Section 4: Note to Users

The tools in this section invite managers and other users to reflect critically on their agency's approach to engaging with communities and to consider a more community-led approach.

It also recognizes that many managers will have a host of practical questions about things such as qualities to look for in facilitators, the phases of engaging with communities, and the kinds of benchmarks one can use to tell whether one is on a productive track, among others.

Recognizing that there are no "final" or universal answers to these questions, the tools in this section seek to give illustrative examples that stir the imagination and invite one to think how it might go in a particular context.

Managers also may find it useful to have a more in-depth look at an example of community-led work, together with tools that were used to support it. For this reason, this section includes a case study from Sierra Leone and some of the tools used as part of the community-led work.

It is important to recognize, though, that there is no one-size-fits-all in regard to community-led approaches. The Sierra Leone example and tools are best seen as illustrations and should not be seen as prescriptions for how to do community-led work.

MGM 2. The Sierra Leone Case Study: Community-led Child Protection and Bottom-Up System Strengthening

Note: Community-led child protection work is highly contextual, and there is no single "best way" of doing it. This case study is intended to be illustrative rather than prescriptive.

Following up on a global review of community-based child protection mechanisms[9], a group of NGOs, UN agencies, and donors formed the Interagency Learning Initiative on Community-Based Child Protection Mechanisms and Child Protection Systems in 2010. Save the Children coordinates its global Reference Group, and the Child resilience Alliance (formerly the Columbia Group for Children in Adversity) serves as the technical arm of the Interagency Learning Initiative. Through a consultative process, a decision was taken to develop and test the effectiveness of community-owned and driven work on child protection as an alternative to the dominant, top-down approach. A decision was also taken to investigate community-led approaches in two different regions of sub-Saharan Africa—West Africa and East and Southern Africa, respectively. Primary among the criteria for the selection of a specific country to work in within each region was the willingness of UNICEF to host and support the action research. The two countries selected were Sierra Leone and Kenya, respectively. The example given here is of the work in Sierra Leone, but the work in both countries is described on the electronic arm of the Learning Initiative—the Child Protection Exchange (www.childprotectionforum.org).

The Sierra Leone Context

Sierra Leone, a West African nation of approximately six million people, is one of the poorest countries in the world. Even before the Ebola crisis of 2014–2015, Sierra Leone ranked near the bottom on the Human Development Index. The average life expectancy was 46/47 years, and the under-five-years' mortality rate was 182 out of 1,000. The population of Sierra Leone has a predominantly rural, agricultural mode of living. Formally, Sierra Leone is led by an elected President and Parliament. Yet many Sierra Leoneans view their main leader as their Paramount Chief, who oversees each of Sierra Leone's 149 Chiefdoms and is viewed as the "keeper of the land."

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[9] Wessells, M. (2009). *What are we learning about protecting children in the community? An inter-agency review of evidence on community-based child protection mechanisms*. London, UK: Save the Children.

Sierra Leone endured a brutal, 11-year armed conflict (1990–2001) that was infamous for its atrocities, some of which had been committed by children.[10] The war displaced approximately one third of the population and created or worsened child protection risks such as exposure to violence, family separation, sexual exploitation and violence, mental health and psychosocial distress, disability, and child recruitment, among many others. Sierra Leone also has serious gender-related issues such as widespread female circumcision and discrimination against females. To address these issues, many international NGOs had formed during the war Child Welfare Committees, which monitored risks and responded to child rights violations.

In an effort to support children's protection, the Government of Sierra Leone (GoSL) passed in 2007 the National Child Rights Act, which had as its conceptual foundations the CRC and the African Charter on the Rights and Welfare of the Child. The Child Rights Act mandated the establishment of a Child Welfare Committee (CWC) in each village to handle minor offences such as petty theft, and to refer criminal violations of child rights such as the rape of a child to Family Support Units (FSUs), which include police and Government social workers who have been trained to handle cases involving children. UNICEF/Sierra Leone and the GoSL encouraged and enabled financial support for work by diverse international NGOs (e.g. Save the Children, Plan International, World Vision, ChildFund, etc.) to establish, train, and make functional chiefdom level CWCs, which were located mainly in chiefdom headquarter towns, and to teach local people—particularly children—about child rights. The approach was top-down since it came from the GoSL and outside consultants, with minimal input from average citizens.

Research Design

The research took place in three phases and, following the advice of members of the national Child Protection Committee, focused on the northern district of Bombali and the southern district of Moyamba, which were seen as broadly typical of many rural areas in Sierra Leone. The first phase, conducted in 2011, consisted of ethnographic learning. Trained Sierra Leonean researchers who knew the local languages lived in rural communities and learned in a non-judgmental manner about who were considered to be children, what harms they faced (other than poverty and health problems), what happened when those harms occurred, and what supported children's well-being. This phase built significant trust with local people and enabled learning about both the challenges and the strengths of local people in regard to their children.

People identified the top four harms to children as being out of school, teenage pregnancy out of wedlock, heavy work, and maltreatment of children not living with their biological parents.

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[10] Denov, M. (2010). *Child soldiers: Sierra Leone's Revolutionary United Front*. Cambridge, UK: Cambridge University Press; Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Cambridge, MA: Harvard University Press.

Further, people spontaneously identified "child rights" as one of the top ten harms to children, saying that child rights had undermined parents' authority and ability to teach their children good behavior through the use of corporal punishment. Overwhelmingly, local people reported that they did not use the CWCs or other formal mechanisms in addressing these problems but preferred to use their traditional family and chiefdom mechanisms for addressing them.[11] In fact, there seemed to be a severe disconnect between the nonformal aspects and the formal aspects of the child protection system. This pattern fit that observed in other research as well.[12] The ethnographic findings were shared 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 the second phase (2012), the research team used a free listing methodology to learn about how local adults and teenagers (13–18 years of age) understand children's well-being.[13] They consistently identified aspects such as participation in education, contributing to one's family, respect for elders, and obedience as key signs that children are doing well. These, together with those derived from the ethnographic research, were used to define key outcome areas regarding children's risks and well-being. Subsequently these outcome areas were used to define specific indicators and to construct a survey that measured children's risks and well-being outcomes. In this manner, local views regarding important outcomes for children were incorporated into systematic measures. The survey that was developed also reflected a balance of outcomes for children that were based on international child rights standards.

In the third phase (2013–2014), the research used a quasi-experimental design in which clusters of communities were assigned on a random basis to an action (intervention) condition or to a comparison condition (see Figure 1 below).[14]

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[11] Wessells, M. G. (2011). *An ethnographic study of community-based child protection mechanisms and their linkage with the national child protection system of Sierra Leone*. New York, NY: Columbia Group for Children in Adversity; Wessells, M., et al. (2012). The disconnect between community-based child protection mechanisms and the formal child protection system in rural Sierra Leone: Challenges to building an effective national child protection system. *Vulnerable Children and Youth Studies*, 7(31), 211–227.

[12] Behnam, N. (2011). *Awkward engagement: Friction, translation and human rights education in post-conflict Sierra Leone.* Unpublished doctoral dissertation. Philadelphia, PA: University of Pennsylvania; Child Frontiers (2010). *Mapping and assessing child protection systems in West and Central Africa: A five-country analysis paper*. Bangkok, TH: Author.

[13] Stark, L., Muldoon, K., Lilley, S., King, D., Hotanga, P., Lamin, D., & Wessells, M. (2013). *Change that counts: Baseline report for the evaluation of an action research intervention to strengthen community based child protection mechanisms in Sierra Leone*. London, UK: Interagency Learning Initiative on Strengthening Community-Based Child Protection Mechanisms and Child Protection Systems.

[14] For both ethical and practical reasons, the action research is currently being extended to the former comparison communities, with support from the Oak Foundation.
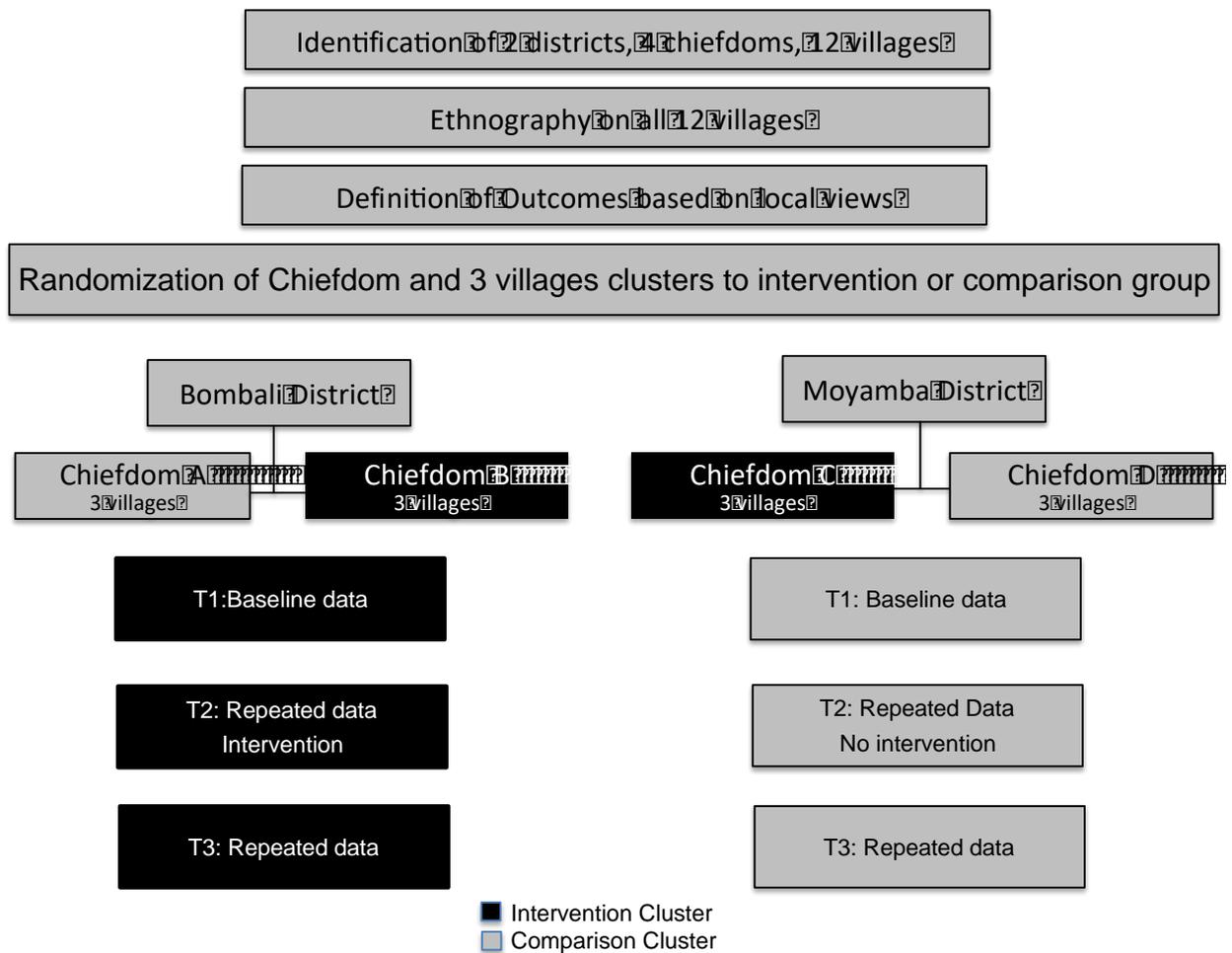
Identification of 2 districts, 4 chiefdoms, 12 villages

Ethnography on all 12 villages

Definition of Outcomes based on local views

Randomization of Chiefdom and 3 villages clusters to intervention or comparison group

Bombali District

| Chiefdom A
3 villages | Chiefdom B
3 villages |

Moyamba District

| Chiefdom C
3 villages | Chiefdom D
3 villages |

T1:Baseline data

T2: Repeated data Intervention

T3: Repeated data

T1: Baseline data

T2: Repeated Data No intervention

T3: Repeated data

■ Intervention Cluster
□ Comparison Cluster

Figure 1. The design of the three-phase action research in Sierra Leone.[15]

To enable community ownership of work to support vulnerable children, the approach taken was that of participatory action research. In participatory action research, local groups of people collectively identify a problem of concern and then mobilize themselves to plan, implement, and evaluate an action to address the problem. This approach generates high levels of community ownership since it is the community that defines the problem, manages or implements the action, and holds the power and makes key decisions. The idea was to have communities choose a harm to children and then implement a self-designed action to address it. To promote bottom-up

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[15] From Stark., L., Macfarlane, M., King, D., Lamin, D., Lilley, S., & Wessells, M. (2014). *A community-driven approach to reducing teenage pregnancy in Sierra Leone: Midline evaluation brief*. London, UK: Save the Children.

system strengthening, the communities were to choose and collaborate with formal (government) actors in the child protection system. The plan was to collect baseline, midline, and endline data by means of the aforementioned survey, and to collect qualitative data as well.

The Work of the Facilitator

Living within each intervention cluster was a trained facilitator who was highly process-focused and who enabled inclusive participation, slow dialogue, and group problem-solving and decision-making by the communities. The facilitator used the skills that are promoted through the use of the tools in Section 1 of this Toolkit. The facilitator rotated among the villages, spending one week per month in each village, and documenting the process through a mixture of summary notes and participant observation records. Working in sequential steps, the facilitator's role was to first help develop a process in which all community members have a voice in taking decisions and then to help the community decide which harm to children to address, which intervention to use, and how to implement it and take stock of its effects.

Avoiding directive action such as counseling or advising, the facilitator asked large numbers of questions that were designed to spark discussion and group awareness or to enable group problem-solving and decision-making. For example, the facilitator enabled inclusive participation by asking questions such as: "How does the community usually make a decision about something?" If local people answered, "By having a whole community meeting in the Chief's *barray*," the facilitator asked, "Does everyone come to the *barray* meetings?" If the answer was, "Yes, everyone comes to the *barray* meetings," then the facilitator followed up by asking, "What about the blind teenage girl who lives over there—does she go to the *barray* meeting?" or, "Are there people here who are poorer than other people and who have to work many jobs? Do they go to the *barray* meetings?"

By asking such questions and enabling discussion about them among many different people, the local people came to realize that the *barray* meetings were useful but excluded particular people. Also, the facilitator asked, "Does everyone who goes to the *barray* meetings speak up—for example, would a 12-year-old girl speak up?" Such questions typically evoked knowing smiles and answers such as "Well, no. It is adults who speak, and a child would not speak unless they were asked to."

The facilitator followed up with questions about what it means for a community to take a decision, asking, for example, whether everyone should have a voice in regard to a full community decision. Over time, people agreed that all community members should have a voice, and that the *barray* meetings, although very important, did not allow everyone to have a voice. This realization sparked much discussion about how the community could create a process that enabled everyone to have a voice. Having small group discussions was an alternative that community members rapidly identified.

To help communities think this option through, the facilitator asked questions such as: "If children and adults are in the small group together, will all members of the group feel free to speak?" or, "If girls and boys are together in a small group, will the girls feel free to speak?" The ensuing discussions evoked the realization that children would be most likely to speak

individually if adults were not present. Also, girls would be most likely to speak freely, particularly about sensitive issues related to gender or gender-based violence, if boys were not present.

Through extended discussion, the communities agreed that there should be a mixture of *barray* meetings and small group discussions among girls, boys, women, men, or elders, respectively. Each small group would identify a representative who would feed back to the *barray* meetings the main points from the small group discussion but without identifying who had said particular things. Because people with disabilities and the poorest of the poor did not attend meetings, communities made provisions for home visits to learn the views of people, including children, whose voices were typically not included in community discussions.

This achievement of an inclusive process for discussion and decision-making is best viewed as a social change process led by the community members themselves. The facilitator did not enter the discussions with a predetermined arrangement they wanted communities to adopt. In fact, communities were free to use their own imagination and to develop different alternatives. Nor did facilitators speak in favor of particular arrangements. Rather, they asked questions designed to help people to reflect on what would create an inclusive process. Community people themselves debated and discussed the merits of different arrangements, and they persuaded each other to change the more customary arrangement wherein the community held a *barray* meeting and took a decision, often with directive inputs from the Chief.

To enable this process of open discussion and collective decision-making, the action research team took three important steps, the first of which was to enable the Chief to step back a bit. This was done by talking with the Chief and asking whether it would be valuable to have the community people more involved in reducing harms to children and enabling children's well-being. Since Chiefs typically favored this, they answered in the affirmative, saying that Chiefs by themselves could not do all that is necessary to reduce harms to children.

This led naturally to a discussion of the benefits of a process in which many community people talked openly about harms to children and decided collectively how to reduce and prevent them. Recognizing that such a process required space for disagreements, the research team asked Chiefs whether they should be involved day-to-day in such discussions. The Chiefs typically replied by saying, "If I take part directly, it may be a problem because no one would disagree with the Chief." Out of these discussions came the agreement that the Chief would not himself participate in the discussions and actions by the community. However, in respect of the Chief's authority, the community process would report to the Chief. Also, the Chief appointed his operational officer—the Chiefdom Speaker—to listen in on discussions without guiding them and to report back to the Chief.

The second important step was to offer training and ongoing mentoring for the facilitators (see tool TRN 11). The initial week-long training was conducted with the support of district social workers, UNICEF workers, selected NGO workers, the research team members, and, of course, the facilitators. Having identified through discussion the key skills that facilitators needed (e.g., skills of listening and empathy, inviting different points of view, allowing time for discussions to occur, managing animated discussions, enabling collective decision-making, etc.), the group developed and conducted numerous scenarios and role-plays that anticipated discussions

between community members and brought to the forefront the role of the facilitators. Examples of these scenarios and role-plays are available in Section Two of this Toolkit. Following each role-play, a reflective space was created in order to invite the facilitators to reflect on how they had done, inviting feedback from the other participants, and discussing various options for improvement. In numerous cases, role-plays were repeated until the facilitators and others agreed that the appropriate skill levels had been attained.

Recognizing that more than one-off trainings were needed and that facilitators would likely encounter new challenges which required outside support, the team organized for the facilitators to be backstopped by more experienced mentors. David Lamin of UNICEF provided much of the backstopping for the facilitator in Moyamba, and Marie Manyeh, formerly of UNICEF, provided the backstopping for the facilitator in Bombali. Ongoing mentoring proved to be valuable in addressing difficult situations like that which arose in one community in Bombali, where there was contestation over who was the Chief. Also, the mentors observed the facilitators in action, suggested improvements, and in some cases helped community members think difficult questions through in a constructive, nondirective manner.

The third step was to emphasize the importance of respecting "community time." This meant that neither the facilitators nor the other research team members would rush communities or expect them to meet pre-defined time-tables and benchmarks. If communities needed more time to discuss which harm to children to focus on, the facilitators respected their process and followed the pace of the community discussions. Also, if the facilitators saw that there continued to be significant disagreement on an issue such as the use of contraceptives (which, for a time, elder men viewed as potentially corrupting teenagers' morals), they encouraged additional time for discussions.

In other words, the facilitators avoided rushing the process, and they harbored no preconceptions that agreement would eventually be reached. In fact, the training for the facilitators had emphasized that it is natural for communities to discuss and reach an agreement on how to move forward on some issues but not on others. It was not the facilitators job to try to force or impose agreement or, if agreement were achieved, to define its terms or elements. Throughout, the focus was on enabling community people themselves to lead the discussions, share divergent views, and take ownership for any decisions that were reached.

Communities' Planning Discussions

The community planning discussions were intended to focus initially on the selection of one harm to children[16] to address and then on how to address that harm through a community-designed action. Although these discussions were flexible and community-guided, they occurred within boundaries set by the action research team. For example, the research team set various action criteria (see tool MGM 5). Because the action research aimed to help strengthen wider child protection systems through bottom-up processes, one criterion was that a community-led action should link or collaborate with a district-level aspect of the formal child protection system. Other criteria were that the action should be low cost, feasible, sustainable, and ethical.

In addition, the three communities in each intervention (action) cluster were asked to work in a collaborative manner, selecting together which harm to children to address and then developing together an action to address that harm. This criterion enabled communities to learn from each other and ensured that the action would be tested in more than one community. Also, it enabled the establishment of a multi-village foundation for eventually scaling up the action to the entire chiefdom.

In order to plan together, the three communities in each action cluster decided to form an Inter-Village Planning Task Force (see tool MGM 3). This Task Force had five members from each of the three villages, with the five members elected from each of the subgroups: girls, boys, men, women, elders. The Task Force had a facilitative role and was not a master planning group. Through an iterative process, ideas were generated at community level through a mixture of *barray* discussions and small group discussions. The ideas from these dialogues were fed into a meeting of the Task Force, where the representatives from different villages could hear the thinking of their counterparts from other villages. At the Task Force meetings, the facilitators did not steer the discussions but helped to keep a focus on the action criteria and on finding common ground. The thinking from the Task Force discussions were then fed back to communities, thereby stimulating another round of discussions.

The discussions for selecting which harm to children to address were conducted over a period of nine months. A slow process was important in enabling the communities to develop highly inclusive participation and also to have the intensive dialogues that were needed to work through different views and to negotiate disagreements. Early in the discussions, male elders resisted the idea of focusing on teenage pregnancy since they were concerned that action would likely involve the use of contraceptives, which they saw as undermining the morals of young people. Their views on this issue did not change by means of debate.

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[16] As pointed out in the accompanying Guide, communities may choose to address multiple harms to children or a single harm. In this case study, the focus on a single harm to children reflected the desire of the research team to simplify the intervention in hopes of making it easier to determine which aspects benefitted children.

Over time, however, the elder men's wives tended to bring them around by asking questions such as, "Isn't it true that our daughters are still being harmed by becoming pregnant out of wedlock and that nothing we have tried has worked to change this? Wouldn't it be better to try a different approach?" Also, moderate men began speaking in favor of the use of contraceptives, setting a model for accepting the use of contraceptives. Equally important was that teenagers gave thoughtful, mature inputs into these discussions, and adults were impressed with their insight and sense of responsibility to their families.

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. As this example indicates, the discussions of which harm to children to address overlapped with discussions about what action to take.

Both clusters of action communities chose teenage pregnancy as the harm to children to be addressed. This was not surprising since the ethnographic research had identified teenage pregnancy as one of the top four harms to children. Teenage pregnancy caused some children to drop out of school, and the conditions surrounding teenage pregnancy were linked to violence. In Sierra Leone, nearly one-third of the teenage pregnancies were the result of sexual abuse and exploitation.[17] Since many families were unable to feed another person, teenage pregnancies and births frequently led girl mothers to turn to sex work as a means of survival. Throughout Sierra Leone, the problem of teenage pregnancy is of such great magnitude that in 2013 the President declared a state of national emergency in regard to teenage pregnancy.

The Community Action and Its Preliminary Effects

In both districts, the action cluster chose to address teenage pregnancy through a mixture of family planning, sexual and reproductive health education, and life skills. These were enabled in part through trainings provided by Marie Stopes and Restless Development in Bombali and by Restless Development in Moyamba. High levels of ownership were achieved by virtue of the fact that the communities themselves created an inclusive planning process, defined the problem to address, chose how to address it, and implemented the action. Collaboration with the government was achieved by virtue of the District Ministry of Health providing contraceptives, training health post staff on how to use implants, and having health workers educate on issues of puberty, sexuality, pregnancy, and pregnancy prevention.

The community action included: dramas followed by discussions; parent–child discussions on puberty, sex, and pregnancy; creation of and transmission by teenagers of youth-oriented messages about preventing teenage pregnancy; ongoing community dialogues and reflection

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[17] Coinco, E. (2010). *A glimpse into the world of teenage pregnancy in Sierra Leone*. Freetown, SL: UNICEF.

about teenage pregnancy; and support from health workers and authorities. The main action elements are outlined in the box below:

Table 1. The main components of the community-driven action to reduce teenage pregnancy.

Element	Description
Collective dialogue, awareness raising, and negotiation	In village meetings and subgroups such as teenage girls, teenage boys, adult women, adult men, and elders, groups discussed 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.
Collective decision-making, empowerment, and responsibility	The communities made their own decisions about which issue to address, how to address it, etc. As a result, they saw the decisions and action process as "theirs," and they took responsibility for ensuring its success.
Linkage of communities with health services	The District Medical Office agreed to keep up the supply of contraceptives and train health post nurses to do procedures such as implants. Feeling supported by health staff, people visited the health post for contraceptives and invited nurses to visit the villages and help to educate people about puberty, reproductive health, and pregnancy.
Peer education	Having been trained by NGOs, community-selected Peer Educators (including teenage girls and boys) helped to educate their peers on an ongoing basis. Informal peer education occurred also through everyday discussions in the community.
Use of culturally relevant media	Using song and drama, peer educators conducted culturally appropriate educational activities such as role-plays followed by group discussions in which teenagers and adults discussed the benefits of good decisions made by young people, and the problems associated with bad decisions.
Child leadership and messaging	Girls and boys played leadership roles. Recognizing that children talk in distinctive ways, children created their own messages based on what had been learned in NGO-led workshops and discussions with health workers.
Inclusion and outreach	Representatives of diverse subgroups took part on the Task Force that facilitated much of the work to prevent teenage pregnancy. To include marginalized people such as children with disabilities, the Task Force members and also Peer Educators made home visits on a regular basis.

Parent–child discussions	Rejuvenating an older practice that the war 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.
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 constructively with their children about teenage pregnancy.
Legitimation by authority	The Paramount Chiefs publicly supported the importance of preventing teenage pregnancy and encouraged people to get involved in the intervention. Other community leaders such as teachers and religious leaders, also encouraged support for preventing teenage pregnancy.

The flavor of the community-led action may be obtained by considering a drama and discussion activity. Following the action plan developed by the communities (see tool MGM 12), a teenage girl and teenage boy acted out informally two key scenarios designed to stimulate awareness and discussion of the harm caused by teenage pregnancy and of means of preventing it. In front of a village audience, the first scenario showed a girl and a boy feeling attracted to each other and agreeing to meet up later at the video hall that night. There, they consumed alcohol and marijuana and afterwards had impromptu, unprotected sex. The next scene showed the girl being pregnant, having morning sickness, and feeling very badly because she had dropped out of school. The boy, too, was feeling badly since he had dropped out of school and was uncertain whether he was ready for family responsibilities. Both felt their futures had been ruined.

The second scenario showed the same girl and boy feeling attracted to each other. This time, however, they discussed their relationship and their mutual dream of obtaining an education and building a family together. Exploring the question, "What will it take for us to fulfill our dream?", they agreed that early pregnancy could shatter their dreams. Having agreed to be careful in their sexual activity and to use contraceptives, they went on to earn their education, and married happily and started a family when they were ready.

Together, these scenarios sparked animated discussion about the harm caused by teenage pregnancy, about sexual and reproductive health, and about the importance of life skills in enabling young people to make good decisions and act in a responsible manner. These discussions frequently continued between parents and their children and also between teenagers who had not been in the drama. Together with the other intervention elements, they helped communities to mobilize themselves for social change away from the norm of teenage pregnancy.

With the community action having begun in March–April, 2013, the midline effects of the action were assessed in 2014 using the quantitative survey[18] and qualitative findings from key informant interviews and a community self-assessment.[19]

As shown in the box on the following page, the results at this stage were promising and featured high levels of community ownership and diverse signs of the action effects in addressing teenage pregnancy.

However, the results are preliminary in that more time was needed to see fully the effects of the action. Also, descriptions and qualitative data were not triangulated fully with the quantitative data. It was hoped that the subsequent endline measures would allow full triangulation and thorough analysis of the results, including systematic comparisons with the control clusters.

Unfortunately, the Ebola crisis erupted in Sierra Leone in August 2014. This made it impossible to collect the endline survey data as had been planned at the end of that year and which would have enabled the documentation and analysis of the full effects of the community-led action. Further, as the Ebola crisis continued, data from the field indicated that the Ebola crisis had interrupted the action and had introduced a host of confounding variables and threats to children, including increases in teenage pregnancy.[20]

Policy Impact

Notwithstanding the impact of the Ebola crisis, the interagency research approach and findings, which converged with the findings of other studies (e.g., Child Frontiers 2010), enabled the action research to have a significant influence on the national policy to support vulnerable children in Sierra Leone.[21] The findings that local people relied mostly on family and community mechanisms, and that community-owned processes were effective even in addressing

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[18] From Stark., L., Macfarlane, M., King, D., Lamin, D., Lilley, S., & Wessells, M. (2014). *A community-driven approach to reducing teenage pregnancy in Sierra Leone: Midline evaluation brief*. London, UK: Save the Children.
[19] Wessells, M., Lamin, D., & Manyeh, M. (2014). *An overview of the community-driven intervention to reduce teenage pregnancy in Sierra Leone*. London, UK: Save the Children; Wessells, M. G. (2015). Bottom-up approaches to strengthening child protection systems: Placing children, families, and communities at the center. *Child Abuse & Neglect: The International Journal,* 43, 8–21.
[20] Kostelny, K., Lamin, D., Manyeh, M., Ondoro, K., Stark, L., Lilley, S., & Wessells, M. (2016). *'Worse than the war': An ethnographic study of the impact of the Ebola crisis on life, sex, teenage pregnancy, and a community-driven intervention in rural Sierra Leone*. London, UK: Save the Children.
[21] Wessells, M. G., Lamin, D., Manyeh, M., King, D., Stark, L., Lilley, S. & Kostelny, K. (2017). How collaboration, early engagement and collective ownership increase research impact: Strengthening community-based child protection mechanisms in Sierra Leone. In J. Georgalakis, Ramalingam, B., Jessani, N., & Oronje, R. (Eds.), *The social realities of knowledge for development: Sharing lessons of improving development processes with evidence* (pp. 74–93). London, UK: Institute for Development Studies.

challenging issues such as teenage pregnancy, augured in favor of a policy that emphasized the importance of supporting existing family and community mechanisms. At the same time, research conducted by Harvard University with UNICEF indicated that local people were more likely to report severe violations against children to two people—focal points—who had been chosen by the community and trained for their work.

The findings were sufficiently encouraging that the Sierra Leone Government and UNICEF decided to develop a new policy that placed support for families and communities at the center and avoided the "add a structure" approach that governments frequently take in addressing problems. To support the drafting and development of a new policy, UNICEF hired Child Frontiers, the consulting group that had led the initial mapping of the child protection system in West Africa.

The development of this new policy was interrupted by the Ebola crisis beginning in August 2014, and also hampered by turnover in the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA). Nevertheless, the Government of Sierra Leone enacted in December 2015 a new Child Welfare Policy that embodied the insights from the interagency action research. Ultimately, the GoSL listened to the research because they saw it as their own and as addressing the questions that were at the heart of their efforts to support vulnerable children.

Promising Findings

The results included positive outcomes related to child protection, the community process, and system strengthening.

Community ownership. High levels of community ownership were evident in how many people volunteered their time and work, without material compensation, and regularly referred to the intervention as "ours," stating that NGOs and the government support them but do not lead the intervention.

Nonformal–formal linkage and collaboration. The intervention process significantly improved communities' collaboration and linkage with the local health posts. In contrast to previous low use of health posts, many teenagers and/or their parents visited the health posts regularly for contraceptives or advice. Also, villages frequently invited nurses and other health staff to visit in order to educate villagers about puberty, sex, and preventing teenage pregnancy.

Contraception. The District Medical Officers fulfilled their promise to supply the contraceptives and train the health staff. Relative to the comparison condition, teenagers in the intervention communities reported increased intent to use condoms regularly and increased willingness to ask their partner to use a condom. These can be precursors of wider changes in behavior and social norms related to sex.

Life skills. Teenage girls reported that because of the intervention, they said "No" more frequently to unwanted sex. Both girls and boys said that they had learned how to discuss and negotiate with their partners in regard to sex, and also how to plan their sexual activities in light of wider life goals. In addition, boys said openly that they had a responsibility to prevent teenage pregnancy. This responsibility-taking contrasted sharply with the boys' previous behavior.

Teenage pregnancy. Participant observations and interviews with health post staff, monitors, teenagers, and adults indicated a significant decrease in teenage pregnancies. In the intervention communities in both districts, participants reported that in an average school year (September–June) before the intervention had begun, there were five or six teenage pregnancies. In contrast, in the 2013–2014 school year, many fewer teenage pregnancies had occurred. During that period, half the communities reported no new teenage pregnancies, and the other half reported only one new teenage pregnancy. Grandmothers, who are respected community figures, assured that it is impossible to hide pregnancies in the villages.

Spinoffs. Participants said that school dropouts had decreased. Also, some villages had spontaneously begun to discuss the problem of early marriage. Having learned more about the adverse effects of teenage pregnancy, villagers had begun to question the appropriateness of any teenage pregnancy and also of early marriage.

The implementation of the new policy faces challenges related to scale, cost, and the capacities of different partners to enable effective implementation. Via UNICEF, a technical unit of four agencies that had been very active in the research has been convened to plan and prepare for the rollout of the new policy using the methods and approach of the research. The plan is to go to scale in a measured approach that enables learning about capacity building and implementation on a continuing basis.

Initially, the approach will be extended throughout Moyamba and Bombali Districts through partners that have been trained on how to facilitate the community-driven approach. Subsequently, the community-driven approach will be extended to cover all 14 districts. In this manner, UNICEF, the GoSL, and the research team hope to address the frequently expressed concern that bottom-up approaches have difficulty going to scale. Collectively, this work will transform the strictly top-down approach to child protection system strengthening toward the mixture of top-down and bottom-up approaches that are needed for building a system that effectively enables children's protection and well-being.