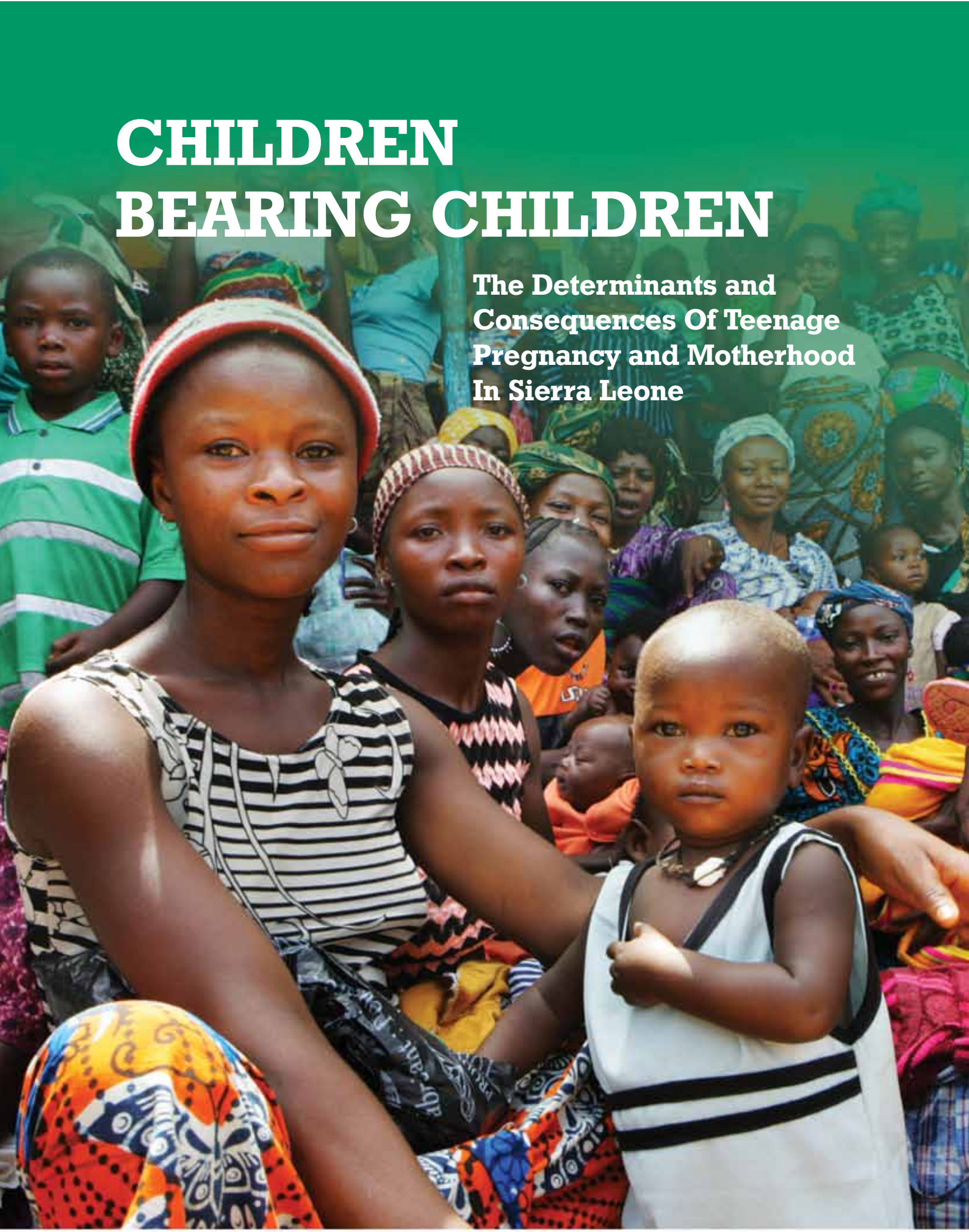
CHILDREN BEARING CHILDREN

The Determinants and Consequences Of Teenage Pregnancy and Motherhood In Sierra Leone



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Children Bearing Children: The determinant and consequences of Teenage pregnancy in Sierra Leone

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Finally special appreciation goes to the consultant
Dr Armand A. Thomas and his team for a job well done

Photo showing teenage mother who is full of life

EXECUTIVE SUMMARY

Teenage pregnancy is one of the universal problems that affect the lives of adolescent and young girl's. Teenage pregnancy often risks girls health and impediments to their, social, economic and political progress and empowerment of adolescent and young girls in Sierra Leone. All teenage pregnancies irrespective of the outcome have adverse consequences for the girls, their parents and the community. At the national level teenage childbearing has been identified as one of the major causes of obstetric fistula in women and a major determinant of high maternal and child morbidity.

The aim of this study is to provide accurate, relevant and reliable statistical and analytical data on teenage pregnancy and motherhood in Sierra Leone. The main objectives are: to determine the factors that lead to teenage pregnancy and to identify the consequences of teenage pregnancy in Sierra Leone. The target population is female aged from 9 to 19 years old.

The Bongaarts (1978) framework, a framework for analysing the proximate determinants of fertility, was used as a methodology for this study. The study is based on two sets of data. The 2008 Sierra Leone Demographic health Survey (2008SLDHS) and the primary data collected during focus group discussion conducted in different communities around the country.

The main findings of this study are: the incidence of teenage motherhood is higher in rural localities than in urban localities, with Freetown having the lowest percentage of teenage mothers. High level of maternal and infant mortality constitutes one of the consequences of teenage pregnancy and mother hood in Sierra Leone. Teenage pregnancy and childbirth are strongly influenced by the high levels of marriage, cohabitation and sexual intercourse at young ages, and a strong desire to have children.

The perceptions of community members why teenage girls become pregnant cover a wide variety of factors. The three leading reasons are: poverty of parents or foster parents, the attitude of girls to emulate their peers and lack of control by single parents.

Teenage mothers had less access to ante-natal assistance from medical and health personnel, but greater access to traditional birth attendants and community health workers. The findings indicate that due to the distance, cost of transportation and negative attitude of health providers are the major reasons why teenage mothers did not deliver at health facilities.

In terms of family planning, the study shows that 72.9 percent of teenage mothers surveyed know about modern contraceptive methods but despite the widespread knowledge about contraceptive, 71.6 percent of them have ever used a modern method of contraceptives. The result of the study also reveals that 71.2 percent of teenage mothers have no formal education and only 3.9 percent of them were able to complete primary education.

This study recommended the following: free health care initiative should be expanded to include all teenage girls, and the enforcement of the child Right Act to protect the girls-child against early marriage force marriage and early circumcision. The scope of family planning programmes be expanded to all women of child bearing ages free access to modern contraceptives.

OCTOBER 2011

CHILDREN BEARING CHILDREN

The Determinants And Consequences Of Teenage Pregnancy And Motherhood In Sierra Leone

by
Armand C. Thomas PhD

PREFACE

Teenage child bearing contributes to one third (33%) of all pregnancies in Sierra Leone. In 2008, the pregnancy rate among adolescents was 146/1000 and 70% of teenage girls were found to be married. That was also of great significance to the health of women and children in 2010, teenage mothers contributed to 40% of maternal death. Childbirth at an early age is associated with greater risk of mortality and morbidity as seen in the high incidence of Obstetric fistula among teenagers in Sierra Leone. There is a high risk of increased HIV epidemic among young people aged 15-19 years, given the high levels of teenage pregnancies due to unprotected sexual behavior.

In Sierra Leone illiteracy rate especially among girls is high, with 66% of women who have never been to school compared with 50 %of men and evidence also shows that 71% of teenage mothers are illiterate and this is directly related to the poor health seeking behaviors including low contraceptive rate of 1.2% for ages 15-19 as was indicated in DHS 2008. Early teenage pregnancy can cause severe health problems for both the mother and child.

Moreover, an early start to childbearing greatly reduces the educational and employment opportunities of women and is associated with higher levels of fertility. Education is negatively associated with adolescent fertility, with uneducated teenagers being more than three times as likely to have begun childbearing as those with secondary or higher education. The study has shown that community members have identified “poverty” as a key influence on each of the proximate determinants of teenage pregnancy.

With data from the 2008 Sierra Leone Demographic and Health Survey Data (2008 SLDHS), and FGDs organized in various communities around the country, this Report presents a comprehensive, accurate, and reliable analysis of the demographic, social, economic and cultural causes and consequences of teenage pregnancy and motherhood in Sierra Leone. This report will be useful to government NGOs, civil society and community based organizations, and individuals who are engaged in providing solutions to the problems of teenage pregnancy and motherhood. It contains the information required for various policies and strategies to improve adolescent sexual and reproductive health. This will also enhance the socio- economic, and political empowerment of all women, especially teenage mothers, in Sierra Leone. In spite of the concerns highlighted above, no detailed analysis has been undertaken to understand the underlying demographic, socio-economic and cultural causes and consequences of teenage pregnancy and motherhood in the country. It is against this background that the Ministry of Health and Sanitation in collaboration with UNFPA commissioned this special study.

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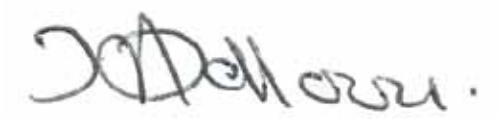

Ratidzai Ndlovu
UNFPA Representative
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1.0 INTRODUCTION

1.1 THE PROBLEM

Teenage pregnancy is one of the more pervasive problems affecting the health, social, economic and political progress and empowerment of women in Sierra Leone. Figures from the 2004 Population Census show that there wer-e 10 live births per 1,000 girls aged 10 to 14 years, and 211 live births per 1,000 girls aged 15 to 19 years. About 20.0 percent of these live births did not survive to the first birthday.

Data on live births in the 12 months preceding the 2004 Population Census confirm the high incidence of childbearing amongst teenage girls; 657 girls aged 10 to 14 years, and 18,390 girls aged 15 to 19 years, had a live birth in the 12 months preceding the Census.

1.2 THE IMPACT OF THE PROBLEM

All teenage pregnancies, irrespective of the outcome, have adverse consequences for the girls, the parents and the communities. Firstly, the education of the girl is prematurely terminated. For many of them, this occurs before they can complete the primary school level. Dropping out of the school system destroys their prospects of further educational advancement, and impairs their social, economic and political empowerment in future.

Secondly failure to complete the primary, or secondary school, system means considerable financial losses to parents, guardians and relatives who paid for the education of these girls. The resulting disappointments, frustrations and trauma are not only limited to the girls themselves, but are also experienced by their parents and the communities in which they live.

At the national level, teenage childbearing has been identified as one of the major causes of obstetric fistula in women, and a major determinant of high maternal and child morbidity and mortality, which in turn require additional investments in health and medical facilities and services.

Because teenage mothers are mainly illiterate or semi-illiterate, unskilled, untrained and therefore unemployable, they do not make any meaningful contribution to national development. Rather, they are a considerable liability to the nation, their communities, and their parents. They can rightly be regarded as a potential source of social instability in the country.

1.3 CURRENT KNOWLEDGE OF THE DETERMINANTS AND CONSEQUENCES OF TEENAGE PREGNANCY

In spite of the widespread, and worrying, incidence of teenage pregnancy in Sierra Leone, no detailed analysis has been undertaken to understand its determinants and consequences. Data from the 2005 Multiple Indicator Cluster Survey (MICS 3) have indicated relatively high levels of early marriage, and the onset of early sexual intercourse, amongst teenage girls.

The data show that amongst women aged 15 to 49 years, who were married or in consensual union, 27.2 percent were married before age 15 years, and 62.0 percent

before age 18 years. In addition, 24.9 percent of women aged 15 to 19 years started sexual intercourse before age 15 years, while 70.7 percent of those aged 20 to 24 years, had sex before age 18 years.

Against this background of the high incidence of early girl-child marriage, and the onset of sexual activity at relatively young ages, the use of modern contraception is restricted to a small proportion of the female population of child bearing ages. MICS 3 data show that amongst women aged 15 to 49 years, who are married or living with a man, 98.0 percent of those aged 15 to 19 years, and 96.3 percent of those aged 20 to 24 years, are not using any method of contraception.

Even less is known about the real impact of teenage pregnancy on the health of the girls, on their sexual and reproductive behaviour, on their level of educational attainment, and on their current or prospective socio-economic status. As a result, there have been no concerted efforts, at the national level, to devise programmes that would reduce the incidence of teenage pregnancy, or help to reintegrate teenage mothers back into the productive socio-economic system, either by continuing their education, or skills training, or accessing opportunities for employment, and income generation.

The impact of teenage pregnancy on particular communities has been more visible, and has forced some traditional leaders to adopt rather innovative, but controversial and ineffective, measures to confront the problem. But these are ad hoc strategies applied to communities at chiefdom level. They fall far short of the more comprehensive strategies required to tackle the problem across the country.

1.4 UNFPA INTERVENTION

It is against this background that UNFPA seeks, in this Study, to provide accurate, relevant and reliable statistical and analytical data on teenage pregnancy and motherhood in Sierra Leone. UNFPA regard this as an important prerequisite for informing policies, programmes, strategies, decisions and advocacy campaigns which seek to improve the sexual and reproductive health of our women. This is within the overall country programme objective of enhancing the social, economic, and political empowerment of all women, especially teenage girls, in Sierra Leone.

This study has therefore conducted a detailed analysis of the determinants and consequences of teenage pregnancy and motherhood in Sierra Leone, as a first step in the task of confronting, and reducing, the impact of the problem on individuals, communities and the nation.

1.5 THE TARGET POPULATION

This Study of teenage pregnancy specifically targets a particular section of the population which is identified precisely by its age, i.e. the “teenagers”. This categorization is preferred to other classifications of the population in terms of “youths” or “adolescents”, which refer to the population within a period of transition and development from childhood to adulthood, but whose age range is not precise, as the lower and upper age limits of the target population can vary between countries, and between analysts.

The definition of the target population by age groups up to age 19 years has a number of

technical advantages for the study of teenage pregnancy. Firstly, it facilitates the calculation of age-specific fertility and mortality rates for conventional five year age-groups, which can be compared with similar rates for other countries and periods.

With the selection of the population up to age 19 years, the problems of teenage pregnancy, and its possible solutions, can be identified and discussed within the framework of existing international and national legal instruments which guarantee that the human rights of children to survival, development and protection are respected.

At the international level, Article 1 of The United Nations Convention on the Rights of the Child, which Sierra Leone signed in 1990, defines a child as follows:

> **"A child means every human being below the age of eighteen years unless under the law applicable to the child , majority is attained earlier".**

At the national level, the 1991 Constitution of Sierra Leone defines the age of majority as 18 years.

In addition, there are a number of existing legislations, which are relevant for the study of teenage pregnancy, and which define a child as *"a person below the age of eighteen years"*. These are:

- The Child Rights Act of 2007
- The domestic violence act of 2007
- The Registration of customary marriage and divorce act 2007.
- The devolution of estates Act 2007
- The "Prevention of Cruelty to Children Act" Cap 31 of 1926. Sections 6 and 7 of this Act specify that having sexual intercourse with a girl under the age of 14 years, whether with or without her consent, is a criminal act which is punishable by long custodial sentence.

These legislations have special legal and social significance for the sexual activity of girls whose age is under 14 years, and the early-age marriage of the girl-child who is under 18 years. They should therefore be utilised as strategic weapons in efforts to eliminate teenage pregnancy and child bearing in the country.

The target population of this study are females aged up to 19 years; the teenagers. They are the children who are having children when they are themselves children. This study will examine their demographic, social and economic characteristics; analyse the factors that are responsible for teenage girls becoming mothers; and discuss the consequences for them, their babies, and the communities in which they live.

1.6 METHODOLOGY OF THE STUDY

The theoretical basis for the analysis of the determinants of teenage pregnancy and teenage motherhood, in this study, is a modification of the Bongaarts (1978) framework for analysing fertility. This framework assumes that various social, economic, and environmental factors exert an influence through a number of biological and behavioural factors which determine the woman's fertility performance, one indicator of which is her age at first child birth.

The biological, behavioural and environmental factors which will form the focus of this Study include:

- marital status especially the age at first marriage, and the type of marital union;
- the age at first sexual intercourse;
- the age of the sexual partner of the teenage mother;
- her circumcision status, especially age at circumcision;
- the use of modern contraceptive methods; and
- the poverty or wealth status of the household.

1.7 SOURCES OF INFORMATION

The study is based on two sets of data. The first is the 2008 Sierra Leone Demographic and Health Survey Data (2008 SLDHS), and the second are primary data collected during focus group discussions conducted in different communities around the country.

1.7.1 THE 2008 SIERRA LEONE DEMOGRAPHIC AND HEALTH SURVEY (SLDHS)

For the purposes of this Study, the 2008 SLDHS dataset files, which are available in the standard recode SPSS and CS Profile formats, were obtained from MEASURE DHS in the United States. There are 10 dataset recode files. For this Study, data from two of these files are utilised to analyse the determinants and consequences of teenage pregnancy and childbirth. They are:

- Individual Woman's Data – Individual Recode (IR), which contains one record for every eligible woman as defined by the household schedule. It contains all the data collected in the woman's questionnaire plus some variables from the household questionnaire.

- Births' Data – All Children Recode (BR), which contains one record for every child born of eligible women. Essentially, it is the full birth history of all women interviewed including information on pregnancy and postnatal care, as well as immunisation and health, for children born in the last 5 years. Data for the mother of each of these children are also included.

Data from these two files, in SPSS format, provide the basis for the analysis of various characteristics of women and their births. Both files have the variable "age at first birth" which is reported in single years. For the purposes of this Study, this variable has been recoded into a new variable called "age of mother at first birth" with two values:

- "Teenage mothers" which groups all "age at first birth" less than 20 years
- "Adult mothers" which groups all "age at first birth" at 20 years and over.

Various other variables, relevant for the study, are then cross tabulated by the "age of mother at first birth", thus facilitate the analysis of various characteristics of teenage mothers, the determinants of teenage pregnancy, and the consequences of childhood motherhood for the girl-child, her baby, and the community.

1.7.2 FOCUS GROUP DISCUSSION (FGD) DATA

Primary data were obtained during a number of focus group discussions which were conducted with five different population groups in each of seven communities around the

country. The population groups were homogeneous in composition, and were based on age, gender and social status in the community. They comprised:

- In school girls aged 13 to 18 years
- Out of school girls aged 13 to 18 years
- Adult females aged 18 years and over
- Adult males aged 18 years and over
- Traditional, Religious and Opinion Leaders in the community

The seven communities were randomly selected from a list of rural and urban localities. They comprised:

- Nongowa Chiefdom in Kenema District (Kenema Town)
- Small Bo Chiefdom in Kenema District (Rural population)
- Bombali Sebora Chiefdom in Bombali District (Makeni Town)
- Gbanti Kamaranka Chiefdom in Bombali District (Rural population)
- Kakua Chiefdom in Bo District (Bo Town)
- Selenga Chiefdom in Bo District (Rural population)
- Western Area Urban (Freetown).

The topics for discussion were selected so as to obtain the views and opinions, of community members, on the determinants and consequences of a number of issues which had emerged from the analysis of the 2008 SLDHS Data. Appendix A is the *"Guidelines for the Focus Group Discussions"*. It shows that the main issues included "early-age pregnancy", "early age at first marriage", "early age at first intercourse", "female circumcision at young ages", "low prevalence rates of contraceptive use", "spousal age differences", and "the consequence of teenage pregnancy and motherhood. Discussants were also encouraged to make their own recommendations for improving the conditions which were discussed.

The format of the focus group discussions, which involved six discussants in each of the five homogeneous groups, required each discussant to respond, in turn, and by name, to the questions posed by the Interviewer. The content of the discussions were tape recorded and transcribed in full, including the identities of discussants. The responses on each issue could then be tabulated as multiple responses to open ended questions.

These tabulations, shown in Appendix B: *"Focus Group Discussion Tables"*, have been analysed to assess the perceptions and opinions of all community members, and of each of the five community groups. Thus, they also allow a more detailed analysis of the prevailing views within each community group, differences in how they perceive the same issues, and their recommendations for solving observed problems. These details should inform the process of designing special messages to target specific interest groups in the community.

1.8 FORMAT OF THE REPORT

- Section 1: Introduction.
- Section 2: Characteristics of teenage mothers
- Section 3: Analysis of the determinants of teenage motherhood.
- Section 4: Consequences of teenage pregnancy and motherhood for the teenage mother
- Section 5: Consequences of teenage pregnancy and motherhood for the children
- Section 6: Consequences of teenage pregnancy and motherhood within the Community
- Section 7: Conclusions and recommendations
- Annex: Statistical tables and focus group discussion results

2.0 CHARACTERISTICS OF TEENAGE MOTHERS

2.1 INCIDENCE OF CHILD BIRTH

TABLE 1: MOTHERS BY AGE AT FIRST BIRTH

Background characteristic	Age of mother at first birth: Teenage mothers	Adult mothers	Total
Number of mothers	63.3% (3719)	36.7% (2157)	100.0 (5876)
Age at first birth(Years)			
10 to 12	9.6%	3.9%	
Under 14	17.7%	6.9%	
Under 18	78.3%	34.3%	
18 and over	21.7%	85.7%	
Total	100.0% (3438)	100.0% (2000)	

SOURCE: SLDHS 2008

Of the total 5,876 women aged 15-49 years in the 2008 SLDHS, 3,719 or 63.3 percent had a first birth before age 20 years, and 2,157 or 36.7 percent had a first birth at ages 20 years or over as seen in Table 1, a pattern that is replicated within the urban and rural localities in each of the four Regions.

2.2 TYPE OF LOCALITY

TABLE 2: MOTHER BY RESIDENCE

Background characteristic	Age of mother at first birth: Teenage mothers	Adult mothers	Total
REGION			
Eastern	60.3%	39.7%	100.0%(1443)
Northern	65.8%	34.2%	100.0%(1802)
Southern	64.0%	36.0%	100.0%(1462)
Western	62.4%	37.6%	100.0%(1169
Total	63.3% (3719)	36.7% (2157)	100.0 (5876)
TYPE OF PLACE OF RESIDENCE			
Urban	38.1%	38.9%	
Rural	61.9%	61.1%	
	100.0% (3719)	100.0% (2157)	
DE FACTO PLACE OF RESIDENCE			
Freetown	59.4%	40.6%	100.0%(859)
Small city	62.5%	37.5%	100.0%(624)
Town	66.8%	33.2%	100.0%(773)
Countryside	63.6%	36.4%	100.0%(3620)
Total	63.3%	36.7%	100.0%(5876)

Sources: SLDHS 2008

There are differences in the incidence of motherhood by the type of locality in which women reside (see Table 2). The majority of teenage mothers, that is 61.9 percent, are in rural localities compared to 38.1 percent in urban localities, a reflection of the rural-urban distribution in the national population. However within either rural or urban localities, the pattern is similar; about 63.0 percent of women had a first birth as teenagers and 37.0 percent as adults.

A further disaggregation by type of place of residence shows that in Freetown, 59.4 percent of the women had a first birth when they were in their teens, while 62.5 percent or more in “Small City”, “Town” or “Countryside”, Sources: SLDHS 2008 had a first birth at these early ages.

2.3 SOCIAL CHARACTERISTICS

2.3.1. RELIGION

Muslims constitute 76.3 percent and Christians 23.0 percent, of teenage mothers. However within each group, there are significant differences in the proportions of teenage mothers and adult mothers: According to Table 3, amongst Christians, 58.5 percent are teenage mothers and 41.5 percent are adult mothers, but amongst Muslims, 65.0 percent are teenage mothers, and 35.5 percent are adult mothers.

TABLE 3: MOTHER BY RELIGION

Background characteristic	Age of mother at first birth: Teenage mothers	Adult mothers	Total
Religion			
Christian	58.5%	41.5%	100% (1457)
Islam	65.0%	35.0%	100% (4357)
Bahai	60.0%	40.0%	100% (5)
Traditional	62.5%	37.5%	100% (8)
None	60.0%	40.0%	100%(25)
Other	50.0%	50.0%	100% (6)
Total	63.3%	36.7%	100.0% (5858)

2.3.2.HOUSEHOLD SIZE

The majority of teenage and adult mothers live in relatively large households of 4 or more members.

TABLE 4: MOTHER BY HOUSEHOLD SIZE

Household Characteristic	Age of mother at first birth: Teenage mothers	Adult mothers
HOUSEHOLD SIZE (NUMBER OF PERSONS)		
1 to 3	9.1%	9.7%
4 to 9	71.7%	72.3%
10 and over	19.2%	18.0%
Total	100.0% (3719)	100.0% (2157)

2.3.3 HOUSEHOLD COMPOSITION

TABLE 5: MOTHERS BY RELATIONSHIP TO HOUSEHOLD HEAD

Within the household, the majority of mothers are part of a nuclear family. Only about 10.8 percent of teenage mothers, and 12.2 percent of adult mothers, are household heads; the rest are mainly wives, or daughters, or daughters-in-law, or sisters (see Table 5).

Household Characteristic	Age of mother at first birth: Teenage mothers	Adult mothers
RELATIONSHIP TO HEAD OF HOUSE		
Head	10.8%	12.2%
Wife	63.8%	65.0%
Daughter	10.8%	10.8%
Daughter-in-law	3.0%	2.7%
Grandchild	0.6%	0.5%
Parent	0.7%	0.3%
Sister	4.5%	3.4%
Other relative	3.1%	3.2%
Adopted/foster child	0.6%	0.2%
Not related	0.4%	0.5%
Niece by blood	0.9%	0.8%
Niece by marriage	0.6%	0.4%
Total	100.0%(3719)	100.0%(2157)

3.0 DETERMINANTS OF TEENAGE PREGNANCY

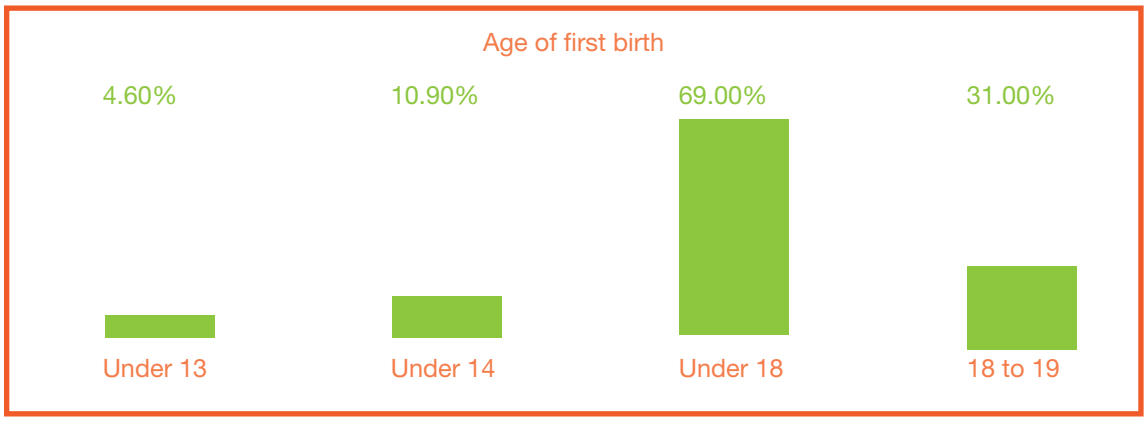
For each of the proximate determinants identified in the theoretical framework, appropriate statistical indices have been computed from the 2008 SLDHS data, to determine the incidence and prevalence of various population characteristics, and any relationships between them. In addition, data from FGDs have been examined to discover some of the social, economic and cultural factors which provide possible explanations of these computed values.

3.1 AGE AT FIRST BIRTH

3.1.1.LEVEL OF INCIDENCE

Amongst teenage mothers child bearing starts early. A few were mothers as young as 9 years; 4.6 percent had a child when they were under 13 years, 10.9 percent at ages under 14 years; and 69.0 percent at ages under 18 years (See Figure 1).

FIGURE 1: TEENAGE MOTHERS BY AGE AT FIRST BIRTH



These reported ages at first birth have important legal and social implications. “The Prevention of Cruelty to Children Act : Cap 31” makes sexual intercourse illegal with a girl aged under 13 years, or between ages 13 and 14 years, whether with or without her consent. On the other hand, “The 2007 Child Rights Act” defines a child as “a person aged under 18 year”, and makes it illegal to marry her, whether she is willing or forced.

3.1.2.COMMUNITY PERCEPTIONS AND OPINIONS OF EARLY AGE PREGNANCY

The perceptions of community members of why teenage girls become pregnant cover a wide variety of factors. The three leading reasons are “poverty of parents or foster parents”; “the attitude of girls to emulate their peers”, popularly termed “milleh”; and “lack of control by single parents”.

A. POVERTY OF PARENTS OR FOSTER PARENTS

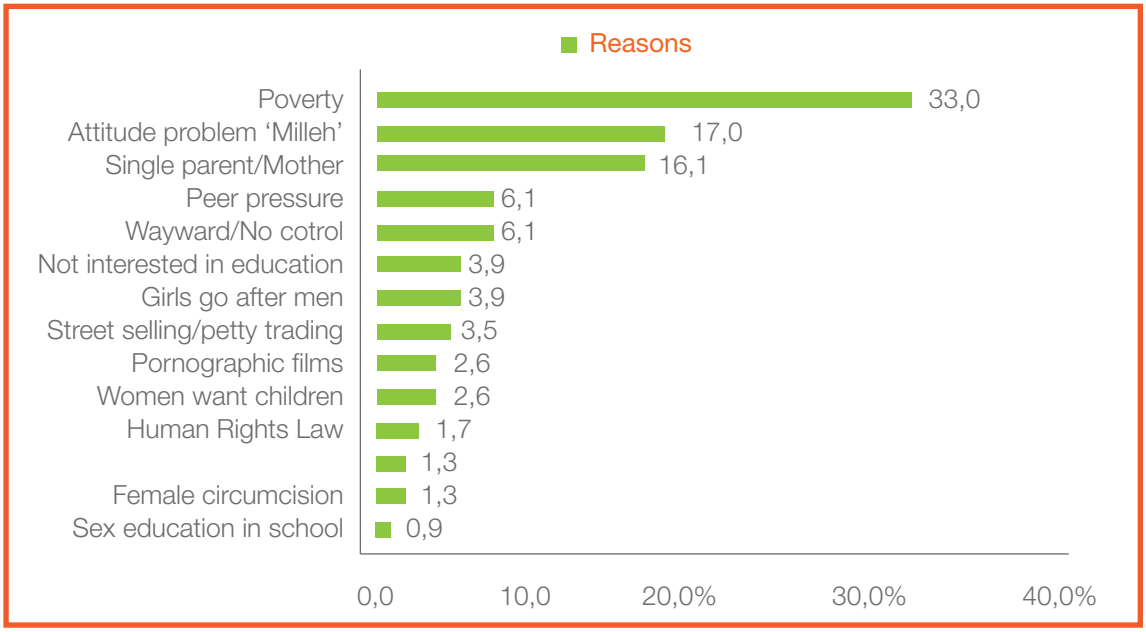
Nearly a third of all respondents think that parents and foster parents are too poor, and are therefore unable to provide adequately for the education, daily sustenance, and other

material requirements of their children (see Figure 2). Mothers therefore seek assistance, or encourage their daughters to seek assistance, from men, who in turn, will provide the assistance for sexual favours.

B. THE ATTITUDE OF GIRLS TO EMULATE THEIR PEERS, MILLEH

About 17 .0 percent (see Figure 2) of all respondents believe that many teenage girls are inclined to copy their peers, and to covet their personal belongings or life style, referred to as "milleh". For this, they require financial resources and support, which they solicit from men.

FIGURE 2: REASONS FOR EARLY AGE OF PREGNANCY



C. LACK OF CONTROL BY SINGLE PARENTS

The third most important reason is that in households which have no effective "father" "the mothers" is the household manager. But mothers are unable to effectively monitor, counsel and control the activities of their daughters, because they themselves are illiterate, uninformed, unemployed, and do not have the financial resources to educate, feed, clothe and take care of the health and welfare of their daughters. The girls are left free to cope for themselves, and do not submit to any parental control.

D. OTHER MAJOR REASONS

In the view of other community members, a variety of other factors are responsible for girls becoming pregnant when young, including "girls are wayward/don't take control/stubborn"; "peer pressure, with no apparent adverse outcome from friends who were pregnant"; "girls go after the men"; "the girls want to have children"; "the practice of street trading/petty trading by the girl-child"; and "female circumcision".

3.1.3 MARITAL STATUS

Only 7.5 percent of teenage mothers, and 7.3 percent of adult mothers, have "never married"; 85.0 percent of teenage mothers, compared to 85.1 percent of adult mothers, are "currently married", and 92.5 percent of teenage mothers, and 92.7 percent of adult mothers are "ever married" according to Table 6.

A. MARITAL UNION

TABLE 6: MOTHERS BY MARITAL STATUS

Household Characteristic	Age of mother at first birth: Teenage mothers	Adult mothers
Number of union		
once	73.6%	78.5%
More than once	26.4%	21.5%
Total	100% (3719)	100% (2157)
Husband lives in house		
Living with her	86.6%	85.6%
Staying elsewhere	13.4%	14.4%
Total	100% (3128)	100% (1820)
Marital Status		
Never married	7.5%	7.3%
Married	73.9%	75.2%
Living together	11.1%	9.9%
Widowed	3.4%	3.0%
Divorced	0.5%	0.7%
Not living together	3.7%	3.8%
Total	100.0% (3719)	100.0% (2157)

About 73.6 percent of teenage mothers, and 78.5 percent of adult mother, have had only one union, while 26.4 percent of teenage mothers, compared to 21.5 percent of adult mothers, have had more than one union from Table 6. This has implications for the risk of exposure to divorce or widowhood, and the demographic and socio-economic implications for them and their children, including remarriage, and inheritance of the husband's property.

B. COHABITATION

The majority of teenage mothers and adult mothers, that is 86.6 percent and 85.6 percent respectively, are living with the husband in the same house according to Table 6. Only 13.4 percent of teenage mothers, and 14.4 percent of adult mothers, have a husband who stays elsewhere.

The majority of teenage mothers and adult mothers, 64.4 percent, are in a monogamous union. However, 34.1 percent of teenage mothers, and 34.0 percent of adult mothers, are in unions with one or more co-wives.

Against the background of prevailing low levels of contraceptive use, and the apparent desire of women to have children, the conditions appear appropriate for high levels of fertility of both teenage and adult mothers. Specific, and measured, interventions would be required to pre-empt the possible adverse demographic, social and economic consequences for both mothers and their children.

3.1.4 AGE AT FIRST MARRIAGE

TABLE 7: MOTHERS BY AGE AT FIRST MARRIAGE

Age at first marriage (years)(grouped)	Age of mother at first birth: Teenage mothers	Adult mothers
10 to 12	9.6%	3.9%
Under 14	17.7%	6.9%
Under 18	78.3%	34.3%
18 and over	21.7%	65.7%
Total	100.0% (3438)	100.0% (2000)

A. LEVEL OF INCIDENCE

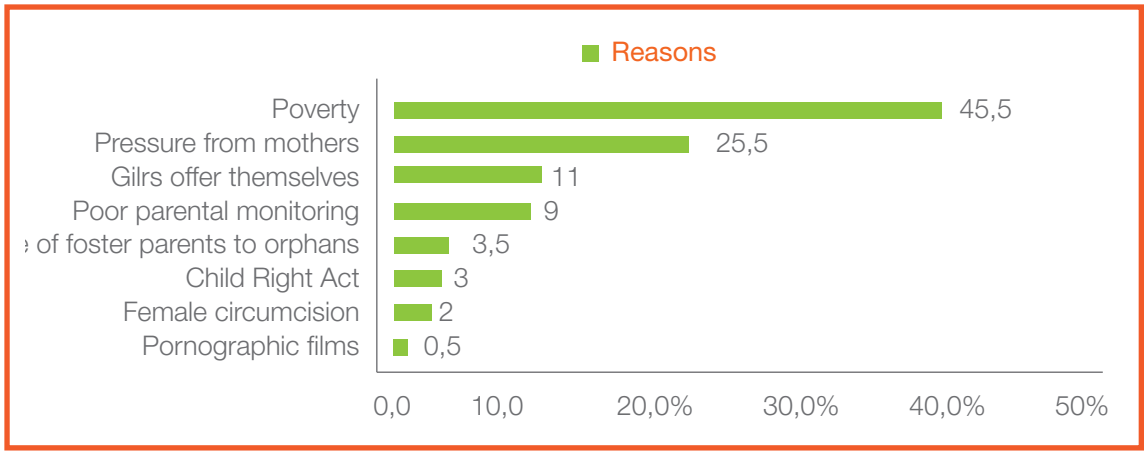
This study has shown that 92.5 percent of teenage mothers, and 92.7 percent of adult mothers, are "ever married". Figures on "age at first marriage" in Table 7 further indicate that they marry at relatively young ages: 9.6 percent of teenage mothers, and 3.9 percent of adult mothers, were married between 10 and 12 years of age; 17.7 percent of teenage mothers, and 6.9 percent of adult mothers were married at ages under 14 years, and 78.3 percent of teenage mothers, and 34.3 percent of adult mothers, were married when they were still under 18 years.

Age at first marriage appears to be a significant determinant of teenage childbearing, and the indications are that the majority of teenage births take place within marriage.

According to "The Prevention of Cruelty to Children Act" (Cap 31), of 1926, having sexual intercourse with a girl aged under 14 years, with or without her consent, is unlawful carnal knowledge, and criminal, with a fifteen year or two year custodial sentence on conviction. On the other hand, the 2007 Child Rights Act makes it illegal to marry a girl-child under age 18 years, whether she is willing or is forced.

B. COMMUNITY PERCEPTIONS AND OPINIONS ON EARLY AGE AT FIRST MARRIAGE

FIGURE 3: REASONS FOR EARLY AGE AT FIRST MARRIAGE



Discussions with community members revealed that many of the married teenage mothers are in consensual unions, entered into when the girl became pregnant, or after the baby was born, and she decided, or was encouraged by her parents (most likely the mother), to live with the man who impregnated her. The decision is sometimes made because the parents of the teenage mother are too poor to care for the teenage mother and her child.

Figure 3 shows that, for all community members, the four most important reasons why girls get married early are "household poverty" (45.5 percent), "pressure from mothers" (25.5 percent), "consenting girls" (11.0 percent), and "poor parental monitoring" (9.0 percent).

Household Poverty

According to all respondents, the most important reason for early girl-child marriage is household poverty. Poverty affects the household as a whole, but more so the mothers, who are the managers, and who are responsible for child caring, in many homes. But lack of money limits her ability to educate, feed, and provide for the welfare of the children. So the only option for both mother and daughter is to accept financial assistance from any man who shows an interest in the daughter, with the intention of making her his wife.

Pressure from mothers for girls to get married

More than 25.0 percent of all respondents believe that in a home where a teenage girl is regarded as "stubborn and wayward", and unwilling to subject herself to parental control, the solution which mothers usually adopt is to initiate her into the bundo society at an early age, and get her married rather than to send her to school. This will prevent her from becoming pregnant while she is still at home with her mother, a situation that would bring shame to the family.

Girls offer themselves in marriage without parental consent

Many respondents claim that girls offer themselves in marriage to men, without the consent or knowledge of their parents, in order to have a child, as a way of emulating their peer groups.

Poor parental monitoring

In contrast to this view, nearly 10.0 percent of all respondents as shown in figure 3, think that the cause of early marriage is poor monitoring and control by parents, especially mothers, who depend on the girl-child for support, which is usually expected if she gets married to a man who will provide care and sustenance of the daughter, her mother and other siblings.

Other causes of early marriage

A number of other factors were cited as reasons for young girls getting married, including "lack of a caring attitude by foster parents of orphans and foster children"; " the Child Rights Act which makes control of children by parents impossible"; and "female circumcision".

3.1.5 COMPARISON OF AGE AT FIRST BIRTH AND AGE AT FIRST MARRIAGE

A comparative analysis of the "age at first birth" and the "age at first marriage" in Table 3 shows that for 23.1 percent of teenage mothers, compared to 8.7 percent of adult mothers, the age at first birth is younger than the age at first marriage, implying that these mothers had their first birth before they were married. But for 20.1 percent of teenage mothers, and 8.4 percent of adult mothers, first birth and first marriage occurred at about the same age. However, 56.8 percent of teenage mothers, compared to 82.9 percent of adult mothers, had a first birth at an age that was older than the age at first marriage.

The figures indicate that there is a strong causal relationship between age at first marriage and age at first birth, but that there is also a substantial incidence of pregnancy and childbearing taking place before marriage, a situation that is more prevalent amongst teenage mothers than adult mothers.

TABLE 8: MOTHERS BY COMPARISON OF AGE AT FIRST BIRTH AND AGE AT FIRST MARRIAGE

Comparison	Age of mother at first birth	
	Teenage mothers	Adult mothers
Age at first birth less than age at first marriage	23.1%	8.7%
Age at first birth equals age at first marriage	20.1%	8.4%
Age at first birth greater than age at first marriage	56.8%	82.9%
Total	100.0% (3439)	100.0% (2000)

3.1.6. AGE AT FIRST SEXUAL INTERCOURSE

A. LEVEL OF INCIDENCE

Mothers, especially teenage mothers, begin sexual intercourse at a relatively early age, a few as early as 8 years; 5.6 percent of teenage mothers, and 2.7 percent of adult mothers, had their first sexual intercourse at ages under 13 years, while 12.1 percent of teenage mothers, and 6.1 percent of adult mothers, had their first sexual intercourse at ages under 14 years as can be seen in Table 9. All of these sexual encounters, with girls under age 14 years, occurred "unlawfully and carnally", according to Sections 6 and 7 of Cap 31 of 1926 "The Prevention Of Cruelty To Children Act".

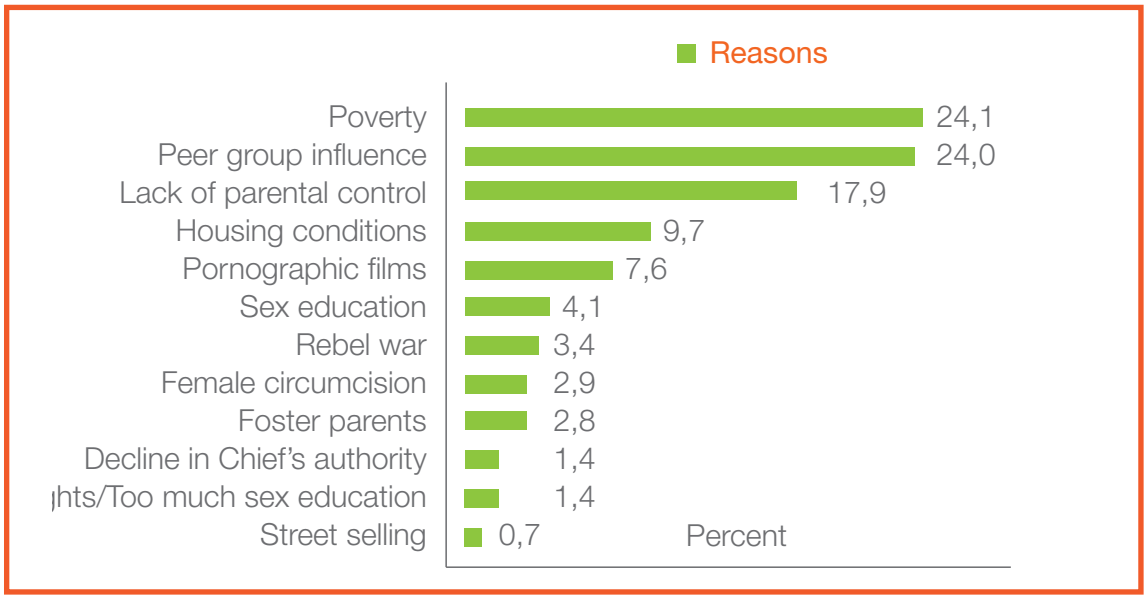
TABLE 9: MOTHERS BY AGE AT FIRST INTERCOURSE

Age at first intercourse (years) (grouped)	Age of mother at first birth	
	Teenage mothers	Adult mothers
Under 10	0.2	0.0
Under 13	5.6%	2.7%
Under 14	12.1%	6.1%
Under 18	66.0%	49.4%
18 and over	34.0%	50.6%
Total	100.0%(3710)	100.0%(2142)

B. COMMUNITY PERCEPTIONS AND OPINIONS ON EARLY START OF SEXUAL INTERCOURSE

Community members report the three leading reasons why girls begin sexual intercourse early as "poverty of parents/mothers who cannot satisfy the wants of their daughters", "peer group influence", and "lack of parental control and monitoring by mothers".

FIGURE 4: REASONS FOR EARLY START OF SEXUAL INTERCOURSE



Other reasons include "overcrowded housing conditions in which parents share the same bed, or room, with children, who observe, and later simulate, the sexual actions of their parents"; "pornographic films shown in public places, to which children have access"; "foster mothers who send girls to do petty street trading"; "female circumcision which is the excuse to start sexual intercourse"; "human rights/child rights/too much sex education in school"; and "the decline of Chief's authority to punish in public men who sexually offend children" as shown in Figure 4.

Poverty of parents and inability to satisfy wants of daughter.

In the view of community members, one of the most important factors which drive girls to start sexual intercourse at an early age is the poverty of their parents, particularly the mother. Mothers are unable to cope with the requirem ents of their daughters, who want to be educated, and to emulate the life styles of their peers, the "milleh factor". Girls will then adopt the most common coping strategy, which is to have sexual relationship with a man.

Peer group influences

About 24.0 percent of community members reported that girls are the victims of peer group influences which are exerted through arranged social contacts, or experiences shared by friends, of the benefits to be gained by having sexual relationships with men, or the desire of girls to get married, and have children just like their peers have done.

Lack of parental control

The inability of parents, mostly single mothers, to counsel, control and monitor their daughters at home is reported by 17.9 percent of all respondents as shown in Figure 4.

Other causes

Other reasons which respondents gave included "overcrowded housing conditions in which parents share the same bed, or room, with children, who observe, and later simulate, the sexual actions of their parents"; "pornographic films shown in public places, to which children have access"; "foster mothers who send girls to do petty street trading"; "female circumcision which is the excuse to start sexual intercourse"; "human rights/child rights/too much sex education in school"; and "the decline of Chief's authority to punish, in public, men who sexually offend children".

3.2 KNOWLEDGE AND USE OF CONTRACEPTIVE METHODS

3.2.1 KNOWLEDGE

Figures from Table 10 indicate that about 72.9 percent of teenage mothers, and 70.5 percent of adult mothers, know about modern contraceptive methods, while 22.7 percent of teenage mothers, and 24.4 percent of adult mothers, do not know any method.

TABLE 10: KNOWLEDGE OF CONTRACEPTIVE METHODS

	Age of mother at first birth	
Knowledge	Teenage mothers	Adult mothers
Knowledge of any method		
Knows no method	22.7%	24.4%
Knows only folkloric	4.2%	4.9%
Knows only traditional method	0.2%	0.2%
Knows modern method	72.9%	70.5%
Total	100.0%(3719)	100.0%(2157)

3.2.2 EVER USE OF ANY METHOD

Despite the widespread knowledge, 71.6 percent of teenage mothers, and 71.1 percent of adult mothers, have never used a modern method as seen in Table 11. Only 25.5 percent of teenage mothers, and 26.2 percent of adult mothers, have ever used a modern contraceptive.

TABLE 11: USE OF ANY METHOD OF CONTRACEPTION

	Age of mother at first birth	
Knowledge	Teenage mothers	Adult mothers
Ever use of any method		
Never used	71.6%	71.1%
Used only folkloric	2.0%	1.9%
Used only traditional method	0.9%	0.8%
Used modern method	25.5%	26.2%
Total	100.0%(3719)	100.0%(2157)

3.2.3 CURRENT USE OF MODERN METHODS

Current use of modern contraceptives is limited to only 10.0 percent of teenage mothers, and 8.9 percent of adult mothers in Table 12. In contrast, 88.3 percent of teenage mothers, and 89.5 percent of adult mothers, do not currently use any form of modern contraceptive. The two most popular methods in current use are “injections” by 4.6 percent of teenage mothers, and 3.2 percent adult mothers; and the “pill” by 3.4 percent of teenage mothers, and 3.2 percent of adult mothers.

These low contraceptive prevalence levels have a strong influence on the high incidence of pregnancy and motherhood amongst teenage mothers and adult

TABLE 12: CURRENT USE OF MODERN CONTRACEPTIVE METHODS

	Age of mother at first birth	
Use	Teenage mothers	Adult mothers
Current use by method type		
No method	88.3%	89.5%
Folkloric method	1.3%	1.0%
Traditional method	0.4%	0.6%
Modern method	10.0%	8.9%
Total	100.0%(3719)	100.0%(2157)

mothers alike, the majority of whom are currently married and are living with the husband.

3.2.4 CONTRACEPTIVE USE BEFORE AND AFTER THE LAST BIRTH

TABLE 13: CONTRACEPTIVE USE BEFORE AND AFTER LAST BIRTH

Pattern of use before and after last birth	Age of mother at first birth: Teenage mothers	Adult mothers
Currently using	11.7%	10.5%
Used since last birth	4.4%	4.4%
Used before last birth	12.3%	14.0%
Never used	71.6%	71.1%
Total	100.0%(3719)	100.0%(2157)

Only 12.3 percent of teenage mothers, compared to 14.0 percent of adult mothers, used a modern contraceptive before the last birth. After that event, even fewer, 4.4 percent of either teenage mothers, or adult mothers, have used a modern contraceptive method according to Table 13.

3.2.5 EVER USE OF CONDOMS

TABLE 14: EVER USE OF CONDOMS

Condom used at first sexual intercourse	Age of mother at first birth: Teenage mothers	Adult mothers
No	97.9%	95.1%
Yes	1.2%	3.8%
Don't know	0.8%	1.1%
Total	100.0%(969)	100.0%(184)

The use of condoms is even less common amongst mothers: 97.9 percent of teenage mothers, and 95.1 percent of adult mothers, did not use a condom during their first sexual intercourse as shown in Table 14. Only 1.2 percent of teenage mothers, and 3.8 percent of adult mothers, used a condom. This study has revealed that significant proportions of teenage mothers and adult mothers have been involved in multiple marital unions, and have had multiple sex partners. Where the prevalence rate of condom use is so low, mothers are at serious risk of contracting and spreading sexually transmitted infections.

3.2.6 DESIRE FOR LAST CHILD

TABLE 15: DESIRE FOR LAST CHILD

Whether wanted a child	Age of mother at first birth: Teenage mothers	Adult mothers
Wanted then	67.4%	74.4%
Wanted later	18.0%	15.0%
Wanted no more	14.6%	10.5%
Total	100.0%(2452)	100.0%(1489)

The low contraceptive prevalence rates are consistent with the desire for the "last child": 67.4 percent of teenage mothers, and 74.4 percent of adult mothers, "wanted the last child at the time of the pregnancy"; while 18.0 percent of teenage mothers, and 15.0 percent of adult mothers, "wanted the child later". Only 14.6 percent of teenage mothers, compared to 10.5 percent of adult mothers, "did not want" the child in Table 15.

3.2.7 INTENTION TO USE MODERN CONTRACEPTIVES

Only 32.2 percent of teenage mothers, and 29.8 percent of adult mothers, intend to use a modern contraceptive method in future as shown in Table 16.

TABLE 16: INTENTION TO USE MODERN CONTRACEPTIVE

	Age of mother at first birth	
Future use	Teenage mothers	Adult mothers
Use later	32.2%	29.8%
Unsure about use	23.6%	23.4%
Does not intend	44.2%	46.8%
Total	100.0%(3239)	100.0%(1911)

REASONS FOR NOT USING CONTRACEPTION

FIGURE 5: REASONS FOR NOT USING CONTRACEPTION

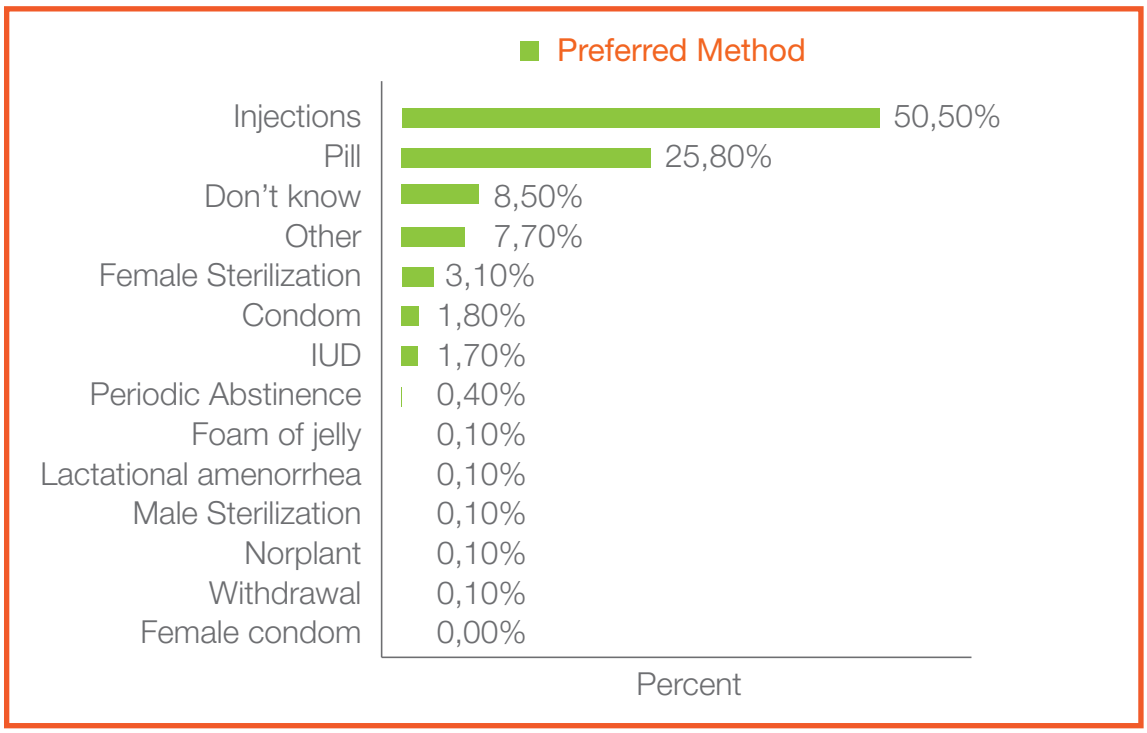
A wide variety of reasons have been provided for their unwillingness to use modern contraceptives. The three leading reasons, as shown in Figure 5, amongst both teenage mothers and adult mothers, are "fear of side effects (13.5 percent), "respondent opposed to it" (13.0 percent), and "husband opposed" (11.9 percent). In addition, 20.4 percent of teenage mothers are either "subfecund/infecund" or "want more children".

Also of significance is that concerns relating to "cost", "lack of access", and "lack of knowledge of sources" affect less than 2.0 percent each of either teenage mothers or adult mothers. This implies that these factors do not constitute serious impediments to the use of modern contraceptives.

3.2.8 PREFERRED FUTURE METHOD

Figure 6 presents the two methods preferred by the majority of mothers who have never used or not currently using; re "injections" by 50.5 percent of teenage mothers, and 46.1 percent of adult mothers; and the "pill", by 25.8 percent of teenage mothers, and 29.8 percent of adult mothers. These are also the two most popular methods in current use. Only 1.8 percent of teenage mothers, and 4.0 percent of adult mothers, prefers a (male) condom, while the female condom is even less favoured.

FIGURE 6: PREFERRED FUTURE CONTRACEPTIVE METHOD



High levels of teenage pregnancy and childbirth appear to be strongly influenced by two prevailing characteristics amongst women. The first is the high levels of marriage, cohabitation and sexual intercourse at young ages. Secondly, associated with their marital status, is an innate desire to have children, which cancels out any strong motivation to use modern contraceptives now or in the future.

FIGURE 7: REASOND FOR LOW LEVELS OF CONTRACEPTIVE USE

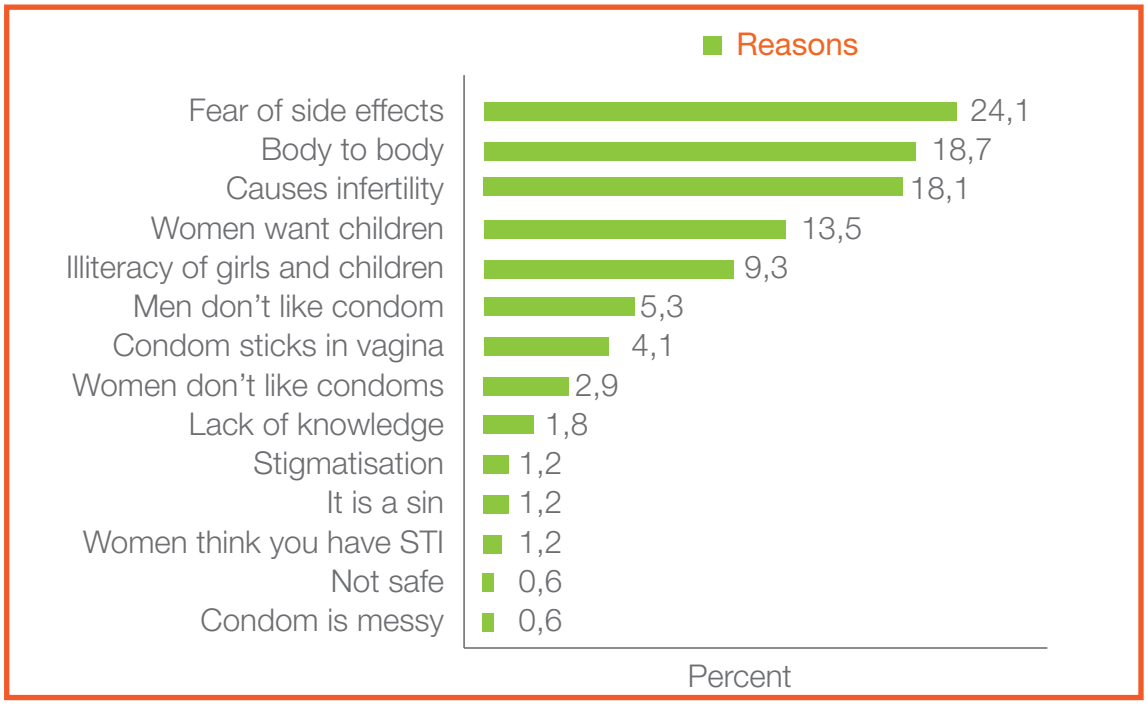


Figure 7 shows that for all respondents, the four leading reasons for not using contraceptives are "fear of side effects" (21.7 percent), "do not use condom so as to enjoy sex: body to body" (18.7 percent), "causes infertility" (18.1 percent), and "women want children" (13.5 percent).

Fear of side effects

The most frequently reported reason for the low rate of contraceptive use by teenage girls is the "fear of side effects" which includes "abdominal pains, infections, bleeding, HIV and cancer".

They want to enjoy sex: body-to-body

A second widely expressed view within communities is that teenage girls do not use condoms because they want to enjoy sex without any interference from a foreign body.

Modern contraceptives cause infertility

Within each community group, many respondents think that teenage girls do not use a modern contraceptive, especially the implant and pill, because they fear it will cause infertility in future.

Women want to have children

Another important reason for the low level of contraceptive use is that women want to have children because they are in a polygamous union, and other co-wives have children, and because they need the children to work on their farms.

Other factors

Other explanatory factors, which were reported by community members include "the high level of illiteracy amongst parents and girls leaves them with no other option but to accept misinformation and wrong advice from friends and relatives about the 'bad' consequences of using contraceptives"; "men do not like using condoms"; "condoms stick in the vagina"; "women do not like using condoms"; and the fear of stigmatisation and being branded a prostitute".

3.3 TRADITIONAL PRACTICES

The possible impact of two traditional practices, namely early girl-child marriage and female circumcision, on teenage pregnancy and motherhood, are examined.

3.3.1 EARLY-AGE MARRIAGE

This study has already shown that marrying young girls at ages under 18 years is widespread and is a major determinant of teenage pregnancy and motherhood.

TABLE 17: CIRCUMCISION STATUS OF MOTHERS

Circumcision Status/ Age	Age of mother at first birth	
	Teenage mothers	Adult mothers
Respondent circumcised		
No	4.1%	5.4%
Yes	95.9%	94.6%
Total	**100.0%(3688)**	**100.0%(2126)**
Age at circumcision(Years)		
At infancy	24.9%	28.3%
1 to 4	1.00%	0.70%
Under 5	25.90%	29.0%
Under 13	61.9%	58.3%
Under 14	67.8%	63.3%
Under 18	89.1%	84.7%
18 and over	3.2%	8.5%
Don't know	7.7%	6.8%
Total	**3719**	**2157**

3.3.2 FEMALE CIRCUMCISION

As with early marriage, female circumcision is widespread; 95.9 percent of teenage mothers, and 94.6 percent of adult mothers, have been circumcised as in Table 17. The majority were circumcised at relatively young ages; 25.9 percent of teenage mothers, and 29.1 percent of adult mothers, before age 5 years, almost all reportedly "at infancy"; 67.8 percent of teenage mothers, and 63.3 percent of adult mothers, before age 14 years; and 89.1 percent of teenage mothers, and 84.7 percent of adult mothers, before 18 years of age.

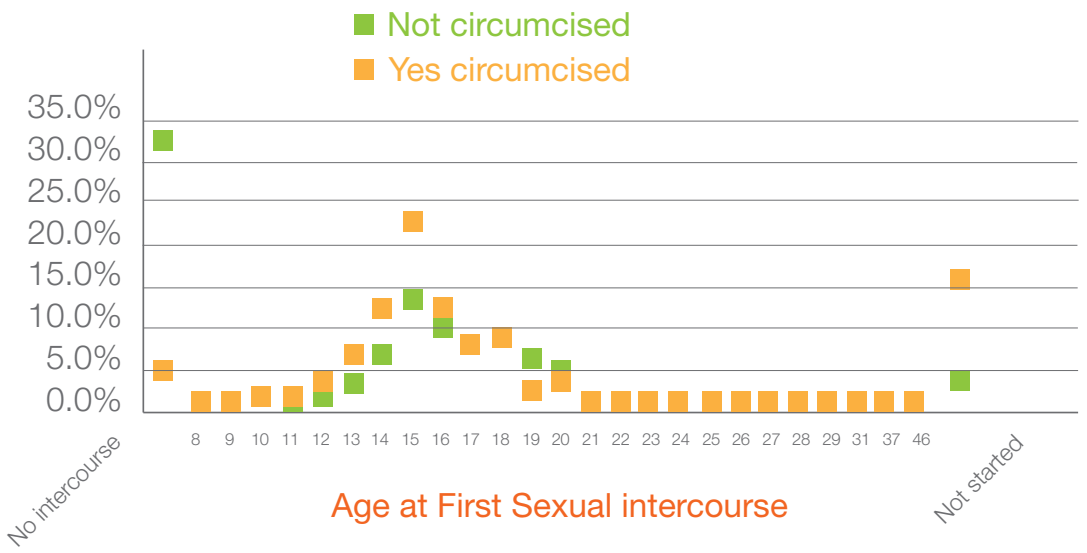
All of these would be in contravention of the 2007 Child Rights Act which provides protection from any "initiation ceremony" for girls under age 18 years.

The impact of female circumcision on teenage pregnancy and motherhood is exerted through three other characteristics of the women; the age at first sexual intercourse, the age at first marriage, and the age at first birth.

3.3.3 EFFECT OF FEMALE CIRCUMCISION ON AGE AT FIRST SEXUAL INTERCOURSE

Mothers start sexual intercourse at the relatively young age of 8 years. At this age, and all subsequent ages up to 17 years, the proportion of circumcised girls who have started sexual intercourse is always higher than the proportion of non-circumcised girls as can be seen in Figure 8. The converse is that only 4.5 percent of circumcised girls, compared to 29.8 percent of non-circumcised girls, had "not had intercourse" at the time of the survey.

FIGURE 8: AGE AT FIRST SEXUAL INTERCOUSE AND CIRCUMCISION STATUS

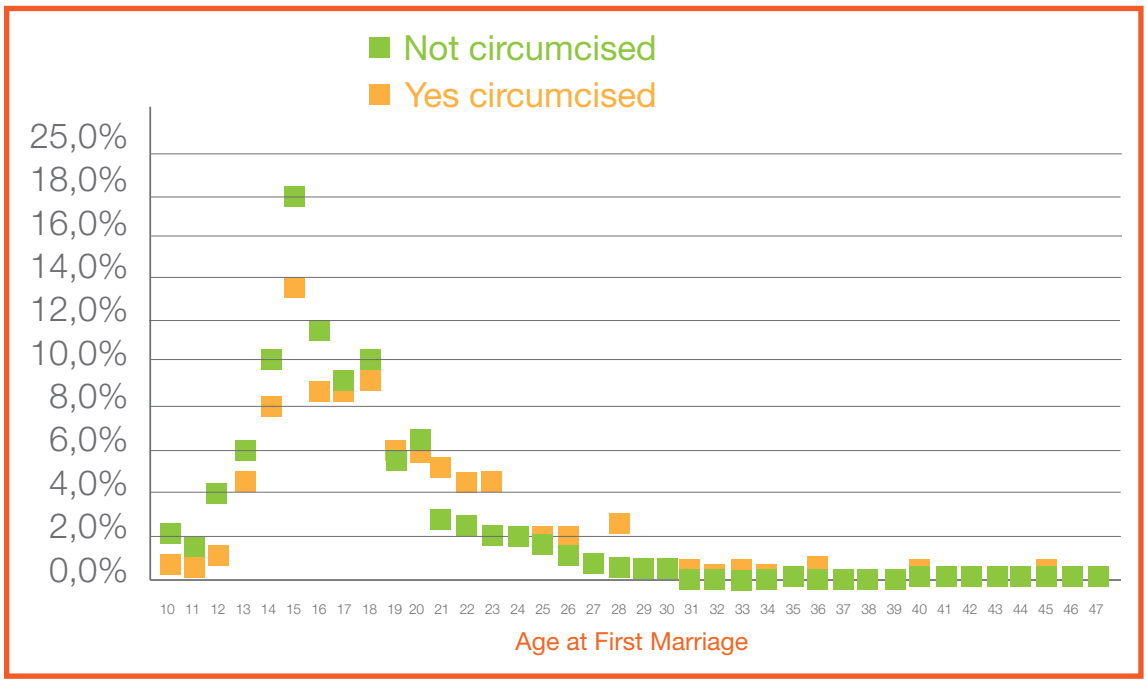


3.3.4 EFFECT OF FEMALE CIRCUMCISION ON AGE AT FIRST MARRIAGE

First marriage, which also occurs at the relatively young age of 10 years, appears to be strongly influenced by circumcision status: Figure 9 indicates that 7.5 percent of circumcised girls, compared to 2.0 percent of non-circumcised girls, were married at ages under 13 years; while 13.6 percent of circumcised girls, compared to 6.4 percent of non-circumcised girls, were married at ages under 14 years. These are ages at which The Prevention of Cruelty to Children Act (Cap 31) of 1926 makes it a criminal offence to have sexual intercourse with girls.

In addition, 62.0 percent of circumcised girls, compared to 45.2 percent of non-circumcised girls, were married at ages under 18 years, the minimum age of marriage stipulated by the 2007 Child Rights Act.

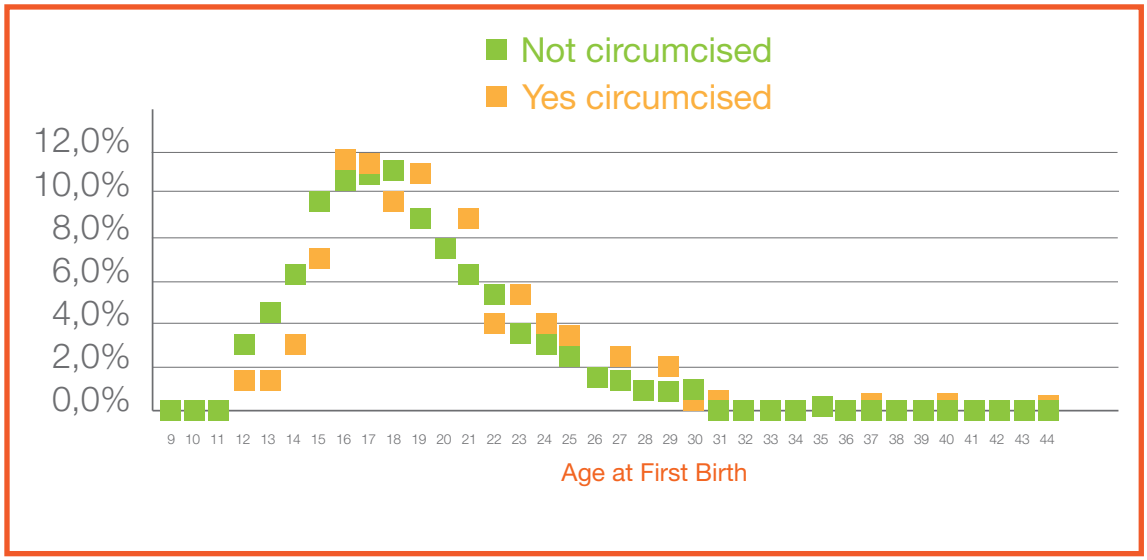
FIGURE 9: AGE AT MARRIAGE AND CIRCUMCISION STATUS



3.3.5 EFFECT OF FEMALE CIRCUMCISION ON AGE AT FIRST BIRTH

Consistent with having first sexual intercourse, and first marriage at younger ages, girls who are circumcised start having children at the relatively young age of 9 years. And at each subsequent age up to age 17 years, the percentage of circumcised girls is consistently higher than for non-circumcised girls as seen in Figure 10.

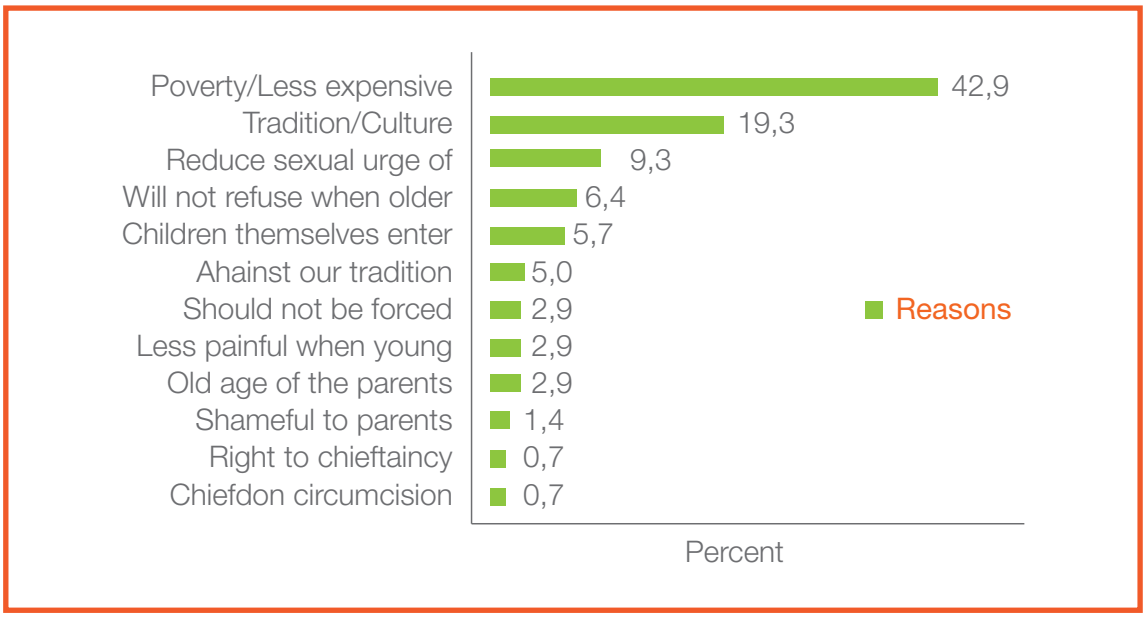
FIGURE 10: AGE AT FIRST BIRTH AND CIRCUMCISION STATUS



3.3.6 COMMUNITY PERCEPTIONS AND OPINIONS ON REASONS FOR EARLY AGE CIRCUMCISION

The three leading reasons for early age circumcision, reported by all community members, are "poverty of mothers/less expensive when young", "tradition and culture", and "to reduce the sexual urge of children" this is portrayed in Figure 11. Other major reasons for circumcising girls when they are young include ensuring that "they do not refuse when they become older and more matured"; "children voluntarily give themselves up for circumcision to emulate their peers"; "circumcision is less painful when girls are young"; and "it is a disgrace to the parents if the girl is not a virgin at circumcision".

FIGURE 11: REASONS FOR EARLY AGE CIRCUMCISION



3.4 SEXUAL PARTNERS AND RELATIONSHIPS

The 2008 SLDHS Data on the age of the "first sexual partner", the "last sexual partner", and the "current partner" of the mother have been analysed to determine the age disparities between mothers and their partners.

3.4.1 AGE OF FIRST SEXUAL PARTNER

The majority of mothers had a first sexual partner who was much older. Table 18 shows that only 8.0 percent of teenage mothers, and 11.5 percent of adult mothers, had a first sexual partner who was either "younger" or "about the same age". For 46.5 percent of teenage mothers, and 56.0 percent of adult mothers, the first sexual partner was "less than 10 years older". But for 35.1 percent of teenage mothers, and 25.3 percent of adult mothers, the first sexual partner was "10 or more years older". In addition, 7.3 percent of teenage mothers, and 3.3 percent of adult mothers, had a first sexual partner who was older, but whose age was not known.

TABLE 18: RELATIVE AGE DIFFERENCE WITH FIRST SEXUAL, LAST SEXUAL, AND CURRENT SEXUAL PARTNER

Relative age difference	Age of mother at first birth	
	Teenage mothers	Adult mothers
First sexual partner younger, same age or older		
Younger	1.2%	3.3%
About the same age	6.8%	8.2%
Less than 10 years older	46.5%	56.0%
10 or more years older	35.1%	25.3%
Older, don't know difference	7.3%	3.3%
Don't know	3.1%	3.9%
Total	100.0%(840)	100.0%(182)
Last sexual partner younger, the same age or older		
Younger	1.2%	2.5%
About the same age	3.0%	0.0%
Less than 10 years older	65.9%	87.5%
10 or more years older	17.4%	7.5%
Older, don't know difference	7.2%	0.0%
Don't know	5.3%	2.5%
Total	100.0%(167)	100.0%(207)

3.4.2 AGE OF LAST SEXUAL PARTNER

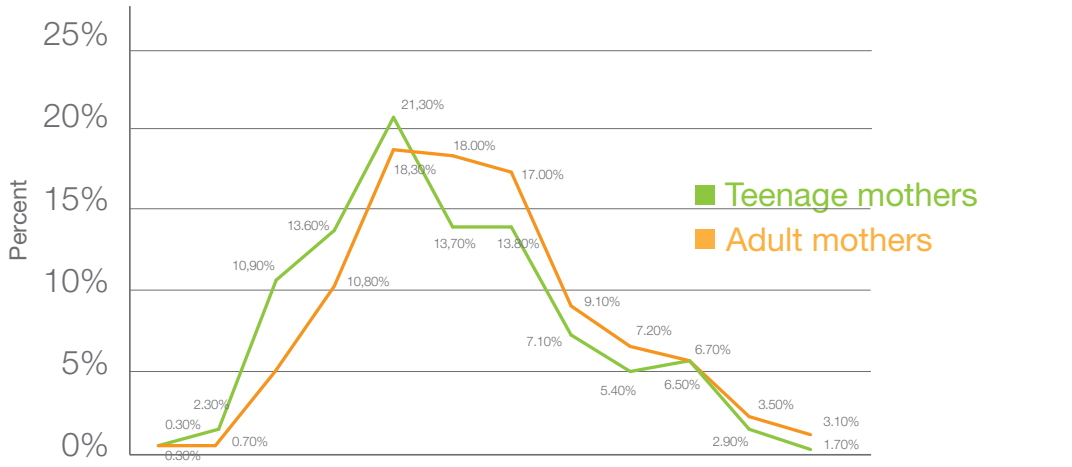
Also, only 4.2 percent of teenage mothers, and 2.5 percent of adult mothers, had a last sexual partner who was either "younger" or "about the same age". For the majority of mothers, the last sexual partner was much older: 65.9 percent of teenage mothers, and 87.5 percent adult mothers, had a last sexual partner who was "less than 10 years older". But for 17.4 percent of teenage mothers, and 7.5 percent of adult mothers, the last sexual partner was "10 or more years older". In addition 7.2 percent of teenage mothers had a sexual partner who was older, but whose age was not known (see Table 18).

The analysis of the age of the first sexual partner, and of the last sexual partner, indicate a stronger tendency amongst teenage mothers, than adult mothers, to have sexual relationships with partners who were "10 or more years older".

3.4.3 AGE OF CURRENT SEXUAL PARTNER

Only 0.3 percent of either teenage mothers, or adult mothers, have a current sexual partner who is a teenager, that is aged 15 to 19 years, while 75.9 percent of teenage mothers, and 70.3 percent of adult mothers, have partners who are aged 20 to 49 years as shown in Figure 12. However, 23.6 percent of teenage mothers, and 29.6 percent of adult mothers, have a partner who is aged 50 years and over.

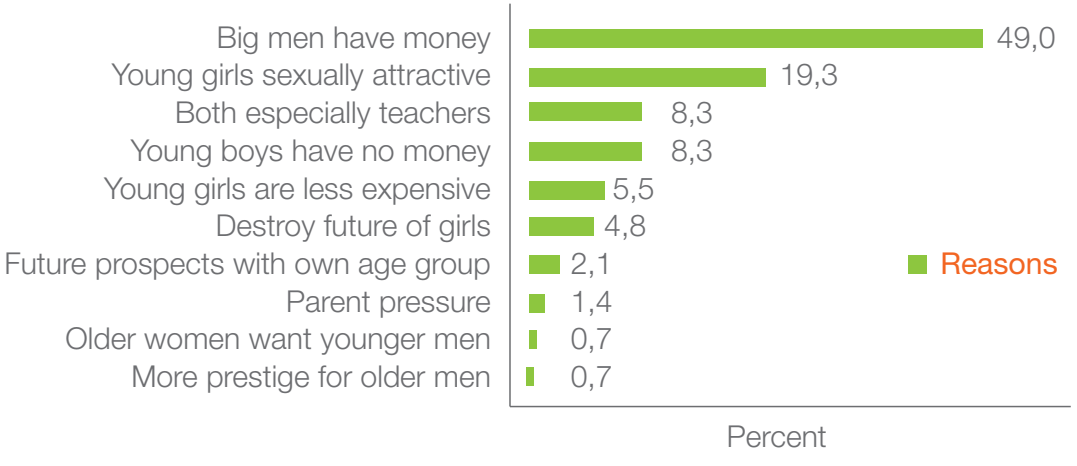
FIGURE 12: AGE OF CURRENT SEXUAL PARTNER



These age disparities, with the "first sexual partner", "last sexual partner", and "current sexual partner", show a similar pattern; that the majority of mothers, especially teenage mothers, have relationships with partners who are much older, rather than with their peer groups. They however contradict popular perceptions that the majority of teenage mothers have "first time", or "current", sexual partners from amongst their peers. They therefore have serious implications for efforts to reduce teenage pregnancy and motherhood in the country. They call for fundamental shift in focus, emphasis, types of strategies, and message content in community-level activities which seek to influence deeply entrenched attitudes on the relationship between older men and younger women.

3.4.4 COMMUNITY PERCEPTIONS AND OPINIONS ON PARTNER AGE DIFFERENCES

FIGURE 13: REASONS FOR AGE DIFFERENCES BETWEEN TEENAGE MOTHERS AND SEXUAL PARTNERS



Within communities, members hold a wide variety of views on why there are big age differences between teenage mothers and their sexual partners. Figure 13 presents the four most important reasons as "poverty, big men have money", "the sexual attractiveness of young girls", "poor and irresponsible attitude of young boys", and "male teachers".

3.4.5 ABILITY TO REFUSE SEX

58.3 percent of teenage mothers, and 54.9 percent of adult mothers, say they "can refuse sex", while 38.2 percent of teenage mothers, and 41.6 percent say they "cannot refuse".

3.4.6 REQUESTING PARTNERS TO USE CONDOM

Only 22.5 percent of teenage mothers, and 23.4 percent of adult mothers, reported that they "can ask partner to use condom"; the majority either cannot or are not sure that they can. This analysis implies that the majority of mothers cannot make independent decisions, or negotiate with their partners, on matters relating to their sexual and reproductive preferences and performance.

3.4.7 TOTAL LIFETIME NUMBER OF SEXUAL PARTNERS

Only 35.7 percent of teenage mothers, and 31.5 percent of adult mothers, have had only one life time sexual partner; the majority of both teenage mothers and adult mothers have had 2 or more. Against the background of a low prevalence rate of modern contraceptive use, especially condoms, many teenage and adult mothers are potentially exposed to the risk of contracting sexually transmitted diseases and unwanted pregnancies.

3.5 WEALTH OR POVERTY STATUS

3.5.1 WEALTH INDEX

Data on the household wealth index from the 2008 SLDHS do not show any consistent relationship between the wealth index and age at first birth. These inconsistencies are at variance with the views expressed by the majority of community members that "poverty" is the root cause of teenage pregnancy, early marriage, and early motherhood, in the country.

TABLE 19: WEALTH INDEX/POVERTY STATUS

Wealth index	Age of mother at first birth		
	Teenage mothers	Adult mothers	
Across wealth quintiles			
Poorest	19.1%	20.7%	
Poorer	18.0%	18.2%	
Middle	19.6%	16.9%	
Richer	22.0%	19.3%	
Richest	21.3%	24.9%	
Total	100.0% (3719)	100.0% (2157)	
Within wealth quintiles			
Poorest	61.4%	38.6%	100.0%(1155)
Poorer	63.1%	36.9%	100.0%(1064)
Middle	66.7%	33.3%	100.0%(1093)
Richer	66.2%	33.8%	100.0%(1234)
Richest	59.6%	40.4%	100.0%(1330)
Total	63.3%	36.7%	100.0%(5876)

3.5.2 PERCEPTIONS AND OPINIONS OF COMMUNITY MEMBERS ON HOUSEHOLD POVERTY

Community members perceive wealth, or poverty, as the ability, or lack of it, to provide for the education, feeding, housing, health and other essentials of living to ensure that children develop to become useful citizens. Poverty exists in many households because the father/husband has died, or has abandoned the mother and children, or has many more children than his resources can adequately support and care for. Poorly educated single-parent mothers are engaged in only relatively low level economic activity like subsistence agriculture and petty trading. As a result, they do not have the financial resources to meet all the demands of their children, especially the daughters.

This study has already shown that community members have identified "poverty" as a key influence on each of the proximate determinants of teenage pregnancy.

4.0 CONSEQUENCES OF PREGNANCY AND MOTHERHOOD FOR TEENAGE MOTHERS

4.1 LEVEL OF EDUCATION

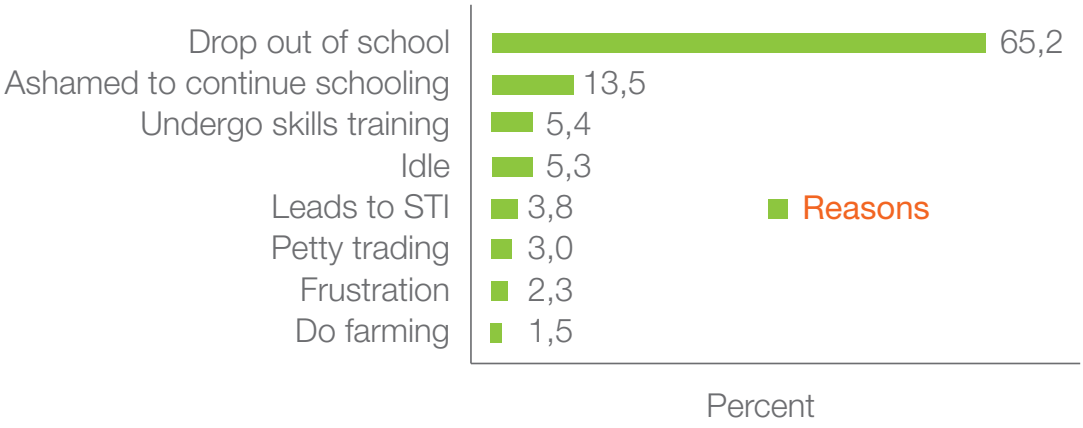
The inability of teenage mothers to make significant advancements in their education is one of the most adverse and sustaining consequences of teenage pregnancy and motherhood: 71.2 percent of teenage mothers, and 69.0 percent of adult mothers, have no formal education as seen in Table 20. Only 3.9 percent of teenage mothers, and 3.2 percent of adult mothers, were able to complete their primary level education, and 1.2 percent of teenage mothers, and 3.6 percent of adult mothers, completed secondary level education. In addition, only 1.1 percent of teenage mothers, compared to 4.3 percent of adult mothers, have a post-secondary level education.

TABLE 20: LEVEL OF EDUCATIONAL ATTAINMENT

	Age of mother at first birth	
Population Characteristic	Teenage mothers	Adult mothers
Level of education completed		
No education	71.2%	69.0%
Incomplete primary	9.2%	7.9%
Complete primary	3.9%	3.2%
Incomplete secondary	13.4%	12.0%
Complete secondary	1.2%	3.6%
Higher	1.1%	4.3%
Total	100.0% (3719)	100.0% (2157)
Literacy status		
Cannot read at all	79.7%	76.5%
Able to read only parts of sentence	4.0%	3.0%
Able to read whole sentence	16.1%	20.3%
No card with required language	0.2%	0.2%
Total	100.0% (3710)	100.0% (2148)

4.1.2 FACTORS WHICH LIMIT ACCESS TO EDUCATION FOR THE TEENAGE MOTHER

FIGURE 14: CONSEQUENCES OF MOTHERHOOD FOR TEENAGE MOTHER



A number of economic and psycho-social factors were reported as impeding the access of the teenage mother to formal education. As seen in Figure 14, most importantly because of the pregnancy, she must drop out of school, and "it is the end of her education". Several factors may contribute to this condition. She may lack the financial resources to enable her to return school, or she may be forced to sit at home and be a housewife and care for the baby. Alternately, she may not be motivated to continue her education, because she feels ashamed to meet her peers, who have been promoted to higher levels, and who will stigmatise her as a result of her child. The influence of teenage pregnancy and child bearing on the education of the girl-child is always negative.

4.1.3 LITERACY

The impact on their literacy status is also negative; 79.7 percent of teenage mothers, compared to 76.5 percent of adult mothers, "cannot read at all".

4.1.4 OCCUPATION

TABLE 21: MOTHERS CURRENT OCCUPATION

	Age of mother at first birth	
Currently working/ Occupation	Teenage mothers	Adult mothers
Mother currently working		
No	18.4%	20.8%
Yes	81.6%	79.2%
Total	100.0%(3696)	100.0%(2136)
Mother's occupation		
Not working	18.4%	20.8%
Professional, Technician, Manager	3.0%	4.7%

Table 21 shows that the majority of mothers are engaged in some form of occupation, 81.6 percent of teenage mothers, and 79.2 percent of adult mothers, are currently working. But because of their poor education, the majority are constrained to low level, subsistence economic activities, especially "agriculture-self-employed" and "sales". Relatively large proportions of teenage and adult mothers must engage in economic activity because of the sparse financial resources available to them.

Clerical	0.1%	0.5%
Sales	29.4%	27.2%
Agric-self employed	45.8%	44.1%
Household & domestic	0.1%	0.1%
Services	1.5%	1.3%
Skilled manual	1.6%	1.2%
Unskilled manual	0.1%	0.1%
Total	100.0%(3689)	100.0%(2154)

4.1.5 FERTILITY PERFORMANCE

Early age at first birth lengthens the exposure to the risk of childbearing, and results in high levels of fertility, and large family sizes, especially where the practice of using modern contraceptives is restricted to only relatively small numbers in the population.

TABLE 22: TOTAL CHILDREN EVER BORN AND TOTAL CHILDREN DEAD

	Age of mother at first birth	
Number of children	Teenage mothers	Adult mothers
Total children ever born		
1	16.6%	25.3%
2 to 3	34.4%	40.4%
4 to 6	33.5%	27.6%
7 and over	15.5%	6.7%
Total	100.0%(3719)	100.0%(2157)
Total children dead		
0	56.7%	73.4%
1	22.2%	16.7%
2 to 3	16.3%	8.5%
4 and over	4.8%	1.4%
Total	100.0%(3719)	100.0%(2157)

A. TOTAL CHILDREN EVER BORN

About only 16.6 percent of teenage mothers, and 25.3 percent of adult mothers, have had one live birth and 34.4 percent of teenage mothers, compared to 40.4 percent of adult mothers, have had 2 to 3 live births as in Table 22. For the higher birth order, the percentage of teenage mothers is always higher: 33.5 percent of teenage mothers, compared to 27.6 percent of adult mothers, have had 4 to 6 live births; and 15.5 percent of teenage mothers, compared to 6.7 of adult mothers, have had 7 or more live births.

B. TOTAL CHILDREN DEAD

Child mortality is more frequent amongst children of teenage mothers than those of adult mothers. From Table 22 only 56.7 percent of teenage mothers, compared to 73.4 percent of adult mothers, have never lost a child through death. In contrast, the percentage of teenage mothers, who have lost one or more children, is consistently higher for teenage mothers than for adult mothers: 22.2 percent of teenage mothers, and 16.7 percent of adult mothers, have lost at least one child; while 21.1 percent of teenage mothers, but only 9.9 percent of adult mothers, have lost 2 or more children.

C. CURRENTLY PREGNANT

Repeat pregnancy affects 8.2 percent of teenage mothers, compared to 6.3 percent of adult mothers in Table 23; the majority of mothers "wanted" the current pregnancy. Of the women who were currently pregnant, 66.2 percent of teenage mothers, and 75.6 percent of adult mothers, "wanted the pregnancy then"; 20.1 percent of teenage mothers, and 15.3 percent of adult mothers, "wanted it later"; and only 13.7 percent of teenage mothers, and 9.2 percent of adult mothers, "did not want it at all'.

TABLE 23: CURRENT PREGNANCY

Pregnancy aspect	Age of mother at first birth: Teenage mothers	Adult mothers
Currently pregnant		
No or unsure	91.8%	93.7%
Yes	8.2%	6.3%
Total	100.0%(3719)	100.0%(2157)
Duration of current pregnancy (Grouped)(Months)		
1 to 3	20.0%	20.0%
4 to 6	39.0%	34.0%
7 and over	41.0%	46.0%
Total	100.0%(305)	100.0%(135)
Current pregnancy wanted		
Then	66.2%	75.6%
Later	20.1%	15.3%
Not at all	13.7%	9.2%
Total	100.0%(293)	100.0%(131)

TABLE 24: TERMINATED PREGNANCY

Aspect of termination of pregnancy	Age of mother at first birth: Teenage mothers	Adult mothers
Ever had a terminated pregnancy.		
No	86.4%	88.9%
Yes	13.6%	11.1%
Total	100.0%(3715)	100.0%(2153)
Month pregnancy ended		
1 to 3	32.8%	30.8%
4 to 6	27.6%	31.7%
7 and over	36.8%	34.2%
Don't know	2.8%	3.4%
Total	100.0%(492)	100.0%(234)

TABLE 25: NUMBER OF LIVING CHILDREN AND CHILD CAR

Aspect of Child Survival and Care	Age of mother at first birth: Teenage mothers	Adult mothers
Number of living children		
0	2.9%	2.9%
1 to 4	75.3%	82.8%
5 and over	21.8%	14.3%
Total	100.0%(3719)	100.0%(2157)
Arrange care of biological children under age 18		
No	66.5%	66.1%
Yes	31.6%	32.3%
Unsure	1.9%	1.6%
Total	100.0%(3408)	100.0%(2020)
Primary caregiver of children under age 18		
No	74.8%	75.5%
Yes	25.2%	24.5%
Total	100.0%(3679)	100.0%(2135)

As with the analysis of mother's preference for her first pregnancy, these figures imply that there are strong innate desires for children by all mothers. At the same time, they show that there is a small but significant minority who are burdened with "unwanted" pregnancies.

D. TERMINATION OF PREGNANCY

Termination of pregnancy is more prevalent amongst teenage mothers than adult mothers: 13.6 percent of teenage mothers, compared to 11.1 percent of adult mothers, have had a pregnancy terminated (see Table 24). Against the background of the number of pregnancies that were not wanted, especially by teenage mothers, some of these terminations may have been voluntary abortions.

This analysis implies that strategies to tackle the problem of teenage pregnancy and motherhood must firstly discourage, or at least delay, the desire of teenage girls to become mothers, and secondly, reduce the incidence of abortions as a result of unwanted pregnancies.

E. NUMBER OF LIVING CHILDREN

Table 25 indicates that only 2.9 percent of either teenage mothers, or adult mothers, currently, do not have a surviving child. On the other hand, 75.2 percent of teenage mothers, and 82.8 percent of adult mothers, have 1 to 4 living children, while 21.9 percent of teenage mothers, compared to 14.3 percent of adult mothers, have 5 or more living children.

These figures would normally mean that teenage mothers have considerable care-giving responsibilities, which may even be greater than for adult mothers. These responsibilities can compromise their ability to continue formal education, or undertake job skills training, or engage in any productive income earning economic activity. However, the majority of teenage mothers belong to large households and composite families, in which they are

either “wife”, or “daughter”, or “daughter-in-law” or “sister”, and in which other household members will assist in the primary care-giving of their children (see also Table 5). They can therefore continue with their formal education, or skills training programme, or can be engaged in income-generating activities.

F. CHILD CARE

Only 31.6 percent of teenage mothers, and 32.3 percent of adult mothers, “arranged care of biological children aged under 18 years”, even fewer mothers “provided primary care for their children”, as shown in Table 25, conditions which are consistent with the large-sized households and composite families to which they belong.

4.2 CHARACTERISTICS PARTNERS OF TEENAGE MOTHERS

4.2.1 LEVEL OF EDUCATION

As with teenage mothers, the majority of their partners have low levels of education: 62.2 percent of teenage mothers, and 64.0 percent of adult mothers, have a partner with “no education” as seen in Table 26. Furthermore only 5.5 percent of teenage mothers, and 8.0 percent of adult mothers, have a partner who attained tertiary levels of education as shown in Table 26.

TABLE 26: PARTNER’S EDUCATION AND OCCUPATION

Population characteristic	Age of mother at first birth: Teenage mothers	Age of mother at first birth: Adult mothers
Partner’s education level		
No education	62.2%	64.0%
Primary	10.3%	7.3%
Secondary	20.2%	19.2%
Higher	5.5%	8.0%
Don’t know	1.8%	1.5%
Total	100.0%(3388)	100.0%(1977)
Partner’s occupation		
Did not work	1.7%	1.8%
Professional, Technician, Manager	10.0%	11.5%
Clerical	2.0%	2.1%
Sales	14.6%	14.0%
Agric-self employed	54.4%	54.5%
Agric-employee	0.1%	0.0%
Household & domestic	0.2%	0.1%
Services	3.8%	3.2%
Skilled manual	6.7%	6.7%
Unskilled manual	6.4%	6.1%
Other	0.1%	0.0%
Total	100.0%(3381)	100.0%(1966)

4.2.2 OCCUPATION

The three leading occupations in which the partners of mothers are engaged are “agriculture-self-employed”, “sales”, and “professional, technical and management”, as seen in Table 26. Other occupations with 5.0 percent or more of respondents are “skilled manual” and “unskilled manual.

4.2.3 END OF PREVIOUS MARRIAGE OR UNION

Data from Table 27 on “how the marriage or union ended” and “distribution of the late husband’s property”, show that 34.3 percent of teenage mothers, and 31.5 percent of adult mothers, who had their husbands, lost them through death; while 14.8 percent of teenage mothers and 14.2 percent of adult mothers were “divorced”; and 50.9 percent of teenage mothers, and 54.3 percent of adult mothers, were “separated”.

The higher rates of widowhood amongst teenage mothers, in comparison with adult mothers, is consistent with the higher percentage of teenage mothers who had partners who were “10 years or older”.

TABLE 27: END OF PREVIOUS MARRIAGE AND INHERITANCE OF HUSBAND'S PROPERTY

End of previous marriage and inheritance of husband's property	Age of mother at first birth: Teenage mothers	Age of mother at first birth: Adult mothers
How previous marriage or union ended		
Death / widowhood	34.3%	31.5%
Divorce	14.8%	14.2%
Separation	50.9%	54.3%
Total	100.0%(732)	100.0%(352)
Who received most of late husband's property		
Mother	14.1%	16.0%
Other wife	6.2%	5.7%
Spouse's children	8.6%	9.7%
Spouse's family	45.1%	47.4%
Other	6.5%	5.7%
No property	19.5%	15.5%
Total	100.0%(370)	100.0%(175)
Mother received any of late husband's assets or valuable		
No	89.8%	83.8%
Yes	10.2%	16.2%
Total	100.0%(315)	100.0%(148)

4.2.4 DISTRIBUTION OF THE HUSBAND'S PROPERTY

However, on the death of the husband/partner, only 14.1 percent of teenage mothers, and 16.0 percent of adult mothers, "received most of the husband's property" according to Table 27. The principal beneficiaries were other family members, and children, of the husband. Only 10.2 percent of teenage mothers, but 16.2 percent of adult mothers, "received any of the late husband's assets or valuables".

These traditional practices in the devolution of estate within customary marriages, which disinherited many teenage mothers, have now been overturned by the Customary Marriage and Divorce Act of 2007, and the Devolution of Estates Act of 2007, and about which all women must be properly sensitised.

5.0 CONSEQUENCES OF TEENAGE PREGNANCY AND MOTHERHOOD FOR THE CHILDREN

5.1 INTRODUCTION

The total of 3,719 teenage mothers had a total of 14,518 live births, giving an average of 3.9 live births per teenage mother, while the 2,157 adult mothers had 6,618 births, an average of 3.1 live births per adult mother.

Data available from the 2008 SLDHS have been analysed to determine the possible impact of teenage pregnancy and motherhood on these children. Their numbers have been analysed in relation to the mother's access and utilisation of medical and health facilities and services during the pregnancy, at childbirth, and in the post-natal period. The comparisons with adult mothers, the format for the discussion of possible determinants of teenage pregnancy, will be maintained so as to provide a basis for comparing the incidence and nature of any relative disadvantages to the children of teenage mothers.

5.2 ANTENATAL CARE

5.2.1 NUMBER AND TIMING OF ANTE-NATAL VISITS FOR PREGNANCY

Only 5.3 percent of teenage mothers, and 6.2 percent of adult mothers, did not make an ante-natal visit; while 58.7 percent of teenage mothers, and 58.4 percent of adult mothers, made four or more visits, the majority during the second and third trimesters as seen in Table 28.

TABLE 28: BIRTHS BY NUMBER OF ANTENATAL VISITS

Number and timing of antenatal visits	Age of mother at first birth: Teenage mothers	Adult mothers
Number of antenatal visits		
No antenatal visits	5.3%	6.2%
1	1.5%	1.1%
2 to 3	17.8%	17.6%
4 to 5	29.1%	26.5%
6 to 7	13.2%	12.2%
8 and over	16.4%	19.7%
Don't know	16.6%	16.7%
Total	100.0%(2433)	100.0%(1476)
Number of months pregnant at time of visit		
Less than 4	33.1%	32.1%
4 to 5	43.3%	46.8%
6 to 7	19.0%	17.2%
8 to 9	2.0%	1.9%
Don't know	2.6%	2.0%
Total	100.0%(2307)	100.0%(1388)

5.2.2 TETANUS TOXOID INJECTION

About 78.4 percent of teenage mothers, and 78.6 percent of adult mothers, had received 2 or more tetanus toxoid injections before the last birth, and were fully protected against neonatal tetanus as in Table 28. On the other hand, there was no, or inadequate, protection for 19.6 percent of teenage mothers, and 19.0 percent of adult mothers, who received either no injection, or only one injection, respectively.

Before becoming pregnant, 64.2 percent of teenage mothers, and 65.2 percent of adult mothers, received no tetanus injection; 10.8 percent of teenage mothers, and 15.5 percent of adult mothers, received one injection; and only 15.2 percent of teenage mothers, and 11.9 percent of adult mothers, received two or more as shown in Table 29.

TABLE 29: BIRTHS BY TETANUS TOXOID INJECTIONS RECEIVED

Number of Tetanus Toxoid Injections	Age of mother at first birth: Teenage mothers	Adult mothers
Tetanus injections before birth		
Received no injection	8.8%	11.0%
1	10.8%	8.8%
2 or more	78.4%	78.6%
Don't know	2.0%	1.6%
Total	100%(2433)	100.0%(1471)
Tetanus injections before pregnancy		
Received no injection	64.2%	65.2%
1	10.8%	15.5%
2 or more	15.2%	11.9%
Don't know	9.8%	7.4%
Total	100.0%(517)	100.0%(310)

5.2.3 TYPES OF ANTE-NATAL CARE PROVIDED DURING PREGNANCY

The three leading service providers of ante-natal assistance for both teenage mothers and adult mothers were "traditional birth attendants", "nurse/midwife", and "auxiliary midwife". "Doctors" provided assistance for only 1.5 percent of teenage mothers, and 3.6 percent of adult mothers as shown in Table 30.

The figures imply that a greater percentage of adult mothers received ante-natal assistance from medical and health personnel, while greater percentages of teenage received assistance from "traditional birth attendants", "community health workers", and "no one".

TABLE 30: BIRTHS BY PRENATAL ASSISTANCE

Type of prenatal assistance	Age of mother at first birth: Teenage mothers	Adult mothers
Doctor		
No	98.5%	96.4%
Yes	1.5%	3.6%
Nurse/Midwife		
No	67.6%	66.1%
Yes	32.4%	33.9%
Auxiliary Midwife		
No	85.3%	82.7%
Yes	14.7%	17.3%
Traditional Birth Attendant		
No	54.1%	56.8%
Yes	45.9%	43.2%
CS Community Health Worker		
No	86.7%	88.3%
Yes	13.3%	11.7%
Other Assistance (uncoded)		
No	99.8%	100.0%
Yes	0.2%	0.0%
No One		
No: some care	98.9%	99.1%
Yes: no care	1.1%	0.9%
Total	100.0% (3405)	100.0% (2102)

5.2.4 PROPHYLACTIC USE OF ANTI-MALARIAL DRUGS DURING PREGNANCY

TABLE 31: BIRTHS BY MALARIA TREATMENT DURING PREGNANCY

Type of Malaria treatment	Age of mother at first birth: Teenage mothers	Adult mothers
Took Fansidar for Malaria	20.5%	22.9%
Took Chloroquine for Malaria	13.2%	12.0%
Took other drug for Malaria	5.0%	4.1%
Took no drug for Malaria	59.6%	59.6%
Total women	2436	1472

Table 31 shows that overall, 59.6 percent of all mothers took no drug for malaria; only 36.5 percent of teenage mothers, and 37.3 percent of adult mothers, had some type of treatment. The majority took Fansidar or Chloroquine or some other drug

5.2.5 TYPES OF ANTE-NATAL SERVICES AND FACILITIES PROVIDED

Mothers had access to a number of the services and facilities which they required during pregnancy. But the figures (in Table 32) show a sharp variation in the level of access of these services, according to the needs to pay for them. On the one hand, the majority of mothers were “told where to go for pregnancy complications”, were “weighed”, had their “blood pressure taken”, were “told about pregnancy complications”, and were “given or bought iron/tablets syrup”. These are all services and facilities for which the mother would be required to make little or no payment.

TABLE 32: BIRTHS BY TYPE OF ADVICE/SERVICE ON PREGNANCY COMPLICATIONS

Type of Advice/ Service	Age of mother at first birth: Teenage mothers	Adult mothers
Told where to go for pregnancy complications	95.7%	96.5%
Total women	1384	889
During pregnancy - urine sample taken	39.7%	45.6%
Total women	2307	1385
During pregnancy – weighed	89.6%	89.9%
Total women	2313	1384
During pregnancy - blood pressure taken	87.8%	88.7%
Total women	2313	1384
During pregnancy - blood sample taken	45.6%	48.8%
Total women	2306	1384
Told about pregnancy complications	60.3%	64.9%
Total women	2305	1377
During pregnancy, given or bought iron tablets/syrup	83.2%	80.4%
Total women	2440	1476
During pregnancy, had difficulty with night blindness	9.0%	6.5%
Total women	2433	1471
During pregnancy, had difficulty with daylight vision	18.8%	16.3%
Total women	2427	1471

5.3 FACILITIES ACCESSED DURING CHILDBIRTH

5.3.1 SERVICE PROVIDER

TABLE 33: BIRTHS BY ASSISTANCE DURING CHILDBIRTH

Type of Assistance	Age of mother at first birth: Teenage mothers	Adult mothers
Doctor	1.5%	3.6%
Nurse/midwife	32.4%	33.9%
Auxiliary midwife	14.7%	17.3%
Traditional birth attendant	45.9%	43.2%
Other assistance (not specified)	0.2%	0.0%
No one	1.1%	0.9%
Relative, friend	13.3%	11.7%
Total women	3405	2102
Aspect of Delivery		
Respondent at home	44.6%	41.8%
Other home	27.0%	27.1%
Government hospital	8.0%	8.5%
Government Health Centre	12.7%	13.5%
Government Health post	4.3%	4.6%
Other Public	0.1%	0.0%
Private hospital/clinic	2.3%	3.7%
Other private medical	0.1%	0.2%
other	0.8%	0.4%
Total	100% (3392)	100% (2096)
Delivery by caesarian		
No	98.9%	97.4%

The three leading providers for both teenage mothers and adult mothers are "traditional birth attendants", "nurse/midwife", and "auxiliary midwife" as presented in Table 33. In general, more adult mothers tend to access the professional medical service providers, while more teenage mothers relied on the non-professional and non-medical service providers.

5.3.2 CHARACTERISTICS OF DELIVERY

A. PLACE OF DELIVERY

Mothers delivered their baby in a variety of facilities, but the majority were "at home". Fewer births to teenage mothers, than to adult mothers, were delivered at a government health facility, while only 2.3 percent of births to teenage mothers, compared to 3.7 percent of adult mothers, were delivered in a private medical facility as indicated in table 33.

B. DELIVERY BY CEASARIAN SECTION

Only 1.1 percent of births by teenage mothers, and 2.6 percent by adult mothers, were delivered by caesarean section, a reflection of the relative differences in access to government and private hospitals for delivery as indicated in table 33

5.4 POST-NATAL CARE

5.4.1 CHARACTERISTICS OF POST-NATAL CARE

Mothers who had a birth at a health facility tend to spend relatively short periods there. But the majority received a health check before discharge. For the majority, the health check was done within a relatively short period.

TABLE 34: BIRTHS AT HEALTH FACILITY BY POST-NATAL CHECK OF MOTHER BEFORE DISCHARGE

	Age of mother at first birth	
Aspect of Births at Health Facility	Teenage mothers	Adult mothers
Time spent at place of delivery		
Zero hours	2.0	2.2
Less than 4 hours	18.3	19.4
4 to 23 hours	26.5	23.8
1 to 2 days	32.2	29.4
3 to 6 days	12.4	15.5
1 to 4 weeks	6.1	7.7
5 weeks and over	0.4	0.6
Don't know	2.1	1.4
Total	100.0(934)	100.0(644)
Anyone checked respondent health before discharge		
No	14.6%	10.6%
Yes	85.4%	89.4%
Total	100.0%(933)	100.0%(644)
How long before discharging mothers health check took place		
Zero hours	15.7	14.9
Less than 4 hours	53.1	55.4
4 to 23 hours	12.5	12.3
1 to 6 days	11.5	11.3
1 week and over	1.7	0.6
Don't know	5.5	5.5
Total	100(585)	100(424)

Almost all mothers, who delivered at a health facility, were checked before discharge by a medical or health professional. The most important service providers in these health facilities were "nurse/midwife" and "auxiliary midwife. In contrast, a "doctor" checked only a small percentage of mothers. The figures in Table 34 suggest that more teenage mothers relied on "nurse/midwife" and "auxiliary nurse", and more adult mothers depended on the "doctor".

Who checked respondent health before discharge		
Doctor	12.5%	19.1%
Nurse, midwife	62.5%	56.2%
Auxiliary midwife	24.4%	23.6%
Traditional birth attendant	0.3%	0.9%
Community/village health worker	0.3%	0.2%
Total	100%(582)	100%(423)

5.4.2 REASONS WHY MOTHER DID NOT DELIVER AT HEALTH FACILITY

Mothers who did not deliver at a health facility reported that the most important limitations were, "too far/no transport", "cost too much" and was "not opened". These are presented in Table 35. Others did not use the health facility because they thought it was "not necessary", "not customary", or for some "other" unspecified reason. These are mothers who should be the target for special sensitisation campaigns to increase their use of the free health care facilities.

TABLE 35: BIRTHS BY REASON MOTHER DID NOT DELIVER AT HEALTH FACILITY

	Age of mother at first birth	
Reason did not deliver at health facility	Teenage mothers	Adult mothers
Cost too much	23.4%	25.2%
Facility not open	9.2%	9.0%
Too far/no transport	59.4%	57.6%
Don't trust facility	2.2%	1.8%
No female provider	0.6%	1.0%
Husband/family did	1.8%	1.8%
Not necessary	16.7%	16.0%
Not customary	1.1%	1.5%
Total women	1710	977

5.4.3 POST-NATAL HEALTH CHECK AFTER DELIVERY AT HOME

Of the deliveries which took place "at home", 37.7 percent of teenage mothers, and 38.4 percent of adult mothers, did not get a health check after the delivery from Table 34. These rates are higher in comparison with mothers who delivered at a health facility.

The majority of mothers had a health check "less than 1 day" after delivery. In comparison with mothers who delivered at a health facility, more mothers who delivered at home are denied the immediate health check which they require. Teenage mothers appeared to be more disadvantaged, than adult mothers, in getting access to immediate health check.

The three leading service providers were "traditional birth attendants", "nurse/midwife", and "auxiliary midwife".

5.4.4 POST-NATAL BABY CHECK

The majority of babies, 61.6 percent of teenage mothers, and 55.9 percent of adult mothers, received a health check two months after delivery as seen in Table 34. On the other hand, 37.6 percent of teenage mothers, and 43.4 percent of adult mothers, did not receive any check. Only about a third of all mothers were checked "less than a day" after delivery. For the majority, the check was done between "1 to 6 days" after delivery. Differences between teenage mothers and adult mothers do not show any consistent pattern.

The three leading service providers were “nurse/midwife”, “auxiliary midwife”, and “traditional birth attendants”. “Doctors” provided the service for only about 3.0 percent of either teenage mothers or adult mothers.

There is no consistent pattern in the differences between teenage mothers and adult mothers. However, these figures emphasise the role that traditional birth attendants continue to play as service providers in all aspects of child birth and post-natal care, especially amongst teenage mothers.

The majority of babies of both teenage mothers and adult mothers were checked at a government facility. Only about 3.0 percent were checked at a private hospital/clinic, although about a third were checked “at home”. Many mothers who had a delivery at home subsequently took the baby to a government facility for a post-natal check-up. Also, fewer births of teenage mothers, than adult mothers, have had access to a private hospital/clinic for the post-natal check. These levels of access should increase with the free health care scheme.

5.4.2 REASONS WHY MOTHER DID NOT DELIVER AT HEALTH FACILITY

TABLE 36: BIRTHS BY CHARACTERISTIC OF BREASTFEEDING

	Age of mother at first birth	
Characteristic of breastfeeding	Teenage mothers	Adult mothers
Duration of Breastfeeding (Months)		
1 to 6	3.5%	3.2%
7 to 12	8.6%	10.7%
13 to 18	15.2%	16.1%
19 to 24	13.2%	9.4%
25 and over	2.4%	2.0%
Never breastfed	4.4%	5.0%
Still breastfeeding	51.3%	51.9%
Don’t know	1.4%	1.7%
Total	100.0%(2394)	100.0%(1448)
When child was put to breast		
Immediately	45.1	47.2
After 1 hour	12.3	12.6
2 to 24 hours	36.2	34.7
More than 1day	6.4	5.5
Total	100.0(2309)	100.0(1384)

The majority of the mothers breastfeed their babies, according to Table 36 and for the majority, breastfeeding started “immediately” after birth, or “after 1 hour”. Also, majority of mothers stated that they breastfeed for “6 or more” times during the day, and “1 to 5 times” at night. The differences between teenage mothers and adult mothers do not show any consistent pattern.

5.4.6 INFANT AND YOUNG CHILDREN FEEDING PRACTICES

About 41.0 percent of babies of teenage mothers, and 38.3 percent of adult mothers, were not given any pre-lacteal feed during the first three days after birth. However, the majority of babies, that is 59.0 percent of teenage mothers, and 61.7 percent of adult mother, were given a wide variety of food, apart from breast milk. More than half of all babies received “plain water”.

5.4.7 VACCINATION COVERAGE (POLIO & BCG)

The majority of children, aged 12 to 23 months, had a health card, which signified that 83.5 percent of children of teenage mothers, and 81.3 percent of children of adult mothers, had made use of a health facility as seen in Table 37.

Vaccination coverage for specific diseases was generally high for children of both teenage mothers and adult mothers. In general, the figures in Table 37 imply that teenage mothers are providing better coverage for their children than adult mothers, possibly due to the improvements in national vaccination campaigns over the more recent past.

TABLE 35: BIRTHS BY REASON MOTHER DID NOT DELIVER AT HEALTH FACILITY

	Age of mother at first birth	
Vaccination coverage	Teenage mothers	Adult mothers
Has health card	83.5%	81.3%
Total	3038	1892
Received BCG	78.9%	75.5%
Total	3095	1938
Received DPT 1	71.1%	68.3%
Total	3083	1930
Received DPT 2	63.4%	61.0%
Total	3079	1929
Received DPT 3	52.0%	50.7%
Total	3079	1929

5.4.8 INCIDENCE OF DIARRHOEA

About 10.0 percent of children, aged under five years, had diarrhoea in the two weeks preceding the survey. Table 38 shows that of those who had diarrhoea, about 20.0 percent had diarrhoea with blood, a symptom of dysentery.

TABLE 38: CHILDREN WHO HAD DIARRHOEA RECENTLY

	Age of mother at first birth	
Incidents of diarrhoea	Teenage mothers	Adult mothers
Had diarrhoea recently		
Yes, last two weeks	13.1%	10.1%
Total	3044	1893
Blood in the stools		
Yes	22.8%	21.9%
Total	394	187

5.4.9 TREATMENT FOR DIARRHOEA BY FACILITY

Figures from Table 39 show that about 56.6 percent of children of teenage mothers, or adult mothers, "received treatment", but 43.4 percent "received no treatment". For the majority, the treatment was not a "medical treatment"; only 46.2 percent of children of teenage mothers, and 46.5 percent of adult mothers, received "medical treatment". Children with diarrhoea were treated in a wide variety of both government and private facilities, but the majority were treated in a government facility.

TABLE 39: CHILDREN WHO HAD DIARRHOEA AND RECEIVED TREATMENT

	Age of mother at first birth	
Type of treatment facility	Teenage mothers	Adult mothers
No treatment	43.4%	43.3%
Medical treatment	46.2%	46.5%
Government hospital	4.3%	6.4%
Government health Centre	25.9%	20.9%
Government health post	5.6%	8.0%
Mobile clinic	1.5%	1.1%
Community health worker	1.8%	1.6%
Total women	394	187

5.4.10 TREATMENT FOR DIARRHOEA BY TYPE

TABLE 40: CHILDREN WHO HAD DIARRHOEA, RECEIVED TREATMENT BY TYPE OF TREATMENT

Type of treatment	Age of mother at first birth: Teenage mothers	Adult mothers
Given oral rehydration		
Yes: ORS - probed	70.1%	70.3%
Total women	100.0%(391)	100.0%(185)
Given recommended home solution		
Yes: RHS - probed	16.2%	22.0%
Total women	100.0%(278)	100.0%(141)
Given antibiotic pills or syrups		
Yes	39.9%	41.7%
Total	100.0%(393)	100.0%(187)
Given antimotility		
Yes	1.0%	0.0%
Total women	100.0%(393)	100.0%(187)
Given an antibiotic injection		
Yes	5.3%	4.8%
Total women	100.0%(393)	100.0%(187)
Given an intravenous (IV)		
Yes	0.0%	1.1%
Total women	100.0%(393)	100.0%(187)

The most popular single type of treatment was "oral rehydration salt (ORS). From Table 40, other widely used forms of treatment were "antibiotic pills or syrups", "recommended home solution", "antibiotic injection" and "home remedy, herbal medicine". However, some children may be getting treatments which were harmful to their health, including antibiotic pills, and injections, which are not generally recommended, by the World Health Organisation, for use in treating non-bloody diarrhoea in young children. Of even greater concern, is that over 10.0 percent of children were "given unknown pill or syrup", and "given unknown injection".

5.4.11 RESPIRATORY TRACT INFECTION (ARI)

TABLE 41: CHILDREN WHO HAD FEVER TWO WEEKS PRIOR TO SURVEY

Fever in last two weeks	Age of mother at first birth: Teenage mothers	Adult mothers
Had fever in last two weeks	27.4%	23.3%
Total	3035	1886
Had cough in last two weeks	21.8%	18.3%
Total	3039	1886
Short, rapid breaths	50.5%	47.9%
Total	654	336
Problem in the chest or blocked or running nose		
Chest only	28.7%	31.2%
Nose only	32.0%	32.5%
Both	33.8%	31.9%
Other	0.9%	0.0%
Don't know	4.6%	4.4%
Total	100.0%(328)	100.0%(160)

Symptoms of ARI had a greater prevalence amongst the children of teenage mothers than those of adult mothers. The leading government facility was the "health centre", while fewer children received treatment from other government facilities. Relatively small proportions of children received treatment from private facilities.

5.4.12 MALARIA

The most commonly used anti-malarial drugs used were Chloroquine, Artemisinin Combination Therapy (ACT), and Amodiaquine. Relatively large proportions of children were treated with other types of medications, including unnamed "pills/syrup", "Acetaminophen", "Aspirin", and some "other treatment for fever/convulsion" (see Table 42). For all children, the figures imply that the present coverage of anti-malarial treatment is inadequate.

About two-thirds of all children did not sleep under a bed net; less than a third slept under "only treated bed nets". Fewer children of teenage mothers, than adult, enjoyed the protection of insecticide-treated bed nets. As with the treatment of malaria, the present coverage with insecticide treated bed nets is relatively low, and inadequate to achieve the objectives of the 2005 National Malaria Strategy.

TABLE 42: CHILDREN WHO HAD FEVER TWO WEEKS PRIOR TO SURVEY BY TYPE OF TREATMENT

	Age of mother at first birth	
Type of treatment taken for fever/cough	Teenage mothers	Adult mothers
Fansidar	2.00%	2.10%
Chloroquine	15.10%	14.20%
Amodiaquine	2.90%	4.10%
Quinine	1.30%	0.40%
Combination with artemisinin	4.90%	7.00%
CS - Gbangba root/ sheku ture leaves	3.30%	2.50%
Other antimalarial	2.1%	2.1%
Pills/syrup	24.4%	25.9%
Injection	4.4%	5.3%
Aspirin	12.4%	11.9%
Acetaminophen	18.5%	20.9%
Ibuprofen	0.9%	0.8%
Other treatment for fever/convulsion	13.4%	12.5%
Nothing taken for fever/convulsion	18.4%	17.5%
Total women	100.0%(941)	100.0%(487)

5.5 LIMITATIONS TO ACCESSING MEDICAL HELP BY MOTHER

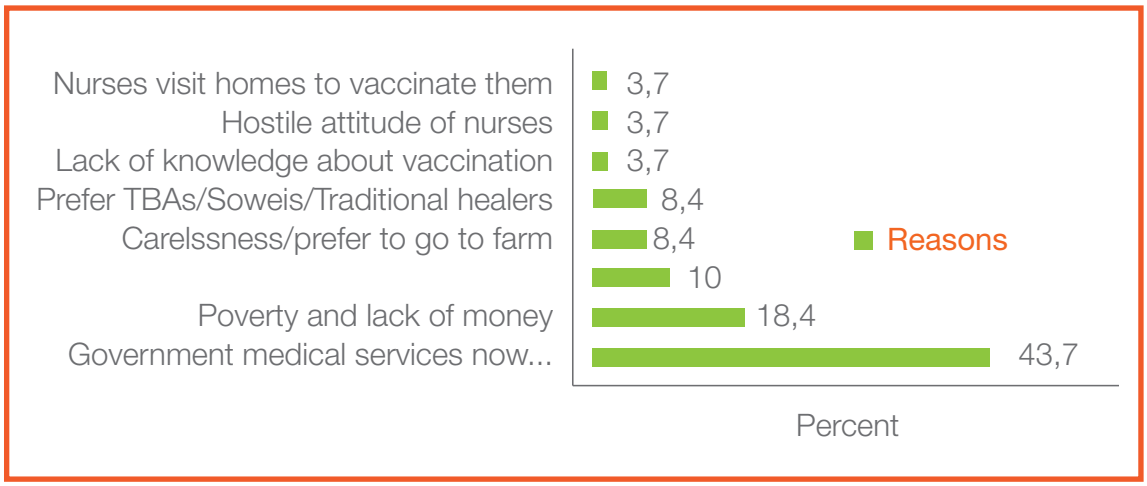
The biggest problems which can prevent mothers from getting access to the medical services and facilities which they need are "getting money for transport", "distance to health facility", "no drugs available", "no health provider", and "not wanting to go alone" as portrayed in Table 43.

TABLE 43: CONCERN OF MOTHER IN GETTING MEDICAL HELP

	Age of mother at first birth	
Type of Concern	Teenage mothers	Adult mothers
Getting permission to go	6.6%	6.1%
Getting money needed for transport	82.7%	80.1%
Distance to health facility	53.1%	53.2%
Not wanting to go alone	19.2%	19.7%
Concern no female health provider	19.9%	22.0%
Concern no health provider	36.8%	38.8%
Concern no drugs available	49.8%	52.0%
Total	100% (14396)	100% (6587)

5.5.1 COMMUNITY PERCEPTIONS AND OPINIONS OF THE USE OF MEDICAL AND HEALTH FACILITIES BY TEENAGE MOTHERS

FIGURE 15: REASONS FOR NOT USING MEDICAL AND HEALTH FACILITIES



About, 43.7 percent of community members reported that teenage mothers are utilising "available government medical services and vaccination facilities" as shown in Figure 15. In contrast, 56.3 percent reported that teenage girls who are pregnant, or who want to deliver, do not use these facilities. Their most important constraint is the question of poverty, and the inability to source enough money meet the cost of transportation, drugs and other services at the government medical and health facilities. Pregnant teenage girls also have attitudinal or psych-social concerns, or other preferences, which prevent them from going to ante-natal clinic.

6.0 CONSEQUENCES OF TEENAGE PREGNANCY AND MOTHERHOOD WITHIN THE COMMUNITY

6.1 FOR THE TEENAGE MOTHER AND CHILD

6.1.1 ON THE EDUCATIONAL DEVELOPMENT OF THE TEENAGE MOTHER

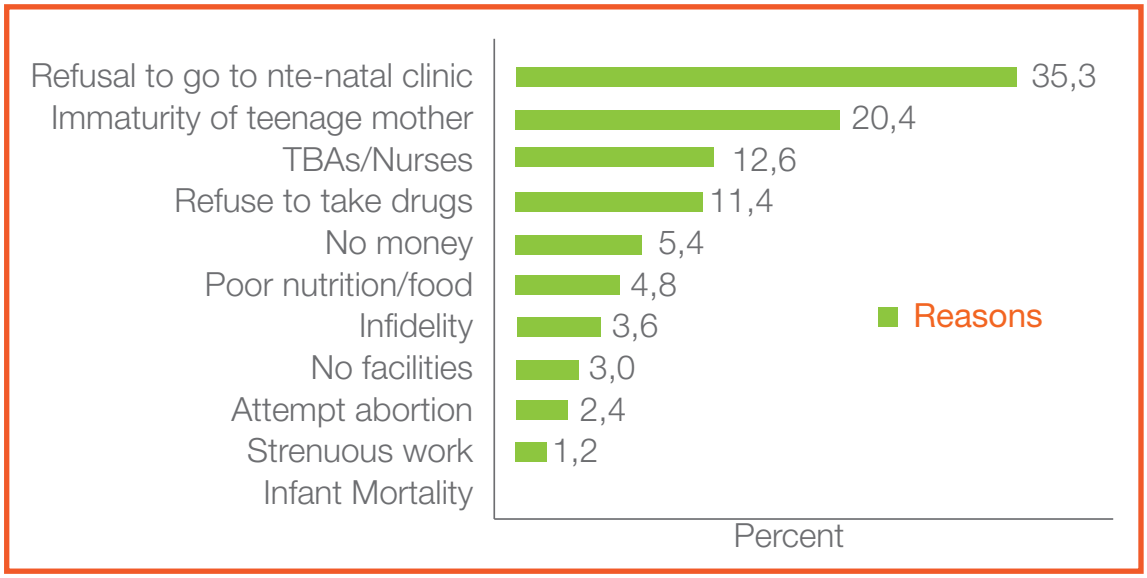
This study has already shown that one of the most reported consequences of pregnancy and motherhood for the girl child is that she is forced to drop out of school for lack of financial support, or because she is forced to marry the father of the baby, or because she cannot endure the reactions of her peers in school or in the community.

According to community members, a teenage mother should return to school, or to tertiary educational institutions, to continue her education. Or she can undergo skills training in technical and vocational institutions. Otherwise, she cannot be engaged in any productive economic activity because of the poor quality of her education. Teenage mothers are therefore seen as "idle, live on hand-outs, and are at risk of repeat pregnancies".

6.1.2 MATERNAL AND INFANT MORTALITY

Community members have recognised that one of the major consequences of teenage pregnancy and motherhood are high levels of maternal and infant mortality. The 2008 SLDHS does not include data on causes of morbidity or mortality. However for this study, during the focus group discussions, community members were asked for their views on possible reasons for the high levels of maternal and infant mortality amongst teenage mothers in their communities.

FIGURE 16: REASON FOR HIGH MATERNAL AND INFANT MORTALITY



According to community members, the four leading causes of maternal and infant mortality are the "refusal of pregnant teenagers to go to antenatal clinic, because they cannot afford the cost of transportation" (35.3 percent); "immaturity of teenage mothers coupled with their inability to endure pain" (20.4 percent); "unskilled TBAs and Nurses in the villages are unable to handle complications in pregnancy and delivery, and can use primitive and brutal methods to induce birth during labour, which eventually lead to the death of the child and the mother" (12.6 percent); and "refusal of pregnant teenagers to take drugs prescribed for them in government medical and health facilities, but rely instead on traditional medicines and herbs." (11.4 percent) as can be seen in Figure 16.

Amongst other causes of high maternal and infant mortality, reported by community members, poverty has a strong influence on three, namely "teenage mothers do not have money to pay for caesarean sections in hospitals"; "they suffer from poor nutrition because they eat poor food", and "they are engaged in strenuous work during pregnancy".

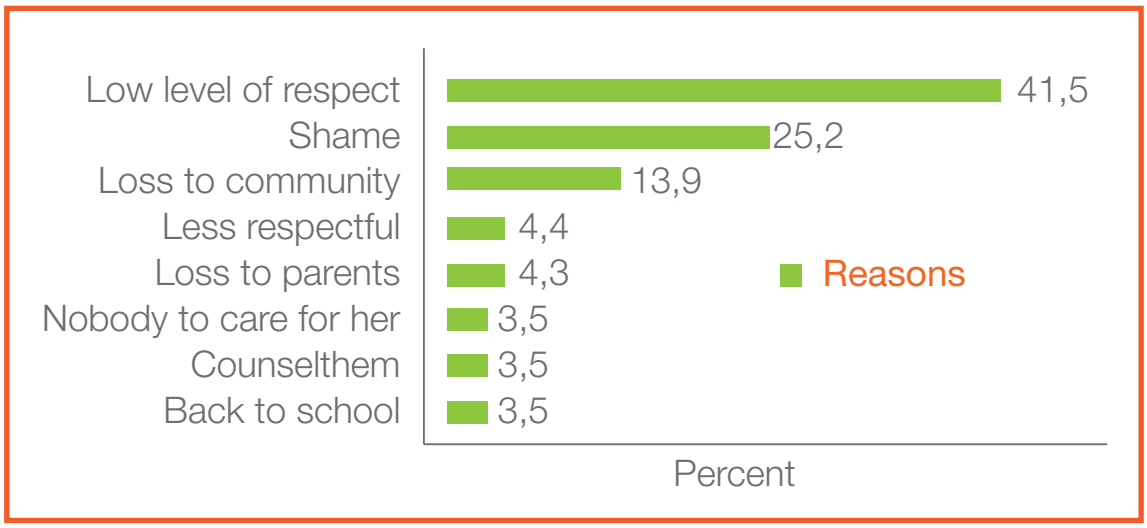
In addition a number of respondents associated maternal deaths amongst teenagers with folk beliefs, including "infidelity of the girl during the pregnancy", "the pregnant teenager changing the identity of the putative father of the child", "no sex during pregnancy".

A number of respondents reported the possibility of other adverse health and psycho-social consequences arising from early pregnancy and motherhood. These include the contraction of sexually transmitted infections, "frustration, attempted abortion, attempted suicide, and possibly death".

6.2 FOR THE COMMUNITY

Figure 17 shows that the perception which the community has of the teenage mother is always negative

FIGURE 17: COMMUNITY PERCEPTIONS OF A TEENAGE MOTHER



The three most important views the community has of her are that the teenage mother will have" little or no respect, because she is seen as an idler", "the teenage mother is usually the object of shame, gossip and rejection especially by her peers who are still going to school", and she is "a loss to the community".

Some respondents have provided opinions on the impact which teenage motherhood has on the community. These include "nobody to take care of the teenage mother except her own mother", "the teenage mother is a loss to her parents", and "teenage mothers are less respectful to their elders and parents".

However some respondents expressed the view that teenage mothers can be a positive influence within the community, provided that they are engaged in useful activities, including "encouraging them to go back to school", and "counselling them, so they can serve as an example to others of how pregnancy and motherhood affects the teenager".

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 CONCLUSIONS

7.1.1 CHARACTERISTICS OF TEENAGE MOTHERS

Teenage pregnancy is widespread. Teenage mothers constitute over 60.0 percent of women aged 15 to 49 years in the country, a pattern that is replicated in each of the four regions. But the incidence of teenage motherhood is higher in rural localities than in urban localities, with Freetown having the lowest percentage of teenage mothers.

There are a greater percentage of teenage mothers amongst Muslims than Christians. The majority of teenage mothers live in relatively large households, in the capacity of either wife, or daughter, or daughter-in-law, or sister.

7.1.2 DETERMINANTS OF TEENAGE PREGNANCY

A. AGE AT FIRST BIRTH

Teenage mothers start child bearing at very young ages, a few as young as 9 years. Amongst the many reasons which community members give to explain teenage child bearing, the most important were "household poverty", "the attitude of girls to emulate their peers", and "the inability of mothers to exert parental control over their daughters".

B. MARITAL STATUS

Nearly all the teenage mothers are married; about 92.5 percent are "ever married", while 85.0 percent are "currently married"; 86.6 percent are living with the husband in the same house, the majority in a monogamous union. Marriage amongst teenage mothers also commences at relatively early ages. Age at first marriage appears to be a significant determinant of teenage childbearing.

Comparison of the age at first birth and the age at first marriage indicates that the majority of first births took place after marriage. However, many children were born before marriage, a situation that was more prevalent amongst teenage mothers than adult mothers.

"The Prevention of Cruelty to Children Act" (Cap 31), of 1926, makes it criminal to have sexual intercourse with a girl aged under 14 years, with or without her consent; while the 2007 Child Rights Act makes it illegal to marry a girl-child under age 18 years, whether she is willing or is forced.

C. AGE AT FIRST SEXUAL INTERCOURSE

Teenage mothers, begin sexual intercourse at a relatively early age, a few as early as 8 years. Community members consider early age sexual intercourse as a reaction primarily to the poverty of parents, particularly mothers, who cannot satisfy the wants of their daughters who therefore resort to sex-based coping strategies.

The analysis of age differences between teenage mothers and the "first sexual partner", "last sexual partner", and "current sexual partner", show that the majority of teenage mothers have relationships with partners who are much older, many by 10 years or more, rather than with their peer groups.

The most important reason for these age disparities is "the poverty of parents, and the pressure and encouragement from parents, especially mothers". Both factors combine to motivate teenage girls to have relationships with older men, who are wealthy, and able to provide for the welfare of the teenage girl, her baby, parents and siblings.

These age disparities contradict popular perceptions that the majority of teenage mothers have "first time", or "current", sexual partners from amongst their peers, who are mainly school boys, and who make them pregnant. To reduce teenage pregnancy and motherhood, there is need to target the appropriate groups in the community, with strategies and messages, which seek to change deeply entrenched attitudes, on the relationship between older men and younger women.

D. KNOWLEDGE AND USE OF CONTRACEPTIVE METHODS

Although 72.9 percent of teenage mothers know about modern contraceptive methods, current use is limited to only 10.0 percent of teenage mothers, with the two most popular

methods being “injections” and the “pill”. Only 12.3 percent of teenage mothers used a modern contraceptive before the last birth and 4.4 percent after that event. Condom use is even less common. This has serious health implications for teenage mothers, many of whom are involved in polygamous unions, and have had multiple sex partners.

High levels of teenage pregnancy and childbirth appear to be strongly influenced by the high levels of marriage, cohabitation and sexual intercourse at young ages, and a strong desire to have children; conditions which are not compatible with the use of modern contraceptives.

E. FEMALE CIRCUMCISION

As with early marriage, female circumcision is widespread; 95.9 percent of teenage mothers have been circumcised; 25.9 percent before age 5 years, almost all “at infancy”; 67.8 percent before age 14 years, and 89.1 percent before 18 years of age. All of these would be in contravention of the 2007 Child Rights Act which provides protection from any “initiation ceremony” for girls under age 18 years.

The influence of female circumcision on teenage pregnancy and motherhood is exerted through three other characteristics of the women; the age at first sexual intercourse, the age at first marriage, and the age at first birth.

At age 8 years, when some teenage mothers start sexual intercourse, and at all subsequent ages up to 17 years, the proportion of circumcised girls, who have started sexual intercourse, is always higher than the proportion of non-circumcised girls. Likewise, age at first marriage commences at the relatively young age of 10 years. From this age, to about age 17 years, the percentage of circumcised girls who are married is always higher than the percentage of non-circumcised girls. In addition, girls who are circumcised have a first birth at the relatively young age of 9 years, and at each subsequent age up to age 17 years, the percentage of circumcised girls, who have had a first birth, are consistently higher than for non-circumcised girls.

A major reason for early age circumcision is that mothers who are poor find it cheaper to circumcise their daughters when young, as they will be satisfied with relatively cheap post-circumcision gifts.

F. INFLUENCE OF WEALTH OR POVERTY

The 2008 SLDHS data, on the household wealth index, do not show any consistent pattern between the wealth index quintile and age at first birth.
However, within communities, poverty is perceived as the inability of parents, especially the mothers, to provide the education, feeding, housing, health and other essentials of living for their children. It has been identified in all communities as the most important explanation of early age at first sexual intercourse, early age at first birth, early age at first marriage, early age at circumcision, and age disparities between teenage mothers and their sexual partners.

7.1.3 CONSEQUENCES OF PREGNANCY AND MOTHERHOOD FOR TEENAGE MOTHERS

A. SOCIO-ECONOMIC CONSEQUENCES

The inability of teenage mothers, to make significant advancements in their education, is one of the most adverse and devastating consequences of teenage pregnancy and motherhood. Lack of financial resources, the need for the teenage mother to marry, be a

housewife, and care for the baby, and the inability of teenage mothers to cope with the taunts and stigmatisation of their school mates, are the major constraints to get teenage mothers back to school. Only a tiny percentage can overcome these constraints to continue their education beyond secondary level. As a result, nearly 80.0 percent of teenage mothers "cannot read at all", and the majority of them are engaged in small scale agriculture and petty trading.

B. DEMOGRAPHIC CONSEQUENCES

Teenage mothers not only start childbearing earlier, but also have larger sized families, higher incidence of repeat pregnancies, and terminate more pregnancies, than adult mothers. In addition, levels of child mortality are higher amongst children of teenage mothers than those of adult mothers.

C. PARTNERS OF TEENAGE MOTHERS

The majority of partners of teenage mothers have low levels of education, and are mainly engaged in "agriculture-self-employed", "sales" and "professional, technical and management". Other occupations include "skilled manual and "unskilled manual".

D. DISSOLUTION OF PREVIOUS MARRIAGE AND DISINHERITANCE

Of those teenage mothers who were formerly married, over one-third were widows, a pattern that is consistent with the large age disparities with their partners.

However, on the death of the husband/partner only a small minority received most of the husband's property, assets or valuables. The principal beneficiaries were other family members, and children of the husband, a consequence of traditional practices in the devolution of estate within customary marriages. The Customary Marriage and Divorce Act of 2007, and the Devolution of Estates Act of 2007, contain provisions to correct these injustices.

7.1.4 CONSEQUENCES OF TEENAGE PREGNANCY AND MOTHERHOOD FOR THE CHILDREN

A. ANTENATAL CARE

The majority of teenage mothers made four or more ante-natal visits to a health facility. The majority had received two or more tetanus toxoid injections before the last birth and were fully protected against neonatal tetanus. They were not adequately treated with prophylactic anti-malarial drugs during pregnancy, and they did not receive adequate treatment with recommended anti-malarial drugs when they suffered from malaria.

In comparison with adult mothers, teenage mothers had less access to ante-natal assistance from medical and health personnel, but greater access to traditional birth attendants and community health workers. They also had better access to those services which did not require payment, than to those for which they were required to pay. The majority of teenage mothers took no drug for malaria during their last pregnancy.

B. FACILITIES ACCESSED DURING CHILDBIRTH

Teenage mothers tend to rely more on non-professional, and non-medical service providers including traditional birth attendants, and relative/friend; and less on the professional medical service providers. The majority delivered at home, and generally appear to have less access to 'quality' medical facilities than adult mothers, including delivery by caesarean section.

C. POST-NATAL CARE

Teenage mothers, who had a birth at a health facility, tend to spend shorter periods there than adult mothers. The majority received a health check within a relatively short period before discharge, almost all by a medical or health professional. In comparison with adult mothers, teenage mothers relied more heavily on nurse/midwife and auxiliary midwife, and less on a doctor, and were more disadvantaged in getting access to immediate health check.

D. POST-NATAL BABY CHECK

The majority of babies of teenage mothers received a health check two months after delivery, mainly from nurse/midwife or midwife at a government health facility, and from traditional birth attendants, who continue to play important roles as service providers in all aspects of child birth and post-natal care, especially amongst teenage mothers.

E. CURRENT REPRODUCTIVE PRACTICES

The majority of teenage mother's breastfeed their babies, almost all started immediately after birth, and breastfeed at frequent intervals during the day and night.

F. INFANT AND YOUNG CHILDREN FEEDING PRACTICES

In addition to breast milk, other pre-lacteal feeds were widely given during the first three days after birth.

G. VACCINATION COVERAGE

Over 83.0 percent of children, aged 12 to 23 months, of teenage mothers have made use of a health facility. Teenage mothers appeared to be providing better vaccination coverage for their children than adult mothers, possibly the result of the improvements in national vaccination campaigns over the more recent past.

H. INCIDENCE OF DIARRHOEA

About 13.1 of children, aged under five years, of teenage mothers had diarrhoea in the two weeks preceding the survey. Of these, 22.8 percent had symptoms of dysentery. The majority of children received treatment in government facilities, and fewer in private facilities. However, traditional practitioners were more active in treating children of teenage mothers than adult mothers, while fewer children of teenage mothers, than those of adult mothers, were treated at a private facility.

Oral rehydration salt (ORS) was used to treat more than 70.0 percent of children of teenage mothers. Other forms of treatment, some not recommended by WHO, were administered to the children.

I. RESPIRATORY TRACT INFECTION (ARI)

About 27.4 percent of children of teenage mothers displayed symptoms of ARI, a rate higher than for children of adult mothers. About half of these children received treatment from various government and private facilities, with access being poorer for children of teenage mothers than adult mothers.

J. MALARIA

Nearly half of the children of teenage mothers were affected by symptoms of malaria. The majority first sought treatment at a government health facility. In general, more children of teenage mothers were treated in a government health facility, while more children of adult mothers were treated in a private facility.

The most commonly used anti-malarial drugs were Chloroquine, Artemisinin Combination Therapy (ACT), and Amodiaquine. A variety of other medications were also used. However, for all children, the figures imply that the present coverage of anti-malarial treatment is inadequate.

The majority of children under five years did not sleep under a bed net, and fewer slept under treated bed nets. Children of teenage mothers had slightly poorer access to mosquito bed nets than those of adult mothers, possibly a reflection of the poorer access they have to fixed or permanent beds in overcrowded rooms.

K. LIMITATIONS TO ACCESSING MEDICAL HELP BY MOTHER

Amongst the many factors that can prevent mothers from getting access to the ante-natal, delivery, and post-natal services which they need, are "getting money for transport", "distance to health facility", and "the lack of drugs". Some teenager mothers have other attitudinal problems or preferences.

7.1.5 CONSEQUENCES OF TEENAGE PREGNANCY AND MOTHERHOOD WITHIN THE COMMUNITY

A. ON THE EDUCATIONAL DEVELOPMENT OF THE TEENAGE MOTHER

According to community members, a teenage mother should continue her education, or undergo skills training in technical and vocational institutions. Teenage mothers who have dropped out of school are seen as "idle, live on hand-outs, and at risk of repeat pregnancies".

B. MATERNAL AND INFANT MORTALITY

High levels of maternal and infant mortality constitute one of the major consequences of teenage pregnancy and motherhood. It is caused primarily because of the refusal of pregnant teenagers to go to antenatal clinic; their physiological immaturity; primitive delivery methods of TBAs; and refusal of teenage mothers to take drugs prescribed for them in government health facilities.

7.2 RECOMMENDATIONS

This study has analysed the proximate determinants of teenage pregnancy and motherhood, its underlying social, economic and cultural factors, and its impact on the teenage mother, her baby and community. It recommends a number of strategies to end early age marriage, and reduce the incidence of teenage childbearing.

7.2.1 ECONOMIC EMPOWERMENT

The Government, NGOs and the private sector need to create the opportunity for mothers, and their teenage daughters who have dropped out of school, to engage in income-generating activities by providing them with seed capital, in the form of micro-finance loans, and simple business management techniques, with which they can start self-owned small or medium scale business enterprises.

7.2.2 EDUCATING TEENAGE GIRLS

Government must provide free and compulsory education for all girls, under 18 years, up to the end of the senior secondary school, or equivalent levels in technical and vocational training institutions. Teenage mothers, who want to continue their education in any formal educational institution, or in adult education programmes, should be given the opportunity to do so.

This recommendation, for free and compulsory education for girls, is consistent with the intentions of the 1991 Constitution of Sierra Leone.

Education Authorities should improve children's awareness of the potential risks of early age marriage and teenage pregnancy by including appropriate materials on their causes, consequences, and solutions in the school curricula of primary, as well as junior and senior secondary schools.

7.2.3 ENFORCING EXISTING LEGISLATIONS PROTECTING THE GIRL-CHILD AND WOMEN

It is recommended that the following existing legislations, which provide protection of the sexual and reproductive rights of children, and which have been discussed in this study, are more vigorously and effectively enforced.

A. THE PREVENTION OF CRUELTY TO CHILDREN ACT CAP 31 OF 1926

This Act protects girls against early sexual intercourse, before age 14 years, whether with or without her consent. The effective enforcement of this law will reduce teenage pregnancy and motherhood by 10.9 percent. In the population, this will mean protection for hundreds of vulnerable girls

B. THE CHILD RIGHTS ACT OF 2007

The Act provides protection for the girl-child against early marriage, forced marriage, and early age circumcision. The effective enforcement of these provisions will provide immediate protection for the 78.3 percent of teenage mothers who were married when they were still under 18 years, and will solve completely the problem of teenage marriage.

In addition, effective enforcement will reduce the incidence of early age circumcision by 89.1 percent, thereby protecting thousands of girls not only from early age circumcision, but also from early marriage, early sexual relationships with men, and early childbirth.

C. THE DOMESTIC VIOLENCE ACT OF 2007

This Act provides protection of the girl-child in three key areas of sexual and reproductive health. It defines Domestic Violence to include both "physical or sexual abuse of any age" The effective enforcement of its provisions will ensure the protection of young girls against sexual violence and early age circumcision.

By deliberately depriving girls of the capacity to be involved in sexual relationships with their partners, as normal human beings, and because of the risk it poses to the health of young girls, female circumcision can be regarded as degrading and dehumanising, and therefore a serious violation of their child rights.

It is recommended that early age circumcision of girls should be treated as a violation of their human rights. The need for this is given added urgency in view of new policy objectives of some international organisations, including the United Nations, to fast-track the eradication of female genital mutilation in those countries in which it is still practised. This is because early age circumcision has been noted as a factor increasing early age of sexual initiation and therefore if addressed would have a great impact on reducing teenage pregnancy.

D. THE REGISTRATION OF CUSTOMARY MARRIAGE AND DIVORCE ACT 2007

This Act stipulates that customary marriage is valid only if "both spouses are not less than 18 years old, and consent to the marriage". The effective enforcement of these provisions will end early and forced marriage, and ensure marital stability and equity for teenage mothers involved in customary marriage.

E. THE DEVOLUTION OF ESTATES ACT 2007

This Act deals with the distribution of the property of a deceased, who died without making a will. It thus provides social protection, economic security, and demographic safeguards for the teenage mother who marries an older partner, bears his children, and eventually becomes a widow.

7.2.4 INCREASE ACCESS TO AND USE OF MODERN CONTRACEPTIVES

It is recommended that the scope of family planning programmes be expanded by giving all women of child bearing ages free access to modern contraceptives, including the "injection", pill, implant and condom.

It is recommended that this increased access should be accompanied by intensive awareness raising campaigns which deal specifically with the fears, myths, misinformation and stigma which some people associate with all forms of modern contraceptives, particularly condoms.

7.2.5 INCREASE ACCESS TO MEDICAL AND HEALTH FACILITIES

It is recommended that the free health care initiative should be expanded to include all teenage girls, whether they are mothers or not, and that it should have a duration of more than five years. To this end, the government should train more doctors and nurses to operate the free health care services.

7.2.6 SENSITISATION CAMPAIGNS

The following types of sensitisation and advocacy campaigns are recommended to cover the key issues of teenage pregnancy and motherhood which have emanated from this study.

- On the impact of early pregnancy and motherhood
- On the advantages of girl-child education.
- On the advantages, myths and misconceptions of using modern contraceptives
- On changing women's perceptions on having children
- On the harmful effects of early age circumcision to the child
- On all existing laws protecting the rights of children and women

7.2.7 THE ROLE OF TRADITIONAL AND RELIGIOUS LEADERS

It is recommended that traditional rulers should enforce all existing laws, and make and enforce new bye-laws, in their chiefdoms, which provide protection for girls from sexual intercourse, circumcision, and marriage, when they are under the respective minimum ages stipulated by law.

In addition, both religious and traditional leaders must be actively involved, as motivators of change, in all the various sensitisation and advocacy campaigns on the reproductive and sexual rights of women that this study has recommended.

7.2.8 DIRECT GOVERNMENT INTERVENTIONS

Various MDAs of the Government should intervene more directly to end early marriage, and reduce teenage pregnancy in the country, by requesting that chiefs, as one of their civic functions, must provide information, on an annual basis, on a number of indicators. These include the number of girls under 18 years in and out of school; the number of initiation ceremonies and the age distribution of the girls; the number of girls, aged under 18 years, who had a birth; the number of deaths of mothers aged under 18 years; the number of customary marriages contracted, and the number of widows and the distribution of the estate, assets and valuables of the husband.

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ANNEXES

FOCUS GROUP DISCUSSION GUIDELINES FOR TEENAGE PREGNANCY STUDY

A. THEMES

1. Age at first birth – early born
2. Age at first marriage – early marriage
3. Age at first sex – early intercourse
4. Age at circumcision
    - Why so early
    - Advantages to the girl
    - Disadvantages to the girl
5. Contraceptive use – people dislike using it
6. Partners age
7. Consequences for the mother/children
    - Education/training
    - Position in society
    - Medical facilities
    - Health services
    - Maternal/infant mortality
    - Maternal and infant mortality
8. Recommendations
    - To stop teenage pregnancy and motherhood

B. GROUPS IN EACH LOCATION

- In school girls aged 13 to 19 years
- Out of school girls (Mothers) aged 13 to 19 years
- Adult Females/Parents/Guardians
- Adult Males – 18 years and over
- Traditional/Religious/Opinion Leaders.

C. TABULATIONS OF FOCUS GROUP DISCUSSION RESPONSES

Table 1 : REASONS FOR EARLY AGE PREGNANCY

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Poverty of parents or foster parents so seek assistance from men for children	27.9	46.4	34.0	33.3	30.4	33.0
Attitude problem "Milleh"/Dress code	13.1	10.7	25.5	25.0	8.7	17.0
Single parent/Mothers are responsible/lack of control	23.0	10.7	14.9	14.6	13.0	16.1
Wayward/No Control /Stubbornness	8.2	10.7	6.4	6.3	0.0	6.1
Peer pressure/no adverse outcome from friends who are pregnant	6.6	10.7	4.3	4.2	6.5	6.1
Girls go after men	6.6	0.0	0.0	2.1	8.7	3.9
Not interested in education	8.2	0.0	4.3	4.2	0.0	3.9
Street selling/petty trading by girl child	4.9	3.6	4.3	4.2	0.0	3.5
Pornographic films	0.0	0.0	2.1	2.1	8.7	2.6
Women want children	0.0	3.6	4.3	4.2	2.2	2.6
Human Rights Law	0.0	0.0	0.0	0.0	8.7	1.7
Neglect of public punishment in the community/Decline in authority of chiefs	0.0	0.0	0.0	0.0	6.5	1.3
Female circumcision which leads to early sex	1.6	3.6	0.0	0.0	2.2	1.3
Sex education in school	0.0	0.0	0.0	0.0	4.3	0.9
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 2 : REASONS FOR EARLY AGE AT FIRST MARRIAGE

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Poverty so seek assistance from a potential husband of girl-child	42.0	56.0	51.3	48.5	37.7 4	5.5
Pressure from Mothers/ Stubbornness of daughters at home/Mothers prefer to initiate them and get them married rather schooling, and so preempt her becoming pregnant at home or after her first birth.	26.0	20.0	20.5	33.4	26.5	25.5
Girls offer themselves in marriage without consent of parents/Girls want to have children like their friends or society mates “Milleh”	18.0	12.0	5.1	12.1	7.6	11.0
Poor parental monitoring by single mothers/widowed or abandoned by husbands/Illiteracy, ignorance of mothers	8.0	8.0	10.3	3.0	13.2	9.0
Attitude of foster parents to orphans/foster children from the village/provinces	4.0	4.0	7.7	3.0	0.0	3.5
Child Rights Act/cannot control children	0.0	0.0	0.0	0.0	11.3	3.0
Female circumcision	2.0	0.0	2.6	0.0	3.8	2.0
Pornographic films	0.0	0.0	2.6	0.0	0.0	0.5
TOTAL	**100 .0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 3 : REASONS FOR EARLY AGE SEXUAL INTERCOURSE

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Poverty of parents/mothers who cannot educate their children and unlimited wants of children/"Milleh"	22.2	18.8	30.8	22.2	22.3	24.1
Peer group influence	22.2	50.0	20.5	18.5	22.2	24.0
Lack of parental control/ monitoring by mothers/Single parents	25.9	6.3	20.5	29.6	5.6	17.9
Housing conditions parents exposed	11.1	0.0	10.3	18.5	5.6	9.7
Pornographic Films	11.1	0.0	7.7	7.4	8.3	7.6
Family life education/ sex education	0.0	0.0	2.6	0.0	13.9	4.1
Rebel war/Children not afraid	7.4	0.0	0.0	3.7	5.6	3.4
Foster parents and guardians of orphans and foster children	0.0	25.0	0.0	0.0	0.0	2.8
Female circumcision excuse to start sexual intercourse	0.0	0.0	5.1	0.0	5.6	2.9
Human Rights/Child Rights/ Too much sex education	0.0	0.0	0.0	0.0	5.5	1.4
Decline of authority of Chiefs, and inability to name shame and punish perpetrators in public	0.0	0.0	0.0	0.0	5.5	1.4
Street selling	0.0	0.0	2.6	0.0	0.0	0.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Table 4 : REASONS FOR EARLY AGE AT CIRCUMCISION

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Poverty/Less expensive when young/Copy friends/Help from family friend or potential husband	41.2	43.8	37.0	20.3	66.7	42.9
Tradition/Culture	17.6	25.0	25.9	26.0	9.1	19.3
To reduce sexual urge of children	8.8	6.3	7.4	23.3	0.0	9.3
So they will not refuse when older	20.6	6.3	0.0	3.3	0.0	6.4
Children themselves enter the bush to emulate peer groups	0.0	6.3	7.4	10.0	6.1	5.7
Against our tradition/Girls should be matured before circumcision/	2.9	0.0	7.4	0.0	12.1	5.0
Old age of the parent before dying	0.0	6.3	3.7	0.0	6.1	2.9
Less painful when young	5.9	0.0	3.7	3.3	0.0	2.9
Should not be forced	2.9	0.0	0.0	10.0	0.0	2.9
Parents to maintain respect in community/Shameful to parents if not virgin at circumcision	0.0	6.3	0.0	3.3	0.0	1.4
Chiefdom circumcision	0.0	0.0	3.7	0.0	0.0	0.7
To have right to chieftaincy	0.0	0.0	3.7	0.0	0.0	0.7
TOTAL	100.0	100.0	100.0	99.6	100.0	100.0

Table 5 : REASONS FOR LOW LEVEL OF CONTRACEPTIVE USE BY TEENAGE MOTHERS

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Fear of side effects for example Abdominal pains/Infection/ Bleeding/HIV/Gives cancer	30.6	20.0	12.5	26.5	19.4	21.7
Do not use condom so as to enjoy sex/flesh to flesh/body to body	5.6	16.7	25.0	20.6	25.8	18.7
Causes infertility	22.2	26.7	7.5	23.5	12.9	18.1
Women want to have children/ In polygamous family/For farming	11.1	6.7	20.0	5.9	22.5	13.5
Illiteracy of girls and parents/ Information and advice from friends and relatives	11.1	16.7	2.5	5.9	13.0	9.3
Men don't like condom/ puncture the condom	5.6	10.0	2.5	8.8	0.0	5.3
Condom sticks in vagina	5.6	0.0	5.0	5.9	3.2	4.1
Women don't use condoms/ Don't like it	0.0	0.0	12.5	0.0	0.0	2.9
Lack of knowledge of contraceptives/pills	2.8	0.0	2.5	0.0	3.2	1.8
Women think you have a STI	0.0	0.0	5.0	0.0	0.0	1.2
It is a sin	0.0	3.3	2.5	0.0	0.0	1.2
Stigmatisation/ Think it is prostitution	2.8	0.0	2.5	0.0	0.0	1.2
Lubricant on condom is messy	2.8	0.0	0.0	0.0	0.0	0.6
Not safe can become pregnant	0.0	0.0	0.0	2.9	0.0	0.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Table 6 : REASONS FOR AGE DIFFERENCES BETWEEN TEENAGE MOTHER AND SEXUAL PARTNER

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Poverty/Big men have money, will accept the responsibility of a pregnancy, will look after and educate the girl, her mother and family	48.4	75.9	19.4	78.3	34.6	49.0
Young girls are more sexually active and attractive	16.1	3.4	44.4	4.3	19.2	19.3
Young boys have no money and will deny pregnancy/do not like responsibility/are violent	9.7	13.8	0.0	8.7	11.5	8.3
Both especially Teachers	3.2	3.4	8.3	0.0	26.9	8.3
Young girls are less expensive less demanding, easier to control and more respectful than old age women	3.2	0.0	16.6	0.0	3.8	5.5
Destroy future of girl/ foolishness of men	6.5	0.0	5.6	8.7	3.8	4.8
Has future prospects with own age group	6.5	3.4	0.0	0.0	0.0	2.1
Parent especially mother pressures and encouragement/ greater prestige for young girls to have older partners	3.2	0.0	2.8	0.0	0.0	1.4
More prestige for older men	3.2	0.0	0.0	0.0	0.0	0.7
Older women want younger men	0.0	0.0	2.8	0.0	0.0	0.7
TOTAL	100.0	100.0	100.0	100.0	99.9	100.0

TABLE 7 : PERCENTAGE OF RESPONDENTS REPORTING POVERTY AS THE CAUSE OF THE PROXIMATE DETERMINANT

Proximate determinant	Percentage reporting "poverty" as a reason
Difference in partner's age	49.0
Early age at first marriage	45.5
Early age circumcision	42.9
Early age pregnancy	33.0
Early age at first sexual intercourse	24.1

Table 8 : CONSEQUENCES OF TEENAGE PREGNANCY AND MOTHERHOOD FOR THE TEENAGE MOTHER

CONSEQUENCE	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Drop out of school/Parent do not pay school fees/end of education/ sit down to care for baby/Forced to marry/focus on husband	69.7	64.9	63.0	63.2	64.7	65.2
Ashamed to continue schooling/ Not motivated to continue	12.2	8.1	14.8	21.1	17.6	13.5
Undergo skills training/Return to school/Return to college/ Continue education	6.0	2.7	11.1	5.3	0.0	5.4
Idle/Repeat Pregnancy/Nothing live on hand-outs	3.0	2.7	3.7	10.5	11.8	5.3
Leads to STI	0.0	13.5	0.0	0.0	0.0	3.8
Engage in petty trading	3.0	5.4	3.7	0.0	0.0	3.0
Frustration/attempted suicide/ Attempted abortion/May lead to death	3.0	0.0	3.7	0.0	5.9	2.3
Go back to village and do farming	3.0	2.7	0.0	0.0	0.0	1.5
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Table 9 : REASONS WHY TEENAGE MOTHERS DO NOT ACCESS MEDICAL FACILITIES

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Government medical services/ vaccination facilities now available	19.2	56.4	56.8	48.4	48.4	43.7
Poverty and lack of money so no proper medical attention is given/Putative fathers not identified or unwilling or switched loyalties, or does not have the money to take responsibility/ household poverty	23.2	20.5	8.1	19.4	19.4	18.4
Ashamed to be pregnant, or afraid their parents will know about pregnancy so do not go to the clinic	9.6	2.6	13.5	12.9	12.9	10.0
Carelessness to go to clinic by girls/and their mothers/prefer to go to farm	13.5	5.1	8.1	6.5	6.5	8.4
Prefer TBAs and Soweis and Traditional Healers	11.5	5.1	10.8	6.5	6.5	8.4
Lack of knowledge of the number of vaccinations/Do not know about vacccinations	13.4	0.0	0.0	0.0	0.0	3.7
Hostile attitudes of nurses	7.7	0.0	2.7	3.2	3.2	3.7
Nurses visit homes to vaccinate them	1.9	10.3	0.0	3.2	3.2	3.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Table 10 : REASONS FOR HIGH LEVELS OF MATERNAL AND INFANT MORTALITY

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Refusal to go to ante-natal clinic/ Due to transportation costs	48.1	19.4	31.8	36.1	44.8	35.3
Immaturity of teenage mother/ Afraid of pain	22.2	25.8	13.6	25.0	17.2	20.4
TBAs/Nurses in the villages use force to deliver/cannot handle difficult complications	7.4	12.8	11.4	16.7	13.8	12.6
Refusal to take drugs/prefer traditional medicines/herbs	3.7	9.7	15.9	11.1	13.8	11.4
No money to pay for CS/ Hospital before Free Health Care	3.7	12.9	4.5	2.8	3.4	5.4
Poor nutrition/food	0.0	9.7	6.8	2.8	3.4	4.8
Infidelity/Giving the pregnancy to another man/No sex after pregnancy	7.5	3.3	4.5	2.8	0.0	3.6
No facilities/hostile nurses/ time wasting no drugs	7.4	0.0	2.3	2.8	3.4	3.0
Attempted abortion	0.0	0.0	9.1	0.0	0.0	2.4
Strenuous work during pregnancy	0.0	6.5	0.0	0.0	0.0	1.2
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 11 : COMMUNITY PERCEPTIONS OF TEENAGE MOTHER

REASON	In School Girls	Out of School Girls	Adult Male	Adult Female	Trad/ Religious Leaders	Total
Low level of respect/Regarded as idlers	37.9	61.5	26.7	40.0	61.1	41.7
Shame/gossiping them/rejection/ ostracized	31.0	30.8	26.7	28.0	5.6	25.2
Loss to community	13.8	0.0	20.0	8.0	22.2 1	3.9
Less respectful to elders/parents	13.8	0.0	0.0	0.0	5.6	4.4
Loss to the parents in time/money/ and expectations	0.0	0.0	13.3	4.0	0.0	4.3
Encourage them to go back to school	0.0	0.0	6.7	8.0	0.0	3.5
Counsel them – to be an example to others	0.0	7.7	0.0	12.0	0.0	3.5
Nobody takes care of her except her mother	3.4	0.0	6.7	0.0	5.6	3.5
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**