Government of Sierra Leone

National strategy for the reduction of adolescent pregnancy and child marriage

2018-2022

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Foreword

Adolescent pregnancy and child marriage in Sierra Leone pose a dire threat to girls, preventing them from realising their full potential in all aspects of their development. Despite the government's efforts to tackle these issues, particularly through the establishment of a National Secretariat for the Reduction of Teenage Pregnancy in May 2013 and the development of the National Strategy for the Reduction of Teenage Pregnancy (2013-2015), significant work needs to be done. Progress was hampered by the outbreak of the Ebola virus disease in 2014, which had an adverse impact on the implementation of the strategy, and directly impacted on the education of adolescent girls as a result of school closure. Furthermore, utilisation of health facilities by adolescents, especially for seeking services related to sexual and reproductive health, remains low.

Such problems shall not be ignored, as they contribute to the high incidence of adolescent pregnancy, especially among school-aged girls. The consequences are alarming; according to the 2013 Demographic Health Survey, nearly 30 per cent of adolescents aged 15-19 years in Sierra Leone had begun childbearing.

The post-Ebola Presidential Recovery Priorities have provided a platform for development to close the gaps in building a resilient nation. Within this framework, the secretariat has been expanded to school health and the reduction of Teenage pregnancy and Child marriage prioritised by his Excellency the President as one of the programs that are key to saving lives. Accordingly, the Ministry of Health and Sanitation will take the lead to engage relevant stakeholders such as community leaders, civil society organisations, donors, United Nations agencies and non governmental institutions in the development and implementation of the strategy.

We want our adolescents, especially girls, to survive, thrive and transform.Sierra Leone has committed to the Global Strategy for Women's Children's and Adolescents' Health, which aims for the highest attainable health standards and well-being for all women, children and adolescent boys and girls. We can put an end to adolescent pregnancy and child marriage by providing our girls with basic ed ucation, including comprehensive sexuality education, in addition to life skills training and quality sexual and reproductive health services.

To achieve this goal, we must build on the good practices that have worked in the past and utilise current international best practice evidence, while applying the lessons we have learned to overcome existing and emerging challenges.

Let us continue to invest in our next generation by creating an enabling environment that upholds the health and well-being of every adolescent in and out of school and young person of Sierra Leone. Together, we can support them in better preparing for adulthood and improve the lives of future generations.

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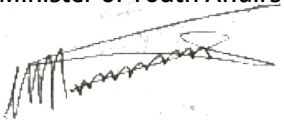

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To the consultant, Ms. Regina Bash-Taqi, we value your work as a true reflection on the needs of our adolescent girls and boys. Many thanks.

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Abbreviations

AU	African Union
AYPF	Adolescent and Young People Friendly
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
EVD	Ebola Virus Disease
CSE	Comprehensive Sexuality Education
GBV	Gender-Based Violence
GoSL	Government of Sierra Leone
JSS	Junior Secondary School
MBSSE	Ministry of Basic and Senior Secondary Education
MCC	Multi-Sectoral Coordinating Committee
MoHS	Ministry of Health and Sanitation
MoYA	Ministry of Youth Affairs
MLGRD	Ministry of Local Government and Rural Development
MLSS	Ministry of Labour and Social Security
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
MTC	Multi-Sectoral Technical Committee
NAS	National Aids Secretariat
NGO	Non-Governmental Organization
NSRTP	National Secretariat for the Reduction of Teenage Pregnancy
PHU	Peripheral Health Units
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1.BACKGROUND

1.1 Introduction

WHO reports that about 16 million girls aged 15 to 19 and some one million girls under the age of 15 give birth every year, mostly in low- and middle-income countries. Complications during pregnancy and childbirth are the second cause of death for 15 to 19 year-old girls globally, while 3 million girls in the same age bracket undergo unsafe abortions every year.[1] For some adolescents, pregnancy and childbirth are planned and wanted, but for many they are not – often times, girls may face social pressure to marry and, once married, to have children.

Adolescent pregnancy, defined as an adolescent girl, within the ages of 10 to 19, becoming pregnant, is closely linked to issues of human rights. Girls who lack choices and opportunities in life, or who have limited or no access to sexual and reproductive health care, are more likely to become pregnant. Girls forced into child marriage are also more likely to become pregnant. In developing countries, nine out of 10 births to adolescent girls occur within a marriage or a union. [2] Child marriage, defined as a formal marriage or informal union before the age of 18, is a global issue impacting the lives of millions of girls each year. Globally, more than 700 million girls and women alive today had been married as children, and of them, more than one in three (approximately 250 million) had entered into union before the age of 15. [3]

Marriage in childhood is a fundamental violation of a number of human rights − the right to make choices in life, health, education, safety, and security – that hinders progress towards sustainable development all over the world. Child marriage has many adverse effects on a young girl's social, mental, physical health and well-being. [4] It carries with it an increased risk of early pregnancy, domestic violence, sexually transmitted infections (STI), depression and anxiety, and reduced opportunities for education and employment.

Adolescent pregnancy and child marriage are inextricably linked. In many cases, child marriage is a driver of early pregnancy; in other cases, marriage follows a girl's often unwanted pregnancy. They are harmful practices that deprive girls of their childhood, and happen merely because they have happened for generations. These practices can be linked to the process of rite of passage, deeply rooted in dominant social norms (beliefs, values, and attitudes) that construct gender roles. Additionally, for many poor families, marrying their daughter off at an early age essentially is a strategy for economic survival, as it means one less person to feed, clothe, and educate.

Given the enormity of the problems of adolescent pregnancy and child marriage in the world, global momentum to address these practices is increasing. For example, 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 Sustainable Development Goals (SDGs).

Sierra Leone has committed to reducing adolescent pregnancy and child marriage with its commitments to the SDGs and the WHO's Global Strategy for Women's Children's and Adolescents' Health (2016–2030). In 2016, the country joined the ranks of African countries such as Ethiopia and Ghana to launch the AU Campaign to End Child Marriage.

Significant efforts are also underway to address adolescent pregnancy and child marriage in Sierra Leone. Following the establishment of a National Secretariat for the Reduction of Teenage Pregnancy (NSRTP) in May 2013, the Teenage Pregnancy Reduction Strategy (2013-2015) was developed that same year. Sierra Leone is one of the target countries for the ongoing UNICEF-UNFPA Global Programme to Accelerate Action to End Child Marriage, which was developed to support the elimination of child marriage in 12 countries with a harmonized vision.

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018-2022) was developed to guide the prioritisation of all evidence-based adolescent pregnancy and child marriage reduction interventions in the country during this period. The strategy sets out:

A national goal and the objectives to achieve this goal

Priority strategies to achieve the stated objectives

Guiding principles to inform implementation of the strategies

The coordination mechanisms

A monitoring and evaluation framework

A costing framework for 2018-2022

One of the key lessons emerging from the development of similar strategies around the world is that such a framework is more likely to be implemented if it is 1) integrated and 2) developed with significant involvement of relevant stakeholders including media. This enables these actors not only to define the priority strategies to reduce adolescent pregnancy and end child marriage, but also to build a sense of joint ownership in the implementation. Accordingly, this document is a culmination of a series of intensive consultations with a range of stakeholders from different government sectors and agencies, as well as civil society organisations.

The eradication of child marriage and the prevention of early childbearing and adolescent pregnancy would contribute to the improvement of women's and girl's health as well as their social and economic participation, and the realisation of their rights and institutionalisation of gender equality. Given the fact that such harmful practices are perpetuated by a myriad of problems, their elimination requires rigorous and consistent efforts and the commitment of national and international stakeholders; this endeavour cannot happen overnight.

1.2 Rationale for the national strategy for the reduction of adolescent pregnancy and child marriage (2018-2022)

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018–2022) is a follow-on to the National Strategy for the Reduction of Teenage Pregnancy (2013–2015). The increasing recognition of child marriage as a national problem in Sierra Leone – and given the strong link between child marriage and adolescent pregnancy – has led to the need to address the two issues jointly. Thus, as an integrated document, the strategy details the commitments of multisector stakeholders across five government ministries to tackle the challenge of adolescent pregnancy and child marriage; the ministries are the Ministry of Health and Sanitation (MoHS), Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA), Ministry of Youth Affairs (MoYA), Ministry of Basic and Senior Secondary Education (MBSSE), and the Ministry of Local Government and Rural Development (MLGRD).

The implementation of the National Strategy for the Reduction of Teenage Pregnancy (2013–2015) was negatively affected by the Ebola virus disease (EVD) outbreak – the attention and resources of the Government of Sierra Leone (GoSL) and its partners were diverted to containing the outbreak. There is anecdotal evidence showing that for the affected population, the search for alternative livelihoods, combined with school closures, the lack of activities for adolescents, idleness, and the disruption of family planning services led to an increase in adolescent pregnancies. [5]

Following the outbreak, the NSRTP commissioned a study to collect up-to-date information on the nature and extent of adolescent pregnancy in Sierra Leone, analyse the factors contributing to the issue, and make targeted recommendations that would inform the NSRTP about strategic planning in the post-Ebola transition phase. The study found that girls who became pregnant during the outbreak lacked knowledge of the conception process: only 5.4 per cent of them demonstrated correct knowledge, and contraceptive uptake among this group was low. [6]

Furthermore, social factors such as having friends who were sexually active and the ability to talk to parents about sex were shown to have an impact on the likelihood that a girl would become pregnant: girls who had sexually-active friends were more likely to become pregnant, and if they could talk freely to their parents about sex they were less likely to become pregnant. **Almost a third of the girls (28.6 per cent) reported that they dropped out of school due to early marriage**. [7]

Finally, in consultations carried out to inform the development of this strategy, adolescents made earnest submissions on the factors that predisposed them to early and unplanned pregnancies which included inadequate parenting, poverty, negative peer group influences, child labour (especially sending girls out to do petty trading), lack of sexual reproductive health (SRH) education, and access to inappropriate sexual content via the internet.

As a government-led initiative, the strategy aims to address the aforementioned issues, and provides a direction for adolescent pregnancy and child marriage interventions in the country. It details the necessary programme activities and costs associated with achieving national adolescent health objectives and goals. The plan gives critical direction to the NSRTP, ensuring that all components of a successful programme are addressed and budgeted for by the government, donors, implementing partners, and all other actors. A monitoring and evaluation framework was specifically developed so that appropriate milestones and targets for each of the indicators can be established and tracked.

The strategy development process began in September 2016 with an initial literature review of challenges facing adolescent girls in Sierra Leone, and an analysis of global evidence on what works and what doesn't work in reducing adolescent pregnancy and preventing child marriage. This was followed by a review of the Teenage Pregnancy Reduction Strategy (2013–2015), including the successes and challenges in implementing it. To develop the specific objectives and strategies, technical advisory groups were set up with participation of UN agencies, MBSSE, MoYA, and non-governmental organization (NGO) partners. Four regional consultation meetings with adolescents and a range of stakeholders was conducted by the NSRTP.

1.3 Review of the teenage pregnancy reduction strategy (2013–2015)

Developed in 2013, the Teenage Pregnancy Reduction Strategy (2013-2015) presents a multi-sectoral approach to empowering adolescents and young people, particularly girls, to better respond to their overall needs and to address specific issues related to early childbearing and adolescent pregnancy.

The review of the strategy was led by a consultant arranged by the NSRTP in order to inform the development of the new National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018–2022). This encompassed an analysis of project documents related to both MoHS-led delivery and NGO-led projects set out in the strategy, in addition to field visits and semi-structured interviews of key informants including members of UN agencies, NGOs, organizations of adolescents and youths, and community stakeholders. Specifically, it assessed how the strategy's framework guided the programming and implementation of the GoSL and its partners' interventions in the fields of adolescent health, education, protection, gender, and other related subsectors. It also captured good practices across a range of key programmatic interventions related to adolescent health and well-being during the period.

Many activities from this strategy were reported as unaccomplished during the EVD outbreak and its response. Schools were closed for almost a year, so any planned school-based activities could not be delivered.

In particular, the inclusion of comprehensive sexuality education (CSE) in schools was given a lower priority whilst schools focused on the delivery of the accelerated education programme to catch up with academic exercises following the 10-month school closure.

It has also been highlighted that with children staying at home and parents out working, girls were more vulnerable to advances from boys and men within the households and community, leading to higher rates of adolescent pregnancy.

Moreover, with children out of school and the financial difficulties that households faced due to quarantines and travel restrictions, there were reports that children were more readily sent out to earn an income through transactional sex and even coerced marriage; this was corroborated during the regional consultations where adolescent girls reported this in every region.

During the review process, the following programmatic recommendations were made to be included in the National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018–2022):

- Interventions targeting parents to provide parenting information, advice and support;
- Interventions targeting pregnant girls and adolescent mothers and their family units to prevent successive pregnancies;
- Interventions targeting the most vulnerable girls such as orphans, those being maltreated, or involved in child labour to prevent them from becoming pregnant;
- Interventions to ensure that adolescents who are survivors of gender-based violence (GBV) receive adequate support services to prevent them from being involved in a spiral of abuse and becoming pregnant;
- Interventions to ensure that girls are adequately prepared for menarche and have access to adequate menstrual hygiene facilities in schools;
- Interventions targeting men and boys for behavioural change;
- Existence of emergency preparedness plans at the community level to provide some level of sustained service delivery to adolescents in the event of an emergency;
- Establish school clinics to provide health information and services to adolescents.

1.4 Situation analysis of adolescent pregnancy and child marriage in Sierra Leone: causes and consequences

Ranked 151 out of 159 in the 2015 Gender Inequality Index, the situation for women and girls in Sierra Leone is among the worst in the world, with the inequalities and vulnerabilities particularly acute for adolescent girls.

Sierra Leone has the **19th highest child marriage prevalence globally[8], with 12.5 per cent of women aged 20–24 years marrying before the age of 15 years, and 38.9 per cent of women in the same age bracket marrying before the age of 18 years.**[9] Considering that 24 per cent of Sierra Leone's 7 million population are adolescents, of which roughly half are girls, this amounts to approximately 330,000 affected girls.

Child marriage is typically higher in rural areas because of greater adherence to traditional norms, a narrower range of life options, stronger community networks, lower educational opportunities, and higher levels of poverty – girls from the poorest households or those living in rural areas face twice the risk of being married before turning 18 as compared with girls from the richest households or those living in urban areas.[10] Within the country, the rate of child marriage is particularly high in Koinadugu and Moyamba districts, followed by Kenema, Pujehun, and Port Loko.

In terms of early pregnancy, among adolescents aged 15–19 years, 28 per cent had already begun childbearing and 24 per cent of those married have had their first birth during the first year of marriage.[11] Also, a larger proportion of teenage pregnancies occur in rural areas – 34 per cent compared with 19 per cent in urban areas.[12]

The UNICEF 2016 out-of-school children study indicated that nearly three out of every 10, or 29 per cent of out-of-school girls, were excluded from school as a result of pregnancy.[13] Once visibly pregnant, girls are banned from attending school and writing public exams. Where girls return to school after child birth, they may face continued challenges in the form of bullying and verbal abuse by classmates and teachers.

Though teenage pregnancy may have been the result of consensual relations between two people, 5.6 percent of teenage mothers/ pregnant teens reported to have ever experienced forced sex. Among this group, 63.8 per cent of girls reported that their husband, boyfriend or partner was the perpetrator of the sexual violence. In 6.4 per cent of the cases, the perpetrator was a teacher. Furthermore, 5.2 per cent of the teenage mothers/pregnant teens reported that they ever had transactional sex (sex for money, favours, or gifts).[14]

Unsurprisingly, pregnancy and poverty are reported as the key drivers of child marriage.[15] When adolescents become pregnant, they are often sent to live with the impregnator. For many families, sending an adolescent girl to be married is considered a way to reduce an immediate economic burden; in communities where economic transactions are integral to the marriage process, a dowry is often welcome income for poor families.

However, it is also important to understand the cultural and normative context as well as the social dynamics contributing to a family's decision to marry a child at a very young age. A family in Sierra Leone is traditionally organized around gendered social roles characterized by male super-ordination and female subordination. Males traditionally hold the power of decision-making, and control economic and public affairs, whilst the female role in most cases includes domestic work and taking care of children. Weak protection, education, and health systems for girls and a lack of economic opportunity all contribute to limiting girls' options, perpetuating child marriage.

Regardless of the reasons, child marriage leads to significant physical, emotional, and social harm for many adolescent girls in Sierra Leone. In particular, girls are often unable to negotiate safe sex with their husbands because of their young age and limited power in the relationship – which puts them at high risk of STI including HIV – and are frequently under pressure from in-laws to immediately become pregnant after marriage.[16]

The Teenage Pregnancy Assessment conducted by the NSRTP in 2016 found that 82.2 per cent of teenage mothers/pregnant teens did not want to become pregnant at the time they became pregnant.[17] The lack of credible information on SRH issues and access to contraceptives for adolescents contributes to the increasing number of unplanned pregnancies.

According to the 2013 Demographic and Health Survey, in Sierra Leone: 12.5% of women aged 20–24 years were married before the age of 15 years and 38.9% of 20-24-year-olds were married before the age of 18 years

These girls are also less likely to receive proper medical care during pregnancy and delivery than their peers who marry later. A combination of their physical immaturity and lack of proper medical care during pregnancy and birth puts these young mothers at increased risk of potentially disabling complications during gestation and delivery, including prolonged labour, obstetric fistula, and death. In Sierra Leone, complications during pregnancy and childbirth are a leading cause of death for girls between ages 15 and 19 years: 46.8 per cent of adolescent girls who die in Sierra Leone are due to complications in pregnancy or childbirth. [18]

Moreover, a strong correlation exists between child marriage and poor mental health. These girls experience higher levels of depression, anxiety, isolation, self-harm and suicide than those who marry later.[19] Child marriage not only deprives the girl of a voice, sense of agency, power and long-term earning potential, it also has intergenerational effects. For example, babies born to mothers younger than 20 are 1.5 times more likely to die than in their first 28 days than babies born to mothers in their twenties or thirties. [20]

Lastly, when girls are married, formal education often ceases. This limits their prospects of employment and also removes the girl from the space within which she develops her social skills, social networks and the support structure provided by the school, leaving her often isolated at home.

1.5 Legal and policy framework

International conventions and treaties combined with national laws and policies provide a powerful normative statement on upholding the rights and well-being of women and girls. In this respect, they provide significant legitimacy from which to protect girls at risk, conduct advocacy, develop programmes, dedicate resources, and support young girls affected by early pregnancy and child marriage.

The reduction of adolescent pregnancy and child marriage is a high priority for the GoSL. Sierra Leone is a signatory to international and regional instruments that protect the rights of girls and women, namely the African Charter on the Rights and Welfare of the Child, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), and the United Nations Convention on the Rights of the Child (UNCRC), which all directly or indirectly address the issue of early pregnancy and child marriage.

In 2016, Sierra Leone reached a significant milestone when it became the 15th country to launch the African Union (AU) Campaign to End Child Marriage, ramping up its efforts to ban this harmful practice in the country. As part of the launch, children across Sierra Leone also made a powerful set of recommendations, which included:

- For parents and caregivers to stop giving children into early and forced marriage below 18 years;
- For local councils, chiefdom committees and Parliament to strengthen national laws and policies on child protection;
- For child protection agencies and service providers to increase their level of support towards children;
- For chiefs, parents, and caregivers to discourage every attempt to compromise when child marriages are reported and to act promptly;
- For the MBSSE to send more female teachers to rural schools, and to provide scholarships for girls to stay in school.

At the national level, the Child Rights Act (2007) articulates the minimum age of marriage, and the Sexual Offences Act (2012) specifies that a person aged under 18 years cannot consent to sex, making sex below this age illegal. The Registration of Customary Marriage and Divorce Act (2009) states that a person can only legally marry if they are over the age of 18 years; however, it has a critical loophole which permits that marriage of 16 year-old boys and girls with parental consent, thus, there is need for these two acts to be harmonised.

46.8% of adolescent girls who die in Sierra Leone are due to complications in pregnancy or childbirth

In the various sectors, there are supportive policies that address the well-being of adolescents, as shown below:

Sector	Policy/Strategy name	Description
Health	Free Healthcare Initiative (2010)	This initiative was introduced to provide free health care to pregnant women, lactating mothers, and children under five. This initiative also supports adolescent mothers and their children.
	National Standards for Adolescent and Young People Friendly Health Services (2011)	This document laid out the standards for provision of adolescent and young people friendly (AYPF) health services in the country.
	Sierra Leone National Reproductive, Maternal Newborn, Child and Adolescent Health Strategy (2017–2021)	This strategy seeks to reduce maternal and neonatal mortality and adolescent pregnancy reduction.
	Sierra Leone Basic Package Of Essential Health Services (2015-2020) July 2015	School and Adolescent Health Services, and prevention, response and mitigation of Teenage Pregnancy are highlighted as key component of the package of services
		Selected services to adolescents is highlighted as one of the key duties of CHWs
Education	The Education Act (2004)	This policy states that basic education is the right of every citizen and makes basic education compulsory.
	National Curriculum and Guidelines for Basic Education	The curriculum provides details of what must be taught in schools, and this includes sexual reproductive health.
Social Welfare	The Child Welfare Policy (2014)	This policy aims to strengthen the child welfare systems by articulating the government's commitment to enhancing the welfare and protection of all children, including the most vulnerable and marginalized.

The major issue in Sierra Leone, therefore, is not an absence of relevant laws and policies but in the weak enforcement of such laws and implementation of relevant policies. Some of the challenges in enforcement and implementation, among others, include:

- Reluctance by families of affected children to report cases due to social pressure;
- Lack of evidence to prosecute cases when families withdraw cases;
- Inadequate training of law enforcement officials in child protection and handling cases of child marriage and GBV in particular;
- Limited resources for implementing agencies such as the police and family and juvenile courts.

2. STRATEGIC DIRECTION

2.1 Overall goal and objectives

The overall goal of the strategy is to reduce the adolescent fertility rate to 74 per 1,000*, and the percentage of women aged 20 to 24 years who were first married or in union before the age of 18 to 25 per cent* by 2022.

*(*Baselines are 125/1000 and 38.9% respectively, both drawn from 2013.)*

As a roadmap to achieve this overall goal, the document will be used to:

Ensure that the government and its development partners focus on delivering evidence-based activities over the period 2018-2022: Part of the process of the strategy development included a thorough review of what is known to be effective in reducing adolescent pregnancy and child marriage. It is expected that all new programmes in the country, regardless of their source of funding, should align with the strategy.

Ensure that one unified country strategy for the reduction of adolescent pregnancy and child marriage is followed by government, development partners, and implementing partners: The strategy articulates the GoSL's consensus-driven priorities for the reduction of adolescent pregnancy and child marriage. The plan will help ensure that all activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their investments and programmes. The strategy is also to be used to hold government, development partners, and implementing partners accountable for their planned activities.

Support resource mobilisation efforts: The strategy is costed. It should be used by the NSRTP and partners to mobilise needed resources, and to systematically track the available resources against those required as stipulated in the strategy.

Provide a framework for tracking performance:

The strategy's monitoring and evaluation framework provides a system to track progress. All implementing partners are required to submit data to the NSRTP as part of their commitment to the plan.

Finally, the strategy is organized around six pillars with the following strategic objectives:

1 Pillar 1: Policy and legal environment

To improve the policy and legal environment for the protection of adolescents and to improve the capacity of implementing agencies to implement laws, policies, and protocols affecting adolescents.

2 Pillar 2: Adolescent and young people friendly services

To ensure that a minimum package of AYPF healthcare services is provided in peripheral health units (PHUs) including outreach services, hospitals, schools, and learning centres.

3 Pillar 3: Enabling school environments

To ensure all adolescents have access to CSE and that the learning environment is enabling for adolescent girls and boys to thrive.

4 Pillar 4: Communication and advocacy

To increase demand for AYPF services.

5 Pillar 5: Community ownership

To engage with communities and empower them so that they take individual and collective responsibility for the reduction of adolescent pregnancy and child marriage.

6 Pillar 6: Coordination, monitoring, and evaluation

To ensure that the strategy's activities are well coordinated, monitored, and evaluated, and that evidence is generated and used to inform decision-making.

2.2 Guiding principles and the ecological framework

The following guiding principles were taken into account in the development of this strategy and should also be followed during implementation:

- The best interest of adolescents: All activities should be planned and delivered with the best interests of the adolescent as the foremost concern.

- Adolescents at the heart of planning and implementation: Adolescents are the experts of their own lives; plans and services delivered for adolescents without their input are unlikely to be ineffective because they will miss the nuanced understanding that the adolescents themselves bring.

- Community ownership: Learning from the EVD outbreak, the strategy recognizes that the changes that are being sought will only materialize when communities take full ownership of the problems surrounding adolescents, and their solutions.

- Multi-sectorality: Adolescent pregnancy is caused by a range of complex factors that cut across sectors. All named sectors must be fully engaged and collaborate for the strategy to be successful.

- Evidence-based strategies: Only strategies that are supported by evidence to be effective have been included in this strategy.

The complex range of factors that influence adolescent pregnancy and child marriage have been conceptualized through an ecological model that considers health determinants at macro, structural, environmental, organizational, community, interpersonal, and individual levels. Using this theoretical model, global evidence of what works (and what doesn't work) in reducing adolescent pregnancy and child marriage, as well as lessons-learnt from the implementation of the Teenage Pregnancy Reduction Strategy (2013-2015), the strategies for programmatic implementation were developed, which will be elaborated in the forthcoming section.

Problem

In Sierra Leone, **12.5 per cent of women aged 20-24 years were married before the age of 15 years, and 38.9 per cent of women in the same age bracket were married before the age of 18 years. 28 per cent of girls aged 15-19 years have begun child bearing.**

Child marriage has many adverse effects on a young girl's social, mental, physical health and well-being. Early childbearing is associated with higher risks of morbidity and mortality for the mother and child, and reduces educational attainment. These harmful practices are interlinked and prevent adolescents, especially girls, from reaching their full potential and making maximum contributions to their community.

Level	Strategies to address problem	Outcomes
Macro	Ensure emergency preparedness for reproductive health, education, and welfare services.	Services are maintained to some degree in emergency situations.
Structural	Improve human and financial resources of implementing agencies to enable them to implement laws, policies, and protocols, and for better coordination.	Laws, policies, and protocols relating to adolescent well- being are well implemented.
Environmental	Improved advocacy and coordination with the NSRTP and other actors to improve access to water at community level to lessen the risks of adolescent girls having to fetch water and their burden to engage in household chores.	Communities are supported to improve access to water and reduce the social consequences on adolescent girls.
Organisational	Ensure all primary, junior secondary, and senior secondary schools provide CSE and that all informal learning centres, community-based interventions, and knowledge-based outreach teams provide sexuality education using the national standardised life skills manual. Ensure all PHUs provide a minimum package of AYPF health care services, including outreach services.	Schools and informal learning centres, including safe spaces, provide CSE and life skills education for girls both in and out of school. Health centres that provide high-quality services and are also welcoming to adolescents, especially girls, are established.
Community	Using existing community platforms, ensure every chiefdom has a body and/or champions responsible for the reduction of adolescent pregnancy and child marriage, who work closely with schools, PHUs, and service providers. Ensure that all parents and caregivers have access to parenting information and support. Ensure that SRH-related advocacy campaigns targeting boys and men are implemented in every community. Ensure there are community-based support schemes for pregnant adolescents and adolescent mothers. Ensure that out-of-school adolescents access CSE through informal learning centres, community-based interventions and knowledge based outreach teams through the use of the national standardised life skills manual.	

Level	Strategies to address problem	Outcomes
Interpersonal	Age-appropriate, targeted information are disseminated, and education campaigns for boys and girls and their support networks are implemented.	Parents, caregivers, family members, and friends of adolescent girls are well informed about SRH, including pregnancy and delivery care.
Individual	Ensure that vulnerable girls (those who are at risk of or who have dropped out of school, those affected by child trafficking, child labour, unlawful sexual penetration, sexual abuse, etc.) receive the social protection, quality health care, and education services that they require.	Most vulnerable girls are protected and supported to recover from any distress they may have experienced.

2.3 Strategies for implementation

Pillar 1: Policy and legal environment

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018-2022) will be implemented within the existing policy and legal framework of Sierra Leone, using existing policies within organizations and laws at all levels of society. New policies and laws that improve adolescent well-being will also be reviewed, developed, and harmonised as needed.

Objective: Improve the policy and legal environment for the protection of adolescents and to improve the capacity of implementing agencies to enforce these laws, policies, and protocols affecting adolescents.

Strategy	Key actions
1.1 Facilitate the review and/or development of laws and policies that improve adolescent well-being	1.1.1 Develop a multi-sectoral adolescent health and well-being policy (it must include what SRH services can be delivered in schools and cover out of school adolescents) 1.1.2 Advocate for a review of the age of consent to 15 years as per global best practices; this will make it legally possible to deliver sexual reproductive health services without parental consent to those aged 15 years and over 1.1.3 Advocate for a policy for free health care for adolescents (The National Health Insurance Scheme has plans to provide free health those aged 0 to 19 years) 1.1.4 Harmonise the Child Rights Act and the Registration of Customary Marriage and Divorce Act to address child marriage
1.2 Ensure implementing agencies are enabled to implement laws, policies and protocols	1.2.1 MBSSE to work with District Education Offices to ensure the Teacher Code of Conduct is enforced in all schools 1.2.2 MLGRD and relevant ministries, departments, and agencies to work together to ensure that laws that protect adolescents from all forms of violence (rape, child marriage, child trafficking, child labour) are effectively implemented 1.2.3 MLGRD to work with district-level offices to ensure that appropriate by-laws are developed to curb all forms of violence against children and adolescents (statutory rape, child marriage, child labour, and child trafficking) 1.2.4 Support implementation and monitoring of laws and policies that protect adolescent from adolescent pregnancy and child marriage

Pillar 2: Adolescent and young people friendly services

The strategy acknowledges that adolescents and young people face barriers when trying to access SRH services; it has, therefore, endeavoured to make services friendly for adolescents and young people. Under the National School and Adolescent Sexual Reproductive Health Programme within the Ministry of Health and Sanitation and the Ministry of Basic and Senior Secondary Education, school-based clinics will be established to provide health information and services to adolescent and girls.

Objective: Ensure that a minimum package of AYPF healthcare services is provided in PHUs including outreach services, hospitals, schools, and learning centres.

Strategy	Key actions
2.1 Ensure all PHUs and hospitals can provide a minimum package of AYPF healthcare services, including outreach services (strong emphasis on being both boy and girl-friendly)	2.1.1 Mapping and identification of girls most at risk in intervention areas 2.1.2 Review standards for AYPF health services (must accommodate different models of delivery most appropriate to context). The package must include STI and HIV services at a minimum 2.1.3 Scale up AYPF centres to all PHUs 2.1.4 Ensure adolescents are included in the governance/steering groups of AYPF centres 2.1.5 Provide pre-service and in-service trainings to health care workers on AYPF health services and GBV management 2.1.6 Ensure adequate monitoring and quality of care for services to adolescents in all PHUs and hospitals
2.2 Set up school-based clinics	2.2.1 Evaluate the performance of existing school-based clinics 2.2.2 Set up more school-based clinics and some in vocational institutions as well 2.2.3 Ensure adequate monitoring and quality of care for services to adolescents in all school-based clinics
2.3 Ensure the MoHS is prepared to deliver AYPF services during emergencies	2.3.1 Coordinate with the Office of National Security (ONS) Emergency Operations Centre to develop emergency preparedness plans (link to district emergency preparedness plans) which highlight addressing the needs of adolescents 2.3.2 Plan and ensure the provision of a minimum initial services packages during disasters
2.4 Ensure adolescents and young people are involved in the governance of AYPF centres	2.4.1 Develop terms of reference for steering committees that provide advice and support for AYPF health workers
2.5 Invest in intentional asset building (health, social and economic assets) for adolescent girls (and boys) including the provision of safe spaces	2.5.1 Establish adolescent safe spaces 2.5.2 Develop content (including life skills, SRH information, psychosocial and referral to services) and life skills training to be provided by mentors targeting both in- and out-of-school girls and boys in the community 2.5.3 Intentionally recruit and administer pre- and post-test for girls being enrolled into safe space activities on life skills 2.5.4 Identification and training of mentors to manage the adolescent safe space activities

Pillar 3: Enabling school environments

The strategy recognizes that school environments are not always enabling for adolescents, particularly girls. The strategy also recognizes that schools can play a central role in influencing adolescent SRH behaviour and that girls who drop out of school are more likely to get pregnant. Whilst the wider issue of poverty and inability to pay fees is dealt with in higher level policies, the strategy addresses the many other factors that also lead to dropout.

Objective: Ensure all adolescents have access to Comprehensive Sexuality Education and that the learning environment is enabling for adolescent girls and boys to thrive.

Strategy	Key actions
3.1 Ensure all primary, junior secondary, and senior secondary schools provide age-appropriate CSE, using culturally relevant approaches. It is important to ensure that culturally appropriate language is used for the term 'sexuality'.	3.1.1 Work with politicians and other influential person such as traditional and religious leaders to get their buy-in 3.1.2 Advocate for teacher training colleges to include CSE in the teacher training curriculum 3.1.3 Develop and disseminate the CSE packages to students (boys and girls), parents (male and female), governing bodies, head teachers, teachers, counsellors, and trainers 3.1.4 Train school workforce to deliver CSE. Include a mandatory induction for all new teachers and continuing professional development for all teachers
3.2 Revive and strengthen guidance and counselling within schools	3.2.1 Train and equip guidance counsellors 3.2.2 Advocate for reduced teaching load for guidance counsellors 3.2.3 Advocate for schools to provide space for guidance and counselling 3.2.4 Ensure guidance counselling services can provide support (including physical spaces) for menstrual hygiene management
3.3 Ensure junior and senior secondary schools provide adequate sanitation facilities for menstrual hygiene management	3.3.1 Conduct a nationwide assessment of school menstrual hygiene facilities 3.3.2 Work with local councils to develop strategies and action plans to improve menstrual hygiene facilities
3.4 Adolescent girls are supported to enrol and remain in formal and non-formal education, including through the transition from primary to secondary education	3.4.1 Provision of learning materials and key services (i.e. health and psychosocial) to vulnerable adolescent girls 3.4.2 Girls clubs established to mentor girls on staying in school and the importance of education and health services 3.4.3 Support capacity building of organizations providing Leadership development Programme for adolescent girls 3.4.4 Provide educational support and reintegrate girls into formal school to reduce dropout 3.4.5 School safety guide developed and head teachers trained to implement school safety plans for protecting girls against GBV

Pillar 4: Communication and advocacy

The main barriers to improving SRH are myths and strongly held traditional beliefs. A robust social behaviour change campaign is needed to bring about change in behaviour. Furthermore, as issues emerge that affect adolescent pregnancy and child marriage, a timely, well-planned, and well-executed advocacy campaign will be needed.

Objective: Increase demand for AYPF services.

Strategy	Key actions
4.1 An age- and gender-appropriate information and education campaign is implemented	4.1.1 Implement the Communication Strategy (The NSRTP already has a comprehensive 5-year communication strategy)
4.2 Undertake advocacy based on emerging evidence	4.2.1 Develop an advocacy strategy 4.2.2 Implement advocacy strategy 4.2.3 Advocate for MBSSE to integrate CSE in school curricula as per the Education Sector Plan 4.2.4 Advocate for right to education for all girls
4.3 Households are increasingly aware of the benefits of investing in adolescent girls	4.3.1 Organize community-based groups (Child Welfare Committee, Village Development Committees, Mothers Clubs, and Youth Clubs) to conduct outreach on ending child marriage and adolescent pregnancy; and the importance of engaging men and boys 4.3.2 Support community engagement with men, women, boys & girls, and awareness-raising among parents and guardians through dialogue sessions on the importance of investing in adolescent girls and the need to end child marriage and adolescent pregnancy 4.3.3 Develop and air jingles (campaign messages) on ending child marriage and adolescent pregnancy

Pillar 5: Community ownership

Learning from the EVD outbreak, community ownership is crucial for solving community-based problems. This strategy places great emphasis on problem-solving at the community level with robust guidance and training from the central team.

Objective: Engage with communities and empower them so that they take individual and collective responsibility for the reduction of adolescent pregnancy and child marriage.

Strategy	Key actions
5.1 Using existing community platforms, ensure every chiefdom/ ward has a body responsible for reduction of adolescent pregnancy and child marriage that works closely with schools, PHUs, and other service providers	5.1.1 Identify bodies and focal point/leaders responsible for adolescent pregnancy and child marriage reduction in each chiefdom/ward 5.1.2 Develop guidance (terms of reference) for the adolescent pregnancy and child marriage reduction bodies (ensure key actors such as chiefs, mammy queens, councillors, and religious leaders are involved) 5.1.3 Provide orientation for bodies responsible for reducing adolescent pregnancy and child marriage 5.1.4 Hold quarterly meetings with bodies responsible for reducing adolescent pregnancy and child marriage at chiefdom/ward level (monthly meetings at the village level) 5.1.5 Identify leaders from chiefdoms and communities as champions to promote adolescent pregnancy and child marriage reduction
5.2 Ensure that all parents have access to parenting information and support	5.2.1 Identify existing platforms such as schools, PHUs, and community-based organizations to provide parents/caregivers information and support services 5.2.2 Develop guidance for parents/caregivers 5.2.3 Identify and train parents/caregivers
5.3 Ensure that SRH behaviour change campaigns targeting boys and men are implemented in every community	5.3.1 Identify existing platforms such as religious institutions, schools, youth organizations/groups, artisans, etc. that can provide behaviour change activities for boys and men 5.3.2 Develop guidance for male behaviour change campaign 5.3.3 Train implementers on how to deliver the campaign 5.3.4 Undertake different types of campaigns to reach boys and men
5.4 Ensure there are community-based support schemes for pregnant adolescents and adolescent mothers	5.4.1 Identify existing platforms such as schools, PHUs, NGOs, and community-based organizations to provide support services for pregnant adolescents and adolescent mothers 5.4.2 Develop standard operating procedures (SOP) for pregnant adolescents and adolescent mother services

Strategy	Key actions
5.5 Ensure that out-of-school adolescents access CSE through informal learning centres, community-based interventions, and knowledge-based outreach teams. The standardised life skills manual will be used.	5.5.1 Map non-formal educational institutions 5.5.2 Train non-formal educational institutions on delivery of life skills using the standardized life skills manual
5.6 Ensure communities are prepared to care for adolescents in emergency	5.6.1 Provide emergency preparedness training for communities 5.6.2 Support communities to develop emergency preparedness plans

Pillar 6: Coordination, monitoring and evaluation

The strategy's monitoring and evaluation (M&E) framework provides a means to collect and analyse data to measure performance and progress towards the strategy's goal. Indicators have also been chosen to ensure that Sierra Leone can be compared to other countries at a global level. Strategic coordination and the use of evidence to drive decision-making are recognized to be key for the successful implementation of the strategy.

Objective: Ensure that the strategy's activities are well coordinated, monitored, and evaluated, and that evidence is generated and used to inform decision-making.

Strategy	Key actions
6.1 Ensure the NSRTP is well-resourced (human and financial)	6.1.1 Develop an operational plan and human resource for the NRSTP 6.1.2 Implement operational and human resource plan 6.1.3 Set up a server for safe storage of documents
6.2 Ensure robust M&E of the strategy's activities and that evidence is used to inform decision-making	6.2.1 Review and implement M&E plan 6.2.2 Commission research to inform decision-making as required 6.2.3 Conduct at least one research project each year
6.3 Ensure the strategy is coordinated well	6.3.1 Hold Multi-Sectoral Technical Committee (MTC) meetings every two months 6.3.2 Hold quarterly Regional Coordination meetings 6.3.3 Hold half-yearly Multi-Sectoral Coordinating Committee (MCC) meetings 6.3.4 Hold an annual review meeting

2.4 Coordination and collaboration

The strategy will be implemented under the general responsibility of His Excellency the President. The general coordination of the strategy will be under the responsibility of the MCC (at the ministerial level), supported by the MTC and the NSRTP.

Direct supervision and day-to-day management of the strategy are delegated to the MSWGCA and the MoHS.

The strategy is also fully integrated with the GoSL's Agenda for Prosperity. As such, the strategy is implemented by all concerned implementing ministries: MoHS, MSWGCA, MoYA, MBSSE, MLGRD as well as other key stakeholders.

The coordinating mechanisms, as well as the roles and responsibilities, are as follows:

Office of the President: His Excellency the President will provide the overall leadership and chair biannual meetings to assess and monitor progress in achieving the expected outcomes of the strategy. He will also provide overall policy guidance.

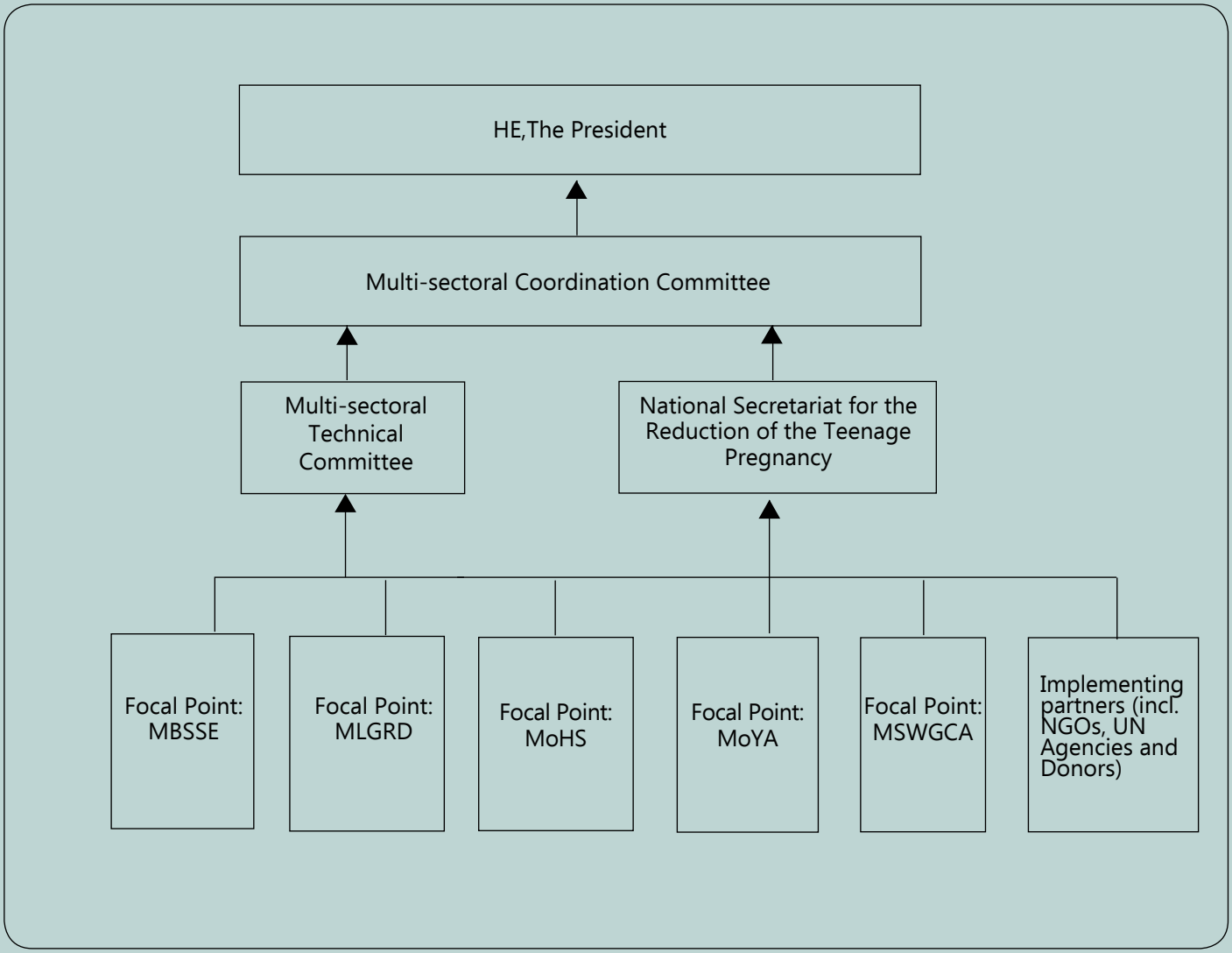
The Multi-sectoral Coordinating Committee (MCC): The MCC is chaired by the MoHS and co-chaired by the MSWGCA. Concerned ministers, heads of UN agencies (UNAIDS, UNDP, UNFPA, UNICEF, WHO, and UN Women), representatives of the donor community, heads of the National Commission for Social Action (NACSA) and the National Aids Secretariat, as well as NGO representatives are members of the MCC meetings. The role of the committee is to provide policy guidance and direction in the implementation of the strategy, to ensure effective inter-sectoral and inter-ministerial communication, and adequate information sharing among all participating partners. Furthermore, it will oversee the progress of activities undertaken. The committee will meet quarterly, unless otherwise instructed by the chairing ministries.

Multi-sectoral Technical Committee (MTC): The MTC is chaired by the Coordinator of the NSRTP. Ministry focal points and relevant technical officers of the MDAs, UN Agencies, NGOs as well as civil society organisations and youth associations are members of the MTC. The role of the committee is to provide technical guidance to the implementation of the strategy, ensure complementarity of interventions, facilitate sharing of technical information across sectors and all participating organizations, and monitor the implementation of planned activities and progress towards achievement of expected results. The committee will meet every two months, unless otherwise instructed by the MoHS and MSWGCA.

National Secretariat for the Reduction of Teenage Pregnancy: The secretariat will be responsible for the general coordination of implementation and monitoring. Its role is to support key ministries and participating organizations in initiating policy dialogue, closely monitor programme implementation, ensure progress in achieving the set objectives, and actively engage in the efforts to strengthen national coverage for the implementation of the strategy.

Ministry focal points: All participating ministries will designate a technical staff person to act as focal points. Ministry focal points will participate in the MTC meetings, provide administrative support for meetings, and monitor efforts of the secretariat, as well as keep senior officers updated on programme implementations and discussions of the MTC.

The following diagram illustrates the coordination mechanism:



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2.5 Monitoring and evaluation framework

The M&E framework details the impact, outcome and output indicators organized by pillar. It has been designed to track progress against specific indicators and enable stakeholders to learn from what is working or not working. A conscious intention was made to keep the framework simple and practical.

Program Goal: To reduce the adolescent fertility rate to 74 per 1,000, and the percentage of women aged 20 to 24 years who were first married or in union before the age of 18 to 25 per cent by 2022									
Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Impact	Percentage of 15-19 year old female deaths that are maternal	46.8%	26.11%	Numerator: Number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, among adolescents aged 10-14 years and 15-19 years in a specified period Denominator: Number of live births to adolescents in the specified period	DHS, MICS, Population-based surveys	Administrative records DHS	Disaggregation 15–19 years	Quinquennial	SSL
Impact	Annual number of births to adolescents aged 10-14 years & 15–19 years per 1,000	To be established/125.1	To be established/74	Numerator: Number of live births to adolescents aged 10-14 years and 15-19 years Denominator: Total number of girls aged 10-14 years and 15-19 years	Civil registration and vital statistics system, DHS, MICS, United Nations, Population Division (denominator)	Administrative records DHS	By sex, age	Quinquennial	SSL
Impact	Percentage of adolescents living with HIV in the general population	To be established (10-14 year olds) 1.1% (15-19 year olds)	To be established (10-14 year olds) 0.55% (10-15 year olds)	Numerator: Number of adolescents aged 10-14 and 15-19 years living with HIV Denominator: Number of adolescents aged 10-14 and 15-19 years in the population	HIV surveillance systems, HIV prevalence surveys	Surveys, surveillance data	By sex, age	Quinquennial	SSL
Impact	Percentage of 20-24 years that are married before age 15 or 18	Under 15 - 12.5 Under 18 - 38.9	Under 15 - 8.03 Under 18 - 25	Numerator: Number of 20-24 year olds married before aged 15/18 Denominator: Total number of respondents aged 15/18	MICS, DHS	Household surveys	By district	Quinquennial	SSL

Pillar 1: Policy and legal environment									
Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Output	Availability of policy that stipulates access for adolescents age 15 and above to SRH services without parental consent	18	15	N/A	NSRTP	Annual review	National	Annual	NSRTP
Output	Availability of a policy which allows adolescents up to19 years of age access to free health care	5	19	N/A	NSRTP, NASSIT	Annual review	National	Annual	NSRTP
Output	Availability of a multi-sectoral adolescent health and well-being policy	0	1	N/A	NSRTP	Annual review	National	Annual	NSRTP
Output	Percentage of implementing agencies' work plan that is funded	To be established	70%	Numerator: Funding received Denominator: Total cost of implementing agency work plan	Implementing agencies' work plan and budget with details of activities undertaken to implement the policy, financial reports of implementing agencies	Work plans, financial reports, review of quarterly/annual program reports	National	Annual	NSRTP/ MoHS/ MOJ/ MOI/ Police/ FSU/ MLSS/ MSWGCA
Output	Proportion of schools that are enforcing the teacher code of conduct	To be established	100%	Numerator: Number of schools in which the teacher code is enforced Denominator: Total number of schools in the country	Inspectors of schools report	Inspectors of school reports	By district, region	Bi-annual	MBSSE and partners

Pillar 2: Adolescent and young people friendly services

Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Outcome	Percentage of unmarried girls aged 15-19 years that are sexually active using modern contraceptives	62%	72%	Numerator: Total number of unmarried sexually active girls aged 15-19 years using modern contraceptives Denominator: total number of sexually active girls aged 15-19 years sampled	MICS, DHS (linked to Costed Implementation Plan for Family Planning - note CIP is to 2022)	Household survey	By age, district	3yrs / 5yrs	SSL
Outcome	Percentage of sexually active male adolescents aged 15-19 using condoms for dual protection	0.8%	0.9%	Numerator: Total number of sexually active 15-19 year olds using condoms Denominator: Total number of sexually active 15-19 year olds	MICS, DHS (Aligned to CIP Method Mix)	Household survey	By age, district	3yrs / 5yrs	SSL
Output	Boys and girls 10-14 years and 15-19 years of age acquired knowledge of adolescents and youth sexual and reproductive health and rights and GBV	To be established	To be established	Numerator: Total number of adolescents aged 10-14 years and 15-19 years aware of AYSRHR and GBV drivers Denominator: Total number of adolescents aged 10-14 years and 15-19 years sampled	Adolescent pregnancy study (Baseline to be set with the Adolescent Pregnancy Study)	KAP survey	By sex, district	Every 18 months for duration of Strategy	NSRTP
Outcome	Proportion of adolescents who had sexual intercourse before age 15 years	19.3%	11%	Numerator: Number of adolescents who report having had sexual intercourse before the age of 15 years in the survey Denominator: Total number of adolescent respondents in the survey	Adolescent pregnancy and child marriage study, DHS	Household survey	By age, sex	3yrs / 5yrs	NSRTP/ SSL

Pillar 2: Adolescent and young people friendly services									
Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Outcome	Percentage of girls aged 15–19 years who have ever had an intimate partner, who reported experiencing physical and/or sexual violence by an intimate partner in the past 12 months	To be established	To be established	Numerator: Number of girls aged 15-19 years who have ever had an intimate partner, who report experiencing physical and/or sexual violence by an intimate partner in the past 12 months Denominator: Total number of girls aged 15-19 years surveyed who have ever had an intimate partner	Adolescent pregnancy study (Baseline to be set with the Adolescent Pregnancy Study)	Household survey	By sex, district	Every 18 months for duration of Strategy	NSRTP/SSL
Outcome	Adolescents and young people and their sexual partners who access youth-friendly HIV, SRH, EVD and harm reduction information and services	To be established	90%	Numerator: Number of adolescents and young people accessing youth-friendly HIV, SRH, EVD and harm reduction information and services Denominator: Total number of adolescents in the population	DHS, MICS	Facility visit reports, annual surveys, periodic facility censuses	By district, region	Monthly	NAS (National Aids Secretariat) /NSRTP
Output	Number of health facilities with basic adolescent-friendly services	66	1200	Numerator: Number of facilities that have the basic service capacity to provide adolescent-friendly services Denominator: Total number of facilities	Facility visits using a standardized questionnaire based on the National Standards for Adolescent and Young People Friendly Health Services to assess the availability and functioning of the components required to meet the basic adolescent-friendly service standards	Facility visit reports, annual surveys, periodic facility censuses	By district, region	Annual	NSRTP
Output	Percentage of facilities with a health worker trained on adolescent-friendly health services delivery	Not known	100%	Numerator: Number of facilities with health worker trained on adolescent health Denominator: Total number of facilities	Programme monitoring data	Surveys	By district, region	Bi-annual	NSRTP

Pillar 3: Enabling school environments									
Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Impact	Proportion of girls completing Primary, JSS3 and SSS	Primary – 49.7% JSS3 – 23.8% SSS – 16.2%	Primary – 60% JSS3 – 30% SSS – 20%	Numerator: Number of girls completing at the official age Denominator: All the girls of completion age in the population	2015 SL Population and Housing Census, School census, Education Management Information System	School census checklist	By age	Annual	MBSSE
Impact	Ratio of girls to boys in JSS and SSS (GPI)	JSS – 0.93 SSS – 0.75	JSS – 0.96 SSS – 0.80	Ratio of girls to boys in JSS and SSS calculated based on the Gross Enrolment Ratio	2015 SL Population and Housing Census, School census	School census checklist	By age	Annual	MBSSE
Output	Percentage of schools with functional toilets and urinals for girls and boys	To be established	To be set after initial mapping	Numerator: Number of schools with functional toilets and urinals for each category that meet standards Denominator: Total number of schools	School survey, administrative data	School survey, inspectors reports	By sex, status (teacher, disabled)	Annual	MBSSE
Output	Percentage of teachers that meet national standards and are accessible to children with disabilities	To be established	To be set after initial mapping	Numerator: Number of teachers that meet national standards Denominator: Total number of teachers trained on national standards	School survey, administrative data	School survey, inspectors reports	By sex, status (teacher, disabled)	Annual	MBSSE
Output	Proportion of schools providing age-appropriate CSE	0%	100%	Numerator: Total number of schools (including primary, junior and senior secondary) that provide age-appropriate CSE Denominator: Total number of schools	Administrative data and field visits, school censuses and surveys	School surveys/ census, inspectors of school reports	By sex, age	Annual	MBSSE

Pillar 3: Enabling school environments									
Level	**Indicators**	**Baseline**	**Target**	**Numerator/ Denominator**	**Data source**	**Data collection method**	**Disaggregation**	**Frequency**	**Who reports**
Output	Percentage of schools with a comprehensive school guidance counselling program according to national standards	To be established	To be set after initial mapping	Numerator: Number of schools with functional guidance and counselling services that meet standards Denominator: Total number of schools	Administrative data and field visits, school censuses and surveys	Inspectors of school reports	By district	Annual	MEST
Pillar 4: Communication and advocacy									
Output	Percentage of the adolescent boys and girls that can name one or more specific location(s) of adolescent-friendly information and services	Not known	To be set after initial survey	Numerator: Number of adolescents that know a source Denominator: Total number of respondents	Adolescent pregnancy study, DHS	Household survey	By age, sex, district	3yrs / 5yrs	NSRTP/ SSL
Output	Percentage of adolescent boys and girls who can name three modern contraception methods	Not known	To be set after initial survey	Numerator: Number of adolescents that can name at least one method Denominator: Total number of respondents	Adolescent pregnancy study, DHS	Household Survey	By age, sex, district	3yrs / 5yrs	NSRTP/ SSL
Output	Percentage of activities in the communication strategy undertaken	0%	70%	Numerator: Number of activities in the strategy undertaken Denominator: Total number of activities in the strategy	Adolescent pregnancy study, DHS	Programme reviews		Annual	NSRTP
Output	Number of advocacy activities implemented.	To be established	To be established	N/A	Programme reports	Programme reviews		Annual	NSRTP
Output	Number of awareness raising events targeting local leaders conducted	To be established	To be established	Number of events, listed by type of activity, numbers and official positions of persons attending	Programme reports	Administrative records	Target groups	Annual	Program M&E

Level	Indicators	Baseline	Target	Numerator/ Denominator	Data source	Data collection method	Disaggregation	Frequency	Who reports
Pillar 5: Community ownership									
Output	Proportion of adolescent boys and girls who report that their parents or guardians understand their problems	Not known	To be set after initial survey	Numerator: Number of adolescents who report that, in the past 30 days, their parents or guardians understood their problems or worries most of the time (in the survey) Denominator: Total number of adolescent respondents in the survey	Teenage pregnancy study, survey	Household survey	By sex, age	Annual	Programme M&E
Output	Proportion of adolescent boys and girls who report that their parents or guardians know what they do in their free time	To be established	To be established	Numerator: Number of adolescents who report that, in the past 30 days, their parents or guardians really knew what they were doing in their free time (in the survey) Denominator: Total number of respondent adolescents in the survey	Teenage pregnancy study, survey	Household Survey	By sex, age	Annual	Programme M&E
Output	Proportions of villages with Community Action Plans to address adolescent pregnancy and child marriage reduction	To be established	To be established	Numerator: Number of villages with action plans to address teenage pregnancy Denominator: Total number of villages targeted by the strategy	Progress reports	Administrative records	By district	Bi-annual	MLGRD / partners
Output	Proportion of chiefdoms with bye-laws supporting the reduction of teenage pregnancy and child marriage	To be established	To be established	Number of chiefdoms with legally binding bye-laws / total number of chiefdoms targeted by the strategy	Programme design survey	Administrative records	By district	Bi-annual	MLGRD / partners
Pillar 6: Coordination, monitoring, and evaluation									
Output	Coordination mechanism for the NSRTP in place			NSRTP strategy work plans, budgets validated, MTC and MCC meetings held	Reports	Desk review	N/A	Bi-annual	NSRTP
Output	Numbers of research recommendations used to inform future programmes on reduction of adolescent pregnancy and child marriage	1	5	Number and quality of studies commissioned, number of studies used in decision-making	Reports	Desk review	N/A	Bi-annual	NSRTP
Output	Functional monitoring and evaluation system established	No	Yes	M&E Functionality Index:Funded M&E Operational Plan (15%) Regular monitoring (as per plan)with reports (35%) Schedule surveys/data collection implemented (25%)Annual report produced and disseminated (25%)	Reports	Desk review	N/A	Bi-annual	NSRTP

2.6 Costing framework

The following table provides the estimated cost of implementing the Strategy over the course of five years from 2018 to 2022. It provides a breakdown for each of the six pillars

	2018	2019	2020	2021	2022	TOTAL (USD)
Pillar 1: Policy and Legal Environment	$350,779	$254,603	$264,642	$224,331	$264,642	$1,358,997
Pillar 2: Adolescent and Young People Friendly Services	$2,201,421	$1,860,656	$643,691	$643,691	$643,691	$5,993,152
Pillar 3: Enabling School Environments	$5,475,857	$7,172,139	$2,371,200	$5,186,970	$2,747,037	$22,953,203
Pillar 4: Communication and Advocacy	$1,139,416	$1,026,028	$1,054,360	$1,830,863	$1,736,015	$6,786,680
Pillar 5: Community Ownership	$627,088	$154,933	$566,839	$154,933	$154,933	$1,658,727
Pillar 6: Coordination, Monitoring and Evaluation	$1,037,384	$865,915	$1,025,528	$824,834	$972,591	$4,726,252
TOTAL (USD)	$10,831,945	$11,334,273	$5,926,260	$8,865,623	$6,518,909	$43,477,010

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