An Overview of the Community Driven Intervention To Reduce Teenage Pregnancy in Sierra Leone

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Background and Context

Globally, the dominant approaches used by NGOs to establish or support community-based child protection mechanisms are characterized by relatively low levels of community ownership.[1] This is problematic since community ownership is one of the primary determinants of the effectiveness and sustainability of interventions. In addition, top-down efforts at strengthening child protection systems have suffered from limited use and also from pushback from local communities. A case in point is Sierra Leone, where people in rural communities have tended not to use state imposed community-based Child Welfare Committees and have viewed child rights education as alien and damaging to parental authority.[2] Overall, the low levels of community ownership of the formal aspects of the child protection system in Sierra Leone have contributed to the disconnect between the formal and nonformal aspects of the national child protection system.

To address these issues, the Interagency Learning Initiative has cultivated a process of community-driven action that addresses needs of vulnerable children in Bombali and Moyamba Districts of Sierra Leone through linkages and partnership between rural communities and the formal health and child protection systems. The initial stage was ethnographic research that enabled learning about local views of childhood, harms to children, what happens when the harms occur, and linkages with the formal system.[3] The research took place in a cluster of three villages from a single Chiefdom in each of the two districts. The ethnographic findings were shared back with each cluster of communities, who validated the findings and reflected on their own on what they should do to address the problems. In important respects, these reflections set the stage for the next phase--the action research phase.

In participatory action research and community mobilization approaches, local groups of people collectively identify a problem of concern and then mobilize themselves to plan, implement, and evaluate an intervention to address the problem. This approach generates high levels of community ownership since it is the community that defines the problem and manages or runs the intervention. In this approach, the community holds the power and makes the key decisions about which problem to address, what steps to take in addressing it, how to organize itself to implement the intervention, whom to partner with and how, and so on. However, community ownership does not occur automatically but through a process of deep, inclusive engagement by different sub-groups within the community. It would be a misnomer, for example, to speak of community ownership if a community elite had hijacked the planning process or had controlled the implementation in a manner that benefitted mainly the privileged people within a community.

In Sierra Leone, both clusters of communities chose teenage pregnancy as the problem to be addressed. This was not surprising since the ethnographic research had identified teenage pregnancy as one of the top four harms to children. Throughout Sierra Leone, the problem of teenage pregnancy is of such great magnitude that in 2013, the President declared a state of

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[1] Wessells (2009).
[2] Wessells et al. (2012).
[3] Wessells (2011).

emergency around it and called for a national strategy to reduce teenage pregnancy. In addition, teenage pregnancy is frequently a gateway to a host of additional problems such as health issues, dropping out of school, and engaging in transactional sex as a means of meeting basic needs. Local people in the research communities were frustrated because they had tried hard to reduce teenage pregnancy but had not succeeded, and their daughters and families were being damaged as a result. Looking for a more effective approach, community people were eager to engage with government officials such as health post staff who could help them to reduce the problem.

The selection of teenage pregnancy as the problem to be addressed was a slow, inclusive process that was guided by inputs from different sub-groups. Although the process was enabled by a trained, Sierra Leonean facilitator who lived in and rotated among three villages in each cluster,[4] the communities themselves guided the process and took the key decisions. They decided, for example, that it was important for sub-groups such as teenagers and women to have considerable voice in the planning process. If the planning discussions had been conducted only in the barray (the village meeting point where the community discussed key issues), the men would likely have dominated, and the women and girls might have been less likely to express their views. Accordingly, the communities decided to supplement open community discussions in the barray with small group discussions among teenage girls, teenage boys, adult women, and adult men, respectively. They also decided that it would be useful to have a single Task Force that facilitated and coordinated the planning across the three villages in the cluster. This Task Force had five members from each of the three villages, with the five members elected from each of the sub-groups identified above. To include the views of marginalized people such as out of school children or children with disabilities, the Task Force members in each village conducted home visits and fed the learning from those visits into the wider community discussions.

During a period of over nine months, the communities talked extensively among themselves, consulted with other communities via the Task Force members, and negotiated views and priorities among their respective villages. Although these dialogues were part of the selection process, they were also seamlessly interconnected with the intervention itself since the dialogues served to raise awareness about the importance of addressing teenage pregnancy and to identify possible steps that might be useful in addressing it. During these dialogues, people expressed divergent views but also negotiated their views in the service of the common purpose of supporting vulnerable children. By all accounts, the negotiation of views occurred not only in public discussions such as those in the barray but also in private discussions such as those which took place in homes.

Intervention Planning and Preparation

The intervention planning discussions overlapped with the discussions that aimed to select which issue to address. Most likely, community people wanted to choose an issue on which there was general agreement on what to do in addressing it. The intervention planning discussions were highly inclusive and used a methodology very similar to that which had been used to decide on the priority issue to address. During the intervention planning, the facilitators encouraged full

[4] The facilitators were backstopped by two senior mentors--David Lamin and Marie Manyeh, who made periodic visits to the villages.

participation by diverse people and encouraged communities to think about interventions that linked community processes with actors in the formal health or child protection system.

Because the community people had heard of the work done by Marie Stopes and others, the early planning discussions unanimously identified family planning and sexual and reproductive health as key topics for the intervention. The topic of family planning, particularly in regard to the use of contraceptives, was ripe for strengthening the linkages between communities and the formal health system. In fact, the District Medical Officers indicated their willingness to supply contraceptives and insure that health post staff had been trained on how to insert implants. Discussions in sub-groups, villages, and the wider Task Force indicated as well the importance of life skills such as being able to say 'No' to unwanted sex. Fortunately, NGOs such as Marie Stopes in Bombali and Restless Development in Moyamba indicated their willingness to partner and support work on issues of family planning, sexual and reproductive health, and life skills.

To help translate the broad intervention plans into specific plans for implementing the intervention, workshops enabled by the facilitators and mentors were conducted with Task Force members in January, 2013. A key decision was to work closely with male and female youth leaders in the implementation phase since the aim was in part to change the social norms relating to teenage sex and pregnancy. Of note, however, the workshops avoided scripting the implementation in a rigid manner. Room was left, for example, for groups to improvise and exercise their creativity in developing media such as songs and dramas. Following the workshop,

Timeline

January, 2011 - April, 2011: Ethnographic data collection

July, 2011: Feedback of ethnographic findings and community reflection

January, 2012: Training workshop for facilitators, mentors, and District government

February, 2012 - December, 2012: Community clusters in Bombali and Moyamba, respectively, select teenage pregnancy as the priority issue and develop plans to address it through family planning, sexual and reproductive health education, and life skills

January - March, 2013: Workshops conducted in January in Moyamba and Bombali with Task Force members, on developing the implementation plans. Task Forces worked with their communities to finalize the implementation plans during February and March.

June-July, 2013: First training conducted on family planning, sexual and reproductive health, and life skills with government health post staff and Peer Educators

September-October, 2013: In each district, a focal point is established in each of the three intervention villages, and one coordinator is appointed for the intervention cluster

March, 2014: Refresher training conducted on family planning, sexual and reproductive health, and life skills with Peer Educators

June, 2014: Participatory evaluation workshops are conducted in Bombali and Moyamba, with final steps developed for handing the facilitation and coordination functions over to the communities.

the Task Forces worked with their respective communities to finalize the implementation plans. As shown in the timeline below, the communities finalized their implementation plans by March, 2013. Although these discussions preceded the implementation of the full intervention, they were in a sense part of it since they served to raise awareness and heighten community commitment to addressing teenage pregnancy, and they began the important process of building partnership between communities and formal health system actors.

Following the implementation planning, Task Force members began conducting dialogues about the prevention of teenage pregnancies. To build sustainable capacities for work on this issue, each community selected five teenage girls and boys to serve as Peer Educators. The Peer Educators then received week-long participatory training from the NGOs on family planning, sexual and reproductive health, and life skills. The initial training took place June-July, 2013, with follow up training provided March, 2014. Following the initial training of the Peer Educators and the Government training of the health post staff, the full intervention began, as described below. It is to be emphasized, however, that the planning and preparation processes were themselves part of the wider community mobilization and awareness raising processes that were part of the intervention.

The facilitator in each District played an important and evolving role in the community-driven selection, planning, preparation, and implementation processes. From January, 2012 through August, 2013, the facilitators worked full time and spent three weeks in the villages (one week per village) each month. During this period, 75% of their time in the villages was devoted to facilitation, and 25% of that time was devoted to monitoring, using participant observation methodology. Following August, 2013, these time percentages were reversed, as 75% of their time was spent on monitoring and 25% of their time was spent on facilitating. This change reflected the fact that the communities had by that time developed effective means of inclusive planning and action. Also, it was necessary to document the actual implementation activities and process. Since it was important to avoid communities becoming dependent on the facilitator/monitors, progressive reductions were made in the amount of time they spent in the communities. From September-December, 2013, the facilitator/monitors worked half time, and from January, 2014 onward, they worked quarter time (one week per month). This process of transition is part of a wider exit strategy that will be described further elsewhere together with a detailed discussion of the facilitation roles and processes.

Ten Key Elements of the Interventions

Although the implementation followed a community-designed plan, it deliberately did not follow a script or protocol but rather had an improvisational quality that was intended to draw on the agency and creativity of teenagers, youth groups, and other sub-groups within the villages. Following a social norms change approach, insiders were empowered to analyze how to best move forward. At any particular moment, they used their judgment to decide whether activities were needed and how to do them. This loosely scripted approach was intended to enable the intervention process to respond in a creative manner to the new moments that would arise as

community awareness increased or, alternately, as dialogues encountered barriers and sources of resistance rose to the surface.

The intervention process was documented in a systematic manner by Sierra Leonean monitors[5] who lived and worked in the villages and who used participant observation methodology to capture various activities. What emerged over time were ten key elements in the intervention process, as shown in Table 1 below.

At the heart of the process were collective dialogues and collective decision making. The dialogues about teenage pregnancy and means of preventing it typically began in the Chief's barray. Throughout the intervention process, Task Force members or village authorities continued to organize dialogues in the barray to discuss issues such as puberty, family planning and contraception, sexually transmitted infections, the importance of delaying sex or engaging in safe sex. Since not everyone participated in discussions in the barray, the Peer Educators and Task Force members made home visits in order to learn the views of marginalized children and families. Equally important, many dialogues occurred following teenagers' performances of dramas and songs, as outlined below. Also, spontaneous dialogues occurred over meals, in schools, and during daily activities.

Element	Description
Collective dialogue, awareness raising,& negotiation	At each stage, there was extensive collective reflection and dialogue in the barray, and in sub-groups such as teenage girls, teenage boys, adult women, adult men, and elders about issues such as the main harms to children, which issue should be addressed, how to address the issue, and diverse aspects of teenage pregnancy. These dialogues raised collective awareness and created readiness to receive various messages associated with teenage pregnancy. As disagreements occurred, community members negotiated over which views were most useful in addressing teenage pregnancy.
Collective decision-making, empowerment, and responsibility	The communities made their own decisions about which issue to address, how to address it, who should represent them on the inter-village Task Force, and on other key issues. As a result, they saw the decisions and intervention process as 'theirs,' and they took responsibility for insuring its success. The empowerment process occurred from within. Since the community itself defined the problem, community people were motivated to address it. They empowered each other by encouraging participation, mobilizing different sub-groups, and creating public activities that drew in more and more people.
Linkage of communities with health services	To address teenage pregnancy, communities elected to link in more systematically with formal health services. The District Medical Office agreed to keep up the supply of contraceptives of different kinds and to train health post nurses to do procedures such as implants. At local levels, supportive partnership developed between local people and health post staff. People visited the health post for contraceptives and invited nurses to visit the villages and help to educate people about issues related to puberty, sex and reproductive health, and pregnancy.
	Peer Educators were selected by the communities and trained by NGOs

[5] The same people divided their time as facilitators and monitors.

Peer education	on issues of family planning, sexual and reproductive health, and life skills. This created a cadre of people who were respected by communities and who were in a position to educate their peers on an ongoing basis. Less formally, peer education occurred also through discussions of parents with each other, of women with each other or with men, etc.
Use of culturally relevant media	Peer educators and others conducted culturally appropriate educational activities such as song and drama, thereby increasing their appeal and reinforcing increasing community ownership. The activities were accompanied with group discussions in which teenagers and adults discussed the benefits of good decisions made by young people, and the problems associated with short sighted decisions or lack of responsibility taking.
Child leadership and messaging	Teenage girls and boys played a prominent role in all aspects of the planning and action. The intervention was deliberately not 'manualized' but drew instead on young people's energy and creativity. Recognizing that children talk in distinctive ways and that adult developed messages often do not get through, children created their own messages based on what had been learned in the NGO led workshops and the discussions with health workers.
Inclusion and outreach	Representatives of diverse sub-groups (teenage girls, teenage boys, adult women, adult men, and elders) took part on the Task Force that facilitated much of the community driven work to prevent teenage pregnancy. In order to include the voices and perspective of marginalized people such as out of school children and children with disabilities, the Task Force members and also Peer Educators made home visits on a regular basis.
Parent-child discussions	Picking up on an older practice that the war and other events had disrupted, parents and children discussed issues of puberty, sexual and reproductive health, sex, and teenage pregnancy prevention. In some cases, the children were better informed than adults and helped to correct parental misconceptions, for example, regarding the use of contraceptives.
Role modeling	By taking part in activities such as dramas and singing songs, young people, including teenage boys, signaled that they wanted to prevent teenage pregnancy. Similarly, parents provided role models for each other in talking with their children about teenage pregnancy in a constructive manner.
Legitimation by authority	The Paramount Chiefs publicly supported the importance of preventing teenage pregnancy and encouraged people to get involved in the intervention. The Paramount Chief also appointed the number two leader, the Chiefdom Speaker, to monitor progress on the community efforts to reduce teenage pregnancy. The Task Force gave regular reports to these local authorities and also to village and section Chiefs. Other community leaders such as teachers and religious leaders, also encouraged support for preventing teenage pregnancy.

Table 1. Ten key elements of the community-driven intervention to address teenage pregnancy.

Although the collective dialogues were peaceful, they frequently entailed vigorous debate and negotiation of ideas. For example, in both the planning process and the early stage of the intervention itself, some elders argued that the use of contraceptives would corrupt the morals of

young people by encouraging early sex. In response, women, teenagers, and moderate men argued that girls and boys were already sexually active, as indicated by how many teenage pregnancies occurred each year, and that it would be better to insure their protection through the use of contraceptives. Although there was no single turning point in this debate, over time, adherents of the former view persuaded increasing numbers of community members.

The intervention was community driven in the sense that local villagers decided collectively not only which issue to address and which intervention aspects (e.g., family planning) to include, but also how to implement the intervention and what adjustments to make in the intervention process. At each point, it was the community that drove the intervention and decided whether, when, where, and how to implement the intervention. The Task Force facilitated this process, yet there were many smaller decisions made as well by various community members. For example, teachers and school authorities sometimes decided to hold open discussions at school of topics such as puberty, teenage pregnancy, and pregnancy prevention. In churches, pastors sometimes devoted sermons to the topic. Through these and the activities described below, there were steady increases in community awareness of the problems of teenage pregnancy and means of preventing it and increased commitment to the community-defined intervention strategy. At the end of the day, it was community members who empowered and mobilized themselves and took action. Throughout, they viewed the process as 'theirs' since they had constructed and implemented the plans to address teenage pregnancy.

It is worth noting that the intervention was guided neither by the Chief nor a small elite within the village or villages. On an ongoing basis, members of the different sub-groups gave input into the implementation process via the Task Force, and home visits were used to solicit and include the views of marginalized people. As described below, the implementation itself included leadership by teenagers and also by parents. By design, Task Force members reported monthly on the implementation activities to Chiefdom authorities, particularly the Chiefdom Speaker. In this manner, people demonstrated appropriate respect for the Chiefdom authorities, yet the authorities did not direct the process. Near the time at which Task Force members reported to the Chiefdom authorities, they also reported to the community members through venues such as barray meetings.

Consistent with the bottom-up approach to system strengthening, the intervention included community-driven linkages with the local health authorities. Via the mentors to the intervention process, the communities requested that the District Medical Officer provide contraceptives without charge in the local health posts. Having agreed to do so, the DMOs trained the health post staff and kept up the supplies of different contraceptives.[6] The project monitors and senior mentors also checked the supply of contraceptives on a regular basis and reported shortages to the DMO, and to Freetown if necessary. The functionality of the linkages was evident in the fact that there were significant increases in the uptake of contraceptives. Also, the communities invited the health post nurses to visit and help educate people about issues such as puberty and how to prevent teenage pregnancies. The nurses also played a role in clearing up misconceptions

[6] An exception was one community in Moyamba District, where the only contraceptives available were birth control pills since the health post was a maternal care post that did not qualify for the training of its personnel on, for example, the use of implants.

such as the idea that using contraceptives would make it difficult for one to become pregnant later on.[7]

Two Songs Sung by Children in Moyamba

Education is sweet, education is sweet, education is sweet all the way
Teacher help me to learn
Mother pay for me
Father pay for me
Mother told me not to be involved in sex until I complete my education
Father told me not to be involved in sex until I complete my education
I also answered 'yes', I will not be involved in sex until I complete my education

My own body, my own body is for going to school, it is not for getting pregnant.
When a bike rider (okada rider) calls you to the corner, don't go there, he will get you pregnant.
When an adult man calls you to the corner, don't go there he will get you pregnant.
When a teacher calls you to the corner, don't go there, he will get you

Throughout the intervention, awareness of and knowledge about various aspects of family planning, sexual and reproductive health, and life skills was promoted through peer education using youth driven messages and the use of culturally appropriate media. The Peer Educators, who included leaders of youth groups, received training from the NGOs and then conducted various activities in their villages. Among these activities were songs and dramas (vignettes) which fit the local culture and likely contributed further to the sense of local ownership over the intervention. An example of the kinds of songs that were sung is provided in the box above, and an example of drama and discussion is provided on the following page.

Child leadership and messaging were important features of the intervention since young people know better than adults how to communicate with other young people and how to influence each others' behavior in constructive ways. The community adults shared power with children and enabled them to exercise their creativity in composing messages, writing songs, and designing and performing dramas. To illustrate, teenagers in Moyamba constructed the message '5920,' which meant that for five minutes of pleasure, one gets nine months of pregnancy followed by two years out of school, and at the end, one has nothing since his or her education has been lost. Teenagers' use of this message in small gatherings or in public meetings typically

[7] These and other results were documented in participatory evaluations by adult and child Task Force members. See Wessells, Manyeh, and Lamin (2014).

Example of a Drama and Discussion

An example of a drama and discussion with a mixed gathering of girls and boys occurred in Bombali in 2013 and focused on life skills of assertiveness and being able to say 'No' to unwanted sex in a respectful manner. The first role play opened with two boys talking about a particular girl whom they wanted to have as their girlfriend. In the next scene, one of the boys saw the girl as she walked to school, and he shouted 'Baby, baby! Hey, stop! I want to work things with you.' Having stopped abruptly, the girl hissed at the boy and said angrily that if the boy made any moves, he will regret the day his mother gave birth to him. She told him that she is not his type and that he should find a girl who is like him--hopeless and useless. Shocked and speechless, the boy watched as the girl turned and walked away, and he pointed and shouted to her that she will pay for what she had done to him.

The second role play began with one boy talking to himself about a girl in his class who was very serious with her school work. He said that he would do anything to get that girl into his life because the girl is cool, clever, and does not mess around. Seeing the girl walking with her friends, he called out, saying he wanted to talk with her. After the girl had told her friends that she will rejoin them later, he told the girl that he admires her and that she has all the qualities he is looking for and wants her to be his life partner. The girl smiled and thanked the boy for his concern, yet told him in a serious, polite manner that she cannot be his girlfriend because she has no plans to marry in the next five or ten years since she did not want to disrupt her education. She apologized for disappointing the boy, who thanked her for treating him kindly. The skit ended with the girl joining her friends while the boy went on his way.

In the discussion that followed the role plays, teenagers who had watched said that the first role play described exactly the behavior of some girls in the community. Those who had watched commented that the second role play helps teach girls how to behave when faced with pressure from men. The leader described the behavior of the girl in the first role play as aggressive, whereas the behavior of the girl in the second role play was assertive. He explained that one can be assertive without being rude. He added that one needs to be firm on what she thinks is right and communicate it effectively when negotiating. One girl asked the leader what to do if a girl followed the second role model but the boy persisted in trying to have his own way. The leader advised the participants to be firm yet friendly when expressing their rights, in order to convince the boy rather than to coerce him.

evoked much laughter and excitement, in part because it used their way of talking and made public a topic that was very much on young people's minds yet that had not always been discussed openly. The meaning of the message, however, was quite serious, as it embodied teenagers' view that education is the future and that young people should maintain their access to education by not becoming pregnant. Teenagers' delivery of such messages was supported by

adults since the entire communities had agreed on the importance of preventing teenage pregnancy, and adults liked the emphasis on young people continuing their education.

Throughout the intervention, inclusivity was an important concern that communities attended to. In part, inclusivity was achieved by complementing public meetings and performances with home visits by Peer Educators and Task Force members. The home visits made it possible to share knowledge and learning with people who were marginalized and who tended not to participate in public meetings, and they also enabled learning from marginalized people. In addition, various groups that had existed in the community before the intervention had begun were active in mobilizing outreach. For example, in Moyamba, the Mothers' Club had been active on issues of family planning and maternal health even before the intervention but had not included in its trainings material related to children. During the intervention, however, they decided to integrate children's issues and teenage pregnancy into their trainings and outreach activities. Also, the various sub-groups that had been active in the planning process--teenage girls, teenage boys, adult women, adult men, and elders--continued to discuss issues related to the prevention of teenage pregnancy.

Parent-child discussions were a popular and intergenerational feature of the intervention. During the planning stages, some elders commented that before the war, parents had talked with their children about puberty, sex, and pregnancy and that the discussions had benefitted children and families. In order to rekindle this practice, public discussions in the barray and also the NGO trainings encouraged parent-child discussions that were educational and supportive. In some cases, parents led the way by helping younger children to understand the changes their bodies were going through or would undergo, explaining how girls become pregnant, and discussing the importance of preventing teenage pregnancy. Interestingly, children who were Task Force members or Peer Educators also initiated discussions with parents and even became 'teachers' who helped to correct misconceptions such as the idea that male condoms should not be used because they will come off and get stuck in the woman's vagina.

Role modeling was also an important element of the intervention. For one thing, people became involved in the intervention in part by observing the concern and commitment of others who were already engaged, even in relatively simple ways such as speaking up at barray meetings. Also, as children sang songs and performed dramas, for example, they not only provided information but served as role models for other children regarding the prevention of teenage pregnancy. The modeling was not about being a highly visible advocate in the community but about being a positive influence on one's friends and encouraging them to stay in school, not give in to pressure from boys, and avoid early pregnancy. For example, the dramas performed by young people frequently demonstrated how to say 'no' to exploitative sex or unwanted relations. Adults, too, provided important role models, as parents showed their concern and gave advice on how to avoid teenage pregnancy.

The support expressed by authorities such as Chiefs and elders was pivotal in the intervention process. That the Paramount Chiefs and the Chiefdom Speakers were vocal in their support of the intervention helped to legitimate it and to mobilize action by community members. Indeed, the support by the Paramount Chiefs--the 'keepers of the land'-- increased the salience of the work to prevent teenage pregnancy. Community members were more likely to get involved in

addressing the problem because their highest leaders had spoken strongly on the importance of preventing teenage pregnancy. Also, the Chiefs support raised expectations that community members would get involved on this community defined issue. The support of Government workers such as health post staff likely contributed as well to people's ongoing concern and involvement.

Conclusion

At this juncture, it seems clear that the communities themselves drive the intervention, which is being implemented in ways that engage diverse parts of the community and reflect the collective plans that the Task Force had helped to develop. An exit and handover process is currently being implemented that are expected to enable communities to continue their intervention, which will no doubt evolve over time.

Although these ten elements have been presented individually for purposes of clarity, it is important to recognize their extensive, ongoing interaction. For example, as parents talk with their children or teenagers talk with other teenagers about the importance of safe sex or preventing pregnancy, the children may become more likely to use contraceptives. As they access the contraceptives at the health post, the linkages between communities and the health services are strengthened, which in turn enables education in the villages by health staff and likely increases the use of contraceptives still further. Overall, the elements work together to support constructive changes in knowledge, attitude, behavior, and social norms. As teenagers become more knowledgeable about the harmful effects of teenage pregnancy, they become more receptive to the messages of the dramas and songs, and they learn from others how to say 'No' and behave in ways that reduce teenage pregnancy. It is hoped that over time, the social norms will change in ways that promote healthy relationships with good decision making by boys and girls, encourage young people to continue their education, and enable safe sex and the prevention of teenage pregnancy.

Ongoing efforts at documentation and evaluation using both qualitative and quantitative methods are being used to learn from this important intervention, the preliminary results of which are encouraging.[8] The learning from the communities' action will hopefully inspire similar action in many communities to prevent teenage pregnancy and support vulnerable children in Sierra Leone.

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