

A Close look at Teenage Pregnancy and its Intervention Strategies in
Sierra Leone

Written by

Baindu Agatha Kosia

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Senior Supervisor: Dr. Susan Erikson

Second Reader: Dr. Nicole Berry

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Introduction

Overview

Teenage pregnancy in Sierra Leone is a culturally rooted public health problem that transcends the nation's tribal, regional and religious boundaries. It is currently widely practiced and has been accepted for generations in this region of the world. The rate, at present, stands at 122 births per 1000 adolescent females (GoSL, 2013). Many Sierra Leonean citizens, as well as past government administrations, have not considered it a public health problem. However, three years ago the government of Sierra Leone, with backing from donor international health and development organizations, shifted gears and declared it one of the more pervasive health problems affecting women's social, political and empowerment progress. This led to the implementation of a national teenage pregnancy reduction strategic plan in May 2013, which remained operational until the Ebola outbreak in May 2014. The impact of the strategic plan was scheduled to be reported every six months; the first report was released in December 2014. The report scheduled for May 2014 was being compiled when the Ebola outbreak occurred with all subsequent program implementation and reporting put on hold.

There has been a reported increase in teenage pregnancy since the Ebola outbreak. It may still be too soon to determine the ultimate success or failure of the strategy, especially given the absence of the scheduled reports. The purpose of my capstone is to examine the 'cultural dynamics' of teenage pregnancy in Sierra Leone, analyze the teenage pregnancy reduction strategic plan and explain why I believe this plan may ultimately be unsuccessful in achieving its goal. I will provide an analysis of the plan based on my Master of Public Health practicum experience working with the Sierra Leonean Ministry of Health and Sanitation, for the Reproductive Health and Family Planning program of the Reproductive and Child Health directorate—the key stakeholders—from January to May 2014. I examined the roles, actions and programmatic implementation methods of the four major stakeholders

involved in the strategic plan. These stakeholders included the government of Sierra Leone, World Health Organization (WHO), United Nations International Children Emergency Fund (UNICEF) and United Nations Population Fund (UNFPA).

My analysis of the strategic plan showed that even though it was meant to be a partnership and collective effort of the government, various NGOs, development partners and civil servant organizations, the strategic plan ended up mirroring the agendas and programmatic goals of the big UN stakeholder organizations, which were the major funders and part of the multi-sector committee. Based on my findings, I deduce why the 'strategic plan' top-down origins and accountability systems, its inability to effectively use traditional sources of social organizations, as well as its prioritization of quantifiable, biomedical interventions, are the greatest contributors to its inability to remain functional during the Ebola outbreak and why it may not be ultimately successful.

Health Problem

One of Sierra Leone's most long-standing, widely spread and culturally embedded public health problems is the nation's high teenage pregnancy rate. In Sierra Leone, ill health is generally considered the presence of a disease or sickness. Malaria, cholera, tuberculosis and HIV/AIDS, for example, are widely recognized as public health problems, and disease treatments are prioritized by both individuals and the nation. Teen pregnancy, however, and particularly its effect on women's mental health, social well-being and long-term health, is largely ignored because of its deep cultural roots. Pregnancy early in the course of life is widely accepted and even encouraged, thus making it difficult for people who have lived their entire lives accepting and practicing it to view it as a public health problem or work towards its reduction.

Methodology

The primary source of information for this capstone was drawn from my four month (January –April 2014) practicum experience as a Master of Public Health student with the Ministry of Health and Sanitation in Sierra Leone. In my role as an intern at the Reproductive and Child Health directorate of the Ministry of Health and Sanitation, I was part of one of the core government stakeholder organizations involved in the implementation of the national teenage pregnancy reduction strategic plan. This enabled me to work with major non-governmental stakeholder organizations such as the World Health Organization and the United Nation Population Fund, giving me access to organizational and program information, reports and agendas.

Next, I built on the reports and documents obtained from my practicum using Google search engine to find further reports and published documents relating to the teenage pregnancy reduction strategic plan. I used WHO, UNICEF, UNFPA and Ministry of Health and Sanitation data bases for my search.

Keywords included: teenage pregnancy program, Sierra Leone, adolescent reproductive health, strategic plan and Ebola. Inclusion criteria included documented research of teenage pregnancy in Sierra Leone, programmatic interventions, pilot programs, program progress reports and articles published by known stakeholders involved in the national teenage pregnancy reduction strategic plan.

Lastly, as a Sierra Leonean who has spent most of my life in Sierra Leone, this capstone also drew on my knowledge and lived experience with regards to the cultural and behavioural attitudes surrounding teenage pregnancy in Sierra Leone.

Background

Country Health Status

Serra Leone is a small war-recovering nation-state approximately the size of New Brunswick. It is currently dealing with a high teenage pregnancy rate as it simultaneously battles one of the worst recorded Ebola disease outbreaks in human history. A nation of 6.2 million people (De Koning et al, 2013), Serra Leone was among the nations with the worst health status even prior to the Ebola outbreak. Immediately before the Ebola outbreak, the nation had a low life expectancy rate of 46 years (UNICEF, 2013c). Many people in Serra Leone live to old age, but the life expectancy rate is largely influenced by high maternal mortality ratio of 857 deaths per 100,000 births and under-five mortality rates of 140 deaths per 1000 live births (GoSL, 2014). Along with reproductive and child bearing related deaths, preventable diseases such as malaria, diarrhoeal diseases, anaemia, nutritional deficiencies, pneumonia and tuberculosis are the leading causes of deaths in Serra Leone (GoSL, 2012).

The public health system in Serra Leone, which was severely weakened by legacies of structural adjustment policies and the ten-year civil war, has been predominately curative in its approach. Communicable diseases are at the top of the national agenda, while less focus is on non-communicable public health problems like teenage pregnancy. External donor priorities and the capitalist global push for health statics by these donors to enable them develop and maintain power and decision making (Erikson, 2012) have often confounded local public health practice and data collection and national strategies. Figure 1, gives a clear example of this situation with regards to maternal health reporting in Serra Leone. This is particularly disadvantageous now that evidence based public health, which is largely number dependent, is the reigning paradigm in international health (Berry, 2010). Thus, raising questions of Serra Leonean health sovereignty.

Figure 1: Estimated and reported maternal mortality ratios in Sierra Leone (WHO, 2014 and SSL, 2014)

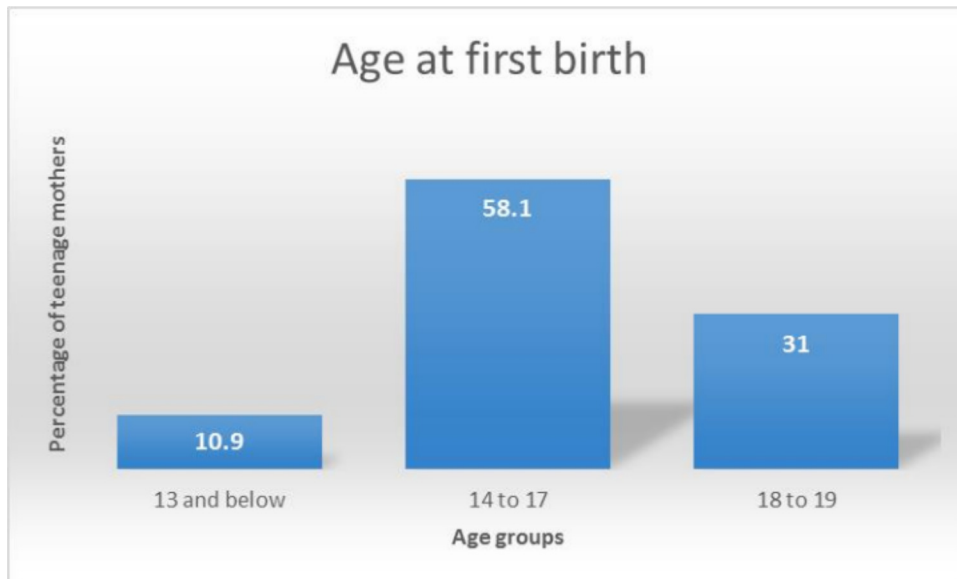
Organization	Maternal Mortality Rates per 100,000 live births	Reported year
Government of Sierra Leone	857	2009- 2013
World Health Organization	1100 [580-2000] estimated	2009- 2013
United Nations International Children's Emergency Fund	1100 [580-2000] estimated	2009- 2013
United Nations Population Fund	1100 [580-2000] estimated	2009 - 2015

Magnitude of Teenage Pregnancy

While the teenage pregnancy problem has been trivialized and ignored for a long time in Sierra Leone, there is irrefutable proof that it exerts a huge burden on the country's health, social and economic development. First, 34% of all pregnancies in the country are teenage pregnancies, and these account for 40% of all maternal deaths. Second, it is the leading cause of school dropout among teenage girls. Third, the severity of teenage pregnancy in Sierra Leone is compounded by the fact that the country has a youthful age structure with almost half (48%) of its population under the age of 18 years; 1.48 million are teenagers, boys and girls, of reproductive age (De Koning et al, 2013). Annually, one in three of the nation's 740,000 teenage girls become pregnant, with the majority (69%) of pregnancies and births occurring in girls between the ages of 14 and 18 (De Koning et al. 2013). The statistics regarding the incidence of teenage mothers as shown by age of first birth is illustrated in Figure 2 below. The high

occurrence and the large demographic of teenage pregnancy is a severe and critical problem that Sierra Leone needs to be tackled.

Figure 2: Teenage mothers by age of first birth in Sierra Leone (Thomas, 2011)



Culture of Teenage Pregnancy

“My son is 8 months old...I had to stop school to give birth to my baby...my boyfriend is now in Makeni for schooling...when he come home and wants to have sex...I can't say no even if I don't want to...his family provides support for me and my son...we are not using any protection...I don't want to get pregnant again..” —14-year-old mother from Kailahun, Sierra Leone (UNICEF, 2010).

Teenage pregnancy is a global public health problem that affects millions of girls around the world. In Sierra Leone, it stems from dynamic shared systems of beliefs, customary practices and behaviours that have been transmitted through generations and have become an accepted way of living. Among these cultural practices are early marriage, early initiation of sex and fear or distrust of contraceptives. These

practices and behaviours are socially learnt, accepted and passed down through belief systems that are co-constructed with patriarchy and exacerbated by poverty.

Early marriage is one of the leading causes of teenage pregnancy in many places around the world, including Sierra Leone where the median age of first marriage is 17.2 years (Armond, 2011). This custom of early marriage is widely accepted and practiced to such an extent that, for example, in 2011, 85% of pregnant or teenage mothers were married (Armond, 2011). Collectively among the various tribes in Sierra Leone, a girl is deemed fit for marriage once she has reached puberty and is initiated into the female secret society known locally as Sande or Bondo. Furthermore, a female's social value in many Sierra Leonean communities is firmly rooted in her role and capacity as a wife and mother. Thus, Sande initiation, followed by the securing of a husband and subsequent child bearing, are socially expected rituals for girls to undertake to become adults that are firmly positioned within their families and communities.

The value placed on marriage and motherhood even for teenagers makes it sought after and encouraged by adult family members. Teenage girls grow up witnessing and embodying these values; thus, many girls eagerly desire to accomplish rather than delay the process. In contrast to the value and respect generally placed on being a wife and mother, sexually active teenagers and those having a child out of wedlock face reproach and stigmatization. In traditional Sierra Leonean societies, particularly in rural Sierra Leone where 44% of teenagers reside (De Koning, 2010), a teenager who is known to have had multiple sexual partners faces a loss of respect in her community and diminished chances of getting married. This is made worse if a young girl becomes pregnant out of wedlock without a known responsible male. For this reason, families increase their teenage girl's chance of obtaining suitable spouses by opting to wed their daughters in their prime teenage years when they are assumed to have been involved with fewer sexual partners. Moreover, in rural Sierra Leone where farming is the predominant occupation and large family size is economically ideal, polygamist practices support early

marriages and are culturally accepted and highly practiced. In these situations, a large family means more hands on the farm, and many men who can have multiple wives opt to marry teenagers who are deemed more fertile. Thus, the majority of teenage mothers (71%) live in larger households, which are typically polygamous (Armond, 2011). Furthermore, poorer polygamous families that want to reduce the burden of their growing family typically do so by marrying off their teenage daughters. Along with polygamy, the patriarchal nature of marriage in the Sierra Leonean society further adds to the practice of early marriage.

While women play the biggest role in raising daughters and preparing them for marriage and their societal and maternal roles, the ultimate decision-making process regarding marriage lies with fathers or other male relatives. Men are at the centre of the marriage ceremony because a child is first and foremost regarded as belonging to their father rather than to their mother, which is why children inherit the last name, tribal identity and hometown of their father rather than their mother. Marital arrangement, therefore, is done among the male relatives of the suitor and the male relatives of the bride. With the typical Sierra Leonean male preferring a younger, less sexually experienced wife, marrying a significantly younger wife is socially acceptable and oftentimes encouraged. Since it is sought after by all involved in the marriage process, suitors, families and teenage girls, the practice is entrenched in society at large.

“All depends on the poverty in the family when a girl has grown up and fully matured, the father of the girl will say let me give my child to a man so that there will be money in the house. Again most of the girls when their parents sent them in school they will not learn, but to involve in sex life. So when their fathers hear that report, sooner the girl comes on holiday the father will say before you waste my money and strain my effort, I am going to give you to a man.” —Focus group discussion by teenage boys in Bo, Sierra Leone (De Koning, 2013).

Alongside patriarchy, poverty contributes significantly to the practice of early marriage in the country. It is not uncommon for a poor family with many children or a family with low social status to choose to marry their teenage daughters off to wealthy families with a higher social status. Many times these suitors are significantly older and are in a better place to provide for the teenage girl and her family. While early marriage is known to typically result in school dropout and pregnancy in teenage girls, in Sierra Leone the opposite situation is also applicable, where early marriage may become a solution for, rather than cause of, school dropout. Some poor teenage girls who have never attended school, along with those who have dropped out of school for financial or other reasons, are more likely to be married off. This is the case because families and the society as a whole are aware that teenage girls who are not in school are more likely to engage in transactional sexual activity in pursuit of money, gifts or food, or are more likely to engage in trade and activities that will put them at risk of sexually related abuses.

“According to this town a girl will be 13, 12 years when her parents give them to marry...I have known one of 10 years...Before they get an early pregnancy, we prefer to send them to their married homes.” —Focus group discussion by teenage boys in Kambia, Northern Sierra Leone (De Koning et.al, 2013).

Early and unprotected sexual debut both within marriage and outside marriage is the most significant contributor to the high teenage pregnancy rates in Sierra Leone. Sex within marriage is considered a cultural duty and social responsibility for married females. Married teenage girls are expected to carry out this duty regardless of their age and willingness. In fact, many teenagers go into these unions eager to get pregnant in order to prove their fertility and to solidify their place in their new families. The support and appeal for early sexual initiation is thus engrained in the society's fibre and conveyed by a Temne proverb, which translates in English as “a mango should be plucked and be eaten immediately it is ripe,” meaning a girl is ready for sexual activities as soon as she has gone through puberty. Sex outside marriage however is typically frowned upon except in cases where it is deemed beneficial for

the family or the girl herself. The aftermath of the ten-year civil war in Sierra Leone saw a massive increase in poverty, unemployment, mass displacement and diminishment of traditional structures and organizations such as the Bondo female secret society, which protected females from male abuse. This, in return, gave rise to an increase in transactional sex and a subsequent rise in sexual abuse particularly among young teenagers. Given the fluid nature of the acceptability of sexual practices based on the context and needs of the family or community in question, many cases acts of sexual abuse are not considered that way, nor are they reported. Nonetheless, half of sexually active teenagers engaging in transactional sex have been sexually abused (Armond, 2010).

“When I was 15, a young man asked me to have sex with him. I did not want to, but he convinced me. He said I am a woman now after having gone through Bondo so I was ready. He also said I will not die from sex; nobody does. He begged me and I did not want to, but said yes.”—Interview with teenage girl, in Moyamba, Southern Sierra Leone (De Koning et al., 2013).

Child (under-18) sexual abuse and any form of underage (14 and below) sex, be it coerced, consensual, within marriage or transactional is illegal in Sierra Leone according to the nation’s “Prevention of Cruelty to Children Act Cap 31” (Thomas, 2011). Yet, it accounts for a significant number of teenage pregnancies in the country. Many of the sexual abuse cases are carried out by older individuals such as affluent males in the community, extended family members, teachers, neighbours, traditional and religious leaders, NGO workers and sometimes peers. These acts of abuse, particularly those within marriages, are typically very under reported to authorities largely due to the fact that many cases are encouraged by family members because of the material and social gains they may bring to the family and teenager in question (Save the Children, 2014). Similarly, the need for money, food or material things their abusers provide, along with fear caused by abusers’ threats, contribute to the creation of an environment where teenagers may refuse to report these assaults. Additionally, the naivety of teenagers, their lack of knowledge and unawareness of their constitutional rights and the laws

pertaining to child protection, coupled with the lack of enforcement of present law and punishment of offenders, makes it less likely for these cases to be reported. In like manner, the absence of support centres to report these abuses, apart from male dominated police stations, make it more difficult for such cases to be reported. Lastly, teenagers might fail to report these abuses even when support centres are available due to the sensitive nature of the subject and the fear of bringing shame, reproach and stigmatization upon themselves and their families. Thus, collectively creating an environment where child sexual abuse goes unpunished is made to look acceptable, as indicated by a 2010 UNICEF survey, which reported that as much as 63% of pregnant teenagers and teenage mothers had a history of sexual abuse which they never reported (UNICEF, 2010). This explains why more teenage sexual abuse cases are reported in urban areas and larger cities where there are increased sensitization campaigns in schools and available sexual abuse support centres. By comparison, in rural locations, there are fewer school enrolments, fewer sensitization campaigns, fewer sexual abuse support centres and fewer reported cases even though there higher abuse rates (UNICEF, 2010).

Typically, pregnant teenagers and teenage mothers who have had an unplanned and unwanted pregnancy are also more vulnerable to new or continued forms of sexual abuse. This may be attributed to the fact that such girls are no longer perceived as innocent and they are generally more highly reliant on people other than family members to help provide for their needs and the needs of their children. What this means is that following their first pregnancy, teenage girls have a higher risk of being sexually abused and/or of becoming pregnant again. Similarly, pregnant teenagers are more likely to drop out of school due to shame or stigma or are expelled by school authorities. These girls are usually pushed to marrying their impregnator, whom along with his family is expected to look after the pregnant teenager and the child whether or not they get married. This relationship dynamic gives the impregnator and his family power and control over the pregnant teenager, at that time or afterwards, and puts her in a vulnerable position for possible continued abuse, more pregnancies and school dropout. In cases where

the impregnator refuses such responsibility, the girl and her family have to do so by themselves. In many cases especially among the poor, this will result in the girl dropping out of school to work and help take care of her child, thus making her more likely to engage in high risk sexual activities. There are, however, cases where teenagers return to school after giving birth to their children, this being more common in urban areas than in the rural areas and more so among wealthier families than poorer ones.

Another significant contributing factor to Sierra Leone's high teenage pregnancy problem is the low utilization of contraceptives and family planning services. The nation's contraceptive uptake prevalence for sexually active females of reproductive age (15–49) in 2008 was merely 10.2%, with an even lower value of 8.4% among teenagers aged 15–19 years—despite 74.6% of the females knowing of at least one form of contraceptive (Statistics Sierra Leone, 2008). Sierra Leone's low (28%) unmet need for contraceptive, despite its high fertility rate of a 5.1 children per woman, shows that there are significant proportion of women who are in need of contraceptive, even though there is a high disdain for them. One of the major reasons for the unmet contraceptive need in the country can be attributed to the nation's poor public health system, which prior to 2010 required females to pay out-of-pocket for reproductive health services, and prior to 2013, had very little availability of contraceptive and family planning services. The major providers of contraceptive and family planning services in the country was and still remains non-governmental organizations such as Marie Stopes and Planned Parenthood, which have more facilities in urban areas or in bigger towns than in rural villages and small towns. For most people, especially those in rural areas, the lack of access to reproductive health care services, the cost of those services where they are available and the lack of skilled administrative staff, prove to be major barriers for their uptake.

Other than systematic barriers, adolescents and adults in Sierra Leone typically refrain from using contraceptive and family planning methods due to religious beliefs, wrongly held misconceptions and the desire to have many children. Commonly held religious beliefs are that children are gifts from God

and therefore pregnancy should be accepted and not prevented. Most commonly held misconceptions about contraceptives are fears that their short term or long term use would result in infertility or barrenness. Similarly, the strong desire of many to conceive more children can be tied to the social and economic rewards that females and families have access to as a result of large families. Due to these reasons, adolescents are socially inclined and encouraged not to use contraceptives. In cases where married adolescents may not be ready for children and consider using a contraceptive, they may be explicitly forbidden by their spouse, in-laws or family members against such decisions, thus eventually not using it. For unmarried teenagers, the cultural expectations for them to refrain from sexual activities before marriage may cause them to refrain from contraceptives in order to keep their active sexual status hidden. Furthermore, the belief and reliance on traditional contraceptive methods such as tying special ropes given by herbalists or older women around the waist, or the withdrawal method, may cause teenagers to not seek modern contraceptive methods. In cases where adolescents do have access to contraceptives and use them, inconsistent use, poor understanding of how they work and incorrect usage may result in pregnancy.

Consequences of Teenage Pregnancy

“It is disgraceful, because she is not married and perhaps the man will not answer for the pregnancy. If the man doesn’t answer, then the girl will suffer and everybody will talk about her. That’s what happens in this community. Again it is not good, because there should be a man who is responsible for the pregnancy. If not, the girl will suffer.”—Focus group discussion with girls, Moyamba, Southern Sierra Leone (De Koning et al, 2013).

Sierra Leone’s teenage pregnancy situation imposes severe and sometimes irreversible health, social and economic consequences on both individual and societal level. Individual health consequences

include high mortality and morbidity rates among teenage mothers. The most common teenage pregnancy-related morbidities are obstructed labour, anemia, haemorrhage and fistula. The nation's poor health care system contributes to many of these deaths and morbidity both in adolescent and older women. For teenagers in particular, Sierra Leone's illegal stance on abortion (except in cases of incest and threat to the mother's life) further contributes to morbidity and deaths. Many teenagers who become pregnant seek underground, unsafe and illegal abortion services, which result in complications. In addition, compared with adults, younger teenagers (14 years and below) experience a more difficult pregnancy and labour than older teenagers (15–19 years) and younger adults (20–25 years) because their bodies are not fully developed to cope with the stress of pregnancy, labour and birth. Under-nutrition, which is more common in young girls than in adult females further, exacerbates this situation. This is especially the case in Sierra Leone where there is a hierarchy for the quantity and quality of food eaten and the order in which family members eat. Atop of this hierarchy are the father figures and older males, followed by younger males and then maternal figures and young girls. This hierarchy is based on the notion that males do more physically demanding work and as such need to be better fed, thus leaving girls underfed and sometimes lacking nutrition, in comparison to their male counterparts or older family members.

Similarly, the lower access to health care services by adolescents further contributes to hinder their health outcome. In many cases, adolescents typically refrain from going to hospitals for antenatal and postnatal care because many (unmarried teenagers) try to hide their pregnancies for as long as possible in order to avoid stigmatization from community members. The judgemental and sometimes insensitive attitudes towards pregnant teenagers by health care workers, who hold similar religious, cultural and moral views against out of wedlock pregnancy, dissuade teenagers from seeking their help. The health consequences of teenage pregnancy also extend to their babies, who are typically more likely to be premature, of low birth weight and to die before their first birthdays. This is mainly due to ill

nourishment of their mothers, and their lack of knowledge with regards to pregnancy and child rearing or the absence of antenatal and postnatal care, as well as the fact that young girls, unlike adult females, are less likely to have control of access to household resources and decision making powers. Thus, few have fewer efficacies to make decisions that might be beneficial to them.

Social consequences of teenage pregnancy include stigmatization and ostracizing of unmarried pregnant teenage girls or teenage mothers. Pregnant teenagers in schools are stigmatized and are seen as negative, deviant influences on other girls. In fact, many Sierra Leonean schools have an unspoken rule to expel or suspend girls from school for this reason (Bagnetto, 2015). In extreme cases, these girls might be even driven away from their homes to go live with the person that impregnated them. If the impregnator refuses to take responsibility, some girls are left to fend for themselves; this may sometimes lead to sexual solicitations, which may further ostracise them. For some adolescents, whether married or unmarried, this exclusion may occur due to birthing morbidities such as fistula.

Economically, teenage school dropout due to either pregnancy and/or marriage results in loss of education and skill potential, which limit future livelihood opportunities. Similarly, dependency on husbands or live-in partners or on illicit sex trade may also result in a cycle of poverty for teenage girls right through their adult years. Lastly, teenage pregnancy typically results in increased fertility and child dependency, which along with increasing trends of globalization, neo-liberalization of global and nation economies and is contributing to the cycle of poverty and ill health in Sierra Leone.

Having gone through some of the negative consequences of teenage pregnancy in Sierra Leone, it is important to also mention that teenage pregnancy, along with early marriage in some cases can be beneficial to teenagers and their communities as whole. Firstly given the respect and reverence given to mothers in the Sierra Leonean society, pregnancy and child birth for teenagers especially, those within marriage can be advantageous because it helps solidifies their roles and position in their families and

societies. Motherhood and wifehood often times give teenagers more decision making power over their lives and their children and their homes in comparison to what they had before. The reason being that, upon giving birth, a girl is regarded a woman and no longer a child and as such is expected to be more mature and responsible since she has to take care of her child and thus, treated with more respect.

Secondly, given the high infant mortality rate in Sierra Leone, early marriage and teenage pregnancy and teenage pregnancy is sought after to help increase number of surviving children. With early debut of child bearing, a teenagers lengthen their fertility life span. This puts them in a better place to be fit to have as more children than women who start child bearing late in life. Thus, can still have their desired number of children even after death of some of the children.

Thirdly, apart from the desire to increase number of surviving children, early child bearing and its consequence increased fertility is typically considered a display of wealth and social security in Sierra Leone. In many Sierra Leonean societies, children are considered as gifts from God and as such they are gladly welcomed, in fact it is not uncommon for a financially poor person with many children to consider herself better off than a richer counterpart with no children. For many girls, having many children ideally at a young age enables them to grow with their children, have them support with earnings and lastly having people to take care of you in your old age.

Lastly poor teenagers who become pregnant for wealthier or more established males, not only solidify their social status as women and mothers, for many it helps improve their financial livelihood and class status, thus putting them in a position to be able to help other family members While these benefits are typically not discussed in health promotion interventions, they are important and need to be factored into intervention plans, because many times they are leading contributors to the pervasiveness of the problem.

Findings

Teenage Pregnancy Reduction Strategy Overview

In a bid to specifically address the nationwide pervasive problem of teenage pregnancy, the government in 2012 decided to prioritize teenage pregnancy on its national agenda and create a strategic plan to address the issue. Cognisant of the complex nature of the problem, its multiple causes and its diverse consequences, the government of Sierra Leone saw the need for a large spectrum multi-sector intervention approach to effectively tackle the issue. As such, it enlisted five government ministries, including the Ministry of Health and Sanitation, the Ministry of Finance, the Ministry of Youth and Sports, the Ministry of Social Welfare, Gender and Children's Affairs and the Ministry of Education, Science and Technology, along with UN health agencies, development partners and other local and international NGOs to devise a multi-sector strategy to reduce teenage pregnancy. Thus, was born the national strategy for the reduction of teenage pregnancy in 2013. The 'strategy' specific goal was to reduce the adolescent fertility rate from 122 births per 1000¹ females to 110 births per 1000 females within 2013–2015 (GoSL, 2013a). The strategic plan outlined numerous types of policy levels; public health and community level action plans that were assumed would directly and indirectly result in the reduction of teenage pregnancy. Each of these action plans was delegated to the concerned government ministries along with several non-governmental organizations and indicators to monitor the progress of the action plan. Collectively, these activities were geared towards: 1) the creation or improvement of policy and legal environment to protect adolescent and young people's right; 2) the improvement of access to quality sexual reproductive health, protection and education services for adolescents and young children; 3) the availability and dissemination of comprehensive age-appropriate information and

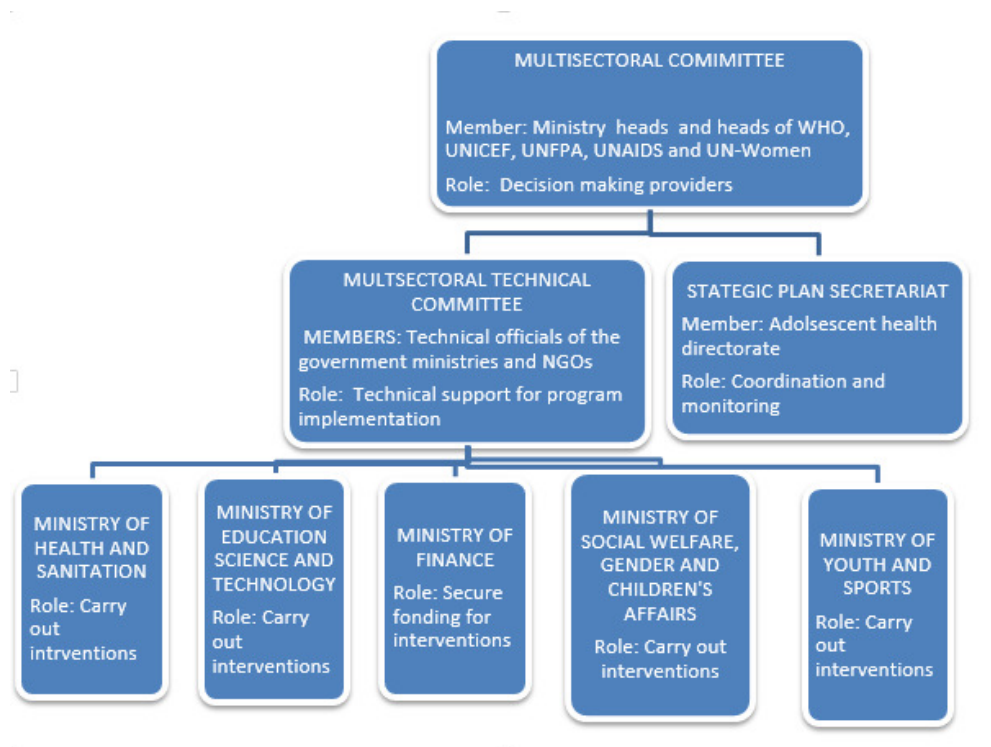
¹ The teenage fertility rate reported by the World Bank stands for the same time period stands at 101. According to the World Bank, this value was at 122 in 2005 and decreased to their present reported value. World Bank <http://databank.worldbank.org/data/views/reports/tableview.aspx>

education for adolescents and young people; 4) empowerment of adolescent and young people to prevent and respond to teenage pregnancy; and 5) coordinating, monitoring, with evaluation mechanisms in place, to allow proper management of the strategy.

The strategic plan was supposed to be implemented with the office of the president providing overall leadership and presidential guidance. Beneath the president was the Multisectoral Coordination Committee (MCC), which included heads of the concerned government ministries, heads of five UN agencies (namely WHO, UNICEF, UNFPA, UNAIDS and UN-Women), along with heads of donor organizations, the National Commission for Social Action and the National Aids Secretariat, as well as representatives from smaller NGOs. The MCC was expected to provide policy guidance and direction for the implementation of the strategic plan, and to ensure effective communication and information sharing among the various ministries, sectors, and group. It was chaired by the Ministers of Health and Sanitation and of Social Welfare and Gender and Children's Affairs. Next was the Multi-sector Technical Committee (MTC), which was tasked with the provision of technical guidance for the strategy and monitoring of implemented planned activities. The MTC was to be made up of relevant technical officials of the government ministries, the UN agencies, NGOs, youth organisations and civil societies, all of whom were to be chaired by a Ministry of Health official. Lastly, was the 'strategy' National Secretariat, which was tasked with providing support to the various involved groups and coordinating and monitoring of the implemented actions. (See Figure 3 for the pictorial organizational and hierarchal representation.) However, upon careful examination of the strategic plan, it became obvious that alongside Government Ministries, the roles of specific non-governmental organizations (namely UNICEF, WHO and UNFPA) were factored into the creation of the actions plans, while the vast majority of other non-governmental partners were lumped together under the term "other NGO." This may be a sign that the agenda-making process of the strategic plan wasn't a inclusive approach. While it was meant to be a partnership and collective effort of the government, various NGOs, development and civil

servant organizations, the strategic plan ended up mirroring the agendas and program goals of the big UN stakeholder organizations, which were the major funders and part of the multi-sector committee.

Figure 3: Coordination mechanism of the teenage pregnancy reduction strategic program implementation (By Author, using GoSL, 2014)



The strategic plan was launched in May 2013 and implemented right away. It remained functional until the outbreak of the Ebola epidemic in May 2014, which put a halt to most of the intervention activities. Within the first year of its implementation, it successfully put into practice several intervention activities. Around that time, the strategic plan was successful at implementing several intervention activities and a progress report was released in December 2014. The list of the activities implemented, along with major stakeholders involved in their implementation, as indicated by the December 2013 progress report and my observations during my January–May 2015 practicum experience, are tabulated in figure 4 below.

Figure 4: Implemented action plans of the teenage pregnancy reduction strategic plan

	Activities Implemented	Lead Organization
1	Creation of adolescent-friendly training tool	WHO, Ministry of Health and Sanitation
2	Training of adolescent-friendly health workers	WHO, Ministry of Health and Sanitation
3	Creation of adolescent-friendly facilities	WHO, Ministry of Health and Sanitation
4	Creation of family planning training tool	UNFPA, Ministry of Health and Sanitation
5	Family planning training of health care workers	UNFPA, Ministry of Health and Sanitation
6	Creation of a reproductive health commodity procurement and tracking system	UNFPA
7	Family planning community outreaches	UNFPA, Ministry of Health and Sanitation, Marie Stopes, Planned Parenthood
8	Training of social workers	UNICEF, Ministry of Social Welfare, Gender and Children's Affairs
9	Training of school teachers	UNICEF, Ministry of Education, Science and Technology
10	Free JSS education for some girls	UNICEF, Ministry of Education, Science and Technology
11	Empowerment and Livelihood for Adolescents (ELA) after-school program	UNICEF, BRAC

From this list it is apparent six of the eleven interventions were bio-medically focused, while the remaining five involved some type of training or social mobilization. Furthermore, it can be observed that here again, the ministries of the Sierra Leonean government, along with WHO, UNICEF and UNFPA, were the most involved organizations. To understand why these specific organizations were so significantly involved in the agenda setting of the strategic plan and why the specific action plans in Table 3 were chosen to be implemented, I proceed to look at the following: 1) the role played by the government in the agenda planning and implementation of the strategic plan; and 2) to analyze the programmatic agendas of the individual organizations and the activities they had been up to preceding the teenage pregnancy.

Government of Serra Leone

The government of Serra Leone's first role was to ensure that teenage pregnancy prevention remained at the top of its agenda. This was successfully completed by allocating a significant portion of the national budget to the teenage pregnancy reduction strategic plan. It was also successful in ensuring that the public, NGO organisations and donor organizations were continuously aware, involved and funding the strategic plan. This was accomplished through extensive media campaigns on radio, billboards and TV, as well as continuous advocating, informing and collaboration with the international community, development partners and stakeholder organizations. Secondly, the government of Serra Leone, represented through the leadership of the president and its various ministry leaderships in the MCC, was expected to be the key provider of policy guidance and direction for implementation strategies. During my practicum, however, I observed that the UN stakeholders, especially the WHO, UNFPA and UNICEF, were more in control than the government and in many cases dictated which activities would be implemented. The third important role the government had to play was to ensure that all the involved ministries worked closely with each other, along with providing technical focal staff to work and liaise between governmental and with non-governmental stakeholder organizations. They were also chiefly responsible for monitoring, curating indicator values and evaluating the program implemented as shown in Figure 5 below.

Figure 5: Strategies for coordination, monitoring and evaluation of the various implemented activities (GoSL, 2014)

Output/Activities	Indicators	Responsible partner(s)
Output 5: Coordination, Monitoring and Evaluation mechanisms in place and allowing proper management of the strategy	Functional coordination mechanisms of the Strategy in place	MCC, MTC, National Secretariat in collaboration of with all partners
	Baseline and mapping of activities established	SPU, MCC, MTC, National Secretariat in collaboration of with all partners
	Functional monitoring system in place with baseline, mapping and regular reports	MCC, MTC, National Secretariat in collaboration of with all partners
	Final Teenage Pregnancy Strategy Evaluation report	SPU, MCC, MTC, National Secretariat in collaboration of with all partners
Regular meeting of the technical and high-level members of the Strategy.	Number of meetings of the MCC and MTC	MCC, MTC, National Secretariat in collaboration of with all partners
Regular District-level coordination meetings with stakeholders	Number of meetings at district level	MCC, MTC, National Secretariat in collaboration of with all partners
Baseline needs assessment, collection of baseline and mapping	Baseline and mapping developed	SPU, MCC, MTC, National Secretariat in collaboration of with all partners
Technical support to line ministries in development of monitoring tools and systems	Technical support regularly provided	MCC, MTC, National Secretariat in collaboration of with all partners
Monthly monitoring of activities at District and National Level	Regularity of the monitoring	MCC, MTC, National Secretariat in collaboration of with all partners
Annual review	Regularity of the Annual Review	SPU, MCC, MTC, National Secretariat in collaboration of with all partners
Evaluation in 2015 to pave the way for post 2015	Evaluation report	SPU, MCC, MTC, National Secretariat in collaboration of with all partners

The government was successful at coordination within its various ministries while unsuccessful in coordinating the entire strategic plan. The success was largely due to the existence of an inter-ministerial structure which was already operational, having been created prior to the implementation of the teenage pregnancy reduction strategic program. Following the creation of the strategic plan, each ministry integrated and prioritized the strategic plan into its agenda and as a team worked to support stakeholder organization. The majority of the 'strategic plan' intervention, including those that were either financially or technically backed by non-governmental stakeholder organizations, were mainly carried out by officials provided by ministry officials. While this resulted in government officials being involved in many of the various interventions, it did not, however, lead to successful coordination of the various interventions; neither did they succeed at strengthening the national coverage of the various interventions. In fact, many intervention activities carried out by the stakeholder organizations,

especially the smaller ones, occurred in specific locations of their choice and for the convenience of partner organisations, but without much coordination on the part of the government or the organizations themselves. Significantly underlying all this, the government failed to accomplish its mandate to improve the policy itself and the legal environment for the protection of adolescents. It barely made any policy changes, nor did it enforce any of the existing laws already in place to protect teenage girls or to prosecute those who abused them. Thus, when the results of all actions are taken into account, the government's success in many of the areas of the teenage pregnancy reduction strategic plan was overshadowed by its failure in critical areas of agenda setting, policy enforcement and effective coordination.

World Health Organization

The World Health Organization (WHO) office in Serra Leone is mandated to provide technical support for health development and health promotion. In reality, however, while the WHO may not carry out interventions on its own, it does provide more than health technical support in Serra Leone. Along with being one of the leading health organizations that fund and provide technical support for government operated programs, the WHO wields immense power with regard to selection of programs for government implementation. For the last five years, the organization's area of focus in Serra Leone, as highlighted by its country cooperation strategic agenda, was a selection of four of the key health issues that most interested them. These are outlined in the Serra Leone national health sector strategic plan and among them are "the reduction of infant, child and maternal mortality and promotion of responsible, healthy sexual and reproductive health behavior" (WHO, 2013). The WHO proposed that the GoSL intervene on these chosen health priority areas by introducing teenage pregnancy reduction task teams, establishing adolescent-friendly facilities and services, implementing free universal access to health care for pregnant women, lactating women and children under five and implementing a maternal

death review process. Following the launch of the teenage pregnancy reduction strategic plan, which WHO was instrumental in creating, its delegated responsibilities shown in Figure 6 below was centred on one of its major programmatic interest which was the creation of adolescent-friendly facilities and services programmatic.

Figure 6: Strategies for the improvement of access to quality sexual reproductive health, protection and educational services for adolescents and young people (GoSL, 2014)

Output/Activities	Indicators	Responsible partner(s)
Output 2: Improved access to quality SRH, Protection and Education services for adolescents and young people	Number of PHUs providing quality youth-friendly clinical services to AYP.	MOHS with UNICEF, UNFPA, WHO and NGOs
	Number of girls and boys in JSS who receive full school fee waivers	MEST and partners
	Number of extremely poor households who receive direct cash transfers	NACSA, MSWGCA, MLESS and partners
	Number of FSU applying the SOP on GBV	MSWGCA with UNICEF, UNFPA and others
Pre-service training of MCH-Aides and midwives	Number of health-care providers receiving pre-service training.	MOHS with UNICEF, WHO and others
In-service training of health workers through MOHS Cascade training	Number of health-care providers who received in-service training on AYF services.	MOHS with UNICEF and UNFPA
Training of social workers on treatment and counseling of AYP, parents and stakeholders.	Number of social development officers who received training	MSWGCA with UNICEF and UNFPA
Training of FSU officers on treatment and counseling of AYP, parents and stakeholders.	Number of FSU officers who received training.	MSWGCA with UNICEF and UNFPA
Refurbishment/Equipment of PHUs to provide AYF services.	Number of Government health facilities that provide youth-friendly clinical services	MOHS with UNICEF, UNFPA, WHO and NGOs
Support multi-partners outreach campaigns to reach young people that are not able to access PHUs	Number of AYP receiving services/counseling through outreach campaign.	MOHS with UNICEF, UNFPA, WHO and NGOs
Provide free basic education in Junior Secondary School	Number of girls and boys in JSS who receive full school fee waivers	MEST and partners
Development of a Pilot Programme allocating cash transfers to extremely poor households	Number of extremely poor households who receive direct cash transfers	NACSA, MSWGCA, MLESS and partners

In this regard, WHO was the principal financial and technical support provider for the creation of the teenage pregnancy reduction 'strategic plan' and standardised adolescent-friendly tool guide and training manual, which was released in January 2014. They similarly sponsored the pre-service training of health care workers. The WHO also provided technical and financial support to various Ministry of Health programs (school and adolescent program, the reproductive health and family planning program, primary health care program and the nutrition program). The aim was to create a horizontal health

system service delivery where health workers, particularly those at the community level, would be trained and equipped to provide adequate services to women, children and adolescents. The health system service delivery creation plan was also on the agenda of the WHO prior to the creation of the teenage pregnancy reduction strategic plan.

United Nations International Children' s Emergency Fund

The United Nations International Children' s Emergency Fund (UNICEF) in Sierra Leone has an organizational mandate to improve child survival in relation to health, human rights and education (UNICEF, 2013). This makes it one of the most multi-sectored intervention-focused organizations in Sierra Leone. The organization' s main areas of focus in Sierra Leone as of 2012 had been: 1) the provision and utilization of essential survival and development services to under-fives, children, adolescents and women of child bearing age; 2) the accessibility of quality basic education for both boys and girls; and 3) the protection of children from abuse and (gender-based) violence and exploitation (UNICEF, 2013). Thus, unlike the WHO, which liaises mostly with the Ministry of Health and Sanitation, UNICEF in addition works with the Ministry of Gender, Social Welfare and Children' s Affairs and the Ministry of Education, Science and Technology, as well as the Ministry of Health and Sanitation. Their typical intervention activities range from vaccinations of newborns to primary school student health education campaigns and training of social workers. With regard to the teenage pregnancy reduction strategy, UNICEF was involved in most of the intervention strategies that were related to each of the three major ministries. This comes as no surprise given that UNICEF was one of the key stakeholder organizations responsible for the production of the document. In fact, UNICEF was the only organization to have conducted a pilot project in Sierra Leone for many of the interventions that would later comprise the strategic plan. Those that were not included in the pilot project were recommended after the project (UNICEF, 2013). Based on this, it was not surprising that UNICEF made a responsible partner

for many of the activities on the action plan, especially those that were focused on the improvement of access to quality sexual reproductive health, protection and educational services for adolescents and young people (see Figure 6), and those that were aimed at disseminating comprehensive age-appropriate information and education for adolescents and young people (Figure 7). It is also because of this connection that UNICEF was tasked with being in charge of the development of the strategic task force' communication strategy and M&E framework.

Following the launching of the strategic plan, UNICEF spearheaded and collaborated with various sectors both in and out of the government. One of its major collaborative programs was the Child Protection Programme, which was designed in partnership among the Ministries of Health and Sanitation, Education, and Gender and Social Welfare. This program was focused on making available information, media campaigns and services relating to adolescent-friendly reproductive and sexual health, abuse and human rights. Adolescents were given access to the information and services through youth action clubs, youth-friendly resource centres, radio programs and counselling by trained peer educators. An estimated 5,396 adolescents received access to the information and services through 24 youth centres within one year (GoSL, 2014). UNICEF also partnered with BRAC to continue the Empowerment and Livelihood for Adolescents (ELA) program, which was a scale up of one of their piloted teenage pregnancy intervention programs. The ELA program was formed to reduce teenage pregnancy and child marriage by promoting social and economic development of adolescents through girls' clubs for girls 13–19-years-old (UNICEF, 2014). Within the first year of its operation, ELA created 200 clubs to serve as a gathering place for 6,000 girls from the four regions of the country (GoSL, 2014). Adolescents in these clubs received life skills training, sexual and reproductive health knowledge training, teenage pregnancy prevention lessons and mentorship from peers trained by BRAC. Furthermore, microcredits were provided to older adolescents who were school dropouts.

Figure 7: Strategies to disseminate comprehensive age-appropriate information and education for adolescents and young people (GoSL, 2014)

Output/Activities	Indicators	Responsible partner(s)
Output 3: Comprehensive age appropriate information and education for adolescents and young people	Number of primary and secondary schools teaching Emerging issues	MEST with UNICEF, UNFPA and other partners
	Number of AYP who participate in out-of-school programmes	MYA with UNICEF, UNFPA, and partners including NGOs, INGOs, NAS and others.
	Comprehensive national communication strategy on teenage pregnancy developed	All partners of the Strategy
Workshop(s) to identify key messages to harmonize partner's programmes and curricula	Partners' curricula and training modules reviewed and harmonized.	All partners of the Strategy under leadership of MEST
Scale up of teacher trainings on gender and SRHR	Number of primary and secondary school teachers and guidance counsellors trained	MEST with UNICEF, UNFPA and other partners
National training programme for social workers, young leaders and peer-educators	Number of SRHR and gender peer-educators trained	MSWGCA and MOHS with UNICEF, UNFPA, Youth Commission, NGOs, INGOs and other partners
Integrate life-skills education in primary schools curriculum covering teenage pregnancy issues	Age appropriate life-skills education integrated into curricula in primary and secondary schools.	MEST with partners
Programmes for out-of-school youth developed (focusing on gender and teenage pregnancy)	Number of young people who participate in out-of-school programmes	MYA with UNICEF, UNFPA, and partners including NGOs, INGOs, NAS and others.
Design comprehensive national behavior and social change communication strategy (including IEC/BCC materials)	Comprehensive national behavior and social change communication strategy and implementation plan on teenage pregnancy developed	All partners of the Strategy

United Nations Population Fund

Like UNICEF, the United Nations Population Fund (UNFPA) country office in Sierra Leone is another stakeholder organization involved in interventions at a multi-sector level. Based on their Sierra Leone country program agenda for 2013–2014 that was released in 2012, the organization claimed to have aligned itself with two of the government's national agenda goals. This was centred on strengthening and creating enabling environments for the development and acceleration of the millennium development goals. Thus, their typical intervention since then has been geared towards: 1) the improvement of maternal and new born health through the implementation, strengthening and capacity

building of a national comprehensive midwifery program; 2) increasing family planning uptake through the strengthening of the national reproductive health commodity security system; 3) improvement of gender equality and reproductive rights through the strengthening of the national capacity to address gender-based violence and provision of high-quality services; and 4) improvement of young people's sexual and reproductive health and sexuality organization (UNFPA, 2012). Thus, UNFPA had been involved in a number of intervention strategies that were similar to those listed on the teenage pregnancy reduction strategic plan, which is why they, along with UNICEF, were the most involved organizations.

Within the first year of the strategic plan's implementation, UNFPA's major contributions to the advancement of the strategic plan was centred on the promotion of comprehensive sexual education and its capacity building of a sexual reproductive service delivery to reach marginalized adolescent and youth (UNFPA 2013), as shown in Figure 3. This was in line with their country agenda and in compliance with the action plans assigned to them in the strategic plan, as indicated Figures 6 and 7. Their main spearheaded interventions were centred on increasing adolescent family planning uptake by strengthening the Ministry of Health's reproductive health commodity security system and by building the capacity of service providers to carry out family planning services. As such, following the strategic plan's implementation in 2013, UNFPA increased its procurement of reproductive health commodities, particularly long term contraceptives such IUD implants. The commodities secured were made available to the Ministry of Health and other NGO organizations such as Marie Stopes and Planned Parenthood. Along with the RH/FP program, they set up a reproductive and family planning logistic management and monitoring system for the Ministry of Health. Furthermore, they provided financial and technical guidance to the RH/FP program to develop a standardized family planning and contraceptive training manual for health service providers. The manual focused on the training of health care workers to effectively recruit adolescents for family planning uptake and insertion of IUD implants and other long-

term contraceptives. This was followed by various training sessions in the four regions of the country starting with a training of trainer workshop in 2013 and a cascade of training in 2014. UNFPA also provided technical and financial support to the RH/FP and AH programs to carry out mass adolescent-friendly reproductive health campaigns and contraceptive and family planning service provision outreach (RH/FP, 2014). Thus, like both of the other UN stakeholder organizations, UNFPA basically continued the programs it had already been doing.

Non-Governmental Organizations

Along with the above three large UN stakeholder organizations, several other NGOs, including those shown in Figure 8 below, contributed to the implementation of the teenage pregnancy prevention strategic plan. While most of the organizations listed in the table did not have the same influence as the larger UN organizations, many excelled in their areas of intervention, albeit some were small-scale while others were larger. For example, Marie Stopes along with Planned Parenthood were the leading contraceptive and sexual reproductive health service providers to adolescents in Sierra Leone both before and after the implementation of the strategic plan. Many of these organizations carried out interventions that were in line with pillars 2, 3 and 4 of the strategic plan, as shown in Figure 8.

Figure 8: NGO organizations involved in the national teenage pregnancy reduction strategic plan²

NGO	Focal Action Pillar in Strategic Plan	Activities	Partner Organization
Marie Stopes	2- Improvement of access to quality sexual reproductive health, protection and education services for adolescents and young children 3- Availability and dissemination of comprehensive age-appropriate information and education for adolescents and young people	Contraceptive and reproductive health services were provided School and adolescent reproductive and sexual health education activities	UNFPA, UNICEF, UNAIDS, Plan International, Restless Development
Planned Parenthood	2- Improvement of access to quality sexual reproductive health, protection and education services for adolescents and young children 3- Availability and dissemination of comprehensive age-appropriate information and education for adolescents and young people		Marie Stopes, National AIDS, UNFPA, UNICEF, UNAIDS, the Global Fund for HIV/AIDS, Plan International,
BRAC	3- availability and dissemination of comprehensive age-appropriate information and education for adolescents and young people 4- Empowerment of adolescent and young people to prevent and respond to teenage pregnancy	Establishment of adolescent after school girls club to teach and talk about sexual reproductive health and teenage pregnancy Giving out of micro credit to older adolescent Vocational training of adolescent teenagers out of school.	UNICEF, MoHS, MSWGCA, World Bank
Restless Development	3- Availability and dissemination of comprehensive age-appropriate information and education for adolescents and young people	School and adolescent reproductive and sexual health education activities Community outreach on sexual gender-based violence and human right violations Community outreach about teenage pregnancy using plays, music, stories	Marie Stopes, UNFPA, DFID, MoHS, UNDP
Health Poverty Action	2- Improvement of access to quality sexual reproductive health, protection and education services for adolescents and young children 3- Availability and dissemination of comprehensive age-appropriate information and education for adolescents and young people 4- Empowerment of adolescent and young people to prevent and respond to teenage pregnancy	Working with local health services and health workers to improve skills and services School and adolescent reproductive health outreach Training and educating woman about abuses and their rights	MoHS, UNDP, UNDF, European Commission

² Created by Kosia, B. for capstone.

One Year Progress

Within one year of the implementation of the strategic plan (May 2013–May 2014) through the collective efforts of the government and its partners, many admirable progressive changes were made. First, 515 health workers including nurses, mid-wives, community health officers and MCH aids were trained and made available to staff adolescent health and youth-friendly facilities around the country (GOSL, 2014). This resulted in the provision of adolescent and youth-friendly services in 96 (64 public and 32 private) of the nation's 1028 health facilities ranging from hospitals, clinics, community health centres and peripheral health units (GOSL, 2014). Along with health facilities improvement, adolescent health outreach service campaigns were conducted in all 13 districts of the country. This was carried out by various organizations including the MOHS staff, Marie Stopes staff and Planned Parenthood staff to reach adolescents in remote areas. The government reported that close to 345,000 adolescents and young people accessed and received age-appropriate and friendly health services and counselling services nationwide (GoSL, 2014). Within this same period, there was an increased availability of contraceptives across the country; long term contraceptives especially were made available for the first time in many places across the country. In fact, the number of health service delivery points offering at least three modern contraceptives jumped from 80.5% in 2011 to 96.6% by the end of 2013 (FH/FP, 2014). Along with the availability of contraceptives, the implementation of the newly developed reproductive health service logistics management system resulted in an improvement in the procurement and circulation of contraceptives in the country. This led to the country avoiding stock shortages of contraceptives at any of its service delivery points for the first time, as there was an exponential increase in the number of contraceptive made available to all health facilities around the country. With the increased availability of contraceptives, increased number of trained staff to provide the services and the increased outreach campaigns, the government and stakeholders speculated that

contraceptive uptake by adolescents increased within the first year. However, there are no recorded statistics to verify this, hence it remains questionable.

Along with the health service related interventions, several social strides were also made during the first year of the program's implementation. Among them was the conduction of massive social mobilization campaigns in 325 communities around the country reaching over 20,000 people. These campaigns were done to sensitize people about the harmfulness of teenage pregnancy and possible mechanisms for its prevention (GoSL, 2014). Community members in these 325 communities were also mobilized to develop action plans to address teenage pregnancy, sexual violence and early marriage. The end product of this mobilization has yet to be achieved as no specific laws or action plans were produced. Similarly, 180 men and 329 boys from various communities were mobilized and trained to act as advocates against teenage pregnancy and to help change patriarchal gender relationships. The success and activities of these advocates are yet to be delivered. Significant strides were made in an effort to retain more teenage girls in school by providing support for up to 75,000 girls to be part of the free junior secondary school education program. Over 750 teachers were trained regarding age-appropriate factors, gender roles, sexual and reproductive health and teenage pregnancy so that fewer teenagers would drop out.

Ebola Outbreak

The outbreak of the Ebola epidemic in May 2014, highlighted many of the weaknesses of the Sierra Leonean public health system including the teenage pregnancy reduction strategic plan. It brought a standstill or regression to the strategic plan's activities and a breakdown of the public health system. This was a clear indication that both the strategic plan and the health system as a whole were

unsustainable, unable to withstand unexpected challenges and lacked strategic long term planning especially for the strategic plan which had only a two year timeline.

Following the Ebola outbreak, the country's health agenda changed drastically with Ebola becoming the country's top priority at the expense of all other public health issues. The occurrence of the outbreak saw a radical shift in resource allocation in order to fight the epidemic, which immediately became more life-threatening. Furthermore, the virus resulted in a high rate of fatalities, especially among public health care providers who were at the forefront of the outbreak. This overburdened an already fragile and weak health care system, thus making it incapable of carrying out previous roles such as reproductive health services, including adolescent health services and family planning.

Apart from resource allocation shifting away from teenage pregnancy to Ebola, the virus increased exponentially. There were many cases where sick people, pregnant women and by extension adolescents were turned away from health facilities either due to the overburdening of the health care system or due to health workers' fear of Ebola transmission. This situation, though sad, was quite logical given that many of the health care workers did not have proper protective gear, nor did they possess adequate training to deal with an infectious disease like Ebola. Along with being turned away from health care facilities, many people refused to visit health care facilities as well, either due to fear of being turned away, fear of being diagnosed with Ebola or contracting it from other patients at the hospital.

Along with the reduced access to health care services by the population, adolescents included, the Ebola outbreak resulted in a decrease and, in most cases, a cessation of many of the teenage pregnancy prevention action plans. Key among the interrupted campaigns was the community mobilization and sensitization, along with the contraceptive and family planning uptake community outreaches. This could be attributed to the enforced quarantines within the country which made it difficult for health

care workers to do rural community outreach, especially for those from the city. Furthermore, the banning of social gatherings larger than 20 people by the government in order to prevent the spread of Ebola further made teenage pregnancy prevention social mobilization impossible. In cases where health workers were able to travel to carry out community sensitization campaigns, very few people are willing to be part of these gatherings. Lastly, when such gatherings were made possible, the focus mostly likely would be Ebola sensitization and prevention campaigns rather than teenage pregnancy reduction campaigns or any other public health campaign.

Another detrimental effect of the Ebola outbreak on the teenage pregnancy reduction intervention resulted from the closing of schools and tertiary institutions, another precautionary measure to avoid large gatherings. This means that adolescent-appropriate lessons in schools were no longer available to students who were at home rather than in school. Similarly, the peer mentorship program set up by UNICEF and BRAC for 6,000 adolescents became non-functional due to the outbreak. Thus, collectively most of the intervention strategies put in place by the various stakeholders were hindered in one way or the other.

Discussion

Serra Leone's teenage pregnancy problem is a complex health dilemma with severe consequences on the nation's health, economic and social development. The country's teenage pregnancy rate and concomitant maternal mortality rates have been among the worst in the world since the end of the war in 2002. Nonetheless, it was only in 2013 when it became obvious to the government and stakeholders that it was a necessary problem to address in order to achieve millennium development goals four and five. A strategic plan for the reduction of teenage pregnancy through the streamlining of efforts from multiple sectors and organizations was drafted for this purpose. The strategic plan was ground breaking in its scope and intent in three major ways. First, the strategic plan brought one of the nation's most pervasive but highly ignored problems out of the shadows and to the forefront of the country's agenda. Secondly, it brought together various ministries, organizations and departments from the government and non-governmental sectors in Serra Leone to work towards a common goal in a way they had never done before. In a place which has been known as haven for multitudes of NGOs pursuing their various projects, without any coordination or collective goal and many times undermining the government and each other's effort, such development was a welcomed improvement. Thirdly, it resulted in the pulling in and distribution of resources by organizations with similar agendas—those who otherwise would have been in competition or hindering each other's progress—rather than working together to create a greater impact. For instance, the collective decision by the Ministry of Health, MSSL, Planned Parenthood Serra Leone and UNFPA to increase contraceptive outreach and contraceptive service provision followed by the distribution of contraceptives to these various entities by UNFPA resulted in a massive increase in the availability of these services that far surpassed previous years. Given the cultural dynamics tied to low contraceptive uptake in Serra Leone, the availability of contraceptive services alone doesn't necessarily guarantee an increase in its uptake. It does, however, alleviate one of the major barriers

(lack of access) to its uptake. Having a larger and more established organization like UNFPA procure and provide contraceptives to all the organizations helped create some form of uniformity and improve the chances of success.

The strategic plan, as a whole, resulted in the availability and/or increase of several health and development services. These outcomes on these services were included in the progress report in the form of indicators such as: the number of trained adolescent-friendly health care workers, the number of health care workers trained to carry out family planning, the number of school teachers trained to use adolescent-appropriate curriculum, the number of social service workers trained to work with adolescents and the number of girls enrolled into after school girls' programs, all of which can be attributed to this single goal-orientation approach of the project. Despite these successes, an outstanding characteristic of the strategic plan was that teenage pregnancy increased following its implementation. While this failure to decrease teenage pregnancy may be attributed to the Ebola outbreak, I strongly believe that the epidemic exposed weaknesses of the strategic plan that in my opinion would have made it unsuccessful at achieving its goals even in the absence of an Ebola outbreak. These weaknesses include: 1) the unequal power dynamic among partners involved in the strategic plan, as evident in the agenda-setting phase and the top-down origins and accountability systems built into the action plans; 2) its inability to effectively use traditional sources of social organizations; and 3) its prioritization of quantifiable, bio-medical interventions. How and why these weaknesses manifested during the Ebola outbreak is the matter that this discussion centrally takes up.

The unequal partnership among the various stakeholders of the strategic plans stands out as its first major weakness. The unequal power dynamic among partners, specifically among the big UN agencies (WHO, UNICEF and UNFPA) and smaller non-governmental organizations, was present from its conception, its implementation and to some extent its evaluation, given that UNICEF created the M&E framework. Partnerships of this sort are very common in low-income countries with internationally

funded health care interventions, where donor organizations who control access to aid determine the management and priorities of the partnerships. Hence, instead of decision-making powers being redistributed among the broad range of stakeholders or the government, the UN stakeholders held the ultimate power, thus reinforcing a status quo where control over the teenage pregnancy reduction strategic intervention, like many programs before it, was retained by the powerful players at the expense of the overall goal. In this case, the big UN stakeholder utilized “leader” partner such as local community members and grassroots NGOs in subordinate roles where their contributions were limited to matters of service delivery rather than design. This excluded diverse perspectives, knowledge and experience that would have resulted in a better outcome of the overall strategic plan.

Secondly, despite the formation of a multi-sector committee with a single goal to decrease teenage pregnancy, the interventions of the strategic plan were uncoordinated in many ways. With individual organizations supporting or funding particular interventions of their choice rather than all of the organizations working together on a particular course of action, the intervention itself was fragmented, thus making it difficult to achieve the overall goal. Even though various organizations and sectors were aware of the work others were doing, the strategic plan failed at coordinating and aligning the efforts of the various parties. Even in cases where organizations had similar intervention objectives, there was no standardized method, or checks and balances that cut across the different organizations. Hence there was an immense lack of uniformity and continuity in the manner in which the interventions were carried out. Once again, the prioritization of donor consent over that of their partners or the strategic plan and the reliance of government on donor organizations limited their ability to effectively control or coordinate their activities. In the absence of coordination, the summation of the various organizational interventions outputs resulted in values that were reflective of huge improvements. However, in reality, the results were overshadowed by gaps in program implementation. As such, many of the programs of the strategic plan resulted in duplication and undermining of interventions, along with unequal

distribution of interventions which collectively resulted in ineffectiveness. A typical example of this scenario would be comparing UNFPA backed governmental contraceptive and family planning health service providers, and Marie Stopes or Planned Parenthood Sierra Leone contraceptive and family planning health service providers. While all three of these health workers ultimately provide reproductive health services such as contraceptive and family planning services to the public, the manner in which this is done, the type of contraceptive used and their location of outreach all depends on the individual organization, as there was no standardized method or checks and balance that cross cuts across the different organizations. The standardized method that was created by the UNFPA only applied to the government officials. However, when progress reports are made, the number of contraceptive and family planning, or adolescent reproductive health service accessed will combine all the various organizations regardless of the quality difference.

Thirdly, along with the strategic plan being mainly in line with the agendas of the big UN partner organizations and not being properly coordinated, the programs implemented within the first year were predominantly bio-medically focused with emphasis on the creation of adolescent-friendly facilities and services and the increased uptake of contraceptives rate. There was limited focus on cultural-appropriate behavioural change interventions and policy-focused interventions. The absence of such intervention was a major contributor to the 'strategic plan' failure, given that people's health-seeking behaviours and their general acceptance of health promotion interventions are influenced by their cultural identity and cultural beliefs. Besides being mostly bio-medically focused, the interventions implemented failed to address structural and institutional factors such as improvised health centres, under skilled health workers, etc., which also contribute to high teenage pregnancy rates. Instead, the activities that were implemented included those which could be easily implemented to produce measureable indicator values within the short two-year timeframe. Thus, rather than strengthening the health care system as a whole through holistic health system planning, rebuilding and development, the

interventions implemented were those that could be easily implemented and could produce measurable quantitative results in a short period. This is again a very commonly used approach for many public health interventions in LIC, particularly those funded by large international NGOs. The interventions focused on easily measured health statistics and indicators rather than on the overall improvement of health or health goals, because stakeholder organizations are eager to produce results to present to their donors or board of directors to ensure the circulation of funds. The 2010 implementation of the Free Health Care Initiative for Pregnant Women and Lactating Women and Child Under Five in Sierra Leone was accomplished in the same manner. Like the strategic plan, the free health care initiative, which was meant to reduce maternal and infant mortality, focused on easily mentioned indicators such as the number of pregnant and lactating women that visited health facilities, the number of administered antenatal and post-natal services, and the number of immunized children, rather than focusing on building and strengthening the health care system through long-term measures such as building more health care facilities and improving the infrastructure (water, electricity) at available facilities. Consequently, five years after its implementation with only four of the nation's health care facilities upgraded, the maternal and infant mortality in Sierra Leone hasn't changed much, even though there has been a remarkable increase in the health care service uptake for the intended demographic. Rather than resulting in better health outcomes, this increase in utilization of the free health care initiative services resulted in a situation where health care providers, especially nurses, became overwhelmed, since their workload increased, while their tools and resources remained unchanged. As such, at present, less time is spent with patients and less care is given to people who seek assistance in these facilities. Thus, the free health care resulted in positive health indicators but failed at achieving its overall goal. The strategic plan has similarly failed to focus on longer term indicators such as the number of health facilities built or upgraded, the availability transportation means to health care services, the

number of highly skill trained health workers, etc., and it is just as likely to be unsuccessful like the former.

Fourthly, the accountability of stakeholders is first and foremost to their donors, rather than to the people the intervention is intended for. This results in a situation where mediocre work that quickly produces statistics is preferred over long-term effective programs. Focusing on long-term, holistic interventions and indicators such as infrastructures development (hospitals and roads to hospitals), transportation availability, training of a new crop of health care workers to increase the available numbers, etc., are not only expensive, but they require long-term investment and are not on the agenda of the big donor organizations who control decision making. This explains why programs supported by the WHO had indicators such as the number of health centres providing adolescent-friendly services and the number of health workers trained to provide adolescent-friendly services. For UNFPA-supported programs, indicators included contraceptive uptake, the number of health service delivery providing contraceptive services, the number of modern contraceptive services provided by the various service delivery points, the amount of monthly stock out at various service delivery points and the number of contraceptive outreach services conducted. Similarly, UNICEF programs had indicators such as the number of girls enrolled in school, the number of school dropouts, skills training provisions for girls out of school, teachers trained to address gender-based violence, social workers trained to address abuse and gender-based violence and the number of community mobilizations carried out. All of these indicators were obtained from programs implemented within the first six months. With a stipulated two-year timeline, all the indicators outlined in the action plan were short-term indicators, as those are the only ones that would be available within such a short timeframe. However, given the pervasive nature of teenage pregnancy and its cultural dynamics, the creation of an intervention plan that lacked strategic mid- or long-term planning and thinking raises questions about the overall intent of this strategic plan in the first place.

The focus of the 'strategic plan' intervention on vertical programs such as the creation of adolescent-friendly health services, by training of youth-friendly nurses or the availability of contraceptives, while the overall health care system remained unchanged, was a very counterproductive action in many ways. Given that many Sierra Leoneans, including teenage girls, refrain from using health care services primarily due to their lack of faith in the services offered, the unavailability of basic infrastructure and the cost of services, it was unlikely that the availability of adolescent-friendly health workers would result in increased access. This is especially unlikely when adolescents continue to witness reproductive health related deaths and infant deaths. Furthermore, the utilization of youth-friendly trained health care workers to engage in community outreach to reach adolescents was sustainable and likely to make some insignificant changes, yet it further weakened the health system. This is the case because outreach health care workers were required to temporarily abandon their posts to do outreach in the community. In the process they would not be able to serve those who seek their services. However, a stronger health system, building intervention that focused on training (more) skilled health care workers, provision of adequate infrastructure and improved health services could lead to increased access and health services and possibly to decreased maternal deaths, increased child survival and overall decreased mortality. A stronger health care system with increased child survival could also result in an increase of voluntary uptake of contraceptives. When more children survive and make it into adulthood, the need for early debut of childbearing to increase fertility and child survival is diminished, hence creating a need and eventual acceptability of contraceptives. Thus, it is without a doubt that until child mortality and other root causes for women's need to have more children is addressed, intervention plans to increase contraceptive campaigns among Sierra Leonean teenagers will be futile. Along with the bio-medical intervention, the 'strategic plan' social intervention strategies that were meant to create behaviour change at community level also failed at creating the intended change. These interventions involved health care workers, social workers and communication teams entering local

communities, mobilizing community members and raising awareness about the dangers of teenage pregnancy and action plans that should be implemented to prevent it. Similar to the bio-medical interventions, these social interventions were focused on measurable indicators rather than the proposed attitudinal and behaviour change. As such, their success was reported in terms of the number of sensitization campaigns carried out in various regions of the country and the number of people mobilized in different communities, and less about the effectiveness of these campaigns with regard to the knowledge, behavioural and attitudinal change. These sensitizations lacked culturally compelling and cultural-appropriate behaviour change communication strategies that take into consideration the social and cultural context of the problem.

Given the cultural dynamics of the problem, it was crucial for the health promotion intervention to be built on existing community strengths, practices, skills and authority rather than bringing “outsiders” to do the sensitization. A major asset that could have been utilized for these campaigns were the leaders and members of the female secret society (Sande). These women are influential, respected people in the community with greater reach and understanding of community dynamics and structure, and thus in a better place to create a more impacting change, since they have an understanding of which factors would be strong motivators for themselves and their communities. Furthermore, in their roles as guardians and teachers to help girls transition into womanhood, they have direct access to and influence on the beliefs and actions of girls who were the main targeted group for the strategic plan and who might otherwise proceed from the initiation ceremony to marriage and child bearing. Using the Sande organization and the Sande women as allies would have resulted in community ownership of the intervention, thus making it more likely to be sustainable with community members becoming more involved. Given that most of the stakeholder organizations involved in the strategic plan are strong opponents of female circumcision, which is part of the Sande initiation, they failed to involve them.

However, without mutual respect of traditional beliefs and valuing of local practices by health promoters, trust and cooperation cannot exist and such health promotion programs will be likely to fail.

Another determining factor for the failure of the 'strategic plan' intervention was its negligence to create and enforce positive policy changes—even this was included in the action plan, as shown in Figure 9 below. Due to the complex nature of teenage pregnancy in Sierra Leone, a health in all-policy approach was necessary to effectively implement a successful cross-sector action plan. Some major policies that the strategic plan failed to review and enforce included those regarding deterrents to sexual abuse violations and human rights violations against young people. Without stronger measures put in place at national and local levels, the above violations continued to go unpunished for the post part.

Figure 9: Strategy for the improvement of policy and legal environment to protect adolescent and young people's right (GoSL, 2014)

Output/Activities	Indicators	Responsible partner(s)
Output 1: Improved policy and legal environment to protect adolescents and young people's rights.	Existing relevant policies (Education policy, Child Rights Act, Sexual Offenses Act, HIV/Aids policy) reviewed and revised	SPU, All Ministries, Parliamentarians, in consultation with partners
	Adolescents and Young People SRHR policy	MOHS in collaboration with all partners of the Strategy and Youth organizations
Review existing policies (Education policy, Child Act, HIV/Aids policy) and adopt revisions	Existing policies (Education policy, Child Rights Act, Sexual Offenses Act, HIV/Aids policy) reviewed and revised to ensure appropriate actions towards the reduction of teenage pregnancy and followed-up at community level through bi-laws and regulations	SPU, All Ministries and Parliamentarians, in consultation with UN Agencies, NGOs, Civil Society and Youth Associations
Advocate for the development of bi-laws at district, chiefdom and community level		All partners of the Strategy as well as local councils and paramount chiefs
Enforce laws through national services and agencies		All Ministries and National agencies as well as local councils and paramount chiefs
Support to MoHS in designing an AYPSRHR policy	Number of meetings with partners of the National Strategy on the preparation of the AYPSRHR Policy	MOHS in collaboration with all partners of the Strategy and Youth organizations

Similarly, most of the interventions in the health and education sector failed to address policy changes.

In the education sector, harmful school policies, such as those denying pregnant teenagers the right to

attend school, remains unchanged and as such remains a leading contributor to teenage school dropout and the cycle of teenage pregnancy. The implemented interventions such as the free junior secondary school enrolments for some girls around the country remained futile when there is not a holistic education policy put in place to ensure that all girls have the right and access to, and are provided with basic education whether pregnant or not. These policies are required because, in many cases, lack of access to school, being expelled during pregnancy, personal beliefs of girls and family members, responsibility for other family members and many other reasons other than cost of education may contribute to teenagers dropping out of school or not attending school at all, but instead getting married and having children. There was equal need for health policy reform, especially in areas of public health intervention planning and coordination. Without proper participatory and inclusive planning of public health intervention strategies, followed by holistic and coordinated implementation programs that are geared to benefit the most number of people, health interventions in Sierra Leone will continue to dance to the beat of donor drums.

Following the Ebola outbreak, the reported rise in the number of teenage pregnancy rates in the country can be linked to many of the above mentioned flaws or weaknesses of the strategic plan. The focus on vertical, indicator-oriented health intervention programs, rather than holistic development of the health care system, contributed to a health care system that easily crashed following the outbreak. The crashing of the health care system resulted in decreased access to reproductive health facilities, cessation of the contraceptive outreach programs and the cessation of schools. The lack of access to reproductive health services meant that sexually active teenagers who had to go without services that might help prevent pregnancy, since most of the available health resources were being invested in the Ebola outbreak. Similarly, the lack of community owned and controlled interventions meant all social sensitization campaigns had to end following the outbreak. The isolation mechanisms put in place by the government, along with the redirecting of human and material resources to Ebola campaigns, meant

teenage pregnancy outreach campaigns and access to health care services was drastically reduced. Had it been controlled by community gatekeepers such as the Sande women, it would have had a better chance of continuity even in the midst of the epidemic. Likewise, the failure of the government to implement laws pertaining to child sexual abuse and human rights violations was a contributing factor to the rise of sexual assault cases and teenage pregnancy cases following the Ebola outbreak. Given that girls are more vulnerable to sexual exploitation and abuse during emergency situations, in Sierra Leone this vulnerability was exacerbated, not only by the lack of law enforcement, but also by the economic meltdown and the high death rate that accompanied the outbreak. The outbreak orphaned thousands of young people, including teenage girls, many of whom in the absence of parents and guardians were forced to take over as head of their households or help their providers. The ensuing economic meltdown, which resulted in the shortage of food and price escalation, helped to push girls into taking roles outside the home that would make them more vulnerable to assault or more vulnerable to engage in illicit sexual activities that would result in pregnancy. This was especially the case given the absence of school institutions and the lack of parental protection and guidance for many of the orphans.

Conclusion and Recommendations

Serra Leone's teenage pregnancy reduction strategic plan was intended to consolidate the efforts of numerous stakeholder organizations to reduce the nation's high teenage pregnancy rate. However, with barely a few months until its proposed deadline, teenage pregnancy in Serra Leone continues to be on the rise. The rapid rise of teenage pregnancy during the Ebola outbreak shed light on several flaws of the strategic plan's program that resulted in its failure. First, it failed to implement holistic health systems and intervention approaches that would be sustainable, and, at the same time, benefit both teenagers and the general population. Secondly, it failed to implement cultural-appropriate behaviour change interventions, which utilize the strengths and resources of local communities, and as such many of the implemented interventions were unsustainable and unsuccessful. Lastly, the strategic plan neglected to utilize a health in all policy approach, and thus failed at implementing policies that would have helped support the health and behavioural related interventions.

Moving on in post-Ebola outbreak conditions, it is imperative that the strategic plan re-strategize both its macro and micro level present action plans if it is to achieve its intended goal. This process should take into consideration why the present strategy failed in the first place, and how the Ebola outbreak would affect future program implementation. Recommended changes that could be made at the macro level include increased political and financial commitment to health of the nation, evident through the strengthening and rebuilding of the health care system. This should involve allocation of resources, development of infrastructures and training of skilled health workers. There is also a need for the advocacy and implementation of strong multi-sector information communication and coordination between government ministries, NGOs, especially the UN stakeholders, civil societies and local communities. Lastly, it is imperative that laws which protect girls and support economic and social empowerment for girls and women are enforced both at the national and local level. At the micro level,

it is recommended that the 'strategic plan', 'program' or intervention consist of a bottom-up approach in parallel with a top-down approach. These should take into consideration the cultural and belief practices of the community as well being sustainable. Lastly, program implemented on the community level should work in unison with those made at institutional and political levels.

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