Government of Sierra Leone

National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage

2025–2030

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FOREWORD

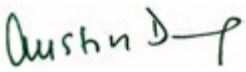
In Sierra Leone, our young people play an important role in contributing to the development of the nation. However, the issues of adolescent pregnancy and child marriage continue to cast long shadows over their futures. These practices not only jeopardize the health and well-being of our young girls but also hinder our nation's progress towards sustainable development and gender equality.

This strategy builds on the success of the last two National Strategies. The 2013-2018 strategy was focused on the Reduction of Teenage Pregnancy and the second strategy focused on both Adolescent Pregnancy and Child Marriage (2018-2022). With the support of our partners under the guide of these participatory developed master plans, we saw adolescent pregnancy reduce from 28 per cent in 2013 to 21 per cent in 2019 (DHS). This strategy calls for immediate and sustained multi-sectoral efforts to address the causes of adolescent pregnancy and child marriage, building on the gains made on programme integration over the last few years. By engaging communities, empowering young people, and fostering partnerships among government, NGOs, and local leaders, the strategy will create an environment where every girl has the opportunity to thrive, pursue her education, and realize her dreams.

Through support to service delivery, education and social support systems, we will dismantle the systemic barriers that contribute to adolescent pregnancy and child marriage. This strategy recognizes that ending adolescent pregnancy and child marriage is not just a goal, but a moral imperative—a commitment to the rights and potential of our young people. It serves as a guiding framework for all stakeholders to plan and implement the needed actions from 2025–2030.

Together, we can pave the way for a brighter future, where every girl is valued, protected, and empowered to contribute to the prosperity of our nation. Let us unite in this critical mission, ensuring that no girl is denied her right to a safe and fulfilling life.

As the Minister of Health, I am deeply committed to the well-being and future of our nation's adolescent girls, and I urge all partners to join us in this vital effort. Let us stand united in our commitment to the health, education, and empowerment of our young girls. With determination and multisectoral action, we can support and create lasting change for generations to come!



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ENDs
Education

ACKNOWLEDGMENTS

On behalf of the Government of Sierra Leone, especially the five line ministries of Health, Gender and Children's Affairs, Basic and Senior Secondary Education, Youth Affairs and Local Government and Rural Development, I extend our sincere gratitude to our development partners, especially UNFPA and UNICEF, for providing their technical and financial support towards the review of the 2018–2022 the National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage and the development of the new comprehensive 2025–2030 strategy.

As a government we would like to further express our profound appreciation to Irish Aid, and to the donors of the UNFPA and UNICEF's Global Programme to End Child Marriage for providing funding not only for the development of this strategy but also supporting its implementation through various partners across high burdened teenage pregnancy and child marriage districts in Sierra Leone.

The National Secretariat for the Reduction of Teenage Pregnancy, and the School and Adolescent Sexual Reproductive Health Programme are grateful to the senior officers from the line Ministries for their technical inputs and guidance in the review and development of this strategy.

To our implementing partners both local and international, and our most knowledgeable community stakeholders, we are grateful for your contributions, ideas and experience sharing throughout the development process.

We are overly grateful to our adolescents and young people who participated in various meetings and consultations leading to the design of our new, cross sectoral and responsive national strategy. Your involvement was crucial in shaping a future where every young person can thrive. Your voices, experiences, and insights were invaluable. They help us understand the challenges you face and the support you need.

To the consultants Dr. TT Samba and Mr. Phillip Wambua, your contribution in making sure the strategy addresses the true reflection on the needs of the adolescents is highly acknowledged.

The entire staff of the National Secretariat for the Reduction of Teenage Pregnancy, the District Health Management Team nationwide, the focal persons from line ministries for your technical inputs and collaboration into finalizing this strategy 2025–2030 is commendable. Thank you for your courage, your dedication, and your willingness to be part of this important journey. Your participation makes a difference, and I am proud to work alongside such an inspiring team.

Together, we are creating a strategy that truly reflects the needs and aspirations of our adolescent girls.

Dr. Patricia Bah

National Coordinator
National Secretariat for the Reduction of
Teenage Pregnancy and Child Marriage


Every girl
deserves a
chance to learn!

Acronyms

ABR	Adolescent Birth Rate
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYFHS	Adolescent and Young-People Friendly Health Services
AYPF	Adolescent and Young People Friendly
CP	Child Protection
CSE	Comprehensive Sexuality Education
CHW	Community Health Worker
CWC	Child Welfare Committee
CAHLS	Child and Adolescent Health and Life Skills
DHS	Demographic and Health Survey
FSU	Family Support Unit
GRM	Grievance Redress Mechanism
HMIS	Health Management Information System
IEC	Information, Education, and Communication
JSS	Junior Secondary School
LMICs	Low Middle-Income Countries
M&E	Monitoring and Evaluation
MBSSE	Ministry of Basic and Senior Secondary Education
MCC	Ministerial Coordination Committee
MHH	Menstrual Health and Hygiene
MHM	Menstrual Hygiene Management
MLGRD	Ministry of Local Government and Rural Development
MoGCA	Ministry of Gender and Children's Affairs
MoH	Ministry of Health
MoYA	Ministry of Youth Affairs
MoSW	Ministry of Social Welfare
MTHE	Ministry of Technical and Higher Education
OOSC	Out-of-School Children
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
SSS	Senior Secondary School
SRHR	Sexual and Reproductive Health and Rights
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Executive Summary

There is an extremely high prevalence of adolescent pregnancy and child marriage in Sierra Leone:

21%
of girls aged 15–19 years have begun childbearing.

30%
of women in the same age bracket were married before the age of 18 years.

12.5%
of women aged 20–24 years were married before the age of 15 years.

Adolescence is a very complex, dynamic, and critical transformational stage in the lifecycle of an individual. It is a unique period in the development of a normal human being, and it is important for the individual to lay a good foundation for future wellbeing. Ensuring a safe transition from adolescence to adulthood is not only desirable from a human rights perspective, but also from the perspective of socioeconomic development of the country.

Adolescent pregnancy is caused by a range of complex factors that cut across multiple sectors and disciplines. While adolescent girls and boys suffer considerably and most visibly as a result of adolescent pregnancy and child marriage, it also adversely affects their families and communities. Furthermore, babies born to adolescents, even if they survive from birth, have an extremely rough start in life and are likely to be deprived in multiple domains of wellbeing. In short, the whole fabric of Sierra Leonean society is adversely affected, calling for immediate and sustained multisectoral efforts to address the causes of adolescent pregnancy and child marriage. This will require strong collaboration across the Ministries, Departments, and Agencies (MDAs), civil society organizations, and development partners, as well as a common vision, goals, and strategic actions. Hence, this strategy was developed. It will serve as a guiding framework for all stakeholders to plan and implement the needed actions during the 2025–2030 period.

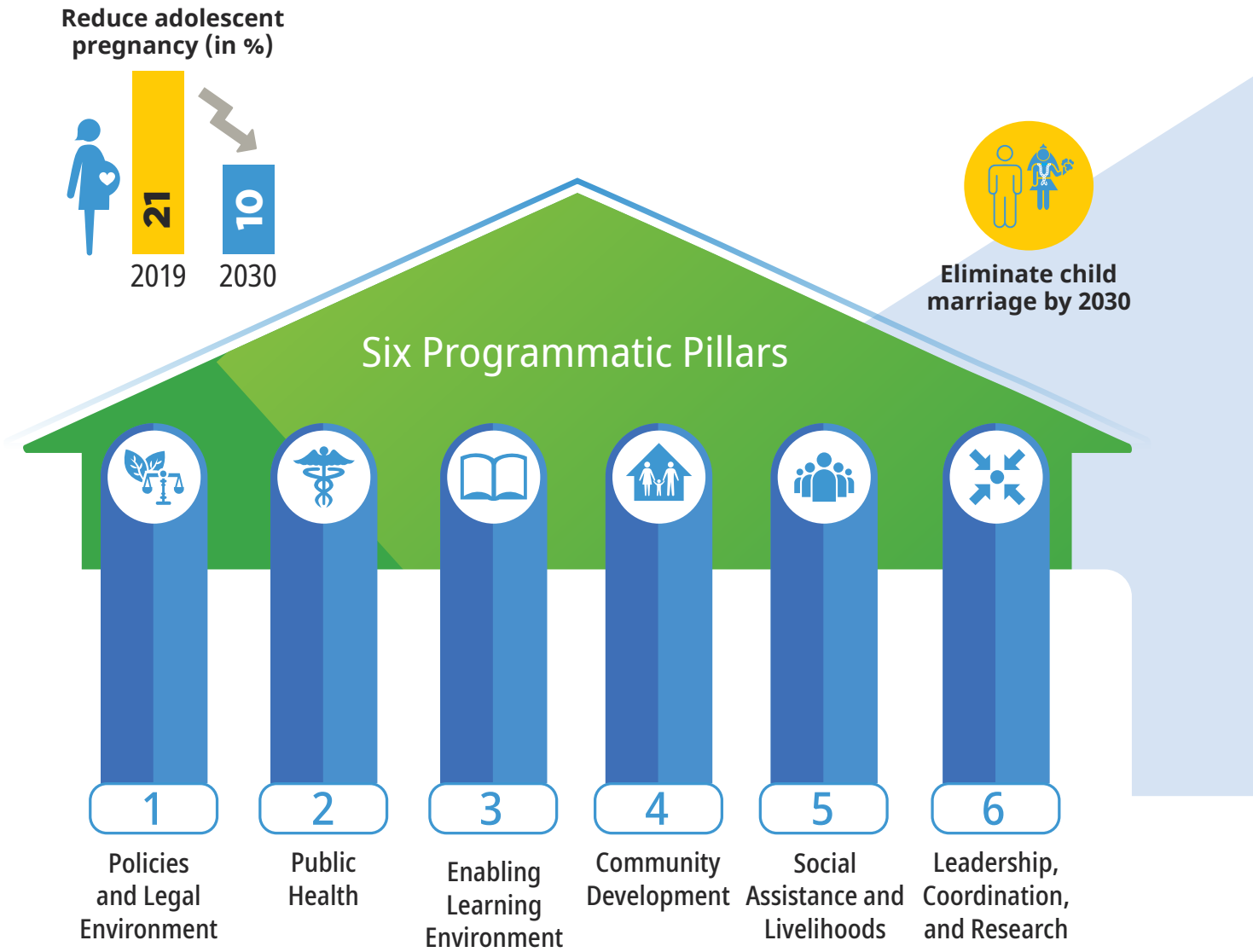
The purpose of this National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage 2025–2030 is to galvanize strong and effective partnerships to accelerate and integrate efforts to improve and sustain a good health status and overall

wellbeing for adolescents in the country. This, in turn, can be expected to promote meaningful socioeconomic growth and development.

In alignment with national, regional, and global commitments, this strategy has two interlinked goals. Goal 1 will focus on adolescent pregnancy and Goal 2, on child marriage. Aligned with the sustainable development goal (SDG) targets for reducing adolescent pregnancy and eventually eliminating child marriage, this strategy will strive to achieve the following objectives:

A causal analysis of adolescent pregnancy and child marriage in Sierra Leone reveals that the main underlying causes include poor accountability for gender-based violence (GBV), inadequate sexual and reproductive health (SRH) and education services for adolescent girls and boys, harmful gender norms and practices, and widespread and persistent poverty.

Hence, a national strategy with the following six programmatic pillars is proposed to address the wide range of underlying causes, which lead to adolescent pregnancy and child marriage:



A monitoring and evaluation (M&E) guide, a costing framework, and an implementation plan will be developed to support the roll-out of the strategy.

1

Introduction

1.1 General Background

Sierra Leone is classified as a low-income country (countries with per capita income of $1,135 or less). As part of addressing the general socioeconomic problems of the country, Sierra Leone identified teenage pregnancy and child marriage as priority areas of intervention.

Adolescents (aged 10–19 years) make up a significant portion of Sierra Leone's population. According to recent data, about 41 per cent of the population is under the age of 15 years, and 62.5 per cent are under 25 years old.

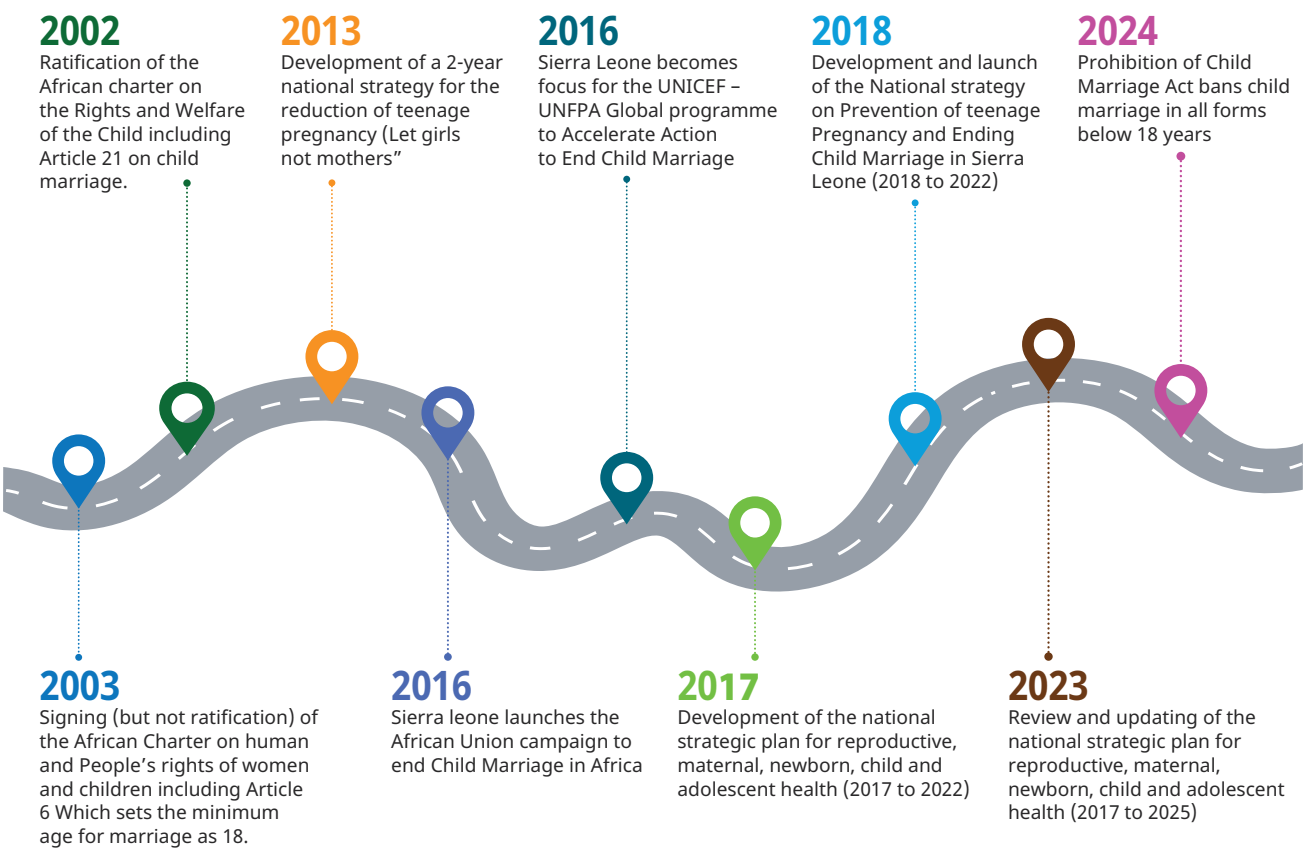
This highlights the youthful nature of the country's demographic structure. Adolescent girls (aged 10–14 years) make up about 12.6 per cent of the female population. The proportion of young adolescent girls in 2004 and 2015 was 5.3 per cent and 6.4 per cent, respectively of the country's population. This demographic structure is crucial for the country's development, given the challenges and opportunities they face.

Following prolonged efforts, as summarized in Figure 1 below, adolescent pregnancy in Sierra Leone has fallen from 34 per cent in 2008 to 21 per cent in 2019, and the proportion of women aged 20–24 years who were married or in union before the age of 18 years has also fallen from 48.4 per cent to 30 per cent during the same period. The adolescent birth rate decreased (from 125.1 per 1,000 women aged 15–19 years in 2013, to 102 in 2019), in parallel with the child marriage rates. Even though these rates have declined, but the percentage of women aged 20–49 years who had sexual intercourse by the age of 18 years has increased from 67 per cent in 2008 to 74 per cent in 2019. A quarter of women (20–49 years) reported that they had their sexual debut before the age 15 years.[1]

1. Child Frontiers. (2022). Child Marriage Strategy.

This demographic structure is crucial for the country's development, given the challenges and opportunities they face. Adolescents (aged 10–19 years) make up a significant portion of Sierra Leone's population.

Figure 1 | *Timeline of Sierra Leone's efforts to reduce adolescent pregnancy and child marriage*



Sierra Leone is a signatory to numerous regional and global initiatives aimed at strengthening collaboration for improving meaningful socioeconomic growth and development of all countries in respective regions of the world. It is also one of the countries chosen for the United Nations Population Fund (UNFPA) – United Nations Children's Fund (UNICEF) Global Programme to Accelerate Action to End Child Marriage. The joint programme is now in its third phase, from January 2024 through 2030.

Concerted work on the reduction of adolescent pregnancy and child marriage in Sierra Leone commenced in 2013. In collaboration with development partners, the country formulated and launched the first strategy in March 2013 for the reduction of teenage pregnancy during the period 2013–2015. Noting the multifaceted complexity associated with the problem, a multisectoral task force was constituted, comprising of the Ministry of Health and Sanitation (MoHS), Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA), Ministry of Basic and Senior Secondary Education (MBSSE), Ministry of Local Government and Rural Development (MLGRD) and Ministry of Youth Affairs (MOYA).

Subsequently, the second National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018–2022) in Sierra Leone was developed. The second strategy was launched simultaneously with the "Hands Off Our Girls" campaign championed by Her Excellency – the First Lady of Republic of Sierra Leone, which strengthened the implementation of the strategy.

The Prohibition Against Child Marriage Act (2024) bans child marriage, closing the previously existing loophole between the Child's Rights Act (2007), and the Customary Rights of Marriage and Divorce Act (2009). However, enforcing this ban in ways that are supportive of adolescents and their families will be important going forward.

1.2 Rationale for the Strategy

Adolescent pregnancy and child marriage are critical issues in Sierra Leone, significantly impacting the health, education, and economic prospects of young girls. Maternal morbidity and mortality rates in Sierra Leone have been driven up by the high prevalence of adolescent pregnancy and child marriage. Pregnancy complications and unsafe abortions are the leading causes of death among 15–19-year-old girls. Most adolescent mortality and morbidity are preventable or treatable, but adolescents face specific barriers in accessing health information and services.

Adolescent pregnancy leads to school dropout for both girls and boys. If boys take responsibility for a pregnancy, they are expected to provide for child and mother, so they leave school so that they can earn money. As for girls, although the "National Policy for Radical Inclusion Policy" has made it officially possible for them to resume schooling following the childbirth, in practice it remains difficult for them to do so due to lack of childcare for their babies (especially before they start walking), their own health complications, family expectations, etc.

Addressing these challenges requires a comprehensive and multisectoral strategy that involves various stakeholders, including government ministries, non-governmental organizations (NGOs), civil society, adolescents, young people, and the communities themselves. Teenage pregnancy rates are also alarmingly high, with significant health risks for both mothers and their children. By protecting and empowering young girls, Sierra Leone can break the cycle of poverty, improve their health outcomes, and promote sustainable development.

Impact on Health and Education

Early pregnancies and marriages often lead to severe health complications, including maternal and infant mortality. Young mothers are more likely to experience complications during childbirth, and their children face higher risks of neonatal and infant mortality. Additionally, teenage pregnancy and child marriage disrupt girls' education, limiting their future opportunities and perpetuating cycles of poverty.

Economic and Social Consequences

The economic impact of teenage pregnancy and child marriage is profound. Girls who marry and have children early are less likely to complete their education and more likely to remain in poverty. This not only affects their personal economic prospects, but also hampers national economic growth. Socially, these practices reinforce gender inequality and limit the potential of half the population.

In Sierra Leone, deep-rooted beliefs about the roles of women and girls in the society reinforce gender inequality and limit girls' potential. Gender and societal norms significantly impact the lives of adolescent girls, influencing their education, health, and overall well-being. Societal expectations often dictate that girls should prioritize domestic duties over education. This results in unequal distribution of time and resources, limiting girls' educational opportunities. High rates of early marriage and teenage pregnancy disrupt girls' education, leading to higher dropout rates. In many communities, there are few female role models, which affects girls' aspirations and motivation to pursue education. Early pregnancies pose significant health risks, including complications during childbirth and higher rates of maternal and infant mortality. High levels of GBV, including sexual violence, leave young girls vulnerable and affect their physical and mental health. Financial constraints often force families to prioritize boys' education over girls', perpetuating cycles of poverty and limiting girls' future economic opportunities.

Gender and societal norms significantly impact the lives of adolescent girls, influencing their education, health, and overall well-being. Societal expectations often dictate that girls should prioritize domestic duties over education.

A multisectoral strategy is essential to address the complex and interrelated factors contributing to teenage pregnancy and child marriage. This approach involves:

Economic Empowerment

Creating economic opportunities for young women and their families to reduce the economic incentives for early marriage.

Community Engagement

Initiatives to engage communities in dialogue about gender roles and the importance of girls' education are crucial. Changing harmful perceptions requires localized efforts and community involvement.

Health Services

Providing adolescent-friendly health services, including reproductive health care and counseling.

Policy and Legal Frameworks

Strengthening and enforcing laws that protect girls from early marriage and GBV is essential. Policies such as the 'Prohibition of the Child Marriage Law and National Policy on Radical Inclusion in Schools' aim to support pregnant girls and adolescent mothers in continuing their education.

Enabling Learning Environment

Ensuring access to quality education for girls, including child adolescent health and life skills to empower them with knowledge and skills.

Support Systems

Providing access to female role models, quality teacher training, and comprehensive sexuality education can help shift harmful gender norms and support girls' development.

Developing a multisectoral strategy to address adolescent pregnancy and child marriage in Sierra Leone is not just a moral imperative, but also a strategic investment in the country's future. This will require strong coordination and collaboration across MDAs, civil society organizations, and development partners, to create a cohesive and effective response. A common vision, goals, and the implementation of a strategic set of synchronized actions is also required.

1.3 Methodology

This strategic document was developed through a highly consultative process. The key phases and approaches for the strategic plan development include: literature review, consultations at national and subnational level, regional- and global-level consultations. There was an initial desk review of all

The purpose of the **desk review** was to ensure strategy alignment to national, regional, and global policy and strategic documents, provide contextual understanding on prevention of adolescent pregnancy and ending child marriage, understand documented drivers of adolescent pregnancy and child marriages, understand documented evidence-based strategies and lessons for prevention of adolescent pregnancy and ending child marriage.

relevant documents, followed by ongoing consultations with Technical Working Group (TWG) and stakeholders including adolescents and caregivers both at national, subnational, and community levels.

The purpose of the desk review was to ensure strategy alignment to national, regional, and global policy and strategic documents, provide contextual understanding on prevention of adolescent pregnancy and ending child marriage, understand documented drivers of adolescent pregnancy and child marriages, understand documented evidence-based strategies and lessons for prevention of adolescent pregnancy and ending child marriage. The literature review involved online research from relevant websites and documents provided by UNFPA, UNICEF, and the secretariat.

To supplement findings in the literature review, targeted consultations were conducted at national and subnational levels. The subnational level consultations were organized at regional levels where several districts were combined in one region and one-day consultative meeting held. Participants at these regional consultative meetings included representatives from line ministries and departments including health, education, social welfare, and gender, implementing partners, teachers, parents, religious and community leaders, and more importantly adolescent boys and girls. Consultations at national level targeted the Secretariat, UNFPA, and UNICEF, relevant development and implementing partners, and the line ministries. Additionally, to ensure alignment to global policies and commitments and to benefit from lessons learnt and best practices, targeted consultations were held with regional and global experts in the prevention of adolescent pregnancy and ending child marriage. One-on-one consultations were also held with key locals from the line ministries to determine the required interventions and to shape the conversations around adolescent pregnancy and child marriage.

These inclusive consultative meetings have not only been educative, but they also have generated a pool of relevant and contextual information that have been used to design the strategy. An inclusive and participatory process with the wider group of stakeholders, including the target population, will further enrich this document and ownership. Practical and overarching issues mentioned by participants have been included in this document. Subsequently, a draft framework was developed and used to formulate the zero draft of the strategy. It was shared with members of the TWG for further consultations on making the document fit for purpose.

2

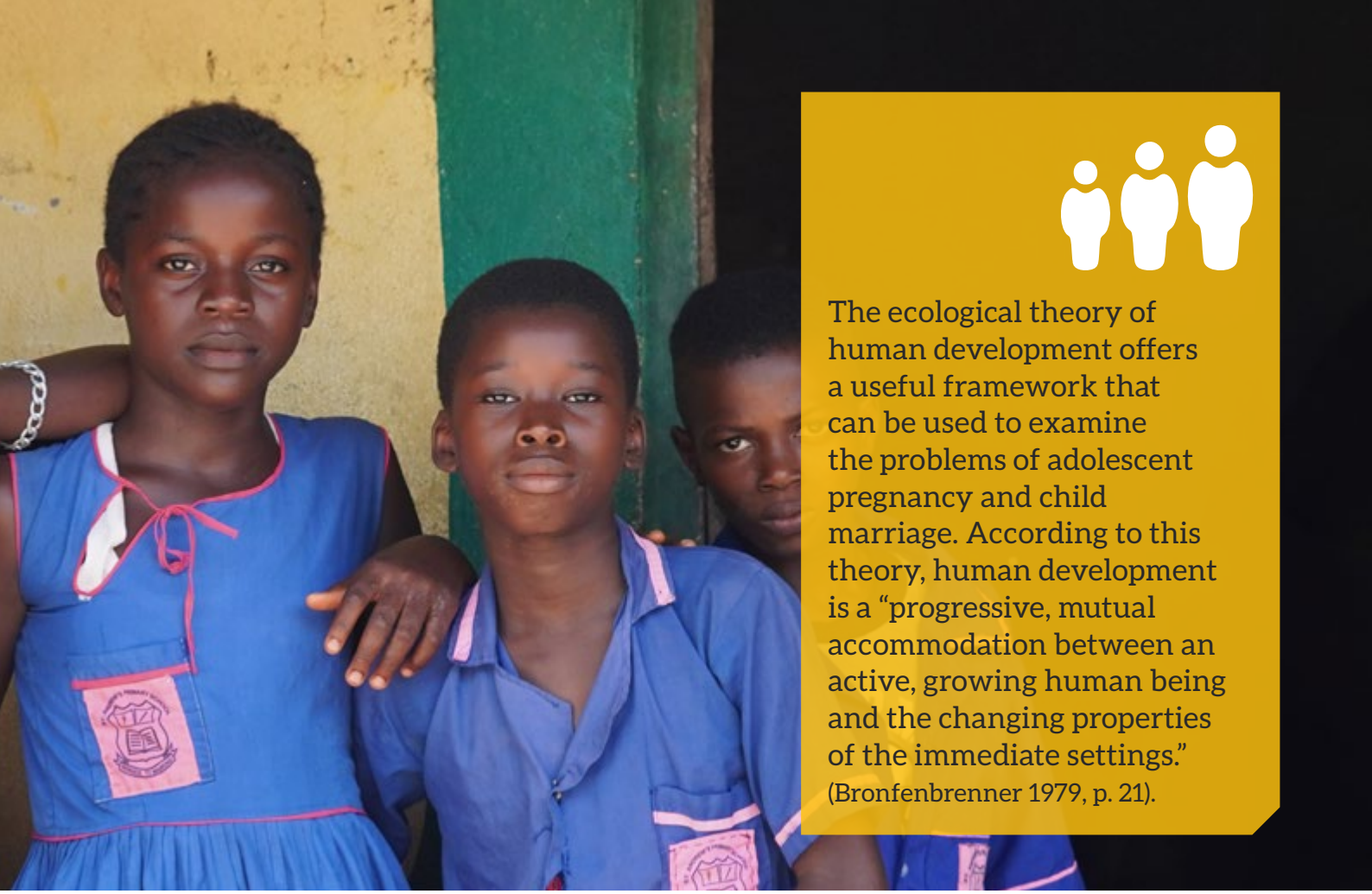
Situation Analysis of Adolescent Pregnancy and Child Marriage

2.1 Definitions and Global Context

Adolescent pregnancy, which refers to pregnancy in adolescents between ages 10–19 years, is a global public health and social problem that affects both developed and developing countries. Often unplanned, it is a global phenomenon with serious health, socioeconomic consequences. While countries across the globe have struggled with the issue of adolescent pregnancy, lower income countries and marginalized communities are particularly vulnerable to the phenomenon. Although a decline in adolescent birth rates has been observed globally, sub-Saharan Africa (SSA) continues to have twice the global average, with over 100 births per 1,000 women, in 2021.

Child marriage, which refers to marriage below the age of 18 years, constitutes a fundamental violation of several aspects of human rights; the right to make choices in life, health, education, safety, and security. It hinders progress toward the achievement of SDGs all over the world. Globally, prevalence (in percentage) and burden (in absolute numbers) of child marriage are going down, but not fast or equitably enough to meet the SDG target of ending the practice by 2030. Global prevalence is 19 per cent, down from 23 per cent a decade ago. Currently, 640 million girls and women alive today were married before the age of 18 years. At current rates of progress, it will take 300 years to end child marriage.

Adolescent pregnancy and child marriage are closely associated problems, with early marriage sometimes leading to early pregnancy, while at other times, it is early pregnancy that leads to early marriage or other forms of domestic unions. Both can adversely affect adolescents, their families, communities, and society. It denotes an unfortunate and premature prospect of a child becoming a mother or father, presenting serious risks to their physical and/or mental health, as well as to their future prospects and



The ecological theory of human development offers a useful framework that can be used to examine the problems of adolescent pregnancy and child marriage. According to this theory, human development is a "progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings." (Bronfenbrenner 1979, p. 21).

to the well-being of any children born under such circumstances.

In most countries, adolescent pregnancy is stigmatized, often resulting in socioeconomic disadvantages. Unmarried pregnant adolescents may face rejection by parents and peers as well as threats of violence. Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership. Adolescent pregnancy also increases the likelihood of dropping out of school, especially for girls, thus limiting their economic prospects, opportunities for future employment and perpetuating the cycle of poverty. Furthermore, the high rates of morbidity and mortality observed in teenagers and their babies exert a huge burden on the health-care delivery system and the overall economy of the country.

In 2015, global leaders included a target to end child marriage under Goal 5 (achieve gender equality and empower all women and girls) as part of the SDGs. Strategies and interventions related to adolescent pregnancy have focused on pregnancy prevention. Preventing adolescent pregnancy and childbearing as well as child marriage is part of the SDG agenda with dedicated indicators, including indicator 3.7.2, "Adolescent birth rate (aged 10–14 years and 15–19 years) per 1,000 women in that age group," and 5.3.1, "Proportion of women aged 20–24 years married before the age of 18 years".

2.2 The Socio-ecological Model for Adolescent Pregnancy and Child Marriage

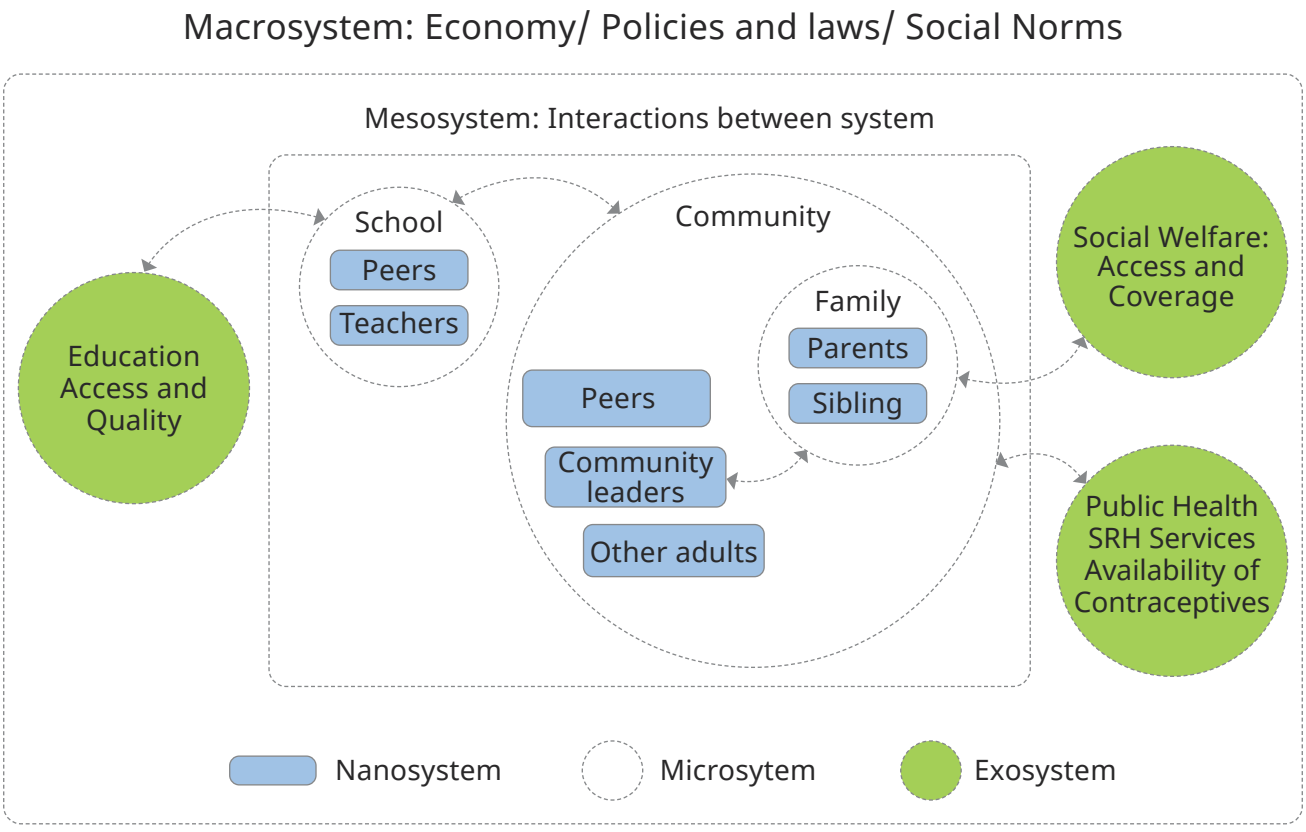
The ecological theory of human development (Bronfenbrenner, 1979) offers a useful framework that can be used to examine the problems of adolescent pregnancy and child marriage. According to this theory, human development is a "progressive, mutual

accommodation between an active, growing human being and the changing properties of the immediate settings" (p. 21). It conceives children's environments as modifiable structures rather than sociological givens, making it an apt model to consider for this strategy.

The theory and its accompanying framework recognize the inherent dynamism of adolescence, an ongoing transition from childhood to adulthood, as well as the importance of the settings in which adolescents are present and how they interact with these tasks. As such, the agency of adolescents, and of others in their immediate settings, is brought to the fore, providing a useful foundation for more empowering and human-centered approaches to addressing adolescent pregnancy and child marriage.

The main elements of this ecological framework are a set of nested structures in which the adolescent is embedded. These include: the macrosystem, this can be the economic and legal environment, as well as overall social norms such as those stemming from religion or national culture; the mesosystem, which represents the interactions between various microsystems and/or exosystems, such as the links between schools and parents; and exosystems, spaces where adolescents need not necessarily step into but nonetheless affect them. Finally, a useful additional structure is the nanosystem,[2] which refers to one-on-one relationships within microsystems, such as relationships that an adolescent might have with a parent, peer, teacher or health worker. Figure 2 illustrates these settings for an adolescent aged 10–19 years. A comprehensive strategy to reduce adolescent pregnancy and child marriage should consider all of them.

Figure 2 | *Ecological context of an adolescent at risk of early pregnancy and marriage*



[2] Stewart, J. (2011). Supporting refugee children: Strategies for educators. University of Toronto Press.

2.3 The Situation in Sierra Leone

Sierra Leone is still evolving from an unenviable era with some of the highest maternal, neonatal, and infant mortality ratios in the world. Through various national programmes, there are imperative drives to improve these indicators to an acceptable range. For instance:

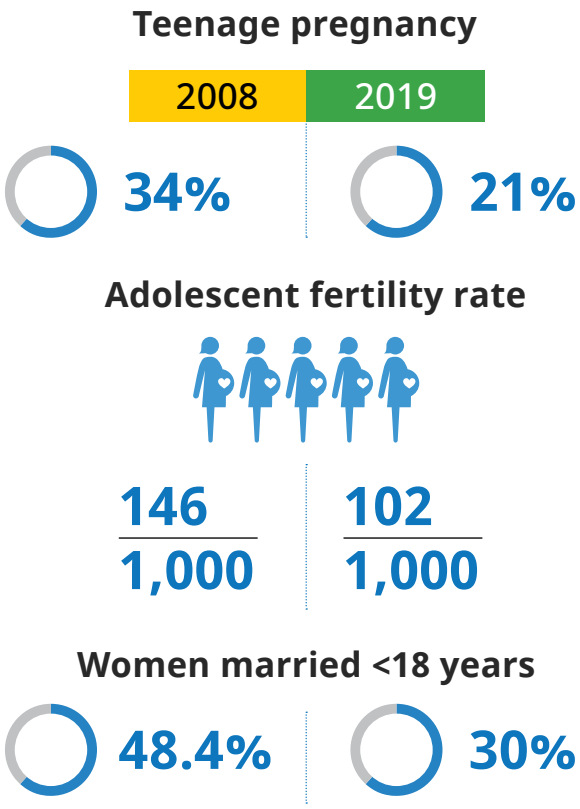


Table 1 | *Trends of key performance indicators*

Indicators	Years			
	2008 DHS	2013 DHS	2019 DHS	Other sources
Proportion of teenage pregnancy in Sierra Leone	34%	28%	21%	–
Adolescent fertility rate/birth per 1,000 women aged 15–19 years	146/1,000	125/1,000	102/1,000	
Proportion of women aged 20–24 years who were married or in union before the age of 18 years	48.4%	39%	30%	
Proportion of women aged 15–19 years who reported physical violence	36%	50%	56%	
Proportion of women aged 15–19 years who reported sexual violence	9%	13%	14%	
Proportion of adolescents treated for STIs	–	16.8%	44.2%	HMIS/DHIS2
Proportion of adolescents who access postabortion care in the facilities	–	18.69%	22.94%	

(Abbreviations: HMIS: Health Management Information System; DHIS2: District Health Information System 2)

Source: Sierra Leone Demographic and Health Survey 2008, 2013, and 2019.

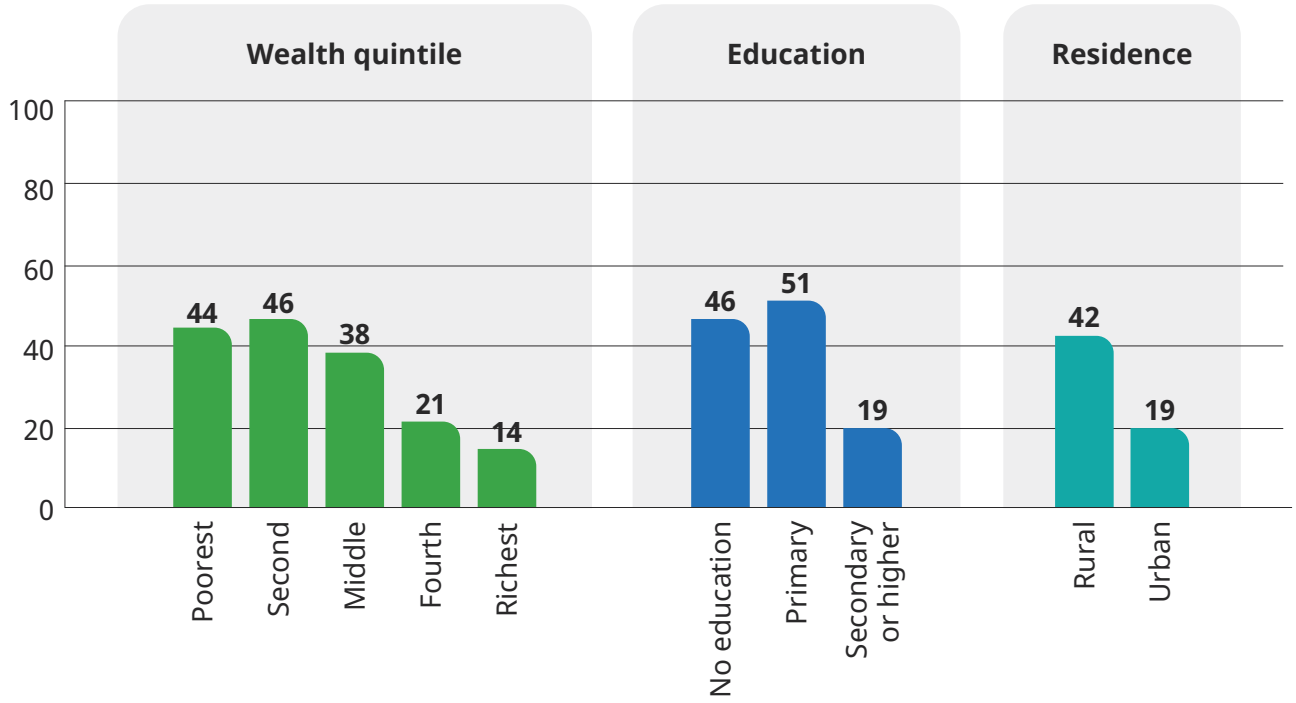
Nevertheless, there is need to continue working assiduously on improving these indicators further and addressing weak areas such as the increasing trends in the rate of reported physical and sexual violence among women aged 15–19 years.

2.3.1 | Patterns and trends of child marriage, adolescent pregnancy, and sexual debut

Sierra Leone is the home to over 776,000 child brides. Thirty per cent of girls are married before the age of 18 years and 9 per cent before the age of 15 years (253,600 girls).

In 2023, an estimated 28,500 adolescent girls were at the risk of getting married in Sierra Leone; 7 per cent boys are married before the age of 18 years. Figures 3A to C given below [adapted from Demographic and Health Survey (DHS) 2019] illustrates some of the patterns of child marriage in the country.

Figure 3A to C | *Percentage of women aged 20–24 years who were first married or in union before age of 18 years by (A) wealth quintile, (B) education, and (C) residence*



Source: Adapted from DHS 2019. Joachim Theis, Child Frontiers - Child Marriage in Sierra Leone: a Strategy Note.

➲ **Child marriage and poverty:**

Child marriage rates are higher among the three poorest quintiles and only drop significantly among the two wealthiest quintiles. This reflects the depth and high levels of poverty in Sierra Leone and means that targeting of interventions to end child marriage has to be broad-based across the three poorest quintiles.

➲ **Child marriage and education:**

Women aged 20–24 years who were married before 18 years are more than twice as likely to have no or primary education than secondary or higher education.

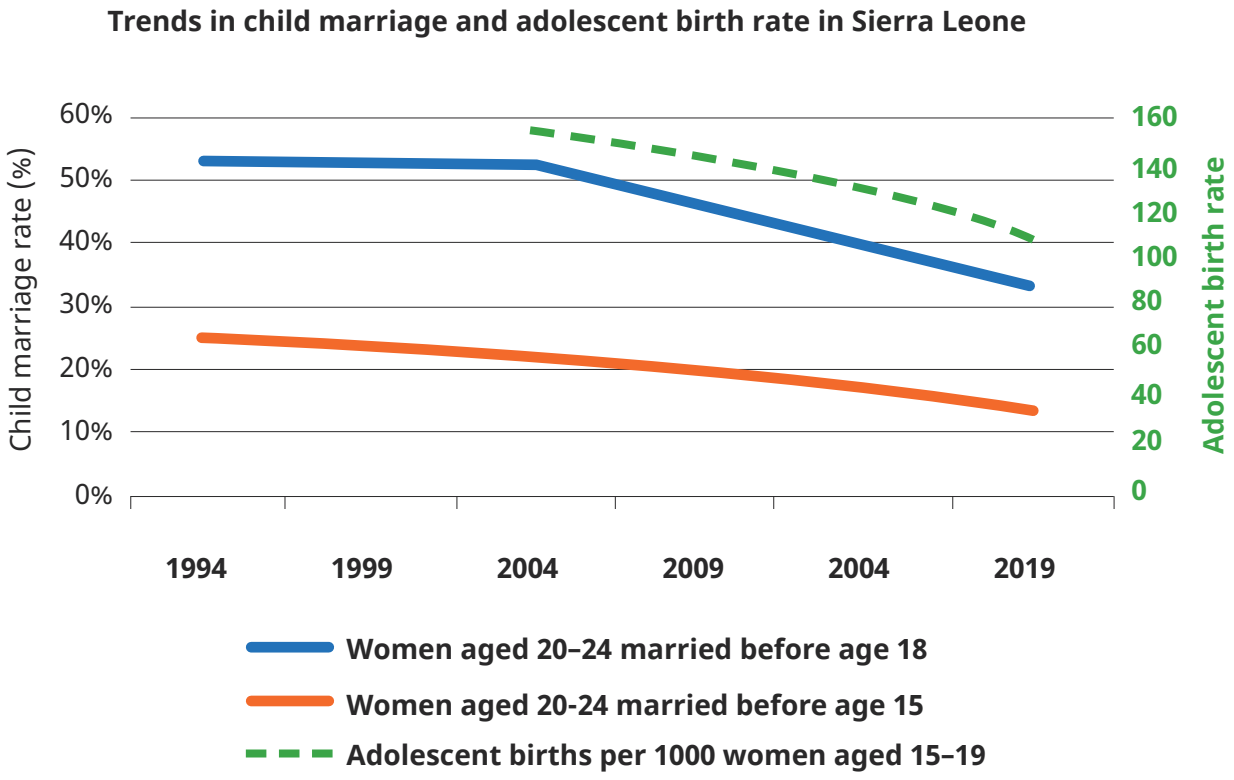
➲ **Child marriage and residence:**

Child marriage rates are much higher in rural areas than urban areas. Women aged 20–24 years who were married before 18 years are more than twice as likely to live in rural areas than urban areas (Figure 4).

Child marriage before the age of 15 years declined from 21% in 1994 to 9% in 2019.

Trends: Child marriage before the age of 18 years declined from 51 per cent in 1994 to 30 per cent in 2019. The downward trend only began in 2004. Child marriage before the age of 15 years declined from 21 per cent in 1994 to 9 per cent in 2019. The adolescent birth rate decreased in parallel with the child marriage rates. While these trends are encouraging, they are not fast enough to end child marriage by 2030.

Figure 4 | *Percentage of women aged 20–24 years who were first married or in union before the age between 15 and 18 years*



Source: Joachim Theis, Child Frontiers - Child Marriage in Sierra Leone: a Strategy Note.

➲ **Median age at first marriage:**

In line with the decrease in child marriage rates, the median age at first marriage among women aged 20–49 years increased from 17.2 years in 2008 to 19.8 years in 2019.

There has been a steady decline in the total fertility rate for all women of reproductive age (15–49 years) in the country from 5.1 children per woman in 2008 to 4.2 in 2019 (Figure 5). There has been a similar decline among women in rural areas (5.8–5.1%) and urban areas (3.8–3.1%) during the same period.

Fertility decreases with increasing levels of education and of household wealth. The median age at first birth among women aged 25–49 is 19.5 years; 21 per cent of women aged 15–19 years had given birth or are pregnant with their first child.

Finally, the median age at first sexual intercourse is 16.1 years among women aged 20–49 years and 18.3 years among men aged 20–49 years. By the age of 15 years, over a quarter (26 per cent) of women (20–49 years) reported that they have had their sexual debut

Figure 5 | *Percentage of teenagers who have begun childbearing (adolescent girls aged 15–19 years)*

Source: Adapted from DHS 2019. Joachim Theis, Child Frontiers - Child Marriage in Sierra Leone: a Strategy Note.

by the time they were 15 years, as compared to 7 per cent of men. While child marriage and adolescent fertility have declined, the percentage of women aged 20–49 years who have had sexual intercourse by the age of 18 years increased from 67 per cent in 2008 to 74 per cent in 2019.

2.3.2 Drivers of adolescent pregnancy and child marriage

Among adolescent girls who had their first birth before the age of 18 years: 50 per cent of these births were outside of marriage, 60 per cent were conceived before marriage and led to marriage/union, while the remaining 40 per cent of births were conceived in marriage/union.

Adolescent pregnancy is often caused by a mix of early-sexual debut and lack of contraceptive usage. These, in turn, are caused by the interplay of a wide range of intermediate causes, including the practice of transactional sex, long distances to school and water sources, which leave girls vulnerable to violence and exploitation, demands for sex, and other forms of GBV from teachers, drop-out from school coupled with lack of access to other learning opportunities, negative peer influence, mistrust and misconceptions about contraceptives, inability of girls to negotiate condom use, difficulties in accessing contraception (especially for unmarried adolescents) and limited interaction, and supportive guidance from parents.

The underlying causes leading to these intermediate causes include extreme poverty, lack of livelihood opportunities, a gendered economy (that leaves adolescent girls and young women with limited options to earn money and patterns of girls working or living outside the family home), inadequate public services (education, SRH, and water), inadequate parenting (including expectations that older girls and boys should provide for themselves), as well as harmful gender norms and inconsistent accountability for GBV.

Adolescent pregnancy is often caused by a mix of early-sexual debut and lack of contraceptive usage.

While adolescent pregnancy is emerging as the main immediate cause of child marriage or domestic unions in Sierra Leone, there are still cases where early marriage precedes pregnancy. This is especially common in rural areas, where girls might be betrothed to better-off, often older, men in the village, in exchange for financial support or other favors to their families who might be struggling to meet needs on their own due to limited disposable incomes. Although poverty and lack of livelihood opportunities are once again the underlying causes for this driver of child marriage, harmful social/gender norms also play a role by contributing to parents' inclination to use the marriageability of their children, especially girls, as a financial coping strategy for the family.

Figure 6 given below depicts these causal pathways for early pregnancy and early marriage for adolescents in Sierra Leone. It shows the multiple possible trajectories to an early marriage or domestic union for an adolescent in the country, so that all adolescents, no matter their trajectory, can be better supported to avoid early pregnancy and early marriage.

Figure 6 | *The causal framework for adolescent pregnancy and child marriage in Sierra Leone*

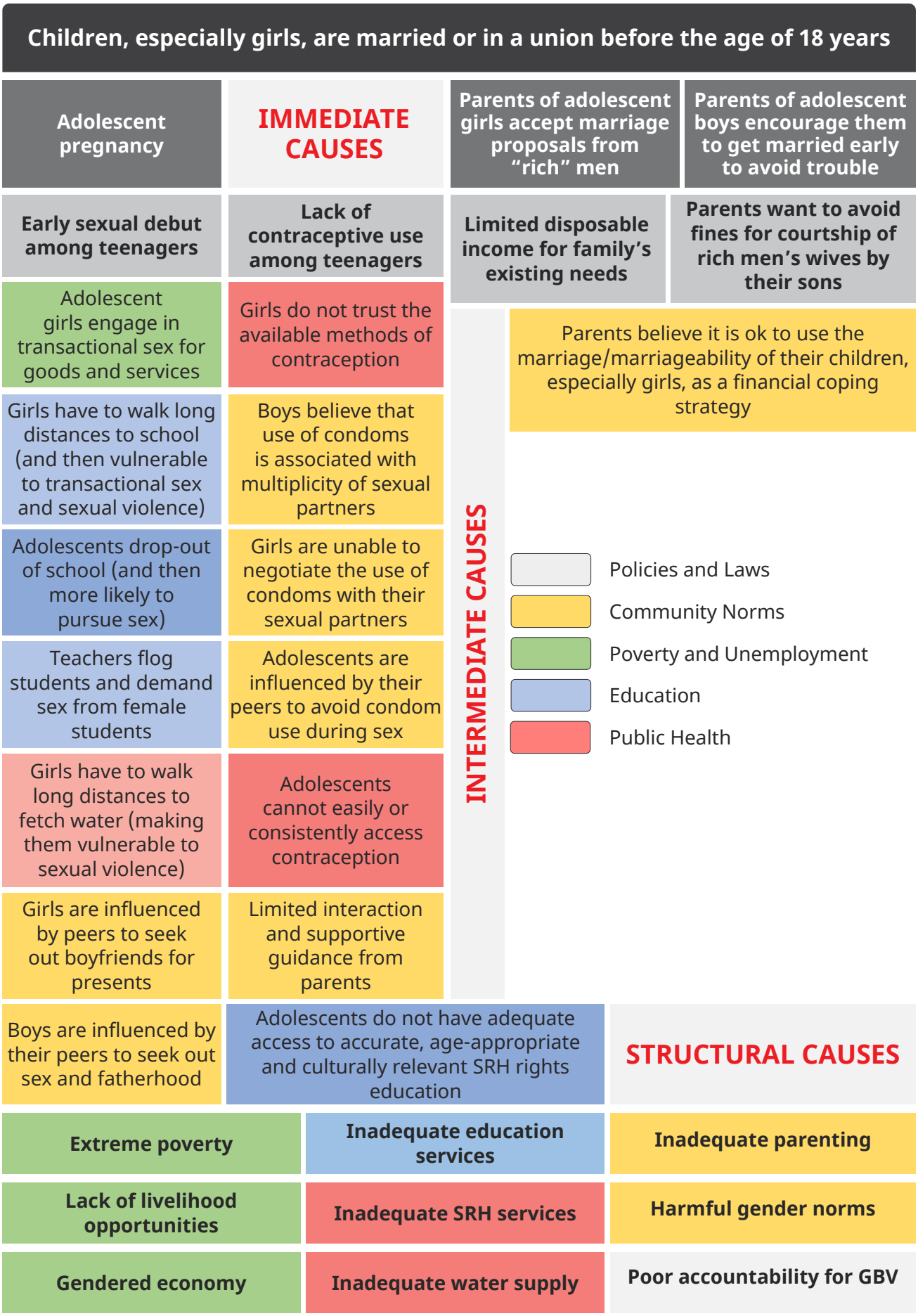
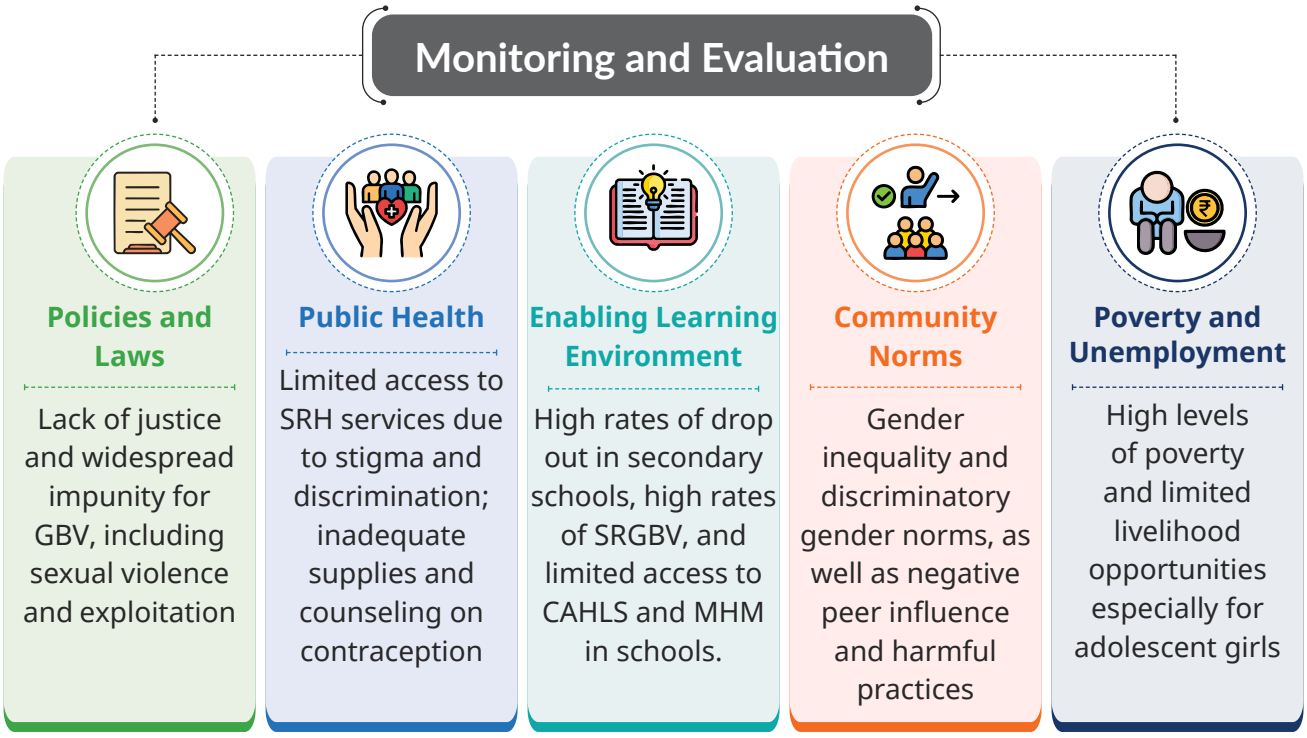


Figure 7 then lists down and categorized by sector, the driving factors (or drivers) which constitute the causal pathways depicted in Figure 6. It shows the issues or gaps specific to each sector, which must be addressed in order to reduce adolescent pregnancy and child marriage. As such, it lays the foundation for the pillars of this strategy, which are then presented in the next chapter.

Figure 7 | *The drivers of adolescent pregnancy and child marriage in Sierra Leone*



As shown in Figures 6 and 7, the causal framework for adolescent pregnancy and child marriage in Sierra Leone is complex, with many contributing factors or drivers across multiple sectors. These drivers are explained in more detail in the paragraphs below.

- **Polices and laws:**

There is poor and inconsistent accountability for GBV. Transactional sex is not perceived as criminal extortion or sexual exploitation. High rates of sexual violence are exacerbated by a context of impunity and victim blaming, where community leaders often discourage parents from reporting violence to the police and value settlement over prosecution. The justice system is weak, slow, and inaccessible for poor people in rural areas. Pursuing justice through the formal system takes time and requires money for transport.

- **Poverty and unemployment:**

Despite economic growth since the end of the civil war, poverty remains widespread in Sierra Leone. Adolescent girls are expected to provide for their own needs but have limited options to earn money. This forces many girls to engage in transactional sex to access goods for themselves (e.g., food, clothes, menstrual hygiene products, school supplies or transport) or to obtain money or food for their household. In turn, transactional sex often leads to pregnancy. Girls in Port Loko reported that most of the time their parents are unable to provide them with money to procure essential items including scholastic materials and sanitary towels. Girls who drop out of school are often left with two pathways to adulthood: working for money or childbearing and marriage (Figure 8). The economy is gendered: many women work in low-paid jobs

in the informal sector or in care professions; while school teachers are overwhelmingly male and transportation is considered a male profession. Okada motorcycle riders are often mentioned in reports to demand sex for transport. In a regional consultation meeting in Port Loko, girls reported "girl's poverty" as one of the big drivers to adolescent pregnancy and marriage. The girls reported that when their parents are unable to provide girl's needs, many of them are given money by men in exchange for sex. The girls reported that this was even worse among girls with single parents. To address this, the girls required monetary support, especially from vulnerable households.

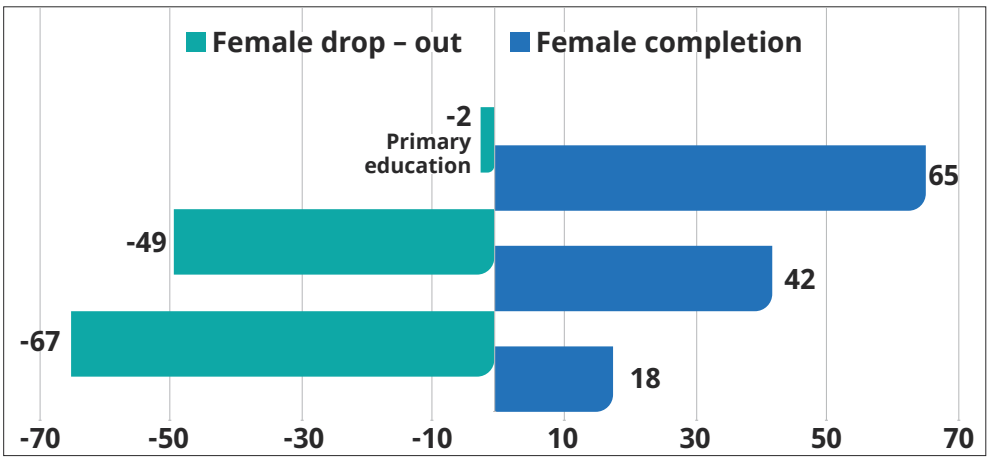
- **Public health:**

SRH service provision is not adolescent-friendly and weak service provision intensifies the problem of teenage pregnancy, especially in rural areas. SRH services may be inaccessible to adolescent girls due to distance, cost, stigma, and negative attitudes of health workers toward unmarried adolescent girls. Myths and misconceptions about the side effects of contraception also reduce their take up. A high level of stigma related to contraceptives means that girls are reluctant to get contraceptives from community health centers, where confidentiality may not be protected. Instead, girls may prefer to buy contraceptives from informal peddlers, who often sell expired products and are not able to advise on proper use. These challenges are underscored by the widespread belief that contraceptives are girls' responsibility and that it is girls who are responsible for ensuring that a pregnancy does not occur. Child protection services generally lack the capacity to provide follow-up support to vulnerable girls. Focus group discussions (FGDs) with girls in Port Loko identified that adolescent girls had challenges accessing youth-friendly services. Girls reported that some health workers had negative attitude and could not provide them condoms and other family planning methods. Many girls were feared about meeting their parents or relatives when they go to collect contraceptives. Additionally, the girls reported to lack of knowledge on family planning methods.

- **Enabling learning environment:**

A significant proportion of adolescent boys and girls is not attending school. As the statistics in the child marriage chapter showed, child marriage rates are less than half among girls who have completed secondary education or higher compared to girls with no or only primary education. Figure 8 (graph) gives a snapshot of girls' completion and drop-out rates for primary, lower and upper secondary education, indicating a sharp rise in out-of-school girls in lower and upper secondary education.

Figure 8 | *The drivers of adolescent pregnancy and child marriage in Sierra Leone*



Source: UNICEF. The State of the World's Children 2021. https://www.unicef.org/reports/state-worlds-children-2021.

Explaining this situation, education officials at the Port Loko consultation meeting identified that one of the biggest challenges with the transition and retention, especially at junior secondary school was the small number of secondary schools in most of the districts. They identified that many students had to travel long distances daily to attend junior secondary school and often migrated to board away from their homes to attend the even more distant senior secondary schools. For a comprehensive analysis, see the Education Sector Analysis of 2020.

Transactional sex and relationships exploit the vulnerabilities of adolescent girls and contribute to adolescent pregnancy. Without the means to pay for indirect school costs, girls are vulnerable to transactional relationships with working men, such as Okada drivers or mine workers. These men give them money for lunch and materials or provide transport to school in exchange for sex. This abuse of adolescent girls, who are too young to consent, increases the risk of adolescent pregnancies, causing girls to drop out-of-school and perpetuating the cycle of poverty. Girls who enter into these relationships often feel they do not have a choice. A teacher in Kambia felt that girls striking up relationships with bike riders was becoming an increasingly serious issue, with some girls even staying at their homes. She said, “When we talk to the girls they say ‘he is the one paying for my lunch’ and they will take it that they have no option. And to leave that is not easy or possible”. The likelihood of transactional relationships increases when girls move away from their parents for school.

Besides long distances and lack of affordable transportation to school, there are also several other reasons leading to drop out from schools, for both boys and girls. The cost of pamphlets, stationery, and other required school materials can be unaffordable for many

Girls are more likely to be called ‘wife’ or ‘girlfriend’ by teachers and receive demands for sex in exchange for grades.

families and reportedly punished by teachers for not paying fees. The problem of GBV in schools is now widely acknowledged, including bullying among peers and abuse of authority by teachers. Students are not taught life skills and struggle to navigate difficult relationships. Flogging of students by teachers is widespread, with boys being more likely than girls to be flogged. On the other hand, girls are more likely to be called ‘wife’ or ‘girlfriend’ by teachers and receive demands for sex in exchange for grades. Finally, the lack of adequate sanitary facilities in schools (i.e., separate toilets for boys and girls, teachers and students, toilets with soap and water available) and difficulties in accessing menstrual hygiene products, makes it additionally difficult for girls to continue their schooling regularly once they start menstruating.

While girls do face significantly more challenges for continuing their education, it should be noted that, for reasons already mentioned, it is not easy for boys to complete secondary education either. Furthermore, it should also be noted that when boys drop out-of-school, they are more likely to engage in risky behaviors such as unprotected sex with girls in their community. Parents too tend to be more inclined to encourage or force child marriage if their child has dropped out-of-school, regardless of gender.

- **Community norms:**

Girls and women are expected to be obedient to men, which makes it harder for girls to express their needs, or to resist control or abuse by men. But the ideal of submissive femininity contrasts with the widespread community perception that adolescent girls engage in sex because they are disobedient and want material goods. While premarital sexual relations are widely condoned, pregnancy out-of-marriage is viewed as a girl’s moral failure and a source of shame for the family. Another common opinion is that girls should focus on their studies and ignore the advances of men in order to avoid pregnancy. But this view ignores the socioeconomic factors that make it difficult for many girls to say “no to sex”. Girls are widely viewed as having a great deal of power to choose whether to engage in sex or use contraceptives – but this is not the case in reality as the access to SRH services is very limited. Girls are also initiated into Bondo, the women’s secret society, once they begin to menstruate. After this imitation, they are considered ready to begin sexual relationships. Sex and pregnancy are viewed as signs of maturity and fertility among adolescents, which results in peer pressure to engage in sexual relationships.

Box 1

A reason to hope: Shifts in community norms and expectations

During the civil war, adolescent girls were forcibly recruited as child soldiers and took on roles that were not compatible with traditional expectations of what girls should or should not do. "It is now widely recognized that conflict throws gender roles and relations into flux, and that women and men are affected differently by conflict. As a result, space can be created for the renegotiation of gendered stereotypes and the consolidation of gains made by women during conflict." As a result of the conflict and of other societal changes (urban migration, etc.), conflicting and contradictory values and expectations exist side-by-side.

Within communities, traditional norms about the value of child marriage exist alongside newer ideas about the importance of girls' education. Beliefs and social norms are not aligned with the realities of gendered poverty that forces girls to extract value from their bodies in order to survive. Cultural norms have already become unstuck. These shifts in values can provide opportunities for advancing new, more empowering norms that can help protect girls from pregnancy and marriage and support them to imagine a greater range of possible futures – beyond marriage and motherhood.

3

The Strategy

3.1 Purpose, Vision, Goals, and Objectives

According to the population pyramid of 2023, Sierra Leone has a young population and low-life expectancy. It is critical to invest in strategies and activities that will ultimately improve the health and education of the youthful population, including boys and girls.

The purpose of this National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage 2025–2030 is to galvanize strong and effective partnerships to accelerate and integrate efforts to improve and sustain a good health status and overall well-being for adolescents in the country. This in turn, can be expected to promote meaningful socioeconomic growth and development.

The proposed pillars of the strategy will provide opportunities for adolescents to access equitable health services, build their agency and better enable them to participate in productive sectors of the economy and contribute to the country's growth and development.

The vision is for all adolescents, girls and boys, to fulfil their full potential free from the risks and adverse consequences of adolescent pregnancy and child marriage.

In alignment with national, regional, and global commitments, this strategy will have two interlinked goals. Goal 1 will focus on adolescent pregnancy and Goal 2, on child marriage. Aligned with the SDG targets for reducing adolescent pregnancy and eventually eliminating child marriage, these twin goals can be presented as follows.

Twin Goals

Goal 1:
Contribute to the SDG target 3.7 of ensuring universal access for adolescents including for family planning

Goal 2:
Contribute to the SDG target 5.3 of eliminating child marriage and other harmful practices in Sierra Leone by 2030

More specifically, this strategy will strive to achieve the following objectives:

- Reduce adolescent pregnancy from 21% in 2019 to 10% in 2030
- Eliminate child marriage by 2030

3.2 Core Principles

The following guiding principles have taken into consideration the complex, diverse, and dynamic array of factors which influence the welfare, prospects, growth, and development of adolescents.

Adolescent-friendliness: in everything we do, the best interest of children and adolescents should come first, as well as their preferred modes of engagement;

Participation: recognizing the agency of children and adolescents, opportunities should be provided to them to participate in all activities and decisions that impact them;

Rights-based approach: we will promote the rights of all children and uphold their dignity;

Ensuring equity: the strategy will work toward achieving equity by considering special needs and leaving no one behind (including girls and boys, those in rural and urban areas, and those with and without disabilities, etc.);

Gender-transformative approach: the strategy will address issues of gender inequality, promote positive masculinities, and empower girls;

Community ownership: establishing strong community ownership of public health programmes serves not only as an effective strategy for achieving the goals and objectives of the programme, but also as a strong foundation for sustainability of its impact;

Multisectoral and multidisciplinary approach: duty bearers and changemakers in all relevant sectors should be engaged and collaborate accountably for the implementation of the strategy;

Evidence-based: only strategies that are supported by evidence as being effective have been included in this strategy;

Context specific: the strategy will adopt all current issues of priority focus at the regional and global levels and adapt them to the context of Sierra Leone.

3.2 The Pillars

Based on the causal analysis of adolescent pregnancy and child marriage in Sierra Leone (see detailed in Section 2.3.2 “Drivers of adolescent pregnancy and child marriage”), a national strategy with five programmatic pillars and one cross-cutting ‘systems’ pillar is proposed. This will allow addressing the wide range of underlying causes, which lead to adolescent pregnancy and child marriage.

These pillars are depicted, along with the strategic objective of each pillar, in Figure 9 below. They include:

Pillar 1: Policies and Legal Environment

Pillar 2: Public Health

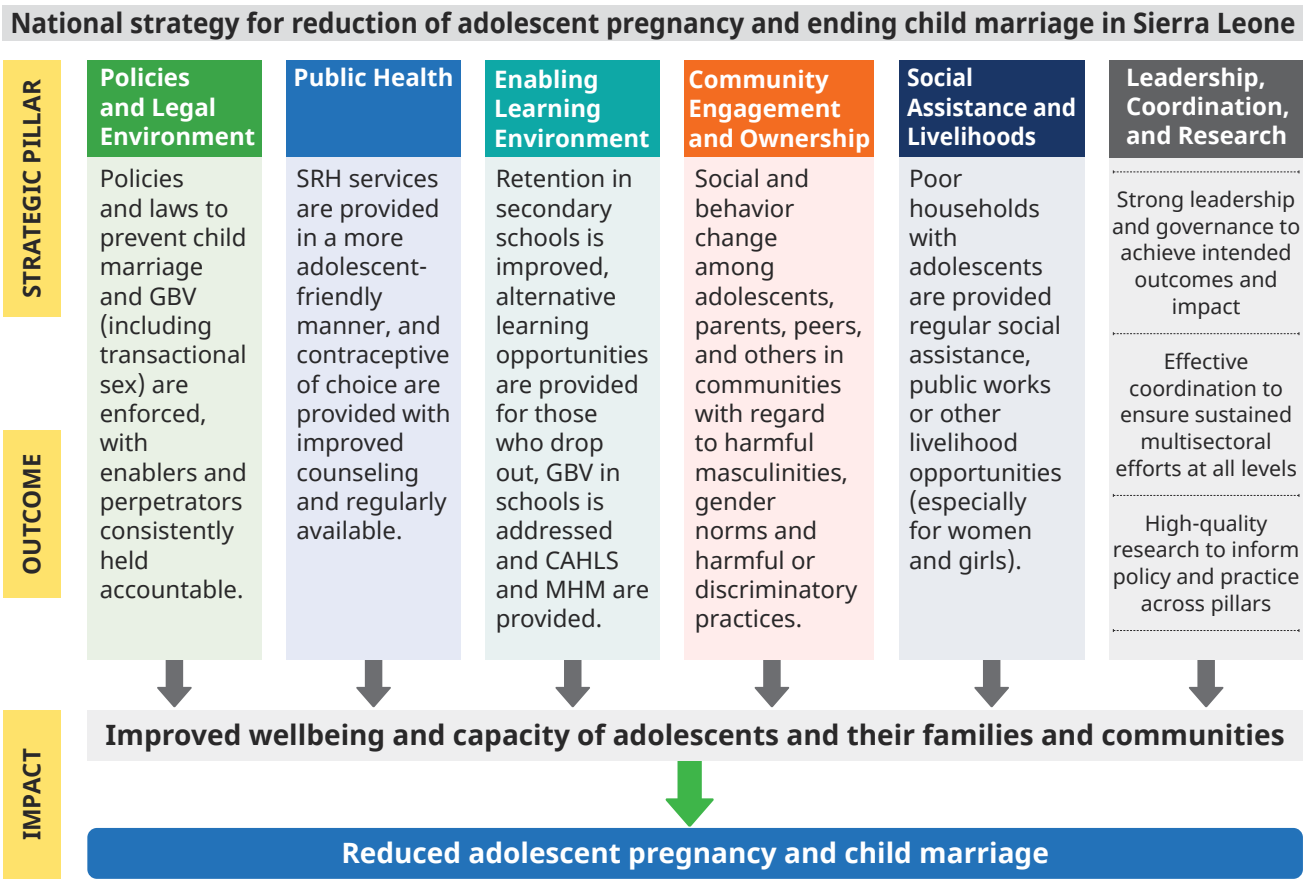
Pillar 3: Enabling Learning Environment

Pillar 4: Community Engagement and Ownership

Pillar 5: Social Assistance and Livelihoods

Pillar 6: Leadership, Coordination, and Research

Figure 9 | *Pillars of the national strategy for reduction of adolescent pregnancy and ending child marriage*



3.3.1 Strategic Pillar 1: Policy and Legal Environment

The development of laws and policies provides the overall framework for affecting change in any domain. As such, this pillar will ensure focus on the review and/or development of new policies and laws that better protect and support adolescents against GBV, taking into consideration the context, needs, and aspirations of adolescents. For policies and laws that have already been developed toward this end, actions needed to enhance implementation and enforcement will also be included under this pillar.

Strategic Objective 1:

Improved and consistent accountability for perpetrators and enablers of GBV (including child marriage, transactional sex, and other forms of sexual exploitation).

Table 1 | *Trends of key performance indicators*

Strategies	Key Actions
1.1. Strengthen formulation, review of relevant policies, laws, strategies, and standard operating procedures (SOPs) for children and adolescents	1.1.1. Support the implementation of policies, laws, and strategies that seek to protect children and adolescents 1.1.2. Review the amended Sexual Offences Act (2019) to ensure sentencing of minors is in line with the Convention on the Rights of the Child 1.1.3. Evaluate and assess the implementation of the National Policy on Radical Inclusion in Schools 1.1.4. Finalize, review, and enact the Child Rights Bill 2024 to include prohibition of child and forced marriage 1.1.5. Facilitate the enactment of the Safe Motherhood and Reproductive Health Bill 2024 1.1.6. Review the National Male Involvement Strategy for the Prevention of SGBV to ensure mainstreaming of gender-transformative approaches 1.1.7. Assess/evaluate the implementation of National School Health Policy 1.1.8. Develop regulation for Prohibition of Child Marriage Act 2024 1.1.9. Facilitate the enforcement of the Prohibition of Child Marriage Act 2024 in ways that are supportive of adolescents and their families 1.1.10. Enforcement of laws relating to transactional sex and increasing duty bearers' understanding of their roles and responsibilities in bringing perpetrators of transactional sex to Justice 1.1.11. Roll-out and scale up the Positive Parenting Education Programme 1.1.12. Implement the National Quality of Care Standards for Adolescent and Young People Health Services
1.2. Ensure national online database for policy and communication materials on adolescent pregnancy and child marriage is created and maintained	1.2.1. Create and maintain online repository for storage and dissemination of relevant policy and strategy documents 1.2.2. Ensure communications materials created by the National Secretariat for the Reduction of Teenage Pregnancy and Child Marriage and all partners are uploaded onto repository for use by all partners

3.3.2 Strategic Pillar 2: Public Health

Adolescent-friendly delivery of public health services, especially SRH services, is critical for reducing adolescent pregnancy and its adverse consequences. As such, this pillar will ensure focus on provision of more adolescent-friendly SRH services to all adolescents, including unmarried girls and boys who seek these services, maintaining confidentiality and dignity. Furthermore, efforts to improve informed choice and counseling for contraception use, as well as the supply of contraceptives (including in remote areas) will also be included under this pillar.

Strategic Objective 2:

SRH services are provided in a more adolescent-friendly manner, and contraceptives of choice are provided with improved counseling and are regularly available, in all service delivery points.

Strategies	Key Actions
2.1. Ensure delivery of adolescent-friendly SRH services	2.1.1. Increase the number of adolescent-friendly centers and improve quality 2.1.2. Clearly define the minimum package of adolescent and youth (AY)-friendly services 2.1.3. Training of district level master trainers on delivery of minimum package of AY-friendly services 2.1.4. Train health care and other service providers on delivery of minimum package of AY-friendly services based on SOPs 2.1.5. Facilitate/fulfill logistics for the delivery of AY-friendly services 2.1.6. Engage adolescents and youths in design and assessment of AY-friendly services 2.1.7. Advocate for recruitment of young professionals as service providers for AY-friendly services 2.1.8. Review and scale up AY-friendly services in all facilities (PHUs, youth centers, schools, hospitals, safe spaces, etc.) 2.1.9. Review and scale up school-based clinics/sick bays 2.1.10. Conduct regular monitoring, evaluation, and supervision
2.2. Ensure contraceptives are provided to adolescents consistently and with adequate counseling to navigate side effects and switch to other alternatives if the adolescent chooses	2.2.1. Contraceptives of different types are regularly sent to all communities and health facilities 2.2.2. Contraceptives are provided with adequate information for adolescents to understand possible side effects and make an informed choice about their contraceptive method 2.2.3. Adolescents experiencing severe side effects due to chosen contraceptive methods are provided emotional support and counseled to consider other contraception alternatives 2.2.4. Conduct regular monitoring, evaluation and supervision of the contraceptives and contraceptive counseling provided to adolescents
2.3. Ensure participation of community health workers/ social workers in the delivery of SRH services at community level routinely	2.3.1. Conduct orientation workshop on community SRH service delivery in all wards/chiefdoms 2.3.2. Support the delivery of SRH services at community level in PHUs, schools and training centers 2.3.3. Encourage and support the provision of SRH services to vulnerable groups (i.e., adolescents who are married, divorced, pregnant, out of school, or living with disabilities, living in extreme poverty) at community level 2.3.4. Strengthen the monitoring and supervision of SRH service delivery at community level
2.4. Ensure equitable distribution of SRH services at community level routinely	2.4.1. Conduct mapping exercise of all SRH service delivery points in all wards/ chiefdoms 2.4.2. Review and upgrade SRH service delivery points periodically at community level with focus on quality and equity 2.4.3. Ensure adolescent-friendly SRH services and contraceptives and counseling are available to all vulnerable adolescents

2.5. Ensure delivery of adolescent friendly services in emergencies	2.5.1. Develop emergency preparedness plan for Adolescent and Young People Friendly (AYPF) service delivery 2.5.2. Conduct resource mobilization to implement emergency preparedness plan for AYPF service delivery 2.5.3. Conduct regular monitoring, evaluation, and supervision of AYPF service delivery in emergencies
2.6. Invest in intentional asset building (health, social and economic assets) for adolescent girls (and boys) including the provision of safe spaces	2.6.1. Map existing safe spaces 2.6.2. Revise and implement SOPs for adolescent safe spaces 2.6.3. Increase number of adolescent safe spaces 2.6.4. Revision of the 2017 National Life Skills Manual 2.6.5. Recruit and train staff and mentors to support management of safe spaces, including to deliver life skills sessions and to refer adolescents to appropriate services 2.6.6. Support the Ministry of Social Welfare to provide supportive supervision to safe spaces 2.6.7. Conduct regular monitoring, evaluation, and supervision of safe spaces and safe homes
2.7. Ensure effective supervision, M&E of AYFHS	2.7.1. Develop a mechanism for quarterly supportive supervision, monitoring and evaluation 2.7.2. Conduct quarterly supportive supervision and routine monitoring and evaluation 2.7.3. Establish a management response mechanism to ensure that findings from the above supervision, M&E efforts are regularly reviewed and acted upon to improve Adolescent and Young-People Friendly Health Services (AYFHS) 2.7.4. Review and upgrade supervision, M&E mechanisms annually
2.8. Ensure survivor-centered and age-appropriate GBV/ child protection services	2.8.1. Support and strengthen National Level Coordination on GBV/child protection (NACGBV)
	2.8.2. Establish and support district level coordination on GBV/child protection (GBV Steering Committee)
	2.8.3. Train protection frontline workers on GBV case management through a TOT approach
	2.8.4. Scale up GBV Information Management System (GBVIMS+) nationally to ensure standardized, safe and ethical management of data through GBV service provision
	2.8.5. Scale up the Digital Referral Pathway (e-RPW) for ease of referrals for GBV survivors
	2.8.6. Support, strengthen and popularize 116 Helpline for GBV response
	2.8.7. Establish One Stop Centers for GBV survivors in districts without such services

	2.8.8. Establish new safe homes and ensure existing safe homes are providing standard services
	2.8.9. Develop SOP manuals for operations of safe homes 2.8.10. Provide basic logistics for safe homes 2.8.11. Review and upgrade number of safe homes annually 2.8.12. Conduct regular monitoring, evaluation and supervision of GBV/child protection services including One Stop Centers and other service providers, 116 Helpline call centers and safe homes (including assessment of their adolescent and youth friendliness) 2.8.13. Implement the National Referral Protocol for GBV 2.8.14. Build the capacity of FSU staff to respond to the unique needs of adolescent survivors through use of AY-friendly approach 2.8.15. Strengthen the social workforce for the effective implementation of case management systems
2.9. Strengthen special programme/projects for rehabilitation and reintegration of destitute and street children, victims of substance abuse and those suffering from mental health challenges	2.9.1. Support national efforts to rehabilitate and reintegrate children and adolescents on the street and at risk of adolescent Pregnancy and Child Marriage through provision of packages including psychosocial support and SRH services 2.9.2. Coordinate programme/projects with stakeholders at the community level to benefit children and adolescents on the street 2.9.3. Conduct regular monitoring, evaluation, and supervision for programme/projects 2.9.4. Review and upgrade programme/projects annually

3.3.3 Strategic Pillar 3: Enabling Learning Environment

Retaining adolescents in school and ensuring that they experience safe and meaningful learning experiences has been touted as one of the most effective strategies to reduce adolescent pregnancy and child marriage in countries around the world. As such, this pillar will ensure focus on retention of adolescents in schools and provision of school experiences that are free of violence, educational on SRH and accommodate and facilitate menstrual hygiene management for girls. Additionally, for adolescents who have dropped out of school and are not able or interested to reintegrate into schools, efforts to expand non-formal learning opportunities and vocational training will also be included under this pillar.

Strategic objective 3.1:

Retention in secondary schools is improved, alternative learning opportunities are provided for those who drop out, GBV in schools is addressed and Child and Adolescent Health and Life Skills (CAHLS) and menstrual hygiene management (MHM) are provided.

Strategic objective 3.2:

For adolescents who have dropped out of school, non-formal learning opportunities and vocational training will be provided.

The complementarity and distinction between Pillar 3 and Pillar 5 should be noted at this point. While Pillar 3 focuses on strategic actions within the purview of the education sector to retain adolescents in school, Pillar 5 focuses on overall economic empowerment of families, including empowerment to allocate more household resources to school-related expenses of adolescents in the family.

Strategies	Key Actions
3.1. Ensure all primary and secondary schools, colleges and training institutions provide age-appropriate health and life skills information, using culturally-relevant approaches	3.1.1. Disseminate Child and Adolescent Health and Life Skills teaching and learning materials to all primary and junior secondary schools 3.1.2. Scale up in-service teacher training package on Child and Adolescent Health and Life Skills for existing teaching workforce in primary and junior secondary schools 3.1.3. Develop, validate, and disseminate Adolescent Health and Life Skills teaching and learning materials to all senior secondary schools (SSS) 3.1.4. Develop Adolescent Health and Life Skills in-service teacher training package for SSS teaching workforce 3.1.5. Implement Adolescent Health and Life Skills in-service teacher training for Senior Secondary teaching workforce. 3.1.6. Develop pre-service Child and Adolescent Health and Life Skills training package 3.1.7. Train Teacher Training Institution workforce on the delivery of pre-service teacher training 3.1.8. Support the roll-out of pre-service teacher training 3.1.9. Revise the National Life Skills Manual (I am Somebody) for the delivery of life skills to out-of-school children and adolescents 3.1.10. Develop a standardized training package for MBSSE and NGO staff, mentors and local councils on the delivery of the revised National Life Skills Manual 3.1.11. Support the roll-out of the National Life Skills manual in MBSSE-operated community learning centers 3.1.12. Work with Ministry of Technical and Higher Education (MTHE) to establish and implement a Health and Life Skills action plan for Tertiary Education 3.1.13. Ensure that all health and life skills information is accessible to persons with disability
3.2. Ensure that primary and secondary schools are equipped to respond to first-aid needs of learners	3.2.1. Develop in-service training manual on first-aid for teachers 3.2.2. Provide in-service training for teachers on first aid and referral pathways for GBV services 3.2.3. Distribute first-aid kits to primary, junior secondary and senior secondary schools
3.3. Ensure that adolescent girls have access to menstrual health and hygiene commodities	3.3.1. Strengthen linkages between schools and health and protection services 3.3.2. Support production of age-appropriate Information, Education, and Communication (IEC) materials for schools on SRHR and protection referral pathways 3.3.3. Support the distribution of Menstrual Health and Hygiene Commodities to in and out-of-school adolescent girls 3.3.4. Develop menstrual hygiene corners in schools
3.4. Reinstitute and strengthen guidance and counseling within schools and training institutions	3.4.1. Support the development of an innovative Guidance and Counseling package which can be implemented at scale 3.4.2. Support the development of SOPs for the provision of guidance and counseling 3.4.3. Support the development of in-service training packages for the provision of guidance and counseling 3.4.4. Support the in-service training of guidance counselors 3.4.5. Support the development of pre-service guidance counseling training

3.5. Ensure a conducive and safe environment in all schools and training institutions	3.5.1. All teachers and school personnel should sign code of conduct for compliance 3.5.2. Support dissemination of teacher's code of conduct through in-service and pre-service teacher training 3.5.3. Engage local leaders on teacher's responsibilities as expressed through the teachers' code of conduct 3.5.4. Establish/strengthen reporting or complaint mechanisms (including via suggestion boxes) for breach of teacher code of conduct in schools, including timely and effective management of any complaints received 3.5.5. Support the roll-out of School-Related GBV training in all schools, including training workforce on e-referral pathways 3.5.6. Train school principals to enforce the teacher code of conduct and hold teachers accountable in case of breaches 3.5.7. Train School Quality Assurance Officers to regularly monitor the occurrence of breaches of teacher code of conduct and the subsequent management of breaches by school principals 3.5.8. Establish linkages between schools and social workers to improve reporting of breaches of teacher code of conduct by students and provision of psychosocial support to affected students
3.6. Improve access to education for all adolescents (including adolescents with disabilities)	3.6.1. Refurbish youth resource centers in all districts 3.6.2. Engage boys and girls in schools to establish school clubs to advocate for improved inclusivity, safety, and accessibility in schools 3.6.3. Provide school materials such as uniforms, bags and support with other prohibitive costs associated with entering a new institution to lessen schooling costs for adolescents with a high risk of child marriage and adolescent pregnancy 3.6.4. Support pregnant and parenting adolescents to remain in schools through provision of school materials 3.6.5. For students living long distances from schools, including in remote areas without proper roads, assess the suitability and sustainability of innovations in school transportation (beyond school buses) that are safe and affordable 3.6.6. Based on the results of the above assessment, pilot scalable solutions for safe and affordable school transportation in selected communities 3.6.7. Develop and roll out innovative learning options for hard-to-reach groups (e.g., EdTech, Radio Teaching Programs, blended learning approaches, and distributing print materials) 3.6.8. Support the roll-out of the Integrated Home-Grown School Feeding Program (INHGSFP), which has specific provisions for government and government-assisted schools in vulnerable areas as outlined in the National School Feeding policy 3.6.9. Provide feedback/reporting boxes in schools that will enable marginalized learners to raise concerns in order to be better supported
3.7. Create viable financial support platforms for adolescents and children, especially the vulnerable	3.7.1. Strengthen existing structures that support adolescent girls and children in school: youth employment scheme (YES), school grants, holiday jobs and income generating activities. 3.7.2. Engage families/parents of adolescent girls at risk of school dropout in livelihood improvement schemes. 3.7.3. Strengthen the implementation of youth employment schemes. 3.7.4. Conduct regular monitoring, evaluation, and supervision. 3.7.5. Review and upgrade youth employment scheme annually

3.8. Create livelihood financial platform to support out-of-school girls	3.8.1. Provide allocation for disadvantaged children, PWD and destitute children. 3.8.2. Support the development and dissemination of Non-Formal Education Policy 3.8.3. Enforce compulsory registration in alternative education, if not in formal education under the age of 16 3.8.4. Strengthen existing community learning centers and establish additional centers in strategic communities. 3.8.5. Development of accelerated non-formal education curriculum including SRHR and life skills information, vocational skills and business training. 3.8.6. Create and implement targeted leadership programs to boost marginalized youth's confidence and empower them. 3.8.7. Integrate out-of-school girls in to formal education in line with the National Policy on Radical Inclusion in schools.
3.9. Develop and implement grievance redress mechanisms (GRMs) in school (including for breaches of teacher code of conduct as indicated under 3.5 above)	3.9.1. Develop a GRM in schools and training institutions. 3.9.2. Provide orientation on GRM 3.9.3. Support implementation of GRM 3.9.4. Monitor and supervise implementation of GRM 3.9.5. Review and upgrade GRM annually

3.3.4 Strategic Pillar 4: Community Engagement and Ownership

While Pillars 2 and 3 will empower adolescents at schools, non-formal learning centers and health facilities, the socio-ecological approach also calls for empowering them to navigate interactions with other members of the community and for their communities to be empowered for supportive interactions as well. As such, this pillar will ensure focus on the necessary social and behavior change to address harmful gender norms and practices. It will include efforts to support the community's own agency and existing structures to ensure the wellbeing of adolescents and to nurture the knowledge, attitude, beliefs, behavior and practices of all community members for gender-transformative change.

Strategic Objective 4:

Social and behavior change among adolescents, parents, peers and others in community with regard to harmful masculinities, gender norms and harmful or discriminatory practices.

Strategies	Key Actions
4.1. Ensure increased awareness about SRH and Child Protection (CP) issues in target groups within the community	4.1.1. Review health promotion, advocacy and communication strategy for SRH and CP in line with emerging issues 4.1.2. Implement advocacy and communication strategy 4.1.3. Collaborate with community leaders and religious leaders and adolescent groups (including youth advisory panel members) to implement the advocacy and communication strategy. 4.1.4. Disseminate SRH/CP messages through appropriate media using effective strategies in schools, training institutions and communities
4.2. Strengthen existing structures at district and community levels for reduction of adolescent pregnancy and child marriage	4.2.1. Strengthen community-based structures through engaging community leaders, religious institutions, women's and youth groups, Village Development Committees (VDCs), health-care workers, teachers, adolescent mentors, social workers, Family Support Unit (FSU), Bike Riders' Union (BRU), media houses and other relevant bodies 4.2.2. Review guidelines and TORs for SRH and CP groups at the district and community levels 4.2.3. Provide orientation training and annual refresher training for district and community SRH and CP groups 4.2.4. Monitor and supervise community SRH and CP groups 4.2.5. Involve community members, adolescents and relevant adolescents' groups in the development and implementation of policies on adolescent welfare 4.2.6. Support community stakeholders and representatives from adolescent groups to formulate and implement community by-laws on SRH and CP 4.2.7. Conduct quarterly meetings between district and community stakeholders to raise, and discuss solutions for, adolescents' issues (SRH and CP) identified in the community. 4.2.8. Mobilize communities' structures to effectively engage adolescents and children on issues that promote their development
4.3. Engage men, women boys and girls in promoting positive gender and social norms for the reduction of adolescent pregnancy, child marriage, GBV and other harmful practices	4.3.1. Support the implementation of the National Male Involvement Strategy 4.3.2. Support the implementation of gender transformative programmes across all levels 4.3.3. Create awareness about positive masculinities and the role these can play in reducing adolescent pregnancy and child marriage 4.3.4. Identify role models among men and boys to promote positive masculinities as a new social norm
4.4. Empower parents and caregivers with positive parenting knowledge and skills	4.4.1. Cascade and popularize positive parenting curriculum 4.4.2. Develop guidelines and messages on positive parenting 4.4.3. Disseminate positive parenting curriculum guidelines and messages through appropriate channels 4.4.4. Provide training for relevant staffs at all levels on positive parenting 4.4.5. Rollout the positive parenting education for parents at community level 4.4.6. Monitor impact of use of positive parenting guidelines and messages regularly 4.4.7. Review and upgrade positive parenting guidelines and messages periodically

3.3.5 Strategic Pillar 5: Social Assistance and Livelihoods

Acknowledging that poverty is one of the most widespread and persistent causes of adolescent pregnancy and child marriage, it is critical to include actions to address it in the national strategy. As such, this pillar will ensure focus on the economic empowerment of families with adolescents through social assistance and livelihood opportunities.

Strategic Objective 5:

Poor households with adolescents are provided regular social assistance, public works or other livelihood opportunities (especially for women and girls).

Strategies	Key Actions
5.1. Social assistance for families with adolescents	5.1.1. Cash transfers are provided to poor households with adolescents 5.1.2. Beneficiaries of cash transfers are sensitized to allocate a greater amount of household resources towards adolescents' needs, including school-related expenses, sanitary pads and uptake of contraceptives 5.1.3. The impacts of the cash transfer program are assessed/evaluated and used to inform decisions in the social protection sector
5.2. Social services for adolescent mothers	5.2.1. Interim childcare services to support livelihood opportunities for adolescent mothers 5.2.2. Safe home services for adolescent mothers and GBV survivors
5.3. Livelihood opportunities for young people	5.2.1. Public works programs are initiated in communities, including rural and remote communities 5.2.2. Economic inclusion programs are initiated in communities, including rural and remote communities 5.2.3. Youth entrepreneurship programs are initiated in communities, including rural and remote communities 5.2.4. Vocational training programs are strengthened and expanded, including in rural and remote communities 5.2.5. Livelihood programs are strengthened and expanded, including in rural and remote communities 5.2.6. Girls, as well as adolescents with disabilities, have access to vocational training and livelihood opportunities 5.2.7. Lessons learnt from above programs are documented and used to strengthen existing and new programs

3.3.6 Strategic Pillar 6: Leadership, Coordination, and Research

While the first five pillars above focus on programmatic actions, mostly sector-specific, the successful implementation of this National Strategy will require some key actions at the systems level as well. As such, Pillar 6 will include key actions, cutting across all relevant sectors, to ensure that the strategic efforts are well-guided, efficient, and evolving based on evidence. It will ensure focus on: (1) Leadership and Governance; (2) Coordination; and (3) Research (or Evidence Generation). The strategic objectives for these three areas are listed below, followed by the associated strategies and key actions.

6.1 Leadership and Governance:

Strong leadership and governance will be critical for achieving the intended outcomes and impacts of the National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage.

Strategic Objective 6.1:

Strong leadership and governance to achieve intended outcomes and impacts.

Strategies	Key Actions
6.1.1 Strengthen institutional capacities to implement policies, laws, strategies, and SOPs	6.1.1.1 Provide institutional, logistical, and technical support to Government MDAs and implementing partners to fully implement the strategy 6.1.1.2 Support capacity building of Government MDAs and implementing partners to fully implement the strategy 6.1.1.3 Support local authorities to translate national laws into local by-laws 6.1.1.4 Provide oversight for the development and implementation of SOPs
6.1.2 Advocate for improved provision of SRHR to adolescent girls and boys	6.1.2.1 Review data collection tools and databases used in the health, education, social welfare, gender and children's affairs and local government sectors to collect information on vulnerable adolescent boys and girls 6.1.2.2 Establish interoperability of databases across health, education and social welfare sectors to enhance identification and cross-referral of vulnerable adolescent girls and boys to various SRHR services 6.1.2.3 Review and upgrade Adolescent Sexual and Reproductive Health and Rights (ASRHR) programme to ensure increased access to vulnerable adolescent girls and boys. 6.1.2.4 Support capacity building of civil society, adolescent and youth groups for demand creation
6.1.3 Ensure accountability and transparency of actions taken by MDAs and other implementing partners	6.1.3.1 Develop an implementation plan for the strategy, with responsibilities assigned to specific MDAs and other implementing partners 6.1.3.2 Develop a reporting mechanism to govern the implementation of the strategy and ensure all implementing MDAs and other partners report on progress on a periodic basis 6.1.3.3 Devise a system for synthesizing progress updates and publishing the state of progress to key stakeholders on a periodic basis

6.2 Coordination:

The complex dynamics causing high rates of adolescent pregnancy and child marriage can only be addressed through a multilateral approach, hence the multi-sectoral nature of this strategy. However, without effective and regular coordination, it will not only be difficult to sustain momentum for the planned actions, but it might also result in duplication and other inefficiencies, as well as potentially lost opportunities to maximize impact. The Coordination Framework for the National Strategy is presented in the next chapter, while the key strategies and actions for effective coordination are listed herein.

Strategic Objective 6.2:

Effective coordination to ensure sustained multi-sectoral efforts at all levels.

Strategies	Key Actions
6.2.1 Establish functional coordination mechanisms at national and district levels	6.2.1.1 Strengthen the capacity of Focal Points on management and coordination of the National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage 6.2.1.2 Mobilize resources for the efficient functioning of the coordination offices (NSRTP) 6.2.1.3 Develop an annual costed operational implementation plan for the duration of the strategy (2025–2030) 6.2.1.4 Develop a human resource and resource mobilization plan to ensure the effective day-to-day operations of the National Secretariat for Reduction of Adolescent Pregnancy and Child Marriage. 6.2.1.5 Develop a resource mobilization plan to ensure the effective day-to-day operations of the National Secretariat for Reduction of Adolescent Pregnancy and Child Marriage 6.2.1.6 Develop a TOC for national-level coordination including clear roles and responsibilities for all focal points 6.2.1.7 Review, and revise as necessary, the terms of reference for the Multi-sectoral Coordinating Ministerial Coordination Committee Meeting 6.2.1.8 Review, and revise as necessary, the terms of reference for district level coordination mechanisms to include quarterly coordination meetings, reporting and action plans 6.2.1.9 Develop indicators for each line ministry to report on a quarterly basis to ensure accountability 6.2.1.10 Support the operationalization of the adolescent and young people TWG

6.3 Research (Evidence Generation)

To ensure that the policies and programs across pillars remain evidence-based, high-quality research will need to be conducted in all domains of adolescent wellbeing and community development. Various sub-contexts within the country, such as urban or rural, north or south, or even particular chiefdoms or communities within a given district, might need different approaches for the reduction of adolescent pregnancy and child marriage, or they might produce very different results with the same strategies. All of this needs to be studied, and these studies should then inform policy and programming for improved outcomes for adolescents and their communities.

Strategic Objective 6.3:

High quality research to inform policy and programs across pillars.

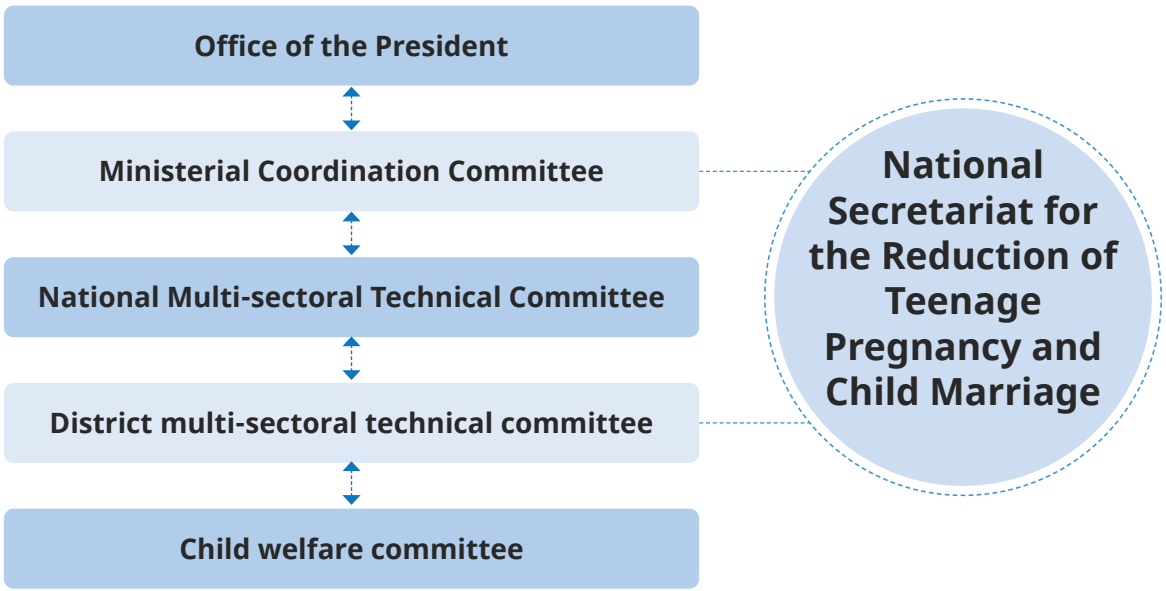
Strategies	Key Actions
6.3.1 Increased capacity to initiate and/or participate in relevant research around adolescent wellbeing and child marriage	6.3.1.1 Develop a research agenda outlining key areas of research to be conducted throughout the implementation period addressing knowledge gaps across pillars 6.3.1.2 Develop a TOC for research and knowledge management. 6.3.1.3 Ensure that all research on adolescent well-being and child marriage carried out by stakeholders are in- accordance with the Sierra Leone ethics and scientific committee guidelines 6.3.1.4 Encourage innovative solutions to addressing issues of adolescent well-being and child marriage and ensure that such initiatives document learning, processes, challenges, and good practices, as well as the outcomes of these good practices, for dissemination to all stakeholders 6.3.1.5 Conduct a mapping of evidence gaps on adolescent pregnancy and child marriage in Sierra Leone, including evidence on what works and what does not work 6.3.1.6 Embark on various research projects annually to fill evidence gaps in the context of Sierra Leone and provide technical inputs to research conducted by various stakeholders 6.3.1.7 Disseminate useful research information to relevant stakeholders through existing coordinating platforms and ad hoc events 6.3.1.8 Ensure that the generated evidence is packaged for advocacy and supplied in a timely manner to policymakers in order to inform policies and programming for, programming, planning and practice on adolescent wellbeing and elimination of child marriage is evidence based 6.3.1.9 Ensure the meaningful participation of adolescents, including vulnerable adolescents, in research planning, implementation, validation and dissemination 6.3.1.10 Review research agenda annually 6.3.1.11 Mobilize resources to support research 6.3.1.12 Establish a technical sub-committee on research to undertake and/or guide the above actions
6.3.2 Support monitoring, evaluation and supervision of the National Strategy for the Reduction of Adolescent Pregnancy and Ending Child Marriage	6.3.2.1 Establish data repository hubs in national and district level coordination offices 6.3.2.2 Take necessary steps to ensure protection of data in the data repository hubs in national and district level coordination offices 6.3.2.3 Identify and train staff on data management and IT 6.3.2.4 Provide logistics for effective and efficient data and information management 6.3.2.5 Develop M&E framework with Specific, Measurable, Achievable, Relevant and Time-bound (SMART) indicators and clearly defined roles and responsibilities 6.3.2.6 Create horizontal and vertical reporting channels at district and national levels 6.3.2.7 Develop data collection tools and conduct capacity building with all partners to ensure timely reporting 6.3.2.8 Develop data analysis and sharing protocol to ensure all relevant data is captured in quarterly and annual reporting 6.3.2.9 Ensure National Secretariat for the Reduction of Adolescent Pregnancy and Child Marriage is adequately staffed to support M&E system

4

Coordination Framework

A set of coordination mechanisms, established at both national and subnational levels, will help to ensure the efficient implementation of the strategy through effective partnership among all relevant stakeholders. These coordination mechanisms are intended to nurture the sustained input of all stakeholders toward the attainment of the goals and objectives of the strategy in a responsible and accountable manner. The coordination mechanisms are depicted in Figure 10 below.

Figure 10 | *Coordination framework for the national strategy*



The composition and mandate of the various coordination mechanisms are detailed below.

Office of the President

The strategy will be implemented under the general leadership of the Office of the President. The Office of the President will have the following roles and responsibilities:

- Provide overall leadership;
- Chair annual and ad hoc meetings;
- Provide overall policy guidelines;
- Monitor progress toward the attainment of the overall goals and objectives and
- Monitor the participation of line ministries and partners.

The Office of the President will ideally meet with the Ministerial Coordination Committee (MCC) once a year. Nonetheless, there will be provision for ad hoc meetings to address urgent issues that may require the attention of the Office of the President.

The Ministerial Coordination Committee (MCC)

The MCC will provide immediate governance oversight for the implementation of the strategy. The MCC is chaired by the MoH and co-chaired on a rotation bases by key-line ministries. The MCC will be constituted by all ministers of participating sectors, heads of United Nations agencies [Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Develeopment Programme (UNDP), UNFPA, UNICEF, WHO, and The UN Women], representatives of the donor community, heads of the National Commission for Social Action (NACSA) and the National AIDS Secretariat, as well as NGO representatives. The MCC will have the following roles and responsibilities:

- Provide policy guidance and direction;
- Ensure effective intersectoral and interministerial communication;

- Ensure adequate information-sharing among partners;
- Provide oversight during the implementation of activities;
- Mobilize adequate resources and
- Report to the Office of the President.

The committee will meet twice a year. However, there will be provision for ad hoc meetings to address emergency and important outstanding issues.

The National Multi-Sectoral Technical Committee (NMTC)

The NMTC is chaired by the Coordinator of the NSRTP. The NMTC is constituted by focal points and relevant technical officers of the MDAs, NGOs, and development partners as well as civil society organizations and youth associations. The NMTC will have the following roles and responsibilities:

- Provide technical guidance and orientation to stakeholders at all levels;
- Ensure complementarity of interventions;
- Facilitate sharing of technical information to relevant stakeholders;
- Supervise the implementation process;
- Monitor progress toward achievement of goals and objectives;
- Develop and share reporting tools and reporting formats for both national and district levels;
- Supervise and monitor ongoing research interventions;
- Conduct annual review and planning workshop and
- Report to the MCC.

The committee will meet every 2 months with inbuilt flexibility for ad hoc meetings to address emergency and important outstanding issues.

The District Multi-Sectoral Technical Committee (DMTC)

The DMTC is constituted by focal points and relevant technical officers of the MDAs, NGOs, and development partners as well as civil society organizations and youth associations. The DMTC will have the following roles and responsibilities.

- Develop and align annual operational plans (AOPs) to their sectoral plan;
- Implement AOPs;
- Provide technical oversight at district level;
- Meet bimonthly to discuss progress and challenges;
- Prepare and submit quarterly reports to national level and
- Report to the NMTC.

The committee will meet every 2 months. However, there will be provision for ad hoc meetings to address emergency and important outstanding issues.

Chiefdom Child Welfare Committee (CWC)

The Chiefdom (or Ward) Child Welfare Committee will have the following roles and responsibilities:

- Follow-up on potential and actual cases of child marriage and adolescent pregnancy and help them access available services;
- Identify community-level services and coordinate services for adolescent girls and boys;
- Provide advice to children, parents, and other community members in promotion of the short- and long-term best interests of the child and eradicating harmful practices;

- Refer to the relevant authorities any matter relating to children's welfare that the committee is not able to deal with for further investigations/ appropriate action;
- Facilitate community dialogue, awareness raising, and mobilization on community sense of responsibility toward children;
- Ensure that the welfare and protection of children at community/village level are of paramount concern and act to prevent or respond to child marriage and adolescent pregnancy;
- Providing information and direction to children and families on the availability of services at community and chiefdom level;
- Provides or take an immediate case by case action and advises to parents, adolescent, and children to prevent child marriage and adolescent pregnancy and report to relevant authorities if it is beyond their capacities and
- Facilitate community resource mobilization initiatives for the care and support of adolescents to prevent adolescent pregnancy and child marriage.

The committee will meet monthly with a flexible provision for ad hoc meetings to address emergency and important outstanding issues.

5

Monitoring and Evaluation Framework

The general objective of the M&E framework for the National Strategy is to lay out how the various actions included in the strategy will be monitored and assessed to determine the extent they have been successful in achieving the desired results. As such, it will help guide decision-making on whether any changes need to be made to strategic areas of interventions and their respective activities.

To achieve this objective efficiently, the existing M&E mechanisms operating within each responsible MDA and other implementing partners could be used to collect information and report on relevant indicators for all the strategies and activities for which they are responsible.

The National Secretariat as lead entity, in collaboration with the technical subcommittee on research, will ensure effective M&E of the Strategy by coordinating:

(a) Development of baselines and targets;

(b) Data collection exercises;

(c) Data processing, analysis, and reporting;

(d) Any joint M&E of the implementation of the strategy; and

(e) Consolidation of M&E reports to be discussed at the national level and annual consultative meetings.

In addition, there will be quarterly, annual, and mid-term M&E to assess performance and provide an opportunity to reflect on good practices, challenges, and lessons learned, including annual reviews on the progress of the implementation of the National Strategy. A final evaluation of the National Strategy will be conducted toward the end of the implementation period (Table 2).

Table 2 | *Summary of the pillars and indicators*

Pillar	Pillar Objective	Indicator
Pillar 1	Improved and consistent accountability for perpetrators and enablers of GBV (including child marriage, transactional sex, and other forms of sexual exploitation).	# of laws formulated and enacted to improve wellbeing of adolescents
		# of SOPs for children and adolescents developed
		# of relevant policies, laws, and strategies for children and adolescents
Pillar 2	SRH services are provided in a more adolescent-friendly manner, and contraceptives of choice are provided with improved counseling and are regularly available, even in remote areas.	# Adolescent-friendly service points which meet the minimum standards
		# of adolescents accessing YF services
		# Adolescent girls and boys accessing family planning services
Pillar 3	Retention in secondary schools is improved, alternative learning opportunities are provided for those who drop-out, GBV in schools is addressed and CAHLS and MHM are provided.	# of schools implementing child and adolescents' health and life skills curriculum
		# of pregnant and parenting adolescent girls in school
		Changes in transition rates from primary to secondary school
		Changes in retention rates in junior and senior secondary schools
		# of junior secondary students benefitting from innovative school transportation schemes
		# of senior secondary students benefitting from innovative school transportation schemes
		# of schools implementing measures to address school-related GBV
		# of schools with adequate WASH facilities
	For adolescents who have dropped out-of-school, nonformal learning opportunities and vocational training will be provided.	# of out-of-school children at risk of adolescent pregnancy and child marriage reintegrated into formal education
		# OOSC provided vocational training or other alternative learning opportunities

Pillar 4	Social and behavior change among adolescents, parents, peers, and others in community with regard to harmful masculinities, gender norms, and harmful or discriminatory practices.	# community meetings organized/conducted for awareness raising
		# communities who have a plan and take specific action to prevent adolescent pregnancy and to end child marriage
		# safe spaces that meet the minimum standards
		# of beneficiaries of male engagement activities
		# of beneficiaries of positive parenting programs
		# communities reached with SRH promotion campaigns
		# of communities with SRH and CP action points integrated into the agenda/TOR of the main community structure
Pillar 5	Poor households with adolescents are provided regular social assistance, public works or other livelihood opportunities (especially for women and girls).	# of adolescents whose families are benefitting from social assistance
		# of communities with livelihood opportunities for young people
		# of young beneficiaries (18–24 years) of livelihood programmes
		# of operational interim childcare centers for adolescent mothers
		# of operational safe homes for adolescent mothers
Pillar 6	Strong leadership and governance to achieve intended outcomes and impacts.	Development of overall implementation plan for full period of implementation
		# of years in the implementation period for which detailed annual implementation plans were developed
	High-quality research to inform policy and programmes across pillars.	# research proposals developed on adolescent pregnancy and ending child marriage
		# research studies conducted on adolescent pregnancy and ending child marriage
		# new innovative approaches adopted and implemented to prevent adolescent pregnancy and to end child marriage
	Effective coordination to ensure sustained multi-sectoral efforts at all levels.	# of coordination meeting held at all levels (disaggregated by level)


Every day in school
brings me closer to
my dreams

6

Costing and Financing

The National strategy is expected to be funded through different resource mobilization mechanisms including central and local government sectors' human and material resource contributions, lobbying for recurrent budget allocations; partner commitments for the implementation of different programmes; private sector provision of technical, financial, and material support; community-based initiatives to mobilize resources.

Efforts will also be made to designing and implementing other resource mobilization mechanisms such as a national campaign for resource mobilization, organizing resource mobilization telethons, minimal deduction from collected taxes, etc. The National strategy costing is being undertaken as part of the detailed strategic plan and amounts to 4,184,723,772.35 SLE (USD 178,073,352 at 1 USD = 23.5 SLE) for the 6-year duration of the National strategy. Table 3 given below provides the estimated cost required for the implementation of the strategy over the period (2025–2030). It is disaggregated by pillars for each year.

National strategy costing is being undertaken as part of the detailed **strategic plan** and amounts to 4,184,723,772.35 SLE for the 6-year duration of the National strategy.

Table 3 | *Summary of costing by pillar and by year (New Leones)*

Strategic Focus Area	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total	Proportion
Policies and Legal Environment	23,665,620.00	21,675,600.00	12,633,400.00	0,584,000.00	11,340,000.00	9,795,200.00	89,693,820.00	2%
Public Health	11,370,525.14	80,606,702.52	79,550,139.39	32,500,026.27	331,197,853.15	346,985,310.02	1,882,210,556.50	45%
Education	76,248,796.35	26,292,854.20	90,526,737.05	11,872,539.90	215,135,442.75	229,861,805.60	1,249,938,175.85	30%
Community Development	96,906,975.00	15,330,080.00	24,478,640.00	34,551,760.00	141,256,200.00	141,479,680.00	754,003,335.00	18%
Social Assistance and Livelihood	6,018,530.00	2,339,080.00	5,966,210.00	1,959,980.00	15,014,550.00	17,097,120.00	108,395,470.00	3%
Leadership, Coordination and Research	6,208,985.00	18,178,680.00	3,370,370.00	14,651,280.00	14,486,550.00	13,586,550.00	100,482,415.00	2%
Grand Total	650,419,431.49	684,422,996.72	636,525,496.44	726,119,586.17	728,430,595.90	758,805,665.62	4,184,723,772.35	100%
	16%	**16%**	**15%**	**17%**	**17%**	**18%**		

Table 4 | *Costing in United States Dollar (USD)*

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Policies and Legal Environment	$ 1,007,047.66	$ 922,365.96	$ 537,591.49	$ 450,382.98	$ 482,553.19	$ 416,817.02	**$ 3,816,758.30**
Public Health	$ 13,249,809.58	$ 11,940,710.75	$ 11,895,750.61	$ 14,148,937.29	$ 14,093,525.67	$ 14,765,332.34	**$ 80,094,066.23**
Education	$ 7,499,948.78	$ 9,629,483.16	$ 8,107,520.73	$ 9,015,852.76	$ 9,154,699.69	$ 9,781,353.43	**$ 53,188,858.55**
Community Development	$ 4,123,701.06	$ 4,907,662.98	$ 5,296,963.40	$ 5,725,606.81	$ 6,010,902.13	$ 6,020,411.91	**$ 32,085,248.30**
Social Assistance and Livelihood	$ 681,639.57	$ 950,599.15	$ 679,413.19	$ 934,467.23	$ 638,917.02	$ 727,537.02	**$ 4,612,573.19**
Leadership, Coordination and Research	$ 1,115,275.96	$ 773,560.85	$ 568,951.91	$ 623,458.72	$ 616,448.94	$ 578,151.06	**$ 4,275,847.45**
Grand Total	**$ 27,677,422.62**	**$ 29,124,382.84**	**$ 27,086,191.34**	**$ 30,898,705.79**	**$ 30,997,046.63**	**$ 32,289,602.79**	**$ 178,073,352.01**

7

The Way Forward

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage will be implemented within the existing policy and legal framework, responsibilities, and mandates of Government and respective MDAs.

This strategy shall be presented and announced to stakeholders at all levels and formally communicated by the National Secretariat or other relevant higher official to each line minister to secure the commitment of each MDA for actively contributing to the implementation of this strategy.

Follow-up shall be made by the National Secretariat and relevant Focal Points to ensure mainstreaming of activities in the implementation plan within the strategic and annual plans of each line ministries.

The roll-out at district level will be determined by the district multisectoral technical committee with the overall follow-up and support by the district administration. The district administration will have a key role in ensuring the implementation of the strategy as part of their key commitments in the district.

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Annexures

Annexure 1 | *Coordination mechanisms*

Mechanism	Composition	Roles and responsibilities	Meeting frequency
Office of the President	His Excellency, the President and team	• Provide overall leadership • Chair biannual/ad hoc meetings • Provide overall policy guidelines • Monitor progress over time • Monitor the participation of line ministries and partners	Annually, *ad hoc*
Ministerial Coordination Committee	Ministers of line ministries	• Provide policy guidance and direction • Ensure effective intersectoral and interministerial communication • Ensure adequate information sharing among partners • Provide oversight of activities • Mobilize adequate Funding • Ensure logistics support	Quarterly, *ad hoc*
National Multi-sectoral Technical Committee	Focal points and implementing partners at national level Civil society	• Provide technical guidance • Ensure complementarity of interventions • Facilitate sharing of technical information to relevant stakeholders • Supervise implementation process • Monitor progress toward achievement of goals and objectives • Develop and share district reporting tools and reporting formats • Supervise and monitor ongoing research interventions • Conduct annual review and planning workshop	Monthly, *ad hoc*
District Multi-sectoral Technical Committee	Focal points and implementing partners at district level	• Develop AOP • Implement AOPs • Meet quarterly to discuss progress and challenges • Prepare and submit quarterly reports to national level	Monthly, *ad hoc*
Chiefdom Child Welfare Committee	Community members and useful organizations	• Implement approved SRH functions at local level • Meet monthly to discuss progress, challenges and make suggestions on the way forward	Monthly, *ad hoc*

Annexure 2 | *Summary of consultation findings with adolescent fathers and mothers*

This report outlines the findings from FGDs held with teenage fathers and mothers to better understand teenage pregnancy in Sierra Leone. These discussions were carefully designed and led by young people, including young mothers, to ensure their experiences and perspectives were authentically represented. The initiative was led by UNICEF, together with National Teenage Secretariat, the MBSSE, and UNFPA.

For many adolescent fathers, the news of a pregnancy brought feelings of fear, anger, and shock, often stemming from a lack of understanding about what it meant to become a parent. They spoke about how their lives changed dramatically, with some leaving school, becoming homeless, or turning to unhealthy coping mechanisms such as substance use. Many highlighted the deep stigma they faced, with some noting that communities actively cut ties with them to "protect their own daughters". This form of rejection not only isolated young fathers, but also denied them access to critical support systems. Despite these challenges, many fathers expressed a strong desire to support their children and partners, even envisioning themselves as incredible providers and role models. However, barriers such as unemployment and limited resources often stood in their way.

Adolescent mothers shared how pregnancy disrupted their education and brought significant stress and financial strain. Many described feelings of rejection and isolation, as some were pushed out of their homes and had to manage early motherhood in difficult circumstances. Despite these adversities, the young mothers expressed a remarkable resilience. Many spoke about their unwavering hope to return to school and provide a better life for their children. Their aspirations to overcome these challenges and secure brighter futures stood out as a testament to their strength.

The discussions highlighted the critical role of education and information. Many participants said they had little to no access to comprehensive sex education. Cultural barriers and taboos often prevented open discussions about topics such as contraception and safe sex, leaving young people unprepared to make informed decisions. Peer pressure and curiosity were also frequently mentioned as factors that led to early sexual activity and, in turn, teenage pregnancies. Some participants noted that the lack of detailed guidance in schools made it even harder for them to navigate these challenges. However, a striking insight was the informal advocacy some young fathers and mothers were already engaging in within their communities, using their experiences to raise awareness and guide their peers. This highlights an untapped opportunity to formalize and support peer-led initiatives in prevention efforts.

Both groups talked about the difficulties of parenting at a young age. While some received informal support from neighbors or community members, many felt they lacked the structured support they needed. Adolescent fathers described feeling excluded and stigmatized, while adolescent mothers often faced harsh judgment and limited access to health care or resources. The need for safe spaces where they could receive counseling, health care, and vocational training came through strongly in their discussions. The aspirations shared by both groups—to achieve better education, skills, and a sense of stability—highlighted the potential for meaningful interventions.

To prevent teenage pregnancies, the young people suggested a number of actions. They emphasized the need for comprehensive sex education in schools, covering topics such as relationships, contraception, and parenting responsibilities. Programmes such as boys' clubs and workshops were proposed to help young men make informed decisions. For young mothers, the creation of safe spaces and support systems was seen as crucial to help them manage their responsibilities while pursuing their goals.

This report draws attention to the urgent need for a holistic approach to addressing teenage pregnancy. Alongside improving access to education and resources, there is a pressing need to challenge the stigma and judgment faced by adolescent parents. Community awareness campaigns and support programs can help create an environment where young parents feel empowered to build better futures for themselves and their children. By working together, we can ensure that the voices of young fathers and mothers are heard and their needs are met.


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