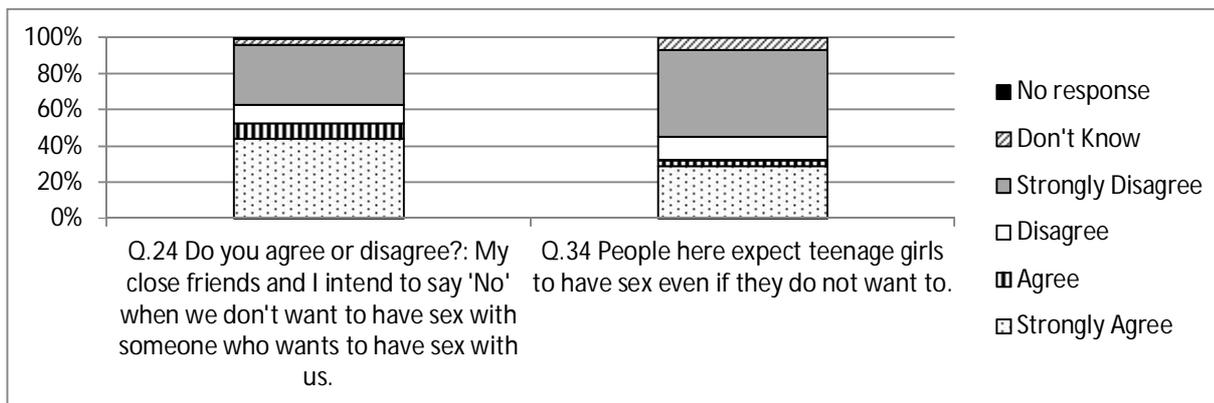


Figure 2. Intentions and community pressures: Comparison group

⁹ Includes “Strongly agree” and “Agree” answers.

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One potentially promising preliminary finding was that out of the 50% of females who became pregnant, the majority (75%) reported that they could talk to a parent, family or friend about it to get help. This finding highlights indigenous features of the social environment that allow girls at risk to seek help and that are valuable assets that communities could mobilize in their subsequent intervention. Findings from the intervention survey also confirmed that overall; there is a relatively widespread perception amongst participants that parents talk with their sons and daughters about sex and pregnancy, with 63.2% of boys and 73.2% of girls strongly agreeing with this statement.

Over a third of teenagers are fearful of ridicule or criticism when asking partners to use condoms

Teenagers were also asked if they would refrain from asking a sex partner to use a condom for fear of being criticized and made fun of. Of those who were sexually active, 30.6% (19) in the Intervention group and 43.6% (25) in the comparison group either agreed or strongly agreed with this statement. Overall, 41.7% (33) of sexually active girls compared to 27.5% (11) of sexually active boys strongly agreed with the statement, suggesting that fear of ridicule was may be more important in influencing decisions by girls to use condoms or request that they be used, however this difference was not found to be statistically significant ($p=0.230$).

4.4 Social norms

Research on social norms (UNICEF, 2010)(Mackie & Moneti, 2012) provides us with a useful framework for interpreting individual actions and beliefs within the context of a group, as well as highlighting some possible explanations for the failure of development programmes focused on individual behaviour change. The term social norm can be explained in the following way:

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".. a social norm is what people in some group believe to be normal in the group, that is, believed to be a typical action, an appropriate action, or both (Paluck and Ball 2010). A social norm is held in place by the reciprocal expectations of the people within that group.... Because of that interdependence of expectation, social norms can be stiffly resistant to change." (Mackie & Moneti, 2012, p. 3)

In other words, for children and even more so for teenagers, it is of utmost importance to understand and engage with what the group "believes" in order to design programmes that translate into improved outcomes for teenagers, such as a reduction in teenage pregnancy rates. It has been shown that while significant numbers of individuals may readily adjust their attitudes towards a specific practice (for example the use of condoms), it may take a "coordinated shift" (Mackie & Moneti, 2012, p. 4) in the adoption of this new practice at community level for this to translate into intended benefits.

The findings of the intervention baseline survey and subsequent data collection exercises will be analysed within this framework in order to track shifts in individual, as well as group attitudes and behaviour. For this reason, median responses to questions for the intervention and comparison groups as a whole are presented in addition to individual responses. The expectation is that the median responses for the intervention group will shift towards favourable attitudes in relation to sexual and reproductive health on the whole.

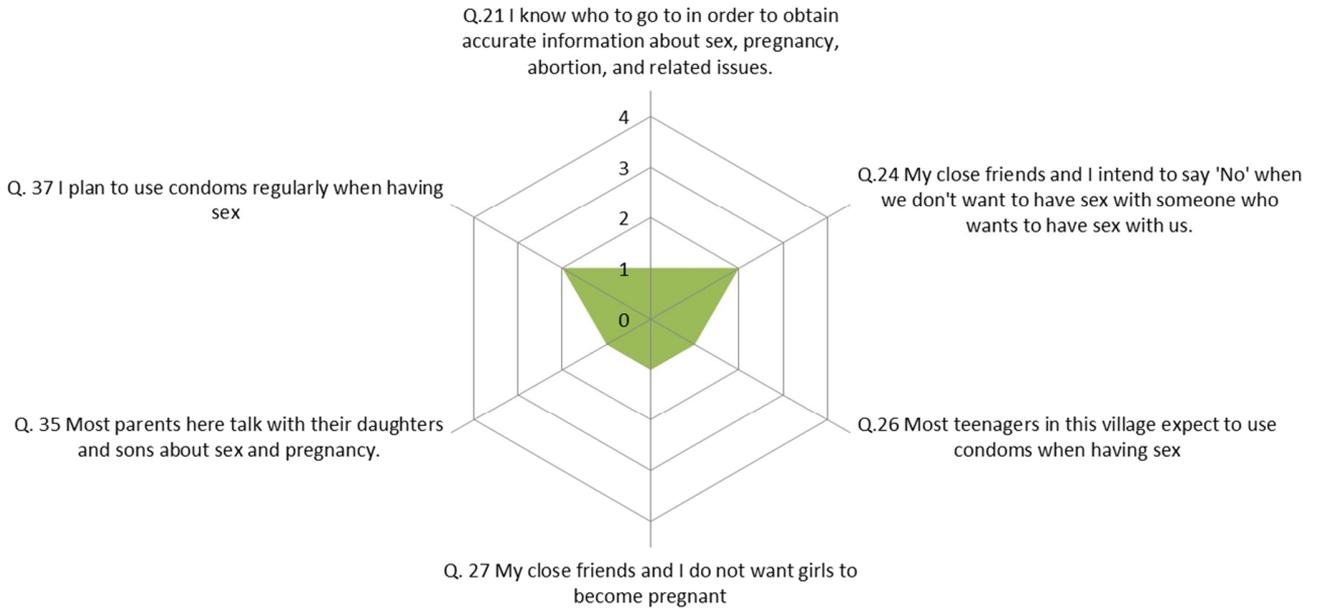
The graphs below show median responses for the intervention and comparison groups in relation to "positive" and "negative" attitudes and intentions towards sexual and reproductive health. The numbers on the axes of the charts represent the Strongly Agree (1), Agree (2), Disagree (3) and Strongly Disagree (4) responses, so smaller shaded areas in a section denote more agreement, and larger areas indicate more disagreement with a specific question.

For the first set of questions, the most favourable response to these questions would be "Strongly Agree" as they relate to positive factors influencing sexual and reproductive health behaviour. During the course of the intervention we would expect the shaded area to *decrease* in size for the intervention group as more responses are given as strongly agree and agree. For example, we would expect well informed and prepared teenagers to agree with the statement "My close friends and I intend to say 'No' when we don't want to have sex with someone who wants to have sex with us". Similarly, we would expect these teenagers to agree with the statement "I plan to use condoms regularly when having sex".

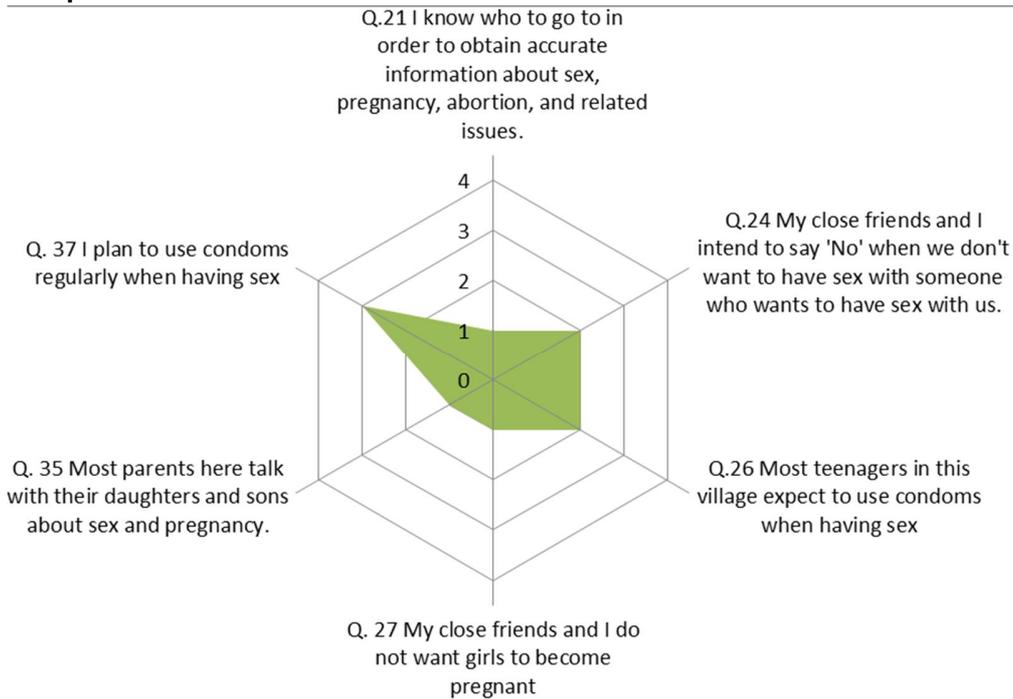
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Figure 32. Median Responses for the Intervention and Comparison Groups – “Positive” attitudes and beliefs:

Intervention Group



Comparison Group



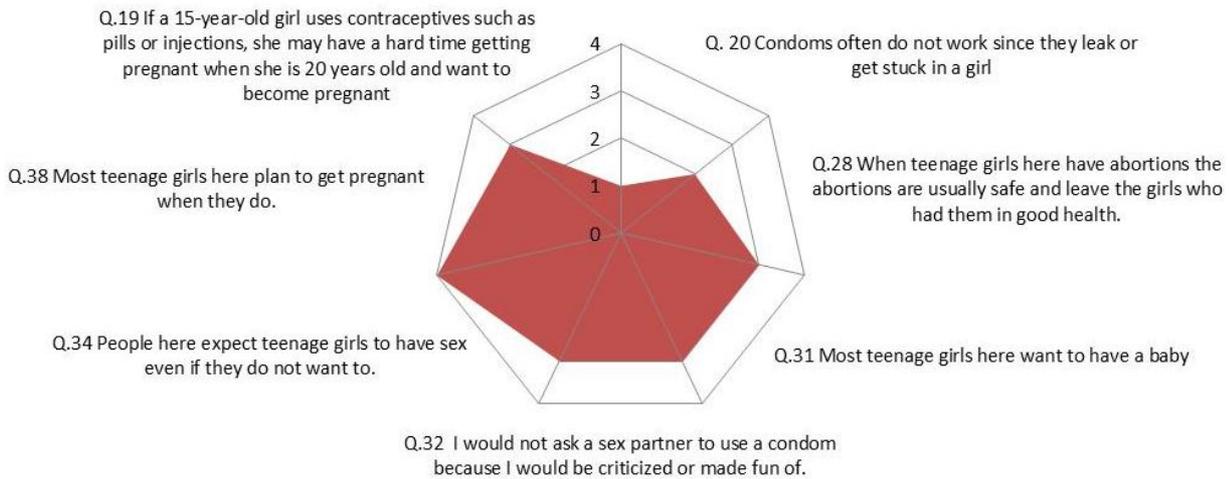
The next set of charts show median responses for the intervention and comparison groups in relation to “negative” attitudes to sexual and reproductive health issues. The most favourable response to these questions would be “Strongly Disagree” (4) as they relate to negative factors influencing sexual and reproductive health or

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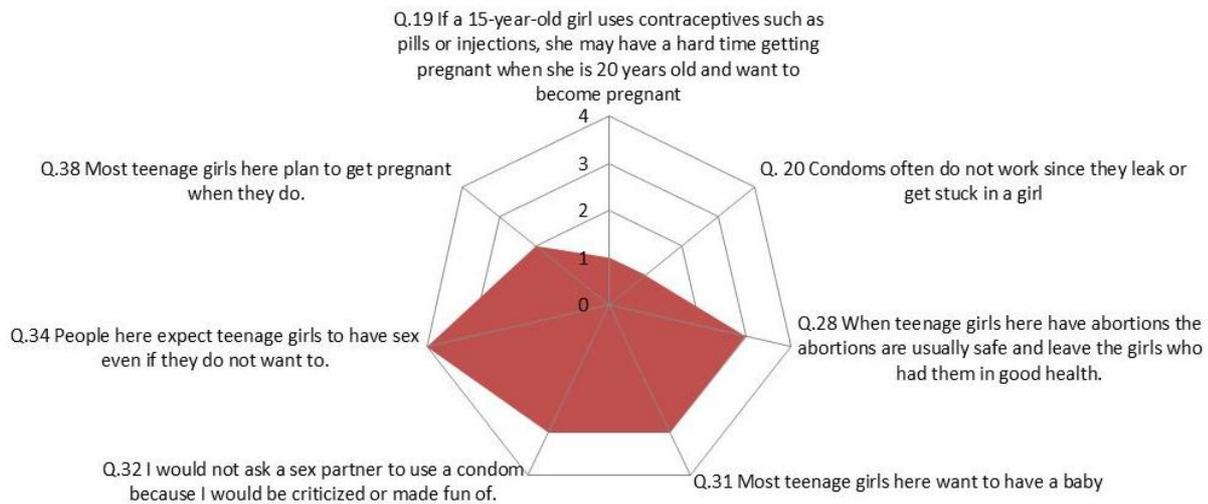
“myths” that teenagers commonly believe in. In this case, a successful intervention would result in an *increase* of the shaded area of the chart as more “Strongly Disagree” responses are recorded. For example, we would expect uninformed or unprepared teenagers to agree with the statement, “I would not ask a sex partner to use a condom because I would be criticized or made fun of”.

Figure 4. Median Responses for the Intervention and Comparison Groups – “Negative” attitudes and beliefs

Intervention



Comparison



4.5 Knowledge and attitudes towards HIV and AIDS

Most young people knew about HIV and AIDS but few knew someone affected

Most of the participants in the original baseline study had heard about HIV/AIDS before (88%), but few knew someone living with HIV (4%), and only two participants reported that someone in their family was living with

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HIV. The HIV prevalence in Sierra Leone is relatively low (1.6%) in comparison to other countries in sub-Saharan Africa. The small number of respondents who reported knowing someone with HIV could be attributed to the fact that often children are not always made aware of illnesses in their family. Also, HIV is an auto-immune disease for which the presenting symptoms are very similar to common illnesses. Although few respondents knew someone living with HIV/AIDS, it was considered a stigmatizing illness. Few teenagers (14%) reported that they would play with someone living with HIV or share a meal with them (11%).

The groups were compared to assess statistically significant differences between the comparison and intervention clusters in each district. In neither Moyamba nor Bombali districts were there statistically significant differences regarding HIV/AIDS.

During the intervention survey participants were asked whether they thought HIV and AIDS was a serious problem in their village. Overall, boys and girls held similar views, with 45.4% of boys and 53.16% of girls strongly disagreeing that this was a problem for their village and only 19.6% and 20% strongly agreeing or agreeing that it was a problem. This indicates that HIV and AIDS is not perceived as a significant problem for young people in the group as a whole, however differences between districts are more pronounced with 31.5% of teenagers in Bombali strongly agreeing or agreeing that it is a problem, compared to only 8.2% in Moyamba. However it should be taken into consideration that in Moyamba a high percentage (32.9%) replied that they did not know if it was a problem.

5. Conclusions

The intervention specific survey findings provide a starting point against which to measure the relative success of the community led intervention in the future. By tracking changes in relation to teenage pregnancy related outcomes such as knowledge about and use of contraceptives, as well as rates of teenage pregnancy in both the intervention and comparison groups, we expect to see discernible differences over time as the intervention progresses.

The findings of the intervention specific survey appear to confirm the original baseline findings of "low sexual health literacy, low access to contraception, and challenges to ensuring consistent use" (Stark, et al., 2013, p. 27) to a certain extent. However teenagers participating in the study did demonstrate some knowledge of the dangers of pregnancy as well as partial knowledge about how to prevent it. Teenagers also thought that peers were acting in similar ways to themselves in terms of contraceptive use.

While there was some knowledge of contraception within the group and no marked differences between intervention and comparison groups in this respect, the findings of the original baseline reveal that sexual practices are not necessarily in line with professed knowledge or attitudes. High pregnancy rates and early sexual debut within the group suggest that there are many factors preventing this knowledge from being acted out despite teenagers' heavy reliance on family and community networks for advice and support.

Beliefs that contraceptive methods are not only ineffective but potentially harmful appeared to be a significant barrier to contraceptive use, highlighting the need to tackle misconceptions and concerns about the use of contraceptives. However other obstacles appear to be related to prevailing social pressures and norms with some teenagers fearing ridicule or criticism for suggesting their use to partners.

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Annexes

Intervention Specific Survey Questionnaire Format



Child Protection Intervention Survey, February 2013

Sierra Leone

Questionnaire for Youth Ages 13-19

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Informed Consent Form – Heads of Household/Caregiver

Greeting

Hello, my name is _____. May I please speak with the head of the household? (*If the child is also the head of household, skip to Child/Youth Consent Form*)

As I said, my name is _____. I am a researcher, and I work for Columbia Group. The full name of the group is The Columbia Group for Children in Adversity. This organization works on behalf of children who are in situations that pose a threat to their wellbeing and safety.

Background of research

We have come to learn about the children of this village. This research is supported by many of the global child protection agencies, like Plan International, Save the Children, and UNICEF. The research is not limited only to your village. It is being carried out in three countries, and Sierra Leone was chosen as one of the countries to conduct this research. And in Sierra Leone, because we could not go everywhere, the Group chose two districts: Moyamba District in the South and Bombali District in the North. And we chose two chiefdoms in each district. Magbainba Ndorhahun and Liebesegahun in Bombali District, and in Moyamba, we chose Upper Banta and Kombora. Within the chiefdoms, we also chose three villages, because we cannot go everywhere. And your village was one of the villages we chose to learn about children's issues.

Purpose of research

The purpose of this research is to learn about how you and your community care for your children. We want to understand how you can work together with the government and child protection NGOs to improve the lives of children.

We have come to this village a few times over the past two years to talk to people and learn about what is happening in relation to children. Most recently, we came last year and asked to young people about their lives, education, family and other issues. Maybe you remember this?

Today, we have come to learn a bit more about how young people are doing in this village. We want to ask young people a few more questions that we did not get to ask last time. Specifically, we want to talk to them about family planning, contraception and about HIV and AIDS.

Confidentiality

The information that they he/she gives me will be confidential. I am not going to tell anyone anything that your daughter/son/youth tells me. I will keep it to myself. Only the Columbia Group research team will see anything that is said. That means they are the only ones who can connect your child's name to the information she gives me. We will write a report, but we won't disclose your child's identity and we will only use the information for the purpose of research to help those who make policy and create programs for children do their work well.

Consent and Managing expectations

There is no pressure on you to allow us to talk with your daughter/son/youth. You are free to say "No" and we will not be offended if you say you prefer that she/he not talk with us. Also, if you agree to permit her/him to talk with us, she/he will be free at any time to not answer any questions or to end the interview.

So I would like to ask permission from you to talk to your daughter/son/youth today. If you agree, I will interview your child. At any point of the interview, if your child does not want to continue, they can say and we will stop. That is fine. We do not pay anybody to take part in the interview. We are undertaking this for the purpose of research and to learn. And the information will be used to know more about how to support families to care for their children. The findings from this survey may also help us find ways to decrease problems among young people. The interview will take about 20 minutes.

Tracing

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If you agree, we would like to speak with your son/daughter/this youth 2 more times over the next two years. Once today to ask some questions about family planning and related issues. Then we would come back again around this same time next year and find out what has changed and what has stayed the same in regards to these questions and the ones we have asked last year. Finally, we would come back one more time the year after that to ask one more time about what has changed and what has stayed the same.

- Do you have any questions?
- Do you understand our purpose?
- Do you understand that the information your daughter/son/youth gives us will not have your or her/his name associated with it and that your and her/his identity will be kept confidential?
- Do you understand that your daughter/son/youth is free not to participate, and, if she/he does participate, to not answer any question or to end the interview at any time of her/his choosing?

Are you willing to allow your daughter/son/youth to talk with us and share her/his experiences? Thank you for listening to me. May God protect us all, Amen.

NOTE WHETHER RESPONDENT AGREES TO ALLOW YOU TO SPEAK TO THE CHILD TODAY:

DOES NOT AGREE TO ALLOW YOU TO SPEAK TO THE CHILD. (*THANK PARTICIPANT FOR HIS OR HER TIME AND END.*)

AGREES TO ALLOW YOU TO SPEAK WITH THE CHILD.

Name of Columbia Group Member Obtaining Agreement _____

Signature: _____ Date: _____

Informed Consent Form –Youth

Greeting

How are you? My name is _____. I am a researcher, and I work for Columbia Group. The full name of the group is The Columbia Group for Children in Adversity. This organization works on behalf of children who are in situations that pose a threat to their wellbeing and safety.

Background

We have come to learn about the children of this village. This research is supported by many of the global child protection agencies, like Plan International, Save the Children, and UNICEF. The research is not limited only to your village. It is being carried out in three countries, and Sierra Leone was chosen as one of the countries to conduct this research. And in Sierra Leone, because we could not go everywhere, the Group chose two districts: Moyamba District in the South and Bombali District in the North. And we chose two chiefdoms in each district. Magbainba Ndorhahun and Liebesegahun in Bombali District, and in Moyamba we chose Upper Banta and Kombora. Within the chiefdoms, we also chose three villages, because we cannot go everywhere. And your village was one of the villages we chose to learn about children's issues.

Purpose of research

The purpose of this research is to learn about how your community cares for their children. Our goal is to better understand how the community can work together with the government and child protection NGOs to improve the lives of children.

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We came last year and talked to lots of the young people here about their lives and how they are doing. We asked about school, family, work, relationships and other issues. Maybe you remember talking to one of our researchers then?

If yes say: Remember when we came the last time and said that we could check in with you a few more times? Is it ok if we talk a bit more today and I ask you a few new questions that I did not get to ask you last time?

Today, we have come to learn a bit more about how you as young people are doing in this village, and to ask some questions that we did not get to ask last time. Today I will ask you some questions about relationships between boys and girls here. I will ask you a bit about sex, contraception and family planning, and about HIV and AIDS.

Confidentiality

The information that you give me will be confidential. I am not going to tell anyone anything that you tell me. I will keep it to myself. Only the Columbia Group research team will see anything that you say. That means they are the only ones who can connect your name to the information you give me. When we write a report, we won't disclose your identity, and we will only use the information for the purpose of research to help those who make policy and create programs for children do their work well.

Consent and Managing expectations

There is no pressure on you to talk to me. You are free to say "No" and we will not be offended if you say you prefer not to talk with us. Also, if you agree to talk with us, you will be free at any time to not answer any questions or to end the interview.

So I would like to ask your permission to talk to me today. If you agree, and at any point of the interview, you do not want to continue, you can tell me, and I will stop. That is fine. We do not pay anybody to take part in the interview. We are undertaking this for the purpose of research and to learn. And the information will be used to know more about how to support families to care for their children. The findings from this survey may also help us find ways to decrease problems among young people. The interview will take about 20 minutes.

Your participation is **completely voluntary** but your experiences could be very helpful to other young people in Sierra Leone.

The interview today will take approximately 20 minutes to complete.

- Do you have any questions?
- Do you understand our purpose?
- Do you understand that the information you give us will not have your name associated with it and that your identity will be kept confidential?
- Do you understand that you are free not to participate, and, if you do participate, to not answer any question or to end the interview at any time of your choosing?

Are you willing to talk with us and share your experiences?

NOTE WHETHER RESPONDENT AGREES:

DOES NOT AGREE. THANK PARTICIPANT FOR HIS/HER TIME AND END.

AGREES.

It is very important that we talk in private. *Interviewer will ask the following question if a centrally located area to conduct the interview has not been identified:* Is this a good place to hold the interview or is there somewhere else that you would like to go?

Name of Columbia Group Member Obtaining Agreement: _____

Signature: _____ Date: _____

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COVER PAGE

To be completed by Interviewer

1. Village name _____
2. ID Number _____
- 3a. Interviewer Name _____ 3b. Interviewer Code _____
4. Date (DD/MM/YYYY) __/__/____
5. Start time __: __ 6. Finish time __: __
7. Result of Interview
 - 1 COMPLETED
 - 2 NOT AT HOME
 - 3 PARENT/CARETAKER REFUSED
 - 4 YOUTH REFUSED
 - 5 PARTLY COMPLETED
 - 6 INCAPACITATED
 - 7 OTHER (SPECIFY) _____
8. Checked By _____
9. Data Entered By _____
10. ID Code _____
11. Matched ID Code _____

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To be completed by Interviewer

12. Is the head of household also the person responding to the rest of the questionnaire?

- 1 Yes
- 2 No
- 88 DK

13. Is the respondent a male or female?

- 1 Male
- 2 Female

Respondent's Participation in Baseline Survey

As I just told you, as part of this project, another group of researchers came to this village at this time last year to talk to young people about the issues facing children. The researchers sat with each child here and asked them a lot of questions about their schooling, work and other aspects of their daily life.

14. Did you take part in answering the questions when the researchers came here before?

- 1 Yes
- 2 No
- 88 DK
- 99 NR

Respondent's Background

I am now going to ask you some questions about yourself, for example your age, religion and about where you live most of the time.

(if they said yes they had been interviewed before add:

I know I asked you these questions last time but I just want to make sure I have the information correct

15. How old are you now?

- _____ years old
- 88 Don't Know
- 99 No Response

16. What religion or religious group do you belong to?

(Do not read list aloud. Mark only one)

- 1 Islam
- 2 Christian
- 3 Other (specify) _____
- 88 DK
- 99 NR

17. What ethnic group is your family a part of?

(Do not read list aloud. Check all that apply)

- 1 Loko
- 2 Temne
- 3 Limba
- 4 Mende
- 5 Fullah
- 6 Madingo
- 7 Susu
- 8 Other (specify) _____
- 88 DK
- 99 NR

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18. How many nights in the last two weeks have you slept here in the village?
(Do not read list aloud. Mark only one)

_____ nights **(if respondent says 14 nights, skip to Q19, if respondent says any number less than 14 nights, go to Q18a)**

- 88 Don't Know
- 99 No Response

18a. What were the reasons why you slept somewhere else outside the village in the last two weeks?
(Do not read list aloud. Check all that apply)

- 1 To attend school
- 2 To work
- 3 To visit family or friends
- 4 To attend health clinic or hospital
- 5 [OTHER OPTION TO BE TRANSLATED]
- 6 Other (specify) _____
- 88 DK
- 99 NR

Intervention questions

As we get older, we can feel that we are ready to start being sexually active. We can feel that we are ready to have a boyfriend/girlfriend or sometimes to get married. Now I'd like to ask you some questions about these things including about sex and contraception. But you are free to say you do not want to talk to me about these things at any time.

Please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree	DK	N R
19. If a 15-year-old girl uses contraceptives such as pills or injections, she may have a hard time getting pregnant when she is 20 years old and wants to become pregnant.	1	2	3	4	88	99
20. Condoms often do not work since they leak or slip off.	1	2	3	4	88	99
21. I know whom to go to in order to obtain accurate information about sex, pregnancy, abortion, and related issues.	1	2	3	4	88	99
22. HIV and AIDS is a serious problem that could affect girls in my village.	1	2	3	4	88	99
23. People here do not have ready access to condoms.	1	2	3	4	88	99
24. My close friends and I intend to say 'No' when we don't want to have sex with someone who wants to have sex with us.	1	2	3	4	88	99
25. I like what Government workers here are doing to help young people to prevent teenage pregnancy.	1	2	3	4	88	99
26. Most teenagers in this village expect to use condoms when having sex.	1	2	3	4	88	99
27. My close friends and I do not want 15- or 16-year-old girls to become pregnant.	1	2	3	4	88	99
	1	2	3	4	88	99

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28. When teenage girls here have abortions, the abortions are usually safe and leave the girls who had them in good health.

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29. Is it dangerous for a 15 year old girl to become pregnant?

1 Yes (*ask Q29a*) 2 No (*skip to Q30*) 88 DK 99 NR

29a. How—what are two specific risks or problems? (**Do not read list aloud. Mark all that apply.**)

1. Increased risk of dangerous abortion
2. Long and difficult (prolonged or obstructed) labor
3. Hypertension (pre-eclampsia--high blood pressure associated with pregnancy)
4. Premature birth
5. Still birth
6. Maternal death
7. Other (specify) _____
88. DK
99. NR

30. What are two reasons why it is important to use condoms when having sex? (**Do not read list aloud. Mark all that apply.**)

1. Reduces risk of pregnancy
2. Reduces risk of contracting HIV
3. Reduces risk of other sexually transmitted infections
4. Reduces risk of death of the mother
5. Other (specify) _____
88. DK
99. NR

	Strongly Agree	Agree	Disagree	Strongly Disagree	DK	N R
31. Most teenage girls here want to have a baby by the time they are 15 or 16 years old.	1	2	3	4	88	99
32. I would not ask a sex partner to use a condom because I would be criticized or made fun of.	1	2	3	4	88	99
32. I like what NGO workers here are doing to help young people to prevent teenage pregnancy.	1	2	3	4	88	99
34. People here expect teenage girls to have sex even if they do not want to.	1	2	3	4	88	99
35. Most parents here talk with their daughters and sons about sex and pregnancy.	1	2	3	4	88	99
36. In this village, abortion is not common among teenage girls.	1	2	3	4	88	99
37. I plan to use condoms regularly when having sex.	1	2	3	4	88	99
38. Most teenage girls here plan their pregnancies.	1	2	3	4	88	99

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44. Interviewer assessment of interview

1 Reliable 2 Unreliable

Supervisor comments:

TRACING & MATCHING FORM

THIS FORM IS TO BE SEPARATED FROM THE REST OF THE SURVEY AFTER THE INTERVIEW AND PASSED TO TEAM LEADER (DORA) FOR SECURE KEEPING

(Ask directly to the young person). If they participated in survey last year say again: I know I asked you these questions before but I just want to check I have the correct information s that we can come and speak to you again next year

What is your full name? _____

What is the name of your caregiver or spouse? _____

What is your phone number? _____

What is the phone number of your caregiver or spouse, or any additional person who is likely to always know where you are (friend, relative, teacher, etc.)? ***(write down the name and number)*** _____

Do you have any plans to move away from this village in the next year?

(Complete the rest of information on this from yourself – do not ask of young person)

Respondent ID code: _____

Respondent Tracing ID code: _____

Village name: _____

Description of how to find house (e.g. behind the market, near the mosque):

Any other information to help find child: _____
