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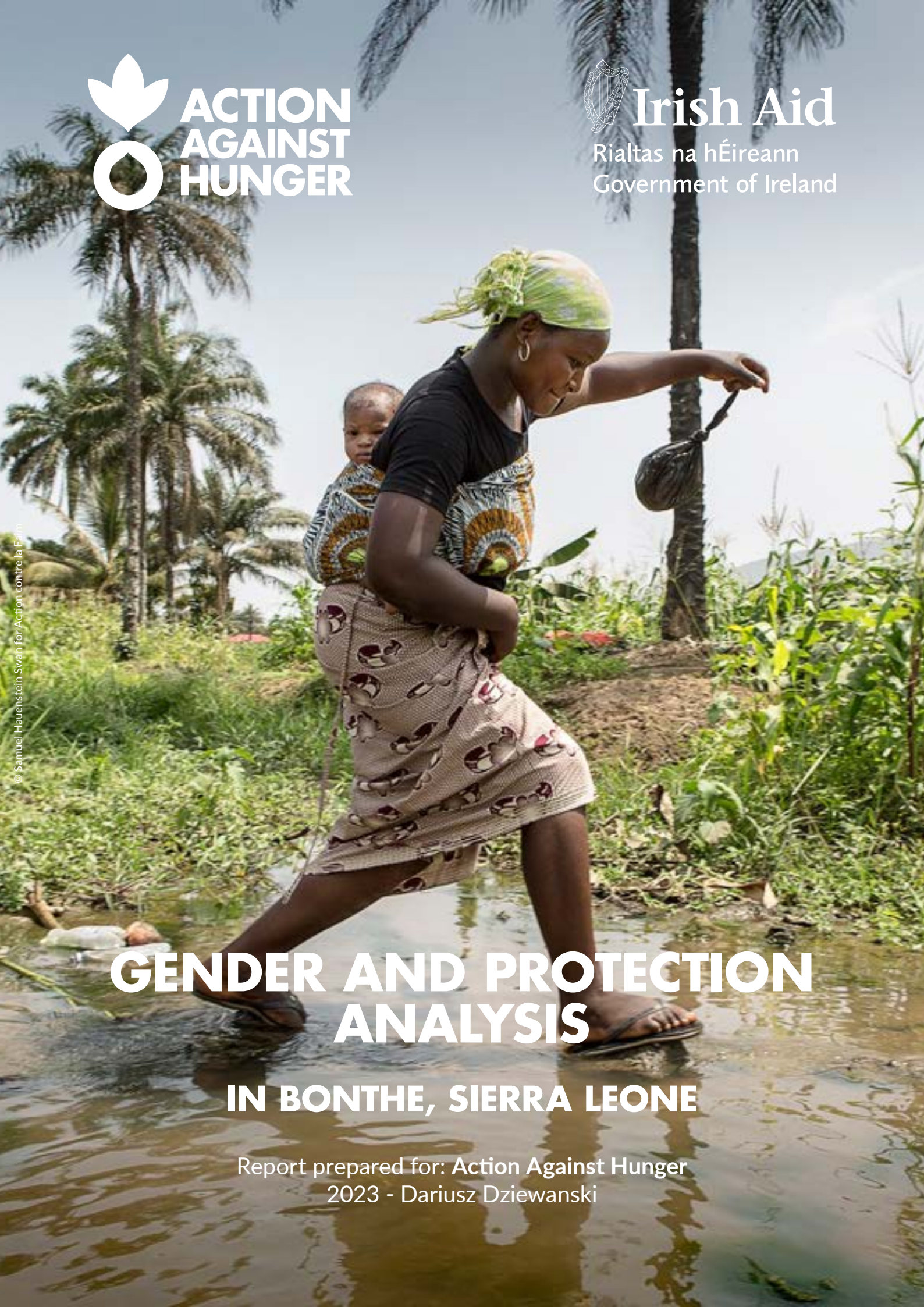
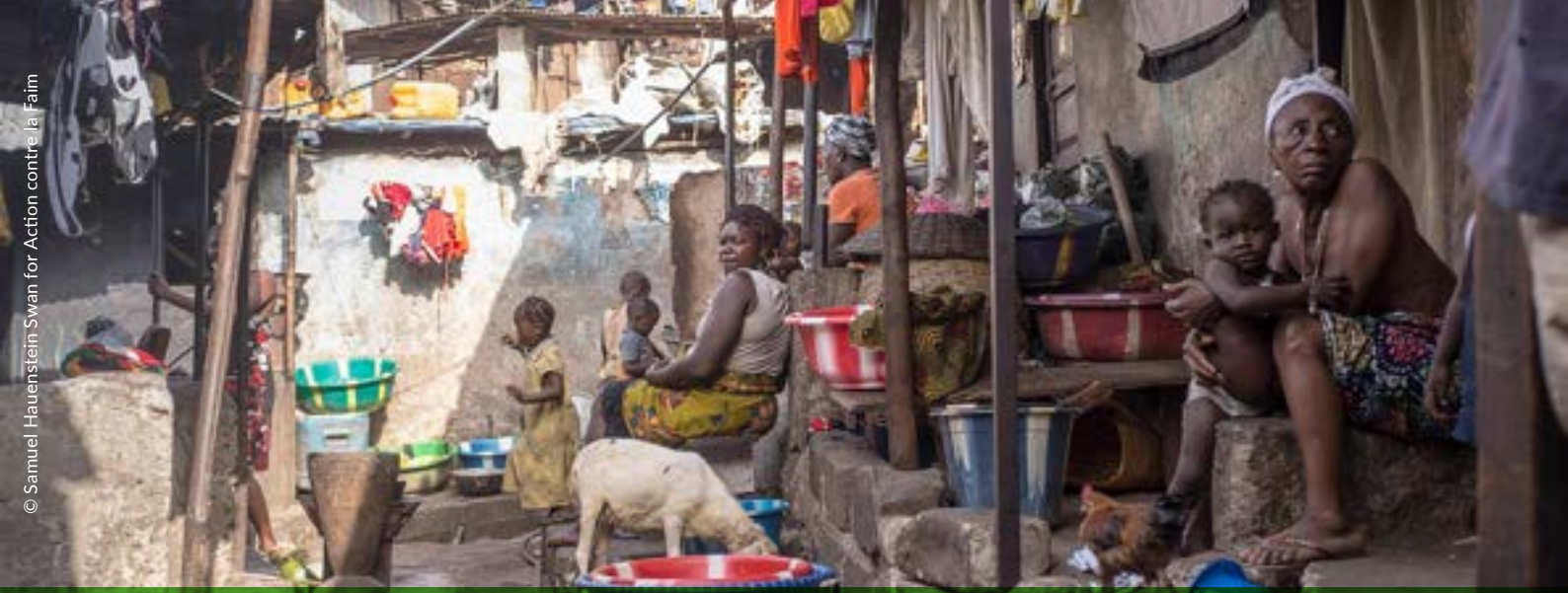


GENDER AND PROTECTION ANALYSIS

IN BONTHE, SIERRA LEONE

Report prepared for: **Action Against Hunger**
2023 - Dariusz Dziewanski



EXECUTIVE SUMMARY

INTRODUCTION

As part of its activities in the country, Action Against Hunger (Action contre la Faim/ACF) is implementing an integrated project entitled multi-sectoral community-led approach to improve nutrition in Bonthe district, Sierra Leone (*MCA-Nut).*

The project supports vulnerable populations in three chiefdoms in Bonthe District: Jong, Kpanda Kemoh, and Yawbeko. *MCA-Nut* is an Irish Aid funded initiative that will run for three years, between August 2022 and July 2025. The principal objective of the project is to contribute to the reduction of under-nutrition in children under five years, and to reduce the chronic malnutrition of adolescents and pregnant and lactating women (PLW) in the target areas. The *MCA-Nut* project design seeks to proactively integrate gender and protection into its different sectoral components, as a way of overcoming barriers vulnerable people face in adopting optimal nutrition behaviours and reaching their full potential.

To this end, this report highlights the findings and recommendations of a *Gender and Protection Analysis* carried out in the three target districts between January and March 2023. The study identifies specific gender and protection risks in the intervention area, so as to create holistic programming approaches that respond to people's needs, including their protection needs. The *Gender and Protection Analysis* relied on a mixed methods approach, pairing quantitative data from available secondary sources with primary research from sixteen key informant interviews (KIIs) and 32 focus group discussions (FGDs). At district level, interviews were conducted with ACF staff, key government partners, and civil society, while at the community level research activities focused on speaking to community leaders, health staff, and women and men in different communities.

KEY FINDINGS

Gender Norms

The *Gender and Protection Analysis* showed how discriminatory gender norms subjugate and subordinate women and girls across Bonthe District. Such norms have far-reaching effects on the lives of women and girls, affecting the roles and responsibilities they have in the community, their decision-making power, and the types and amount of resources they can access and control. For example, men make the most important decisions around the house and in social life, and control most of the income, land, and other resources within households. Men even often control the women themselves, determining where women can go, whom they can visit, and other aspects of their lives.

Livelihoods

Poverty is a key development challenge throughout Bonthe District that affects both men and women. Still, females feel poverty more acutely, because they are usually more dependent on the men in their lives for money for food and other household expenses. It is men who manage earnings from agriculture, which is the main livelihoods activity in the chiefdoms considered.

Women are much more likely to do unpaid work, which cuts into the time they can spend earning money. Many women do earn extra income through gardening and petty trading. But profits from these activities are generally very low. As a result, females are financially dependent on their male partners, creating an unequal relationship that strengthens men's control over women in other aspects of their lives. One poignant example of this is that wives have to ask their husbands for money to access health services for themselves and their families. This has an impact on their own health and the well-being of children.

Food Security and Nutrition

Bonthe has among the highest levels of malnutrition for under-five in Sierra Leone. The effects of malnutrition are most acute among children in poorer households, where most income goes towards food. Overall, Bonthe has high food expenditures as a percentage of total income, making many households in the district vulnerable to very vulnerable to high inflation, especially rising prices of staple foods. Nutrition conditions have recently deteriorated due to decreased purchasing power of already-small incomes. Vulnerable people – like poor households, female-headed households, persons with disabilities (PWDs), the elderly, and others – are the most at risk. Most people do not have enough to eat, usually consuming just one meal per day. Even then they still often rely on food-related coping strategies like: securing food through credit, adults eating less, reducing preferred food, consuming food without sauce/condiments, or eating a less-preferred food. Making matters worse, many people have little intake of nutritionally diverse foods.

On top of that, most people lack of knowledge in terms of nutrition and food diversity, and there exists lots of misinformation about different foods. Because of this, diverse diets are not valued. Those that have vegetable gardens, for instance, would prefer to sell their produce to buy rice, rather than consume the vegetables they grow. Even among people with adequate nutritional awareness, poverty makes it difficult to purchase nutritious food.

Healthcare Services

Many barriers exist to accessing health services in Bonthe: cost of healthcare, distance to facilities, negative interpersonal interactions at health facilities, and the likelihood that people will seek treatment through traditional healers. Overall, women are more likely to be affected by barriers to accessing healthcare.

Firstly, they are responsible for caring for children and sick family members. As well, they are discriminated against in ways that men are not, such as at health facilities where staff may judge how they are dressed. Barriers such as thses have been shown to prevent some PLW from seeking services like as antenatal care. It may also prevent other women from accessing modern contraception, even though awareness about family planning and contraception methods is high. Another key barrier to contraception are controlling behaviours by husbands, who see the wife's role as a primarily childbearing one. Lack of access to contraception is also partly to blame for teenage pregnancy, as is poverty. Another factor contributing to the teenage pregnancy is the dearth of senior secondary schools in Bonthe district.

Education

Despite the Government of Sierra Leone's considerable efforts to promote educational inclusion, study participants still often reported that a lack of money prevents them from sending their children to school. Due to high and persistent levels of poverty, some parents in Bonthe District are still unable to afford the indirect costs of education. Indeed, secondary data shows that children from poor families are more likely to drop out of school than those from wealthier families.[1]

Other barriers to full educational enrolment and retention remain, as well. As mentioned, a key challenge is the lack of access to senior secondary education in most communities requires many boys and girls to relocate in pursuit of their education. Those from out-of-town stay with relatives or family friends, making them vulnerable to sexual exploitation. In particular, girls from poorer households, often resort to transactional sex for food, clothes, or other essential and luxury goods, or to obtain money for themselves.

Gender-based Violence

In general, discussing the issue of gender-based violence (GBV) is still taboo among many people in communities. Yet, KIIs with government and non-governmental stakeholders – triangulated by secondary data – shows that GBV is prevalent in Bonthe. It is women and girls that are most affected, though there were also some reports of GBV committed against males. Overall, girls and young women are most likely to be sexually harassed, while domestic violence on average impacts older married women.

The *Gender and Protection Analysis* found that domestic violence is widespread and often compromised through informal channels, rather than being brought to police and the courts. The by-laws and fines put in place to prevent such violence might actually just be hiding violence, as women's financial dependence on men makes it unlikely that they will bring cases forward for fear that it will cost the household money. On the other hand, community discussions suggest that strict laws against sexual violence are discouraging rape. That being said, even if rape is decreasing overall, it still exists – for example as forced sex within marriage and in very remote communities where there is little police presence.

1 GoSL, UNICEF, and Irish Aid, 2021, *Out-Of-School Children Study Sierra Leone*.

Mental Health and Psychosocial Support

Many men and women reported high levels of stress and anxiety from poverty, since financial pressures are an everyday pressure for most people. Given the social expectation that it is a woman's responsibility to find food for the household, females have added stresses from poverty. If income for food is insufficient, the women must buy food on credit, forage for something to eat, or find some other way to find food for their household. Pressures in the home around money also lead to conflict between men and women in the home, which can lead to GBV.

Women often rely on friends and neighbours for emotional support because few mental health services exist in the district. Importantly, awareness about issues related to mental health is increasing. Yet, there still exist considerable misconceptions about mental issues. There is, for instance, still a widespread belief that mental illnesses are caused by witchcraft or spiritual issues, which cannot be cured by western health care.

Water, Sanitation, and Hygiene

The *Gender and Protection Analysis* also looked at issues related to water, sanitation, and hygiene (WASH), finding that it is a key challenge in Bonthe. Many people in the district do not have improved source of drinking water, access to improved sanitation facilities, or adequate knowledge on hygiene practices. Residents of rural communities in Bonthe are relatively much worse off than those living in the district capital. In rural communities pumps are frequently broken and have been abandoned, increasing the burden of work on the women and children whose responsibility it is to collect water from streams, rivers, and other water sources. Even health facilities often have broken pumps, forcing staff to use well or stream water for activities there. Neither do many schools in Bonthe have access to basic water, handwashing facilities, or menstrual hygiene management.

Because access to improved sanitation is low, many rural communities rely on open defecation. This creates problems with typhoid, cholera, and other diarrhoeal diseases – often affecting under-fives most severely. Again, it is women that must care for sick children. More positively, providing latrines for schools has been a government priority, so schools must have these before they can be accredited. As a result, most schools have toilets for boys and girls.

Programming Recommendations

As show above, communities in Bonthe experience multiple vulnerabilities, meaning that organisations like ACF have many opportunities to help. Taking into the preceding analysis, this study outlines a number of recommendations for ACF to pursue through its programming in the district. These recommendations are presented below by sector.

Food Security and Livelihoods

- Sensitising men as part of *Mother Support Groups*.
- Complement food security and livelihoods activities with training on gender norms.

Health

- Work with health personnel on communication and improving patient-health provider relationship.
- Establish *Village Savings* and *Loan Association* to support emergency transport and health care access.
- Explore innovative ways of promoting family planning.
- Include religious leaders in health messaging, especially about family planning.

Nutrition

- Promote cultivation and cooking of cassava leaves.
- Incorporate sensitisation against misinformation and myth into nutritional work.

Mental Health and Psychosocial Support

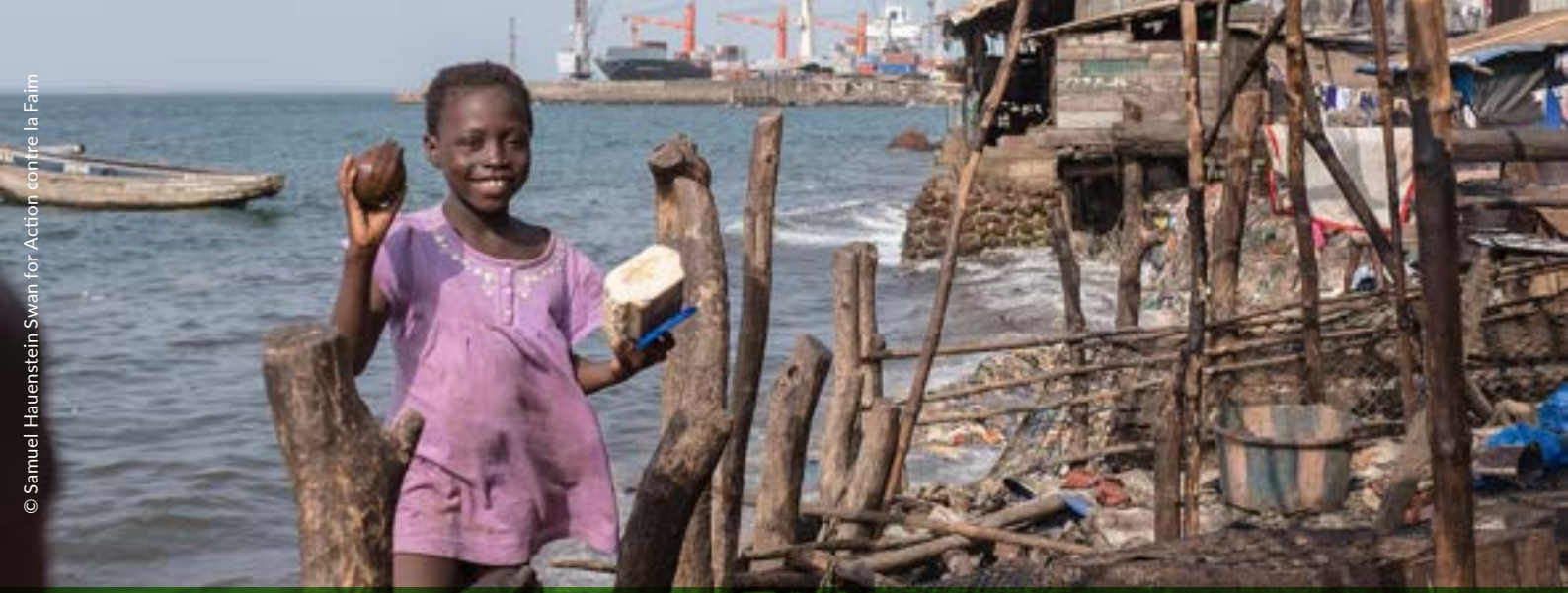
- Engaging community groups in mental health messaging.
- Peer support groups may be formed in project communities.

Water, Sanitation, and Hygiene

- Rehabilitation for water points in communities and at health facilities should take into account sustainability.
- Develop a network of high-skilled rural water supply technicians.

Cross-cutting Gender and Protection

- Create easy-to-communicate gender and protection messaging tools that can be used by all ACF staff and parters for sensitisation across sectors.
- Ensure that gender and protection is mainstreamed into all ACF activities throughout the project management cycle.
- Ensure all ACF staff receive adequate training on gender and protection issues.
- Implement gender-related programming models focused on social transformation.
- Gender programming targeted at men/men's groups.



ACRONYMS AND ABBREVIATIONS

ACF	Action Against Hunger (Action contre la Faim)
BDN	Bonthe District Nutritionist
CHC	Community health centre
CHP	Community health posts
CHW	Community Health Workers
CLTS	Community-led total sanitation
CSO	Civil society organisation
DHS	Demographic and Health Survey
EMAP	Engaging Men in Accountable Practice
EmONC	Emergency obstetric and newborn care
EPI	Expanded programme for immunisation
FBOs	Farmers-based organisations
FGD	Focus group discussion
FHCI	Free Healthcare Initiative
FMC	Facility Management Committees
FQSE	Free Quality School Education
FSL	Food security and livelihoods
FSMS	Food Security Monitoring System
FSU	Family Support Unit
GBV	Gender-based violence
HDI	Human Development Index
KII	Key informant interview
MCA-Nut	Multi-sectoral community-led approach to improve nutrition in Bonthe district, Sierra Leone
MCHPs	Maternal and child health post
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Survey
MIYCF	Maternal infant and young child feeding
MNCH	Maternal, newborn, and children health
MoWR	Ministry of Social Welfare, Ministry of Water Resources
MSG	Mother Support Group

NEMS	National Emergency Medical Services
OSC	One Stop Centre
PWDs	Persons with disabilities
SAM	Severe acute malnutrition
SASA!	Start, Awareness, Support, and Action
SLL	Sierra Leone leone
STI	Sexually transmitted infections
SUN	Scaling Up Nutrition
USD	United States dollar
VSLA	Village Savings and Loan Association
WASH	Water, sanitation, and hygiene

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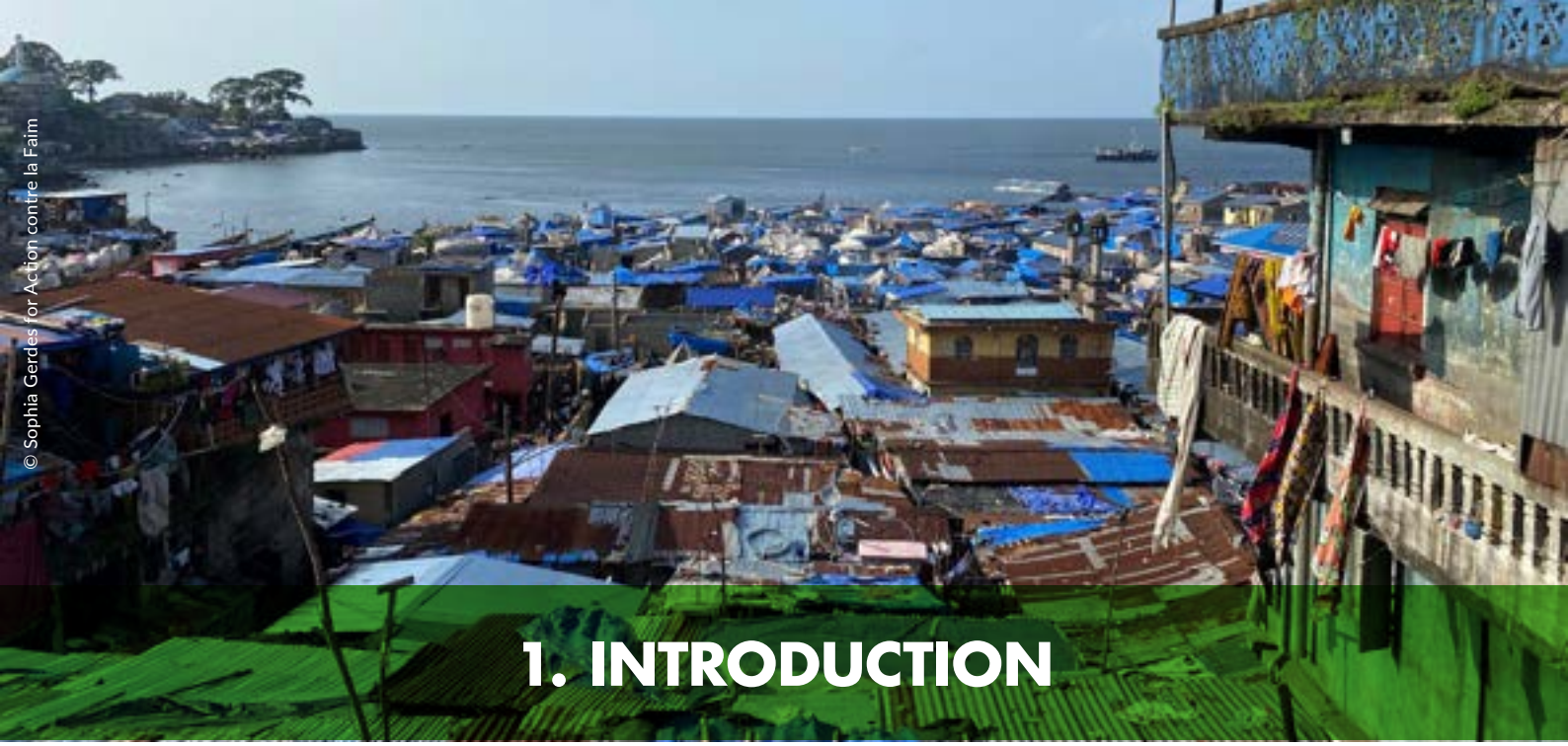


1. INTRODUCTION

Action Against Hunger (Action contre la Faim - ACF) has been working in Sierra Leone since 1991. As part of its activities in the country, ACF is implementing an integrated multi-sectoral project entitled multi-sectoral community-led approach to improve nutrition in Bonthe district, Sierra Leone (*MCA-Nut*) to support vulnerable populations in three chiefdoms in Bonthe District: Jong, Kpanda Kemoh, and Yawbeko.

MCA-Nut is an Irish Aid funded project that is expected to run for three years, between August 2022 and July 2025. **The principal objective of the project is to contribute to the reduction of under-nutrition in children under five years and to reduce the chronic malnutrition of adolescents and pregnant and lactating mothers in the target areas.** ACF nutrition programming is designed to address the underlying causes of malnutrition, through nutrition-specific and nutrition-sensitive interventions. This will include treatment and preventative actions in various sectors, including: food security and livelihoods (FSL), health, mental health and psychosocial support (MHPSS), protection, and water, sanitation, and hygiene (WASH). A range of strategies will be deployed across the project for integrated service delivery across these different sectors, as well as across advocacy work that is both mainstreamed across the project and integrated within specific activities.

Further, the *MCA-Nut* project design seeks to proactively integrate gender and protection into the different sectoral components of the project, as a critical step to overcoming barriers vulnerable face in adopting optimal nutrition behaviours and reaching their full potential. This includes identifying key factors that affect care practices such: maternal infant and young child feeding (MIYCF), sanitation and hygiene practices, and psychosocial care – among others. In order to strengthen the quality of the response led by ACF, this multi-sectoral *Gender and Protection Analysis* was conducted. This analysis highlights the specific problems related to gender and protection risks in the intervention area, so as to create holistic programming approaches that respond to people's need, including their protection needs. The objective is to identify the vulnerabilities of the population by:

- Analysing pre-existing and current power dynamics and gender roles including access to and control of resources, different constraints and risks, gender diversity, and diversity of capacities faced by the women, men, boys, and girls.
- Analysing existing protection risks and the positive and negative strategies adopted by vulnerable people to reduce the risks of protection incidents.
- Understanding existing types of violence, their root causes and causal agents, who is most at risk of experiencing them and for what reasons.

The *Gender and Protection Analysis* commenced in early January 2023. Activities were completed over a period of three months, concluding at the end of March 2023; see *Annex A* for a detailed workplan for the study. **Primary research relied mostly on qualitative methods** to understand the intersecting issues of gender and protection that are affecting the status and lives of women, men, girls, and boys in the three target chiefdoms. **Qualitative research focused on assessing how and why gender differences and inequalities are relevant to the sectors being considered.**

Moreover, the study revealed connections between gendered power relations and discriminatory social norms to identify, understand, and describe gender differences and the types of protection risks that exist as a result. Analysis examined the **protection issues that arise at interpersonal, household, and community level**, and the various factors that cause or contribute to the harms of the district population and to specific groups such as to women and girls across Bonthe District.

Ultimately, the *Gender and Protection Analysis* aims to inform the design and implementation of programming activities undertaken in Bonthe, the help ensure that ACF develops **a multi-sectoral package of integrated services and activities to help vulnerable groups in the intervention areas work towards safety, security, and autonomy**. This report details the different elements of the *Gender and Protection Analysis*, including its programming context, methodology, findings, conclusions, and recommendations.

1.1. PROJECT OVERVIEW

As mentioned, the principal objective of the *MCA-Nut* project is to contribute to the reduction of undernutrition in children under five years, and to reduce the acute and chronic malnutrition of children under five years, adolescents, and pregnant and lactating women in the target areas.

The project has **three expected outcomes**, which are briefly described below.

→ Outcome 1

The objective of *Outcome 1* is to strengthen the detection, treatment, and prevention of undernutrition for children under five and women of reproductive age. This outcome complements the Government of Sierra Leone (GoSL) in its vision of capacity building and supportive supervision, in order to ensure quality care for severe acute malnutrition (SAM) cases in Bonthe District. In addition, the project is implementing prevention activities to promote appropriate care practices, psychosocial support, and improved knowledge, attitude, and practices for caregivers and adolescents. The project scope under *Outcome 1* also is developing skills in the health sector through trainings and community structures community structures through Mother Support Groups (MSG), Facility Management Committees (FMC), and Community Health Workers (CHWs) for improved and sustainable nutrition services at the community level.

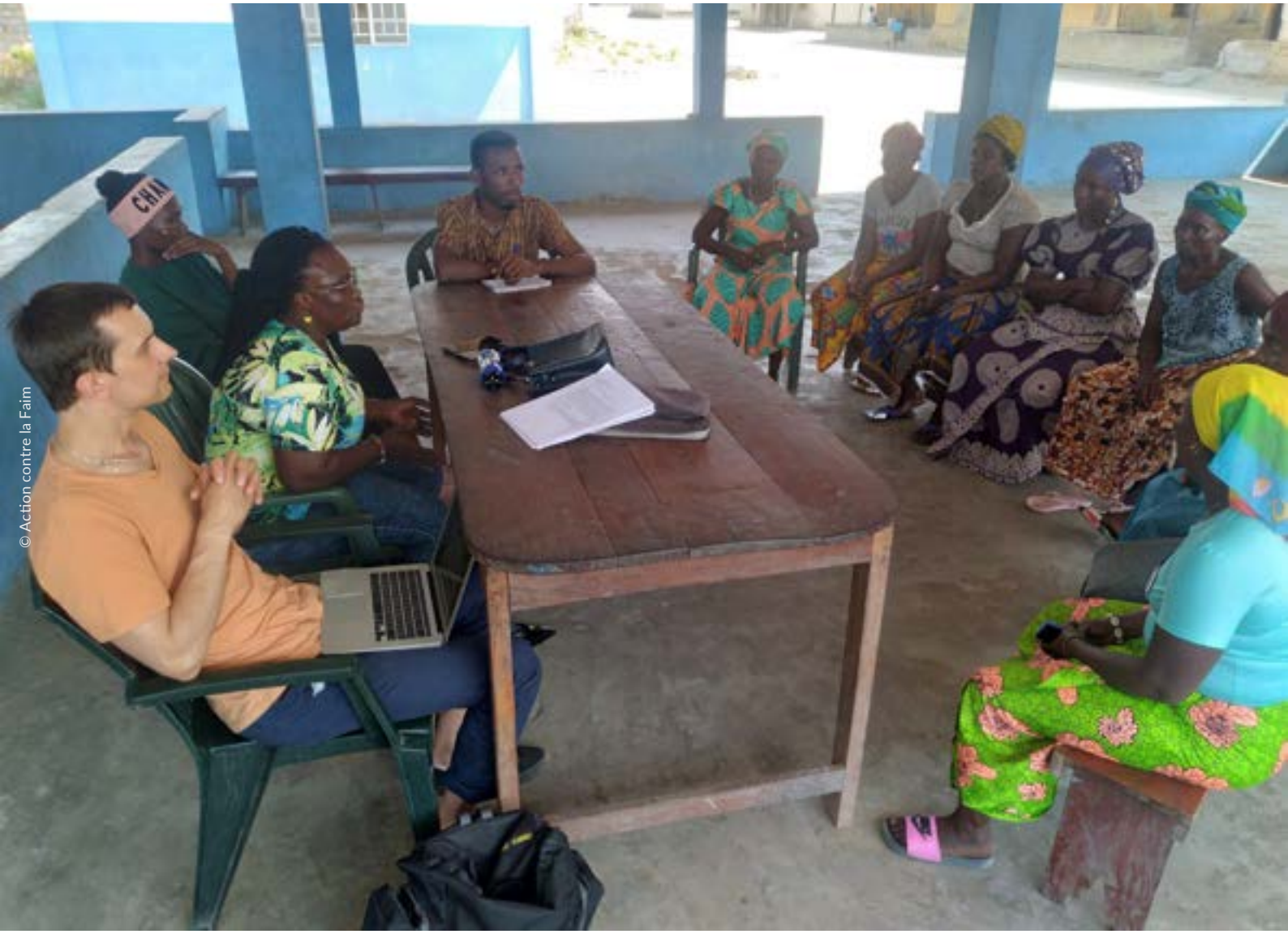
→ Outcome 2

***Outcome 2*'s objective aims to assist the most vulnerable women of reproductive age, children under five, and communities increase their access to healthy diet, safe water, sanitation, and resilience to climate change.** Under this outcome, the project is specifically working to improve access for children under five to a diversified diet by providing the most vulnerable through the MSGs the means to produce, consume, and sell nutritious food. These activities are complemented by the WASH element of the project, which includes the construction and rehabilitation of WASH infrastructures in accordance to national standards in both health facilities and

communities, as well as support for the implementation of community-led total sanitation (CLTS). As well, the intervention supports the most vulnerable communities to increase their resilience to climate change induced or amplified hazards.

→ Outcome 3

The objective of *Outcome 3* is to catalyse the national dialogue to inform policy progress toward achieving increased nutrition investments through the *Scaling Up Nutrition* (SUN) movement and multi-sectoral forums, to address undernutrition among women and children under the age of five. *Outcome 3* focuses on advocacy at the national and district level to address undernutrition across the country to address undernutrition through enhanced discussions with the legislature, executive, and nutrition stakeholders across Sierra Leone. The project also builds capacity of specific ministries, departments, and agencies, as well as local populations, for all stakeholders to actively participate in the development of nutrition-sensitive and nutrition-specific interventions at the national and district level.



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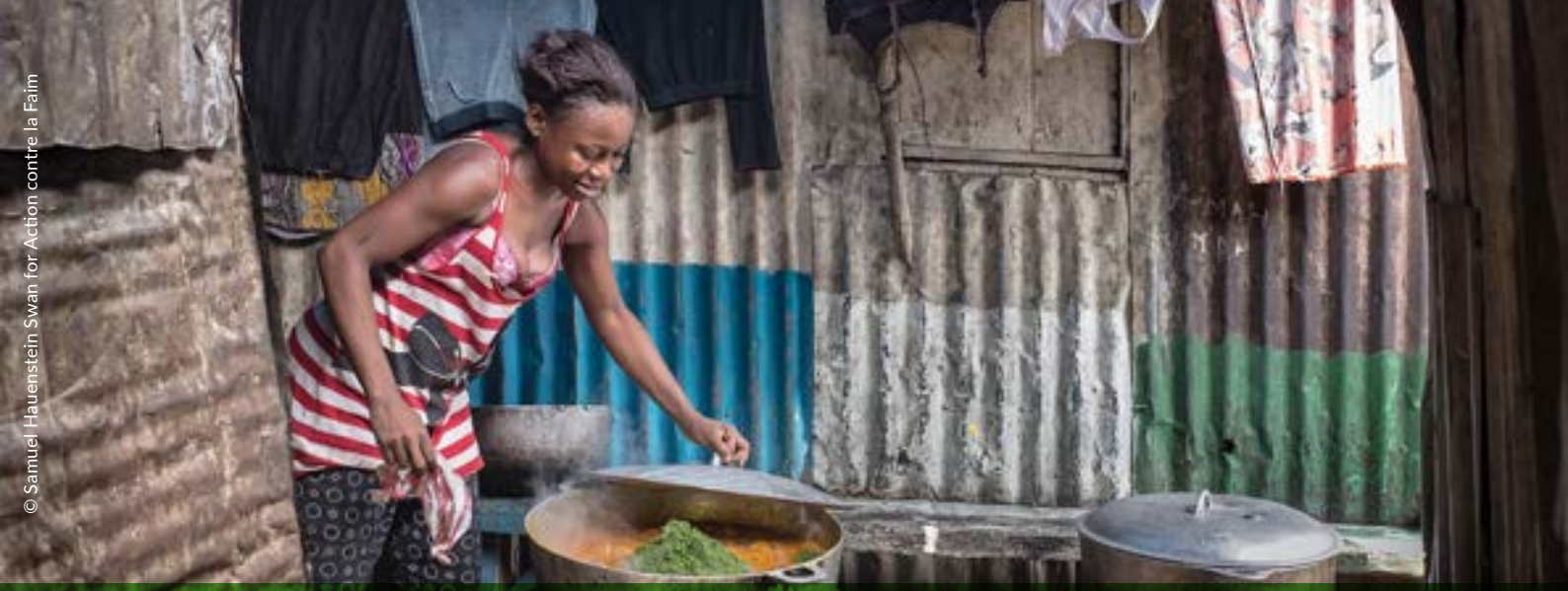

2. PROGRAMMING CONTEXT

Sierra Leone ranks among the world's least developed countries with *Human Development Index* (HDI) of 0.452. That is 182nd out of 189 countries.[2] The HDI of females is particularly low when compared to males. HDI statistics for youth are unavailable. But other indicators show that youth are vulnerable too. For instance, structural unemployment among youth is estimated at 60 per cent, and Sierra Leone has among the fastest growing numbers of young workers living on less than USD 1.00 per day.[3] **From a food security and nutrition perspective, Sierra Leone is vulnerable as well.** The country is designated as having "*serious*" levels of hunger and under-nutrition according to the *Global Hunger Index*.[4]

Sierra Leone recently passed the *Gender Equality and Women's Empowerment Policy*,[5] creating quotas for female representation in the workforce, setting minimums for maternity leave, and offering equal access to bank credit and training opportunities. However, much still needs to be done to achieve gender equality and fully empower women there. For example, women are more than twice as likely to do unpaid work than are men.[6] In the agricultural sector, which accounts for nearly 60 per cent of country's gross domestic product, women's lack of access to and control of productive resources to fully participate in different facets of the agriculture sector.[7] **Discriminatory social norms** about appropriate roles and responsibilities for women and men are key contributor to the gender gaps in agricultural opportunities and outputs.[8] Women and girls in Sierra Leone are also affected by a number of protection issues. **Gender-based violence** is still a big problem in the country. Of women age 15-49, 60.7 per cent say they have experienced physical violence since age fifteen, 7.4 per cent have experienced sexual violence.[9] There are 776,00 child brides in Sierra Leone, 253,600 of whom were married before the age of fifteen.[10] Currently, the prevalence of **child marriage** (marriage before the age of eighteen) among girls stands at 30 per cent.

Many of the national issues just mentioned are also present in Bonthe District. The *MCA-Nut* project targets three out of the eleven chiefdoms in the districts. The chiefdoms that the intervention focuses on – Jong,

2 UNDP, "Human Development Reports: Sierra Leone," http://hdr.undp.org/en/countries/profiles/SLE (30 January 2023).
3 National Youth Commission, and Ministry of Youth Employment and Sports, 2012, *Sierra Leone Status of The Youth Report 2012*.
4 von Grebmer, Klaus, *et al*., 2019, *2021 Global Hunger Index: Hunger and Food Systems in Conflict Settings*, Report published for Welthungerhilfe and Concern Worldwide.
5 GoSL, 2023, *Gender Equality and Women's Empowerment Policy*.
6 DHS, 2019, *Sierra Leone DHS 2019*.
7 GoSL, 2020, *Gender in Agriculture Policy*.
8 WFP, 2021, *Home-grown School Feeding Value Chain Assessment*.
9 DHS, 2019, *Sierra Leone DHS 2019*.
10 UNFPA and UNICEF, 2021, *Country Profile 2021, UNFPA-UNICEF Global Programme to End Child Marriage – Sierra Leone*.

Kpanda Kemoh, and Yawbeko – are situated towards the central and northern parts of the district that border Moyamba and Bo Districts. Also bordering the Atlantic Ocean, and with vast network of rivers that criss-crosses its geography, **Bonthe is classified in the country's coastal food crops and fishing livelihoods zone**.[11] Fishing occurs mainly in the riverine and coastal areas, while the main food crops – rice and cassava – are grown throughout the district. **Rice cultivation** among the farmers includes both upland and lowland rice, much of it in "*bolilands*",[12] though some areas also carry out rice farming in inland valley swamps.[13] **Palm oil** is another important agricultural product, and is a livelihood that more people are engaged in the district in recent years.[14] **Rutile and bauxite** are also mined within the district by companies such as *VIMETCO* and *Sierra Rutile Limited*. These companies now control large portions of land in Kpanda-Kemoh chiefdom.[15] **Efforts to accelerate growth without attending to how economic benefits are distributed are a noted source of instability in Sierra Leone.**[16] Such scenarios have played out in nearby districts like Moyamba, where communities have resorted to violence to express their dissatisfaction being disposed by the companies of available arable land without receiving adequate development benefits in return.[17] Conflict dynamics like these could become a problem in Bonthe in the future, as well, if development is not undertaken in an equal manner.

Currently, Bonthe is still one of the least developed districts in all of Sierra Leone, despite the presence of large multinational companies. According to the 2015 national census, the district has the highest rate of multidimensional poverty[18] of any district in the country.[19] In addition, the *Wealth Index* shows that 22 per cent of district households are in the poorest quintile and 36 per cent are in the second lowest.[20] **The overall poverty level is 50 per cent**, with a *Gini coefficient* of 0.3.[21] According to the *Sierra Leone Food Security Monitoring System* (FSMS) *Report*, published in February 2023, **Bonthe has among the highest proportions of household expenditure on food of any district in Sierra Leone**.[22] The report also indicates that 68 per cent of the population of Bonthe is food insecure, and that 17 per cent of that group are severely food insecure.

Bonthe district is also the least populous in Sierra Leone,[23] **and residents are spread out across a vast network of main and feeder roads.** Upgrading of key roads has been taking place in the last few years, making the district more accessible from other parts of the country. However, feeder road networks remain underdeveloped, generating considerable transport constraints for the residents of rural communities. The district's coastal and riverine nature necessitates the use of **boats and canoes as a primary mode of transport** in lots of chiefdoms. During the rainy season, flooding makes many more roads inaccessible, and boat and canoes become even more common.

Due to the location of the district, as well as the constraints it faces related to topography and underdeveloped transport infrastructure, much remains to be done to ensure adequate presence of services in the district. For example, as of July 2015, the GoSL reported that Bonthe District had just 62 total health facilities, the lowest of any district in the country.[24] The government general hospital is in the district capital. A network of maternal and child health posts (MCHP), community health posts (CHPs), community health centres (CHCs),

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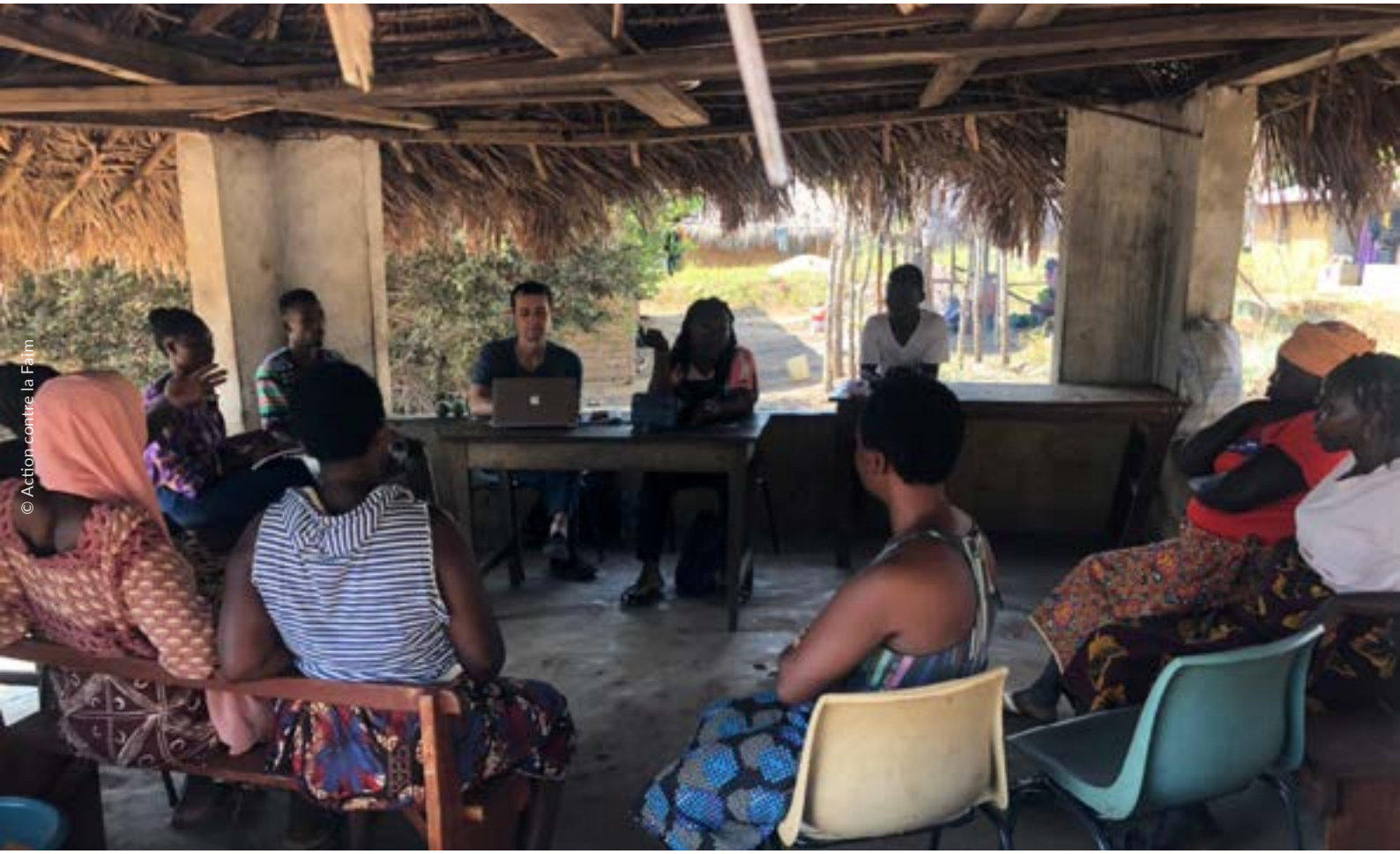
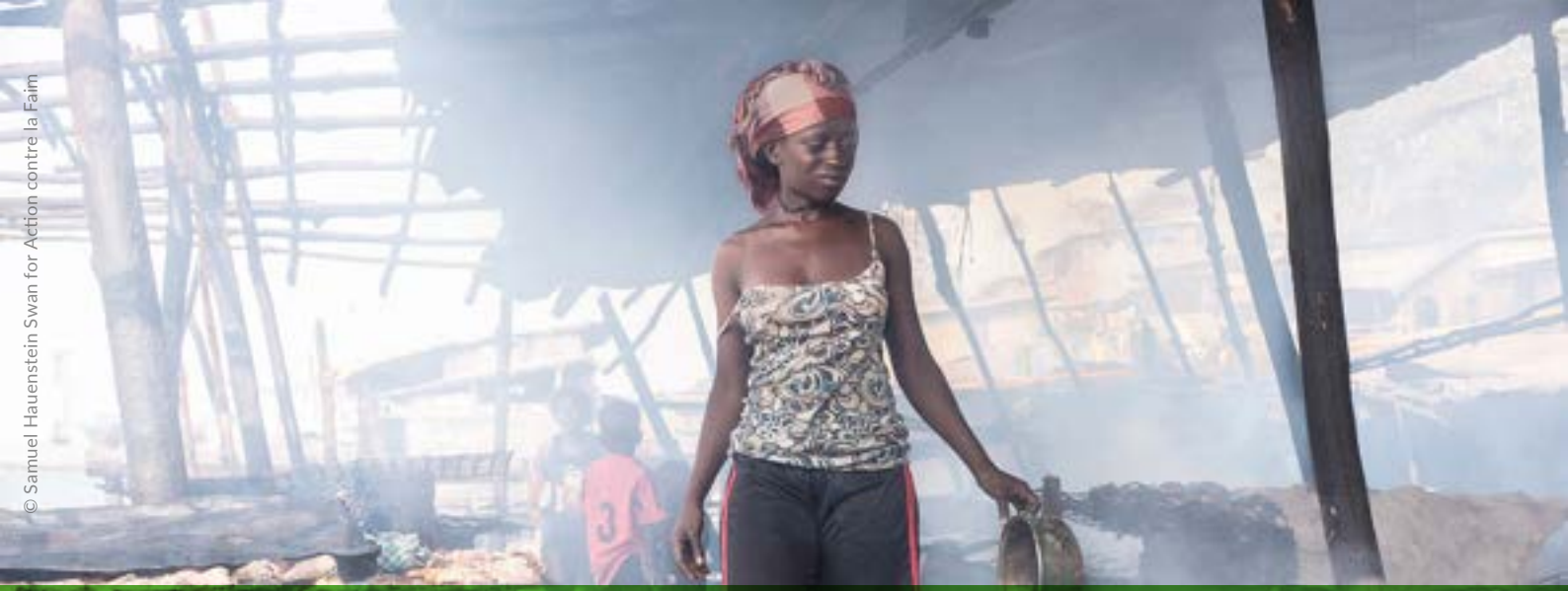
11 GoSL, FEWS, and USAID, 2016, *Sierra Leone Livelihood Zones and Descriptions October 2016*.
12 Rice grown in fields that may be flooded for 2-4 months.
13 Valley bottoms in rainforest not associated with streams, which flood perennially or intermittently with stagnant water.
14 OCHA, 2015, "Sierra Leonea – Bonthe", *District Profile*.
15 Bonthe District Council, 2022, *Bonthe District Council Development Plan 2020-2022*.
16 Herbert M'cleod, Herbert, and Brian Ganson, 2018, *The Underlying Causes of Fragility and Instability in Sierra Leone*, p. 7.
17 *Reuters*, 2018, "Sierra Leone President Urges End to Strike at Iluka's Rutile Mine", 27 November, https://www.mining.com/web/sierra-leone-president-urges-end-strike-ilukas-rutile-mine/ (30 January 2023).
18 Multidimensional poverty is measured by the following twelve indicators: literacy, school attendance, health, immunisation, child mortality, living standards, electricity, cooking fuel, overcrowding, flooring, improved sanitation, drinking water, assets, unemployment.
19 GoSL, 2015, *Sierra Leone 2015 Population and Housing Census Thematic Report on Poverty and Durables*.
20 WFP, 2021, *State of Food Security in Sierra Leone 2020: Comprehensive Food Security And Vulnerability Analysis*, May 2021.
21 OCHA, 2015, "Sierra Leone – Bonthe", *District Profile*, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/district_profile-bonthe-_29_dec_2015.pdf (7 March 2023).
22 WFP and GoSL, 2023, *Food Security Monitoring System Report*, February 2023.
23 GoSL, 2015, *2015 Population and Housing Census Summary of Final Results: Planning a Better Future*.
24 Fifteen maternal and child health posts, 26 community health posts, fourteen community health centres, one government hospital, four private clinics, and two private hospitals; see GoSL, 2015, *Sierra Leone Basic Package of Essential Health Services*.

private clinics, and private hospitals is distributed throughout the rest of the district. Yet, there still is **only one health facility for over an average of 2,800 people and almost 3,000 people per bed**.[25] In terms of WASH, only 47.8 per cent of the population of Bonthe has access to an improved source of drinking water, and just 37.3 per cent can access an improved sanitation facility, while 41.1 per cent of the district practices open defecation.[26]

The 2019 *Demographic and Health Survey* (DHS) indicates that **48.1 per cent of women in Bonthe District have experienced some form of physical violence** since age fifteen, and that in 61.2 per cent of the cases a past or present husband or partner is the perpetrator.[27] The actual rates of domestic violence in Bonthe are likely much higher, as gender-based violence (GBV) of all forms remain grossly underreported in Sierra Leone due mainly to stigma, reprisal, ostracism, and inadequate, weak, and inconsistent response and support mechanisms.[28] The DHS also goes on to show that **41.9 of men in Bonthe believe that physical violence is justifiable against their female partner** if she burns the food, argues with him, or neglects the children, among other reasons.[29] **Women in Bonthe even more likely than men to believe that physical violence is as acceptable** if they violate social norms and expectations. This shows that not only does GBV occur in a context generally characterised by unequal power relations between men and women, with men having control over women's and girls' lives, but that many women have themselves accepted their disadvantaged position as the norm.



25 OCHA, 2015, "Sierra Leone – Bonthe", *District Profile*.
26 DHS, 2019, *Sierra Leone DHS 2019*.
27 DHS, 2019, *Sierra Leone DHS 2019*.
28 GoSL, 2023, *Gender Equality and Women's Empowerment Policy*.
29 DHS, 2019, *Sierra Leone DHS 2019*.



3. METHODOLOGY

The study design and methodology for this *Gender and Protection Analysis* was first detailed in an inception report that clarified and specified the assignment's purpose, objectives, and scope, as well as its approach, tools, activities, workplan, and milestones.

Based on the design and methods laid out during the inception phase, the *Gender and Protection Analysis* relied largely on a qualitative approach to primary research to conduct an analysis of gender and protection situation of the population in Jong, Kpanda Kemoh, and Yawbeko Chiefdoms. This was complemented with **a desk review that brought in quantitative data and qualitative research** from other studies, to round out and triangulate primary research.

3.1. SECONDARY RESEARCH

Desk research focused on survey data from the national census, DHS, *Multi Indicator Cluster Survey* (MICS), *Comprehensive Food Security and Vulnerability Analysis*, and other sources. The DHS is particularly important for providing district level statistics across the sectors covered in the *Gender and Protection Analysis* to help quantify the nature and extent of different protection risks. Additionally, secondary research considered **key government policies** form these sectors to help understand the access to rights that women have within formal legal codes and the judicial systems (for example: the right to title, inheritance, employment, atonement of wrongs, legal representation etc.), as well as protection issues impacting them. Further, desk research also analysed **existing qualitative studies on gender dynamics** in the country and protection issues. All secondary research/data were cited throughout this report.

3.2. PRIMARY RESEARCH

Primary research consisted of **key informant interviews** (KIIs) and **focus group discussions** (FGDs). At the district level, the study targeted important government and civil society stakeholders, as well as ACF management and staff. In each chiefdom, the study sampled the chiefdom capital, a community with a health facility (including a cross-section of CHCs, CHPs, and MCHPs), and two catchment communities. Interviews and/or focus groups were conducted with men and women from the stakeholders listed below:

- At district level:
    - Interviews with ACF staff, Bonthe District Council, *District Education Team*, *District Health Management Team* (including *Bonthe District Nutritionist* (BDN) and mental health nurse), CHWs, *District Agricultural Team*, *Ministry of Gender and Children's Affairs*, *Sierra Leone Police* (in particular the *Family Support Unit* (FSU)), *Ministry of Social Welfare*, *Ministry of Water Resources* (MoWR), health facility staff, non-governmental organisations/civil society organisations (CSOs).

- At chiefdom level:
    - **Chiefdom headquarters**: FGDs with community leaders (including women's leadership) interviews with health facility staff, FGDs with teachers and principals, and FGDs with women (either aged 18-25 years or aged 26-45 years).
    - **Health facility community**: interviews with health facility staff, and FGDs with community leaders (including women's leadership), and with women (aged 26-45 years), young women (aged 18-25 years), and young men (aged 18-25 years).
    - **Catchment communities**: FGDs with women (aged 26-45 years) and young women (aged 18-25 years), as well as with community leaders and young men (aged 18-25 years).

A total of 16 KIIs and 32 FGDs (with 200 female and 98 male participants) were carried out as part of the *Gender and Protection Analysis*; see *Annex B* for a detailed breakdown of study participants. Key informants and focus group participants were accessed through convenience sampling, with every effort made to **proactively include vulnerable groups** such as persons with disabilities (PWDs), female-headed households, adolescent boys/girls, the elderly, and others.

Study tools were adapted from existing resources used by ACF and others to carry out protection analysis across different sectors, as well as gender analysis on gender norms, roles and responsibilities, and access to and control of resources (see *Annex C* for the study tools). Interviews and FGDs were based on a semi-structured format, which was tailored to the knowledge of informants to guide conversations, but not by following a rigid format. KIIs and FGDs allowed for non-standardised follow-up questions that may vary between key informants, so as to conduct an in-depth analysis of key points, as they arise. FGDs were made up of 8-10 persons per discussion. As mentioned, FGDs were stratified both by sex and age.

3.3. DATA COLLECTION, ANALYSIS, AND REPORTING

Fieldwork was carried out by the consultant, with the assistance of a female research assistant and ACF staff. Before data collection commenced the research assistant was trained on the study approach, methods, and tools to ensure that all principles and guidelines, including those outlining safety, respect, confidentiality and non-discrimination.[30] Additionally, the research assistant was trained in the potential types of the physical and emotional harm that respondents could face by participating in the study and appropriate interviewing techniques, such as how to ask questions about sensitive topics.

Once fieldwork started, primary data was captured through a combination of **notetaking and digital recording**. Notes were compiled and analysed throughout the fieldwork process, while digital recordings were analysed

30 Gender-based Violence Area of Responsibility, 2010, *Working Group Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*.

further (as needed) when fieldwork finished. Analysis involved coding of important issues and using these to understand structural inequalities related to gender, as well as key protection risks in the chiefdoms being studied. **Quantitative data from secondary sources was used to complement primary research**, and is presented in tables and as part of narrative analysis. **Triangulating analysis** through different methods helped ensure a multi-faceted understanding of the root causes of vulnerability, including gender inequality, socioeconomic disparity, access and control over resources, etc., all of which is essential for **a comprehensive and gender-responsive protection assessments across different sectors**.

During fieldwork, communication was maintained with the ACF committee supporting this study in order to provide updates on the study's progress, initial findings, and any challenges that arose during its course. Analysis of all data used in this report unpacked the nature and causes of gendered vulnerabilities and protection concerns across all sectors in order to improve outcomes for women and girls.

Findings from the *Gender and Protection Analysis* were first presented at **a learning workshop** that discussed how preliminary conclusions could best be included in within the intervention to mitigate and prevent the risks to women, men, girls, and boys in Bonthe District. **Results from the learning workshop** were then incorporated into this report to understand the best approaches to address gender and protection issues to generate recommendations that could be incorporated into all aspects of ACF's programming cycle: design, implementation, and monitoring and evaluation. Initial drafts of this report were circulated among internal ACF stakeholders for feedback and revision. The definitive final report integrated feedback and revisions, in the sections outlined below.

3.4. ETHICAL CONSIDERATIONS

The highly sensitive nature of protection issues (especially GBV) poses a unique set of challenges for any data gathering activity that touches on such issues. Therefore, a range of ethical and safety issues were considered and addressed prior to the commencement of the *Gender and Protection Analysis*. Failure to make such considerations would have resulted in harm to the physical, psychological, and social well-being of those who participated in the study. Taking this as the starting point, best practices related to studying GBV[31] guided the design and implementation of the *Gender and Protection Analysis*.

Only respondents who provided informed consent could be interviewed. Those who did not grant consent were able to opt out of the study. Moreover, respondents were able to opt out at any other point during the course of the study. **The safety and security of all those involved in data collection was of paramount concern throughout the study.** Taking into account security as the overarching determination when choosing study sites, sampling strategy, tools and questions, training, movement and logistics in-field, interviewing practices, etc. Importantly, all data was anonymised and responses from interviews and FGDs were not revealed to anybody other than the consultant and the research assistant. Throughout the course of all research activities, it was deemed the role of the research team to promote a secure and comforting environment, and to proactively appraise situations for potential sources of insecurity. Because the *Gender and Protection Analysis* also dealt directly with questions around situations of violence, study participants who experienced GBV[32] were informed about their options to connect referral pathway, based on national level standard procedures, as per the *Sierra Leone National Referral Protocol* on GBV, where were adapted to represent the services available in Bonthe District.

31 WHO, 2016, *Ethical and Safety Recommendations for Intervention Research on Violence against Women.*
32 Two such cases emerged during the *Gender and Protection Analysis*. Both were referred to appropriate contacts along the referral pathway based on the circumstance of each survivor and the locations in which each case occurred.

3.5. LIMITATIONS

In implementing the aforementioned methodology there were a number limitations that impacted data collection.

These limitation and their corresponding mitigation strategies are presented below:

- Perhaps the main limitation was **the short timeframe** for the study to be conducted. Planning was important in overcoming this challenge. By working closely with ACF, and others to plan activities in advance, the research team was able to communicate to and prepare study participants. Mobilisation was conducted for all meetings scheduled with different stakeholder groups at community level. This included community mobilisation through CHWs, a key strategy to helping ensure that stakeholders are available when required to participate, especially in consideration of the Sierra Leonean farming calendar.

- Given the limited timeframe and the finite budget available for the *Gender and Protection Analysis*, it was **not possible to include quantitative data collection as part of the primary research**. Quantitative data was brought in from secondary sources – like the DHS and others – to triangulate qualitative research and help quantify the nature and extent of different protection risks. In many cases, secondary sources provided representative district level statistics, serving as a proxy for the chiefdom level primary quantitative research that could not collected through the *Gender and Protection Analysis* due to **time and budgetary constraints**.

- **The study did not include participants below the age of eighteen,** as this would have presented considerable ethical and methodological issues. This means that for groups like adolescents, only those 18-19 year-olds were interviewed. To the extent possible, interviews with government and civil society key informants were used to gauge gender and protection issues affecting girls and boys below the age of eighteen.

- **The consultant's inability to speak Krio and Mende** inevitability limited direct communication with research participants, especially for community level FGDs. Failure to address language barriers can threaten the credibility, transferability, and dependability of cross-language qualitative data. For this reason, **a research assistant was hired to assist with translation and interpretation** of research discussions. The research assistant had considerable experience in the research areas, including requisite language skills, having worked in Bonthe previously fro an extended period of time. The consultant and research assistant worked closely together throughout the project. This included ensuring that the objectives and methods of the study were well understood prior to fieldwork. As well, regular the research team regularly discussed preliminary study findings between research activities, to ensure a common understanding of the qualitative data being obtained.

- **The discrepancies noted below in terms of reporting GBV** are likely a reflection of the social stigma related to discussing the topic in a group setting. This study relied largely on FGDs. By comparison, a study like the DHS collected data through private face-to-face interviews, a methodological approach that is likely to create the rapport, trust, and sense of security required to openly discuss GBV. To more accurately gauge the prevalence of GBV in the study areas, the *Gender and Protection Analysis* used data triangulation, including through representative secondary sources.

4. GENDER AND PROTECTION ANALYSIS FINDINGS

This section outlines the main findings of the *Gender and Protection Analysis*, starting with an examination of the discriminatory gender norms, and how these influence gendered responsibilities and decision-making at the household and community levels. It later looks at gender and protection issues in the context of a number of other areas: livelihoods, food security and livelihoods, healthcare services, education, protection, GBV, MHPSS, and WASH.

4.1. DISCRIMINATORY GENDER NORMS

Social norms[33] play an important role in determining what is acceptable and expected in terms of gender relations in the community and home. Globally, discriminatory gender norms have proven to be an important risk factor in protection issues such as GBV.[34] In Bonthe District, as well, the *Gender and Protection Analysis* consistently found that an underlying factor to many gendered protection risks are the social norms that subjugate women in the sampled communities. Respondents across all stakeholder groups noted the harmful consequences of belief systems that support discriminatory social norms (see *Text Box A* for an example of discriminatory gender norms).

For instance, it will be shown below that discriminatory norms underpin **the acceptability of violence as a form of punishment** for women and girls that deviate from expected behaviour – see *Table 4* – in particular the expectation that women subordinate themselves to their husbands in fulfilling duties associated with homemaking and childrearing. As told by one key informant, "*men in our country treat women like their property, and think they can do whatever they want because men have all the rights*". Such thinking, and the controlling and violent practices that result from such thinking, have been sustained and entrenched over time **to stifle the perspectives, aspirations, and rights of women and girls**, putting at risk their physical security and emotional welfare. Many men interviewed are still deeply invested in maintaining the dominant position of males within Sierra Leonean society, arguing that giving "*too much human rights*" to women and girls makes them more "*quarrelsome*" and "*more difficult to control*". Women that push back against social control and expectations set by men in their lives can be violently punished.

33 Social norms have been described as "*expectations about action – one's own action, that of others, or both – which express what action is right or wrong within a particular social group.*"; see: Coleman, James, 1987, "Norms as Social Capital," In *Economic Imperialism: The Economic Approach Applied Outside The Field of Economics*, edited by Gerard Radnitzky and Peter Bernholz, 133–55.

34 Krug *et al.*, 2002, *World Report on Violence and Health*.

Table 1: Differences in Ownership of Resources between Men and Women in Bonthe[35]

	Females	Males
Own land	41.9%	59%
Own house	52.7%	67.3%
Own mobile phone	30.1%	56.2%
Own and use bank account	2.4%	9.6%

Table 1 also shows that the harmful social forces that suppress women in Sierra Leonean society have **practical and economic consequences**. Women have less ownership and control for each of the assets presented in *the table above*.

Of significance is that **only 4.3 per cent of all women own land alone** (37.6 per cent own land jointly with their husbands), while 29.6 per cent of men own land alone. This makes many women are dependent upon men, who often have final say over investments made on farmland and who generally control the proceeds from that land. **Without access to and control of resources** women are less able to engage in agricultural work, access collateral and loans, stay informed and in contact with family and friends, among other things. Further, it will be shown below that discriminatory gender norms have practical implications in the ways they impact female freedom by **limiting the roles females can take on** in the household and community and by **constraining female participation in decision-making** in the household and community. Women interviewed for the *Gender and Protection Analysis* reported wanting to have more freedom of movement, decision-making power, access to finances, and assistance with household work. In this regard, one woman noted that "*more help from the men with housework is good, if they are not in fields then they can be helping us more [in the house]*", while another said that "*if there was more freedom for us [women] with household money, like if the men gave us more control, then it would maybe make the food issue a bit easier to arrange*".

TEXT BOX A: DISCRIMINATORY GENDER NORMS

The following are **examples of discriminatory gender norms** mentioned during the study:

- A wife is a husband's property and she must defer to him on personal, interpersonal, and household matters.
- Women are expected to be accommodating and nurturing, while men are expected to be assertive and aggressive.
- Men are expected to have opinions and to express these freely in social spaces, whereas women should be deferential.
- Household work and childrearing are women's work that men hold little to no responsibility for.
- Women are more likely to be expected to take time on their physical appearance than are men.

35 DHS, 2019, *Sierra Leone DHS 2019.*

4.1.1. Gender Roles and Responsibilities

Gender inequality, resulting from discriminatory social norms and unequal power relations, continues to limit women's freedom and the extent to which they are able to benefit from economic activities. The *Gender and Protection Analysis* found that, within the household, norms shape attitudes about male and female responsibilities.

Women's labour is more likely than men's to be unwaged – in domestic work, and care of children and the elderly – or within small-scale agriculture and petty trading with low profit-potential. Traditional practices and gender stereotypes place **a heavy burden on women**. Apart from the considerable labour women contribute in the agricultural sector – from production and processing to marketing – they are also expected to carry out the majority of household chores (preparing meals, cleaning the house, washing clothes, fetching water and firewood, etc.), and caring work (taking care of children, elderly, PWDs, etc.), all the while often also contributing financially via income-generating activities like gardening and petty trading.

The daily activities of most women surveyed during the *Gender and Protection Analysis* start with bathing and dressing in preparation for prayers, after which they engage in housework: cleaning the dwelling, fetching water, doing laundry, preparing food, eating, etc. **After completing the house chores**, women may accompany children to school and leave younger children with family or other caregivers, before heading to the fields to **conduct agricultural activities** related to rice, cassava, and palm oil farming. In addition to assisting with farming that focuses on the family's main agricultural crops, women are **also responsible tending to their own gardens**. Women return from the fields between 3-5pm, depending on the time of year, to wash themselves and prepare for cooking dinner (collecting funds for food purchases, buying/collecting ingredients, fetching water, cooking dinner, and feeding children). **After dinner, from 7-8pm onwards**, women will be free to bath, pray, socialise, and prepare their children and themselves for bed. This analysis demonstrates that *"all household responsibilities are the role of women,"* as stated by one key informant. "*Taking care of children, cooking, fetching water, sweeping, and doing laundry are jobs that [most] men do not help with. Only some do. But when a man is done with the fields, his work is finished*", stated another.

Despite the amount of time women spend on labour and household tasks, many men are of the opinion that it is actually males that have the greater burden of work. This is primarily due to the fact that men included in the *Gender and Protection Analysis* frequently devalued household and caring work, emphasising the difficulty of the types of labour-intensive farm work that men are typically responsible for. Their perspectives do not adequately take into account the fact that women also conduct considerable agricultural work.

Women also often agreed that the total of burden of work placed on men is as great, if not greater, than their own. This indicates how deeply normalised is the subservient position of women in Sierra Leonean society, and the devaluation of unproductive labour in Sierra Leonean society. To the point that **even women are often not able to see the value of their own labour**, or fully appreciate the associated the persistent difficulties, strains, stresses, and time burden performing such labour places upon them. The labour that men do is undoubtedly difficult. But study participants also indicated that much of it is also seasonal and/or periodic – such as work done during the farming season – whereas **the household and caring responsibilities that women have are constant throughout the year**. "*Women have more daily tasks. Women do more, even if men focus on how hard their work is*", said one woman involved in a FGD in this study. "*When men are doing farm work it is seasonal, and even brushing [on the farm] might be done once in a month, or every couple of weeks. So men's work happens yearly or seasonally. But women's work is all the time*".

For both men and women, work increases March-May, which are the sowing seasons for rice and cassava[36] and peak harvest times for palm oil, as well as during October and December, when rice is harvested. Yet, women are **also required to spend time year round** performing unpaid domestic and care work, on top of the work they do in the fields. According to one study, female adults living in rural areas in Sierra Leone spend a total of **46.4 hours per week on domestic work areas**, as compared to 23.3 hours for adult males in the same areas.[37] Thus, rural women spend about two times more time than rural men on domestic work, engaging in a burden of domestic work essentially represents a full-time occupation. This has major implications for their general empowerment – for instance, their ability to undertaken gardening or petty trading. As indicated below in *Text Box C*, the considerable burden place on women due to their domestic roles has far-reaching effects, even impacting the health of others in their households – like breastfeeding infants.

4.1.2. Decision-making in the Household

The *Gender and Protection Analysis* found that **many women in the district do not participate in many of the decisions that impact them and their families**. Most participants indicated that a male is the head of their household, mirroring national trends whereby almost three-quarters of households in the country identity as male-headed.[38] **As the heads of households**, men have the final say in most important household decisions on behalf of the family.

In particular, the man controls household finances and makes decisions over investments and big purchases. One woman's explanation regarding the economic power imbalances and decision-making in her home was as follows: "*it is the man that is making the decisions in the home, and even I have to ask my husband for money everyday*". **Men's control over finances disempowers women**, even in those areas where women are thought to have decision-making authority, as with childcare. While mothers are responsible for taking care of children on a daily basis, men actually hold considerable control over major decisions related to their children's lives. One example is in the case of a child's education, where fathers frequently feel they should have final say because they "*are the one's paying the school fees of the children*". Overall, women's economic reliance on men makes them more susceptible to controlling behaviours by those same men, putting them in vulnerable positions that undermine their well-being and security. Men might deprive their wives of food, or money for food, clothes, and other household expenses.[39] **Denial of finances, other resources, or services is itself a form of GBV** that can have a significant impact on the well-being women and children, as they rely a husband's willingness provide income for food, healthcare, education, etc. But it also makes it more likely that other forms of GBV – such as physical and sexual violence – will go unreported and unaddressed, since women are **unwilling jeopardise access to income and other resources** for themselves and their children.

If women do not receive funds for food, because their husband has denied them or does not have any money to provide, they must **source food in whatever way they can**; this is especially true for wives in polygamous unions (see *Text Box B*), who are responsible for what men often referred to as "*their [meaning the wife's] children*". When money for food is unavailable or insufficient, women will buy food on credit, or go to the farm to look for cassava or go into the bush in search of wild cassava. Even if a husband provides food and housekeeping funds to his wife, and the household and housekeeping are seen a in control of women, the husband likely **still decides the food the household consumes on any given day**.

36 Second year cassava harvests also take place January to June, see: FAO, "SMIAR - Système Mondial d'Information et d'Alerte Rapide", https://www.fao.org/giews/countrybrief/country.jsp?code=SLE&lang=fr (20 March 2023).
37 Wodon, Quentin, and Yvonne Ying, 2010, "Domestic Work Time in Sierra Leone", *MPRA Paper* No. 27736.
38 World Bank, "Female headed households (% of households with a female head) - Sierra Leone", https://data.worldbank.org/indicator/SP.HOU.FEMA.ZS?locations=SL (19 February 2023).
39 It is troubling that men themselves often believe it is appropriate they enjoy more power because they are control the main income-generating activities in their households, even though the burden of work place on women may actually be higher due to their many household responsibilities.

For example, according to one man: "*if I have money and I give it to the wife then I have the right to tell her what I want to eat. If she does not listen then she might not get money for food for her and her children the next day*". "*If a man sees a woman pounding cassava and he wants something else, she must throw it out and start again*", said another key informant. These opinions were commonly expressed. Even among many men who professed a desire for greater gender equity, there were **limits to how many rights they believed women should have**. For example, in a discussion about *Sierra Leone's Gender Equality and Women's Empowerment Policy*[40] – which creates quotas for female representation in the workforce, sets minimums for maternity leave, and offers equal access to bank credit and training opportunities – a man stated that "*yes, men and women should be equal, but not fifty-fifty. Sixty-forty [in favour of the man] is ok*"; the group around him widely agreed.

As researchers in other settings have shown, **merely increasing the availability of economic resources women have is insufficient to meaningfully impact their decision-making and control of household resources**; doing so also requires concurrent increases in women's agency.[41] This is because **the controlling behaviours that men enact over women are pervasive**, extending well beyond the economic sphere, inhibiting their ability to fully participate in many personal and interpersonal aspects of their lives. Secondary data supports these findings, showing that less than one-quarter (24.6 per cent) of married women in Bonthe usually make major household decisions – about their own healthcare, major household purchases, or visits to her family – either by themselves or jointly with their husband.[42] What is more, this study found that even in those households that claim decisions are made by both the husband and wife, most concede that **final decision-making authority is given to the husband**. For instance, one man said that "*if I want to take another wife then my first wife can complain to me, and it is up to me to listen to her. But I will then decide what to do*". This quote also shows that **polygamy** (for more information on polygamy and gender see *Text Box B*) is another factor that can **put the well-being of girls and women at further risk**, as well as increase the chance that they could be left economically insecure if the husband favours his other wives.

TEXT BOX B: POLYGAMOUS MARRIAGES

The proportion of married men in Bonthe that have two or more wives is 15.4 per cent.[43] The perception exists among study participants that wives and children from polygamist relationships are **likely to be worse off in their access to income, food, and other resources** than are those in monogamous relationships. This is because already scarce household resources must be spread among a number of wives and more children. In those households where a husband has multiple wives respondents believed that the husband is also less **likely to be involved in the care of children**. Existing research also suggests a link between polygamy and negative development outcomes such as low levels of education and lower wealth quintiles.[44] As in all other households across the district, a husband is the designated head of the polygamous household, making decisions about the distribution of finances and other important decisions. Wives living in polygamous households must negotiate on-going access to income or any other collective resources, based on the discretionary control of their husband. Beyond the consumption of food there is **minimal communal use of collective resources**.

40 Macaulay, Cecilia, 2023, "Sierra Leone Passes Landmark Law on Women's Rights", *BBC*, 20 January, https://www.bbc.com/news/world-africa-64348892 (11 March 2023).
41 Peterman, Amber, *et al.*, 2015, "Measuring Women's Decisionmaking: Indicator Choice and Survey Design Experiments from Cash and Food Transfer Evaluations in Ecuador, Uganda, and Yemen," *IFPRI Discussion Paper.*
42 DHS, 2019, *Sierra Leone DHS 2019.*
43 DHS, 2019, *Sierra Leone DHS 2019.*
44 DHS, 2019, *Sierra Leone DHS 2019.*

"*[Usually] where there is more than one wife, each one has her children and the all eat alone. They will even have their own farms, even the can help each other [too] sometimes*", said one female FGD participant. Wives in polygamous marriages reported using the money that was given to them, primarily for the well-being of themselves and their children rather than for the whole household. This money was supplemented by **any additional income that each wife managed to earn individually**. The result is a specific form of competition[45] within polygamous households, as wives compete for access to communal finances for themselves and their children – a dynamic that is exacerbated in a context of scarce resources.[46]

4.1.3. Decision-making in the Community

At the community level, traditional systems in Bonthe District are also mainly administered by men, making male chiefs and other male community leaders and authority figures the gatekeepers for decision-making. In FGDs it was suggested that male chiefs and elders usually deliberate big community decisions, and then delegate those decisions to other members. In such spaces, women's voices are less likely to be heard. This means that local leadership is less likely to protect the rights of women or take their perspectives into consideration in community life. Some of this dynamic can be observed even in the context of FGDs with community leaders, in which females are grossly underrepresented, and during which it is typically males that dominate the conversation. Greater representation of women in these structures may help make them **less discriminatory in the long-term**. Still, it should be said that **representation alone does not ensure the uptake of gender-sensitive issues** that benefit as many women and girls as possible. Most district, chiefdom, and community structures have some representation from women's leaders. However, if women are included and not listened to by the men in power then the issues that are important to them will continue to be marginalised.

45 Not all social interactions in polygamist households are defined by competition. There is also good level of harmony or cooperation in these households. For instance, one key informant explained that a co-wife that is a lactating mother who cannot currently carry out any farm work, so she conducts that work until the mother is able to again. Other key informant said that wives help each other by working each others plots of land on a rotational basis.

46 Two particularly important factors that determine influence in this regard are thought to be a woman's rank in marital order and her favour with the husband; see: Trócaire, 2017, *Understanding Women's Lives in Polygamous Marriages: Exploring Community Perspectives in Sierra Leone*.

4.2. LIVELIHOODS

Poverty was the most frequently cited development issue cited among study participants in the *Gender and Protection Analysis*. Key informants and FGD participants across all stakeholder groups and geographies repeatedly identified it as a key issue affecting people's lives. *Table 2* indicates that, while poverty affects both males and females there are ways that **poverty affects women and girls more acutely**. By measures of multidimensional poverty rates in Bonthe District[47] there are only slight differences in terms of sex. But switching instead over to examine economic measures of poverty shows that more women live below the poverty line than men by a considerable amount. Not surprisingly, national employment statistics also show that men are more likely to be employed than are women. When we consider paid versus unpaid work, gender disparities are even greater, with almost **twice as many women than men doing unpaid work**. As stated previously, women take more unpaid reproductive labour, comes at the expense of conducting economically productive activities full-time.

Table 2: Difference in Economic Well-being between Men and Women

	Females	Males
Multidimensional poverty (Bonthe)[48]	81.2%	80.4%
Proportion living below the poverty line (Bonthe)[49]	48.3%	39.7%
Employment rate (national, including paid and unpaid work)[50]	84.7%	94.1%
Percentage of unpaid employment (national)[51]	53.9%	27.2%

The *Gender and Protection Analysis* found that the disparities that men and women have in economic opportunities undermine not just the socioeconomic position of women, but it also increases their overall vulnerability to GBV. The implications of women's low economic status within their household limits their ability to escape domestic violence, or speak out against abusive partners, given that reporting cases can have financial consequences for women and their families. For instance, a common collective response to GBV in the communities surveyed is to establish bylaws that fine perpetrators of domestic violence. Because of this, **reporting one's husband or partner creates direct financial costs for one's household**, where men are also their primary source of income for women and for their dependents. As one woman explained, "*fining and punishing a husband might take money away from the family. So the wife might be more likely to be in poverty, and her children also. Some may want to say something. But there is a cost for the family*". "*The problem is that if a husband will be imprisoned then who will be my husband now, so people will not speak up. So that is why many cases are compromised*" explained another.

4.2.1. Agricultural Livelihoods

As in the rest of Sierra Leone, agriculture is the main economic activity for the vast majority of people in Bonthe District. Across the district, 81.7 per cent of all households are considered "*agriculture households*", in which at least one family member is involved in crop farming, livestock production, or fishery activity.[52] The primary crops that are grown by most households are **cassava, rice, and palm oil** (detailed below), depending on the location. With the exception of the district capital – Mattru Jong – communities in the sampled

47 There is even greater parity when it comes to poverty rates: 68.4 per cent of females and 68.2 per cent of males are poor according to multidimensional poverty measures.
48 GoSL, 2015, *Sierra Leone 2015 Population and Housing Census Thematic Report on Poverty and Durables*.
49 UN WOMEN, "Women Count: Sierra Leone", https://data.unwomen.org/country/sierra-leone (3 March 2023).
50 DHS, 2019, *Sierra Leone DHS 2019*.
51 DHS, 2019, *Sierra Leone DHS 2019*.
52 GoSL, 2015, *Sierra Leone 2015 Population and Housing Census Thematic Report on Agriculture*.

chiefdoms depend on smallholder subsistence agriculture as their main means of livelihood. "*There is just enough to eat and very little to sell*", explained one rice farmer, in a description of agricultural output that is applicable to many of the farming communities sampled in this study. Key informants at the Ministry of Agriculture indicated that due to the **small-scale levels of production** of smallholder farmers in Bonthe, any shocks they experience – large or small – can have consequential impacts on their incomes, and thus on their food security. Low agricultural yields are susceptible to be **impacted by the following shocks** according to study participants: floods, pests, and variations in weather due to climate change.

While women are heavily involved in most stages of the cassava, rice, and palm oil value chains, men are the main earners and controllers of the proceeds from farming. A husband then distributes a portion of the income to his wife – or wives – for food, children's education, and other household expenditures. In addition, as heads of their households, husbands are generally also designated to make key decisions about agriculture like: what crop to grow, how to distribute of labour on a daily basis, where and for how much to sell the produce, how to use of agricultural profits, etc. One issue that especially affects women in the context of agricultural livelihoods is **land ownership**. There are many men and women in the district that do not own any land. Landless families must lease from landholding families. Women report face relatively higher barriers to land ownership, and especially control of land, despite protective legislation aimed at making land ownership more equal.[53] As showed above in *Table 1*, only 2.3 per cent of landowning women own land alone, compared to 19.9 per cent of landowning men,[54] meaning that many wives have nominal ownership of land, but must rely on their husbands to access that land. As one woman said, "*the land is [usually] controlled by the husband. For those that are widowed they have inherited their husband's land. [But otherwise] it's up to husband to decide if he gives a bit to the wife for her garden*". Another female focus group discussant added that: "*many families must lease land [because they have no land ownership]. But in [even] in those landholding families, it is the men that take the final decisions about agriculture*". Therefore, **traditional patrilineal systems of inheritance** interfere with legal rights and undermine gender equity, affecting women's capacities to benefit economically and socially from agricultural activities. Without owning land women are denied a vital source of collateral, and miss out on the financial security and social standing that property ownership offers.

4.2.1.1. Rice

Although there also exists the potential for some large-scale development of inland valley swamps in for higher-yield rice farming, **most farmers cultivate small family plots due to a lack of mechanised tools and other resources** with which to undertake swamp development. Key informant interviews with the Ministry of Agriculture indicates that traditional methods are still widely used to process rice, which contributes to high post-harvest losses during harvesting, threshing, drying, and milling. Further, **farmers' access to markets is limited** by long distances, poor road networks, and a lack of transportation options, depressing farm gate prices to the advantage of middlemen and wholesalers. Despite the recent implementation of *Sierra Leone's Gender in Agriculture Policy*[55] **women still face many impediments in rice farming**, and indeed in the agricultural sector as a whole. Important barriers that women farmers reported as part of the *Gender and Protection Analysis* include: inadequate access to extension support, productive inputs, and financial services, as well as discrimination in leadership opportunities among farmers-based organisations (FBOs) and *Agricultural Business Centres*.

53 *The 2015 National Land Policy* is designed to safeguard tenure rights, based on the principles of the *Voluntary Guidelines on Governance of Tenure* (VGGT), to ensure equal access to land and tenure security and protect the rights of all citizens without any form of discrimination; see: FAO, "Addressing the Voluntary Guidelines in policies and laws", http://www.fao.org/tenure/activities/policies-laws/policy-and-legal-reforms-in-sierra-leone/en/ (27 February 2023).
54 DHS, *2019, Sierra Leone DHS 2019.*
55 GoSL, 2020, *Gender in Agriculture Policy.*

4.2.1.2. Cassava

Cassava is the second major staple after rice in Sierra Leone, and is widely grown in many communities sampled in Bonthe District. The Southern Province – where Bonthe is located – leads in cassava production across the country. Men are engaged in the land preparation aspect of production while **women tend to play the dominant role in the planting, weeding, harvesting, and processing**. Most processing is done using traditional methods, making this activity consuming for women in terms of energy and time. Most cassava farmers focus on cultivating roots over leaves, even though leaves are a good source of protein and various vitamins. Cassava is either harvested for personal consumption, or sold – usually unprocessed – to purchase household's preferred food, which is rice.

4.2.1.3. Palm Oil

Palm oil is another key commodity in Bonthe District.[56] This study found that palm oil producers work mostly on an **artisanal scale**, generating crude palm oil for the local market using traditional methods. Women are involved in all segments of the value chain, from palm fruit and kernel production and processing to trading and retailing. **A heavy reliance on traditional processing methods increases workloads**, as manual processing of palm kernels is labour intensive and requires a considerable physical effort and heavy time burden. Despite women's participation in palm oil production, they are typically do not control the majority of profits from palm oil sales, even though they are generally the ones bringing the oil to market.

4.2.2. Other Livelihood Sources

In order to supplement the income available to them, and help overcome discriminatory practices that given control of agricultural profits to men, many women reported undertaking additional income-generating activities. The most often cited sources of alternative income generation are gardening or petty trading. A smaller portion of women indicated engaging in other income generating activities like selling charcoal or doing casual farm wage-labour. Women generally retain and control the profits they earn from alternative income-generating activities. Although considerably smaller than earnings from farming, proceeds from gardening or petty trading are an important supplementary source of household income that is **primarily put towards food consumption**. Anything leftover is usually added towards expenses related to clothing, school, health, etc. As said by one female FGD participant, *"what the women sell they control. It goes for school and for feeding. What the husband makes he controls and gives some for food and I don't know what he does with the rest"*. Another woman similarly said that "*the money women can make from trading or from the garden work is small [compared to farming]. But it is theirs and can help when there is not enough money [offered by the husband]*".

In terms of **income from vegetable gardens**, these are cultivated by women in mixed vegetable[57] backyard gardens[58] or via intercropping[59] on farmland with crops like rice. If vegetable yields are of sufficient quantity, women will bring these to market to sell for income. Otherwise, vegetables will be consumed as part of the household diet. Due to high perishability of many vegetables, women need to sell their produce quickly, often

56 VCA4D, 2019, *Palm Oil Value Chain Analysis in Sierra Leone*, Number 11, January.
57 Popular vegetables like eggplant, okra, onion, tomatoes, hot chilli peppers, and others are found all around Bonthe District. Vegetables and cassava leaves take about one month each to harvest, okra takes 3-6 months, while certain types of take up to a year.
58 Water shortages – exacerbated by climate change – are a problem for vegetable cultivation during the dry season. To mitigate problems associated with access to water, women living in those communities with access to swampland can move gardening activities there during the dry season, while relying on backyard gardens during rainy season to avoid losing crops to flooding.
59 In the instance of intercropping, men might handle labour-intensive tasks such as clearing brush, ploughing, and harrowing, while women work on planting, crop maintenance, and almost all post-harvest activities.

at low prices. Key informants were rarely able to estimate the incomes generated from vegetables, indicating that profits from what is sold is generally put directly into food purchases and other household expenditures.

The same is true for **petty trading of goods** such as cigarettes, *maggi*, and other small consumables. All profits are automatically "*put it back into the family pot*" – that is, putting it straight into purchases of food for the household. Sales from petty trading are usually on a scale so small that study participants were unable to estimate the incomes they earn. The few that were able to estimate their earnings indicated that the make approximately SLL 5,000-10,000 every week, or so.

4.3. FOOD SECURITY AND NUTRITION

According to the *Sierra Leone National Nutrition Survey 2021*, **Bonthe District has one of the highest levels of acute and moderate malnutrition in the entire country among in children 6-59 months**.[60] The survey also indicates that the level of stunting in Bonthe is 23.3 per cent, compared to 26.2 per cent at the national level. The district also has global acute malnutrition rate of 6.4 per cent, which is roughly equal for boys and girls.[61] According to *Gender and Protection Analysis*, cases of malnutrition are **most prevalent among children in poorer households,** where a large percentage of household income goes towards food expenditures. "*Very poor households are the ones that are likely to have cases of malnutrition. Some households are so poor they do not even have enough money for a lantern in their house*", said a key informant form within the health sector. Such statements were common across the study.

As one of the poorest districts in the country, Bonthe has a high reliance on food expenditures as a percentage of total income.[62] As a result, many households in the district are very vulnerable to the high inflation[63] that has emerged in the aftermath of the COVID-19 pandemic, the war in Ukraine, and other global shocks. **Rampant inflation** is contrasted against stable or even deteriorating incomes across the country[64]. The *Gender and Protection Analysis* indicates that the **nutrition conditions across the district have deteriorated** due to decreased overall purchasing power of already-small incomes. The prices of staple foods such as rice and cassava have risen sharply, mirroring a trend seen across the country.[65] The situation of vulnerable populations, such as those in poor households, female-headed households, PWDs, the elderly, and others, may be especially dire, given their lower overall economic status. For instance, the study indicated that PWDs and elderly persons who are unable to work must rely on family, or sometimes extended family or neighbours, to take care of them. The ability and willingness of family and neighbours to do so depends on them having food to spare. Given the qualitative focus of the *Gender and Protection Analysis*, it was not possible to quantify the effects the worsening economic situation has had on nutrition and food security in Bonthe, but available national statistics indicate that **the proportion of food insecure Sierra Leoneans has increased from 44 per cent in August 2019 to 78 per cent in February 2022**.[66] Given the aforementioned qualitative findings, it is likely that these trends hold at the district level as well.

Another important cause of food insecurity and malnutrition reported through the *Gender and Protection Analysis* was the **limited intake of nutritionally diverse foods**. Overall, the study found that most people in the intervention communities do not eat nutritious food. "*When you look at the [FSMS], the district has been in the red, food diversity in district has been weak and this creates problems with nutrition*", said a key informant from the District Council. "*The chiefdoms in-land that we are a bit better off than those on the coasts in harder to reach areas. Still they are not that food secure. Most people only eat once a day*". Even those that have gardens **will prefer to sell their vegetables than consume them** in favour of rice. As said by another key informant: "*food diversity is not practiced here. Families focus on carbohydrates. Poverty affects this because there is so little money to put towards food, so people will buy up rice to fill up, rather than focusing on proteins and other foods that are higher in nutritional value*". As mentioned above, many women undertake gardening of vegetables to supplement their incomes. Vegetables are an important source of vitamins and minerals, especially Vitamin A rich dark green leafy vegetables, including

60 GoSL, 2021, *Sierra Leone National Nutrition Survey 2021*.
61 WFP, 2021, *State of Food Security in Sierra Leone 2020: Comprehensive Food Security And Vulnerability Analysis*, May 2021.
62 WFP and GoSL, 2023, *Sierra Leone Food Security Monitoring System Report*, February 2023.
63 While inflation drive by COVID-19 and other shocks has had a serious impact on livelihoods and food security, it can only be partly attributed to the deterioration of food security. As already discussed, agriculture yields are generally low. Out-dated agricultural methods and lack of quality agricultural inputs contribute to low yields, while high harvest and post-harvest losses and poor access to markets all also contribute to food insecurity in the district.
64 The FSMS indicates that the proportion of households in Sierra Leone with acceptable expenditure spending less than 50 per cent of their total expenditure on food reduced to 5 per cent in February 2023 from 20 per cent in December 2020; see WFP and GoSL, 2023, *Food Security Monitoring System Report*, February 2022.
65 *Rédaction Africanews* and *AFP*, 2023, "Inflation Bites into Sierra Leone's All-important 'Cookeries'", 16 January, https://www.africanews.com/2023/01/16/inflation-bites-into-sierra-leones-all-important-cookeries/#:~:text=As%20of%20November%2C%20the%20latest,died%20of%20Ebola%20in%202014 (11 March 2023).
66 WFP and GoSL, 2023, *Food Security Monitoring System Report*, February 2022.

krain krain (jute), sweet potato and cassava leaves. However, there seems to be an **overall lack of knowledge in terms of nutrition and food diversity**, and there is **considerable misinformation** about consuming certain types of foods. Some believe, for example, that eating pumpkin can make one's child a witch, while consuming eggs will cause your child to steal. Similar stories apply also to plantain, snails, chicken, crab, and other foods. "*There are nutritious foods that the mother doesn't eat, and there are negative nutritional effects on the mother and the child*", said one key informant from the health sector. "*We even did cooking demonstrations along with awareness raising. But it took a long time. In some communities it took three years to change*". Study participants suggested that cooking demonstrations that used a participatory approach that included community members both in the preparation and eating of food were most effective.

In view of low-income levels and increasing market prices, **many households cannot afford a diverse diet on regular basis**. "*If you tell somebody to eat an egg, that egg is SLL 4,000 and most persons here will not be able to afford that*", said one key informant from the health sector. "*Most people prefer to sell what they grow in their gardens and not keep for themselves the more nutritious food. They sell most of it*". This has important implications for nutritional well-being, especially among vulnerable groups, such as pregnant and lactating women (PLW) and under-five children.

As mentioned above, **68 per cent of the population of Bonthe District is food insecure and 17 per cent of that group are severely food insecure**.[67] The majority of participants in the *Gender and Protection Analysis* said that they have insufficient food to eat. Most stated that they eat just once per day. Only a small group of respondents from Mattru Jong **eat twice a day**, preparing dinner in the evening and then consuming its leftovers the following morning; they may also consume porridge, *garri*, or bread in the morning, when sufficient leftovers are unavailable. Even among those that only eat once a day, key informants reported that the increasing unaffordability of food makes it necessary that they employ different strategies to cope with food insecurity. The most frequently cited coping mechanism is to **purchase foodstuffs on credit**. Because the responsibility for sourcing food typically falls to females, the heavy reliance on credit to source food creates **a significant source of economic and emotional stress** in their lives. Other strategies households use to cope with insufficient food include: reducing the amount the preferred food (usually rice) that they eat, reducing the amount of food eaten (especially among adults), and consuming food without sauce or condiments. Despite being in the country's coastal food crops and fishing livelihoods zone, **few interviewees reported consuming meaty fish protein**. Where fish was eaten, it was usually just small amounts put in sauces for flavouring.

67 WFP and GoSL, 2023, *Sierra Leone Food Security Monitoring System Report*, February 2023.

4.4. HEALTHCARE SERVICES

The health facilities sampled during the *Gender and Protection Analysis* provide maternal, newborn, and children health (MNCH) (including antenatal care (ANC), labour and delivery, and post-natal care); cases involving complications during pregnancy, including emergency obstetric and newborn care (EmONC), require referral to a hospital facility. Most facilities sampled also provide services such as: health education, family planning and reproductive health services, child health services (including the expanded programme for immunisation (EPI)), nutrition, as well as diagnosis and treatment for malaria, typhoid, sexually transmitted infections, etc. While it can generally be said that human capital, in the form of health training and skills, is not an impediment to patients receiving services, there are **a number of other important bottlenecks that undermine the provision of services** in the health sector in Bonthe: cost of healthcare, distance to facilities, negative interpersonal interactions at health facilities, and treatment through alternative providers.

4.4.1. Barriers to Accessing Healthcare

4.4.1.1. Cost of Healthcare

In 2010, Sierra Leone introduced the *Free Healthcare Initiative* (FHCI) for PLW and children under five, formally **abolishing user fees for a basic healthcare package**. Other studies suggest that the FHCI has led to greater uptake of government health services.[68] Still, participants in the *Gender and Protection Analysis* described paying for healthcare – including the expectation to pay for services that should otherwise be free – as a key barrier to accessing services at facilities. To begin with, there are **indirect costs to accessing healthcare** for patients traveling long distances, who will require food to eat and might even need a place to stay overnight, adding to the indirect cost of accessing healthcare. As well, respondents accept that will inevitably be forced to pay for some services, even if most are aware of the FHCI. Given that the FHCI is focused on PLW and under-five children (that mothers are usually the primary caregivers for), **any additional expenses** incurred at health facilities are much more likely to be incurred by women.

As in the rest of Sierra Leone, health personnel in Bonthe do not get paid on time regularly, and earn little even when they do get paid.[69] Therefore, many are reliant upon some form of payment from patients in order to earn a steady income. The requirement to have money at hand to pay for health services is described as '*a show appreciation*' – not an outright bribe – that recognises the skills and work of the hospital staff. "*You are not forced to pay. But if you give birth and it is safe, then you must do something. Although I am not paying anything, you must at least give a sign of appreciation*" Such '*appreciation*' **payments might be paid to the staff directly** attending to the delivery, as well as to those playing support roles, creating a significant cost for cash-strapped households. While most people are willing to pay in this way as part of a birth, which is a significant and infrequent health event, they may be unwilling or unable to '*show appreciation*' for other services, despite social pressure to do so.

National estimates suggest that more than half of health expenditures in Sierra Leone come from individual out-of-pocket payments.[70] Medications are major expenditure according to the *Gender and Protection Analysis*. Frequent stock-out of drugs at health facilities were mentioned at every facility visited during

68 Diaz, Theresa, *et al.*, 2013, "Healthcare Seeking for Diarrhoea, Malaria and Pneumonia among Children In Four Poor Rural Districts in Sierra Leone in The Context Of Free Healthcare: Results of a Cross-Sectional Survey", *BMC Public Health* 13 (157).

69 Facilities themselves suffer from insufficient funding. For instance, they often lack lights and clean water. Solar panels that have been provided to many facilities are usually not functional. Late-night deliveries are done by flashlight, or by using the lights on phones, and water is drawn from streams to clean facilities before/after deliveries because the facility's water pump might be broken.

70 World Bank, "Out-of-pocket expenditure (% of current health expenditure) - Sierra Leone", https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=SL (19 February 2023).

the study – even for medications for PLW and under-fives. To deal with drug stock-outs, health facility staff either purchase medicines themselves, selling drugs to patients on a cost-recovery basis, or writing patients scripts to be redeemed at private pharmacies. Paying for medication or other services makes it more difficult for females to access healthcare, as women are often required to seek permission from their husbands before seeking medical care, since it is the man that controls the household finances that cover any health expenses she incurs. Where the household is poor, household economic resources are low, or the husband does not prioritise the health needs/services being sought, he may choose not to authorise or fund the health visit.

4.4.1.2. Distance to Health Facilities

Another major obstacle to reaching health providers is the distance that people have to travel. Accessibility to health facilities is an issue especially for residents in distant catchment communities. According to Sierra Leone's 2015 census, 25.9 per cent of people in Bonthe District live more than five miles from the nearest health facility, while another 23.1 per cent live 1-5 miles away.[71] The inaccessibility of safe and affordable transport from the home to the health facility means that women have to walk along bushes roads to access health care, even to give birth. In emergency cases, travel to health facilities is done by **public transport** – usually a motorbike taxi. As fuel prices continue to increase, access to facilities – even for emergency cases – may become prohibitively expensive. Occasionally, a woman may be carried to a health facility in **a hammock**. But this mode of transport is reliant on enough people – usually men – being willing and able to carry her. **Ambulance services do exist in Bonthe District, but are notoriously difficult to access.** To begin with, ambulances are frequently unavailable due to mechanical issues. But even when a working ambulance is available, requesting one can be time-consuming. To secure an ambulance, health staff must call the *National Emergency Medical Services* (NEMS) dispatch centre in Freetown that connects them to a dispatcher in their district, after which they must undertake an interview with a nurse about their patient's vitals. Only after this screening process can an ambulance be dispatched. Those especially in remote communities will risk the delays cause through this process and will simply encourage patients and their families to hire a public transport. KIIs and FGDs indicated at least three maternal deaths that resulted from inadequate access to emergency transport, because pregnant women were not able to access a health facility or were not referred to a hospital in time to address complications that resulted during birth. **Challenges in accessing health facilities contribute to what is the worst maternal mortality ratio in the world**; in Sierra Leone 1,360 mothers dying per 100,000 live births.[72]

Accessing health facilities is particularly difficult in rainy season – from May to November. During those months, some areas are completely cut off from access to facilities due to flooding. When this happens, patients must **wade through knee-high water** or pay for **canoe or boat transport** to access health services, creating considerable obstacles and making it less likely that they come for anything other than the most severe cases. Or a patient will delay seeking healthcare until his or her case is serious, which can result in serious complications and even death. Although it is important to note that maternal and infant deaths occur all year round. The rainy season exacerbates communities' ability to access health services due to long distances and lack of transport, in ways that directly impacts upon infant and maternal mortality.

MNCH is also affected in other ways by distance to health facilities. In particular, health sector staff interviewed stated that the inconvenience associated with accessing healthcare prevents many women from getting full ANC. One health worker said, for instance, that "*transportation issues for facility access are*

71 GoSL, 2015, 2015 *Population and Housing Census Summary of Final Results: Planning a Better Future*.
72 Mason, Harriet, 2016, "Making Strides to Improve Maternal Health in Sierra Leone", *UNICEF*, 26 May https://www.unicef.org/stories/making-strides-maternal-health-worst-place-to-be-mother (6 March 2023).

a problem pregnant women especially during ANC. There will be challenges [with getting healthcare] and they will not come right away. Many women will remain at the home until the pregnancy is already far advanced". "*Some join halfway through pregnancy, or some right before they deliver. They have information, but will not come because of the distance and because they believe there is no time and it is not important*", said another key informant at a health facility. Many others said similar things as well. Although statistics indicate that 98 per cent of women in Sierra Leone receive ANC from skilled health provider,[73] more than half of pregnant woman had their first ANC visit four or more months into their pregnancy.[74] A small percentage – 1.5 per cent – will not get any ANC at all. **Exclusive breastfeeding in the first six months** is another important area of MNCH where challenges still exist in Bonthe District (see *Text Box C*).

TEXT BOX C: EXCLUSIVE BREASTFEEDING

Sensitisation around exclusive breastfeeding for the first six months of life is another important area of focus for MNCH. "*Some of the mothers prefer to give their kids glucose biscuits and cornmeal, even at 2-4 weeks. So the [health] staff and the CHWs must work hard to convince them to only breastfeed*", said a CHW, echoing opinions from across interviews with health providers, who likewise said many mothers do not practice exclusive breastfeeding for the first six months. "*We give health talks to communities about breastfeeding. The mothers have the knowledge and will tell you everything you want to hear, but they just don't do it*", said one CHW, explaining the different barriers to exclusive breastfeeding. "*In the end they will tell you that the breast [milk] is not enough, or they will say* 'I have too many children and things to do to just sit down with one child for so long'. *Or some mothers [do not themselves have sufficient food to eat] and have too many chores, so they do not feel like they have energy or time*". KIIs and FGDs indicate that **the onerous time expectations of women's gender-mandated social roles are an impediment to the health of their infant.** Relieving mothers of their household duties, by getting men to take more responsibility for household work, can have important positive effects on child health.

4.4.1.3. Negative Interactions at Health Facilities

Decisions about where to seek healthcare are also influenced by previous experiences of treatment. Even health staff interviewed for this study conceded that impolite treatment by medical professionals – including staff being rude, judgemental, and unhelpful – not only deterred patients from seeking care, but also deterred others within their community. Patients experiencing negative interpersonal interactions communicate this to those around them, creating a feedback loop that spreads through word-of-mouth to others in their community to compound apprehensions their friends and neighbours might have about seeking out treatment at health facilities. One recurring reason for rude treatment was staff becoming angry when a patient did not seek treatment early in their condition (causing their condition to worsen), or when a parent or caregiver did not bring a child in for treatment sufficiently early. "*Not all [health] staff treat patients bad. It does not happen all the time at all facilities. But happens sometimes at all facilities*", explained one CHW. "*Maybe somebody wait [too long] to seek treatment or they do not bring their child to the facility right away, then the health staff will become angry and not speak to them well or with respect*".

73 World Bank, "Pregnant Women Receiving Prenatal care (%) - Sierra Leone", https://data.worldbank.org/indicator/SH.STA.ANVC.ZS?locations=SL (19 February 2023).
74 DHS, 2019, *Sierra Leone DHS 2019.*

Females are especially likely to experience rude or unfriendly treatment at health facilities. For starters, women's typical role as caregivers makes it more likely that they are the ones accompanying children to health facilities, so they have **more interactions than men do with health staff**. As well, time pressures that result on women due to household work and caregiving responsibilities makes it **more likely that women will arrive late for treatment**, which was reported to be another source of tension between staff and patients. But there is also another gendered element of how health staff expect women and girls to behave at health facilities. In particular, interviewees reported that some staff hold the expectation that women and girls dress up to visit health facilities, whereas men are not held to a similar standard. Rural women from poor households, who often have to travel long distances to facilities and who may not have what is deemed to be appropriate clothing, are especially vulnerable to stigma associated with '*improper*' dress. As said by one key informant, "*if they don't dress well they don't want to go to the clinic looking shabby, so they might miss 1-2 ANC visits. Then pregnant women might not register on time and only come after 3-4 months*". Such social expectations around accessing healthcare intersect with society's ideas about femininity and how women and girls should dress and behave. This creates **a social requirement** that women and girls take care of their appearance and the expectation that they will be admonished for not doing so.

4.4.1.4. Treatment through Alternative Providers

Barriers to accessing healthcare, like stock-outs, distance, and negative experiences, make it more likely that respondents **seek care instead from outside of the formal health systems**. A number of the factors that the *Gender and Protection Analysis* identified as impediments to accessing medical care have also been identified by other researchers as reasons that people will **choose traditional healers over formalised medicine**: proximity to services, associated costs of care, tradition, perceived effectiveness, and the way users are treated by providers.[75] Study participants indicated people often choose to go to traditional healers to first treat many illnesses. Usually, patients will go to herbalists, who treat illness using plants and animal products.[76] But they may also seek treatment through religious healers, who treat illness through spiritual means. Whereas a large proportion of Bonthe residents would be forced to walk many miles to get to a health facility, **healers are present in every community** in Sierra Leone.[77] "I*f they cannot find a solution [via traditional medicine] they will then come to the health facility*". Traditional medicine is more likely to be tried when illness is believed to be the result of spiritual forces – seizures and convulsions were given as an example of an ailment that healers commonly treat. Even for what one health provider called "*normal illnesses*", like fevers, headaches, body pains, etc., community members reportedly often go to traditional healers or drug peddlers, rather than getting diagnosed and treated at health facilities. Healers usually offer herbs to boil and mix into drinks. Although **drug peddlers** coming into communities offer pharmaceuticals, the products they sell are often counterfeit or of substandard quality.[78]

4.4.2. Family Planning

Awareness about family planning is high. Male and female participants in this study generally said they had heard about it and understood what different forms of contraception do and why the are important, which supports secondary data indicating that high awareness about modern contraception among both men and

75 Denney, Lisa, and Richard Mallett, 2014, "Mapping Sierra Leone's Plural Health System and How People Navigate It", *Briefing Paper 6*, September.
76 Scott, Kerry, *et al.*, 2014, "Navigating Multiple Options and Social Relationships in Plural Health Systems: A Qualitative Study Exploring Healthcare Seeking for Sick Children in Sierra Leone", *Health Policy Plan* 29(3): 292-301.
77 Dziewanski, Dariusz, 2015, "How Traditional Healers Helped Defeat Ebola", *AJE*, 5 November https://www.aljazeera.com/features/2015/11/5/how-traditional-healers-helped-defeat-ebola (20 February 2023).
78 Williams, George, 2021, "Sierra Leone: The Pandemic of Fake Medicine", *Premier News*, 19 November https://www.premiermedia-sl.com/sierra-leone-the-pandemic-of-fake-medicine/ (20 February 2023).

women in Bonthe.[79] Despite this level of awareness, there are indications that people still harbour **misconceptions about contraceptives issues**. For example, CHWs indicated that one widespread belief is that different contraception methods would make women sterile, or that it would make them sick. The result is that some women are reluctant to access contraception. One young woman interviewed shared her experiences, saying: "*I also thought it would make unable to have children forever. So I did not use anything, and I got pregnant. But now I went to the clinic to get injection to not born any more children*".

The *Gender and Protection Analysis* found **one barrier to accessing contraceptives is disapproval from husbands or boyfriends**. Men generally require that women consult them before using modern contraceptives. This prevents some women from accessing contraception. Unequal gender relations often mean that men hold decision-making power around the nature of sexual relationships,[80] but that the burden of child spacing and family planning rests on women. As explained by one man in a FGD, "*even the wives now are on contraception and we can't even get them pregnant. It's* 'man violence'. *We want many kids*". **Many men in the study consider female access to contraception to be a problem**, because it undermined what they believe what one male key informant described as men's "*right to bear many children*". Additionally, health workers participating in this study also suggested that husbands often do not allow their wives to come for modern contraception, and that this view is especially **prevalent in some religious communities.** Muslims, for instance, are more likely to see contraception as "*civilised abortion*". "*They [the imams] are saying that [family planning] is killing children, thinking that the injection will spoil the belly and she won't be able to get pregnant again*", said one health worker. "*So we just continue to work with them to tell them that more children brings more poverty, and that it is better if the keep spacing*". Even if their husbands or partners are opposed to contraception, many women understand the importance of family planning, and **seek out modern contraception without the knowledge of their partners**. As explained by one health worker, "*wives will often come [to the facility] in secret to get contraception in a way that their husbands do not know. These women know about [the importance] family planning, even if their husbands oppose it*". Ultimately, 20.4 per cent of all currently married and sexually active unmarried women years in Bonthe District are using some modern method of contraception, which is slightly below the national average of 20.9 per cent.[81]

4.4.2.1. Teenage Pregnancy

The majority of young women interviewed for this study also said they are using contraception. National statistics indicate that use of contraception is much higher among unmarried women – who are likely to be younger – than among married ones; 58.3 per cent of all sexually active unmarried women are using any modern method of contraception.[82] Despite the relatively higher uptake of contraception among younger women, **teenage pregnancy was also frequently cited as a key health issue in the communities** sampled for the *Gender and Protection Analysis*. At 30.1 per cent, Bonthe has one of the highest rates of any district of females 15-19 years who have had a live birth or who are pregnant with their first child[83] (see *Text Box D* for more information on how early marriage contributes to teenage pregnancy); the national average is just 21.3 per cent, by comparison. Study participants indicated that parents of adolescent girls and young women may restrict them from accessing family planning believing that this will encourage them to become sexually active. As a result, **most young women and girls seek out modern contraception in secret**. Only a small minority indicated that they access contraception with the knowledge of their parents. The study showed that most parents see sex as a moral issues and perceive

79 One hundred per cent of all men and women in Bonthe District had heard about at least one modern method of contraception; see DHS, 2019, *Sierra Leone DHS 2019*.
80 In Bonthe District, only 35.4 per cent said they can ask their husband to use a condom; see DHS, 2019, *Sierra Leone DHS 2019*.
81 DHS, 2019, *Sierra Leone DHS 2019*.
82 DHS, 2019, *Sierra Leone DHS 2019*.
83 DHS, 2019, *Sierra Leone DHS 2019*.

the solution to teenage pregnancy as coming in the form of greater control over young people's sexuality, rather than more open dialogue between parents, teens, and community about family planning and modern contraception usage.

TEXT BOX D: EARLY MARRIAGE

Sierra Leonean law sets the minimum age for marriage at eighteen years. However, study participants indicate that early marriages still occur in rural communities because **traditional norms still support early forced marriages**, as customary law traditionally has not had a minimum age for marriage. This can result in situations where **girls' health is compromised** from early sexual activity and where they are more easily exploited. It also leads to **low education levels** as girls also lose out on educational opportunities due to teenage pregnancies and due to the demands of their household labour and childrearing roles. One motivation for early marriage is to **gain financial support** for girls from poor households, as well as **dowry payments** for their families, which can represent significant material benefits to people trapped in poverty.

There are other barriers that adolescent girls and young women face in accessing contraception as well. For instance, **many young women feel stigmatised by going to health facilities to access family planning**. "*When we [young women] go to the clinic sometimes the nurses shout at us and make us feel ashamed. They [the health staff] say: look how young are, you have no business with men, and they might even tell us we do not look neat or that we are not dressed nicely*", indicated one young woman. "*This might discourage some girls if they are shy*". Interviewees also indicated that **opposition from intimate partners** was key reason that young women and girls did no use contraception. There is some support for this finding in secondary research – albeit from at study based in the Western Area not in Bonthe – indicating that opposition of the partner was the most frequent reason for not using condom or contraception for females 10-24 years (70.2 per cent).[84] Interestingly, this was **also a key reason given by males** (46.8 per cent), indicating that both sexes respectively put the responsibility of opposition to the use of contraception on their partner.

84 Aline Labat, Aline, *et al*., 2018, "Contraception Determinants in Youths of Sierra Leone Are Largely Behavioral", *Reproductive Health* 15 (66).

4.5. EDUCATION

In 2018, GoSL launched a phased *Free Quality School Education* (FQSE) programme that provides **free admission and tuition to all children attending government-approved schools**.[85] While the initiative provided educational access to many children, this study found that **children are still out of school and at risk of dropping out**, for the reasons described in detail below. In addition, **communities with no government-supported school** have no straightforward access to free education. This issue is prevalent in rural areas where school supply is lower and populations are more spread out, meaning families may have minimal choice – if any at all – over which school to attend. Furthermore, despite the GoSL's considerable efforts to promote educational inclusion, participants still often reported that a **lack of money** prevented them from sending their children to school. The *Out-of-School Children's Study* finds that children from poor families are more likely to drop out of school than those from wealthier families.[86] Due to high and persistent levels of poverty, parents in Bonthe District reported that some are even unable to pay indirect costs of education, such as school uniforms, footwear, transportation to and from school, and additional school supplies, which the FQSE initiative does not cover.

In 2021, Sierra Leone passed a *National Policy on Radical Inclusion in Schools*,[87] which builds on *Free Quality School Education* by **actively enabling those from marginalised and excluded groups to enter and remain in school until they graduate**. Importantly, the inclusion policy engages families and communities to provide support for their children at home and at school, including for parent learners,[88] and this should enable pregnant girls to return to school after giving birth and provide support programmes to help them catch up from lost lessons and graduate. Still, the *Gender and Protection Analysis* suggested that **few girls return back to school after giving birth**. Stigma, discrimination, and lack of integrated support for pregnant and young parent learners still remain a barrier to their full participation in school.

The *National Policy on Radical Inclusion in Schools*[89] also aims to **make education more inclusive for children with disabilities**,[90] who have been historically been denied their right to education in Sierra Leone. The 2017 MICS from Sierra Leone revealed that **Bonthe has the highest proportion of children with disabilities** out of any district in the nation; 42.8 per cent of children aged 5 to 17 in Bonthe District have at least one functional difficulty, almost twice the national average (of 23.1 per cent).[91] The *Out-of-School Children's Study* suggests that children living with a disability are more likely to drop out of school than those living without a disability.[92] While the aim is to eliminate barriers to full inclusion, removing physical barriers that make schools inaccessible to students with disabilities and training teachers to be more aware of the needs of students with disabilities in inclusive classrooms,[93] **very little has been accomplished in practice** to make schools inclusive for children with disabilities. The teachers included as part of interviews for the *Gender and Protection Analysis* reported that they had not yet received any specialised training on addressing disability issues within their teaching roles. Those that had a teaching certificate received some training on issues such as GBV during their schooling, under the subject '*emerging issues*'. However, **many teachers working in Bonthe are volunteers** who have not received any formal education for role. Volunteer teachers only receive a brief induction regarding what one teacher referred to as the "*dos and don'ts of the school's code of conduct*", and are expected to acquire the remaining expertise by "*learning on the job*".

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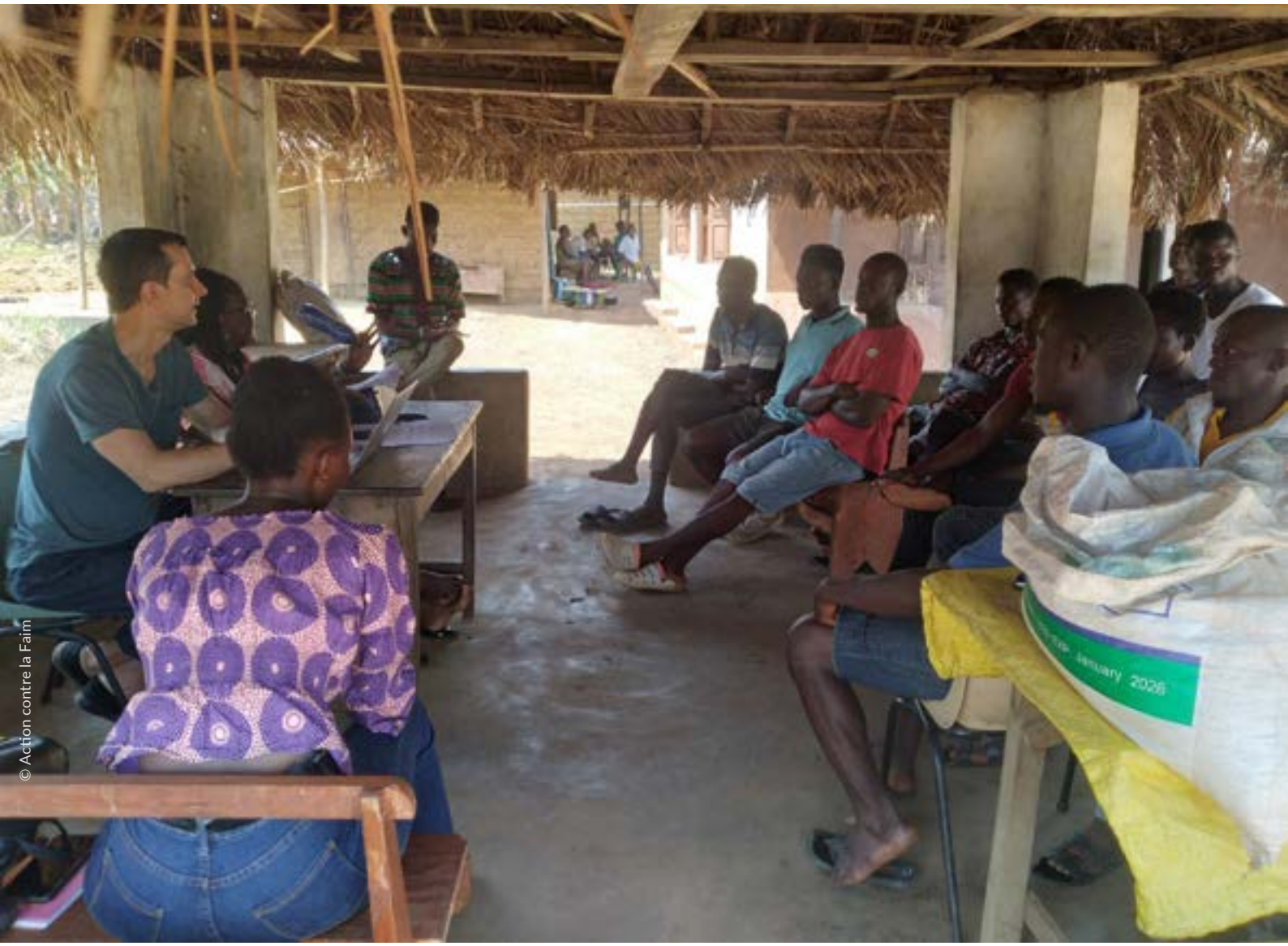
85 UNICEF, "UNICEF Contribution to The Solution", https://www.unicef.org/sierraleone/education (6 February 2023).
86 GoSL, UNICEF, and Irish Aid, 2021, *Out-Of-School Children Study Sierra Leone*.
87 GoSL, 2021, *National Policy on Radical Inclusion in Schools*.
88 Adolescent pregnancy and child marriage in Sierra Leone are among the highest globally, with an estimated 19 per cent of girls aged 15 to 19 having had a live birth in 2017. There are immense disparities as well, with 18 per cent of girls from the wealthiest households giving birth compared to 40 per cent among those from the poorest households.
89 GoSL, 2021, *National Policy on Radical Inclusion in Schools*.
90 GoSL, 2021, *National Policy on Radical Inclusion in Schools*.
91 UNICEF, 2017, *Sierra Leone MICS 2017*.
92 GoSL, UNICEF, and Irish Aid, 2021, *Out-Of-School Children Study Sierra Leone*.
93 In practice, this goal means It means adapting the education system to better meet their learning needs – ensuring school is a place of dignity, safety, and respect for all – while systematically reducing cultural, policy and practical barriers to education.
This includes developing the institutional structures, staff and tools necessary to support the implementation of this radical inclusion policy in schools.

The *Gender and Protection Analysis* also found that **lack of access to senior secondary education** in most communities requires many boys and girls to **relocate in pursuit of their education**. National statistics indicate that 45 per cent of all chiefdoms in Sierra Leone do not have a single senior secondary school.[94] There are secondary schools in Mattru Jong,[95] where older learners from surrounding areas can go. Those from out-of-town who are studying in Mattru Jong stay with relatives or family friends, making them vulnerable to sexual exploitation. Girls, and in particular those from poorer households, often resort to transactional sex for food, clothes, or other essential and luxury goods, or to obtain money for themselves. Although sexual exploitation is often considered an issue of exploitation rather than violence, **engaging in sexual relations to secure basic goods** is related to the same unequal distribution of power and harmful social norms that increase female's vulnerability to violence.



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94 GoSL, UNICEF, and Irish Aid, 2021, *Out-Of-School Children Study Sierra Leone*.
95 GoSL, 2021, "List of Senior Secondary Schools", https://mbsse.gov.sl/wp-content/uploads/2021/07/Senior-Secondary.pdf (24 February 2023).

4.6. PROTECTION AND GENDER-BASED VIOLENCE

Male and female respondents consistently responded that there are no areas in or around their communities where they feel insecure or threatened. These results were consistent across different communities and respondent groups, even when interviewers probed for different types of insecurity, violence, risk, and threats. The one exception to this general rule was **respondents' fear of ritual killings**, which many associated with cannibalism. Although only a few such incidents have occurred in the past few years, they have stuck in the public consciousness in a way that has created a general feeling of insecurity for both women and men around this topic. **By comparison, everyday forms of violence like assault, domestic violence, and others did not create the same sense of fear among respondents as did ritual killings.** This is likely an indication that GBV is normalised in many communities. Indeed, some groups maintained that GBV is not at all a problem in their communities, despite statistics – such as those highlighted above in the programming context section – that suggest that GBV in Bonthe is widespread.

There were some research participants who did openly discuss GBV though, even sharing their firsthand experiences as survivors or perpetrators. Such differences in reporting are probably due to variations in groups' openness and willingness to engage the topic, rather than due to differences between communities in terms of the prevalence of violence. **As is the case over the world, GBV in Sierra Leone is underreported and difficult to measure.**[96] Although some communities are silent about it, there is convincing anecdotal evidence from interviews and FGDs undertaken as part of the *Gender and Protection Analysis* that numerous forms of gendered violence are present throughout Bonthe. For example, one male FGD participant admitted that "*it [GBV] is happening. I have even beaten my wife. I am not proud, but this does happen*". Sadly, this was one of a few such admissions. **Further evidence indicating that GBV exists in the district** came from interviews with government and civil society. Interviewees from these groups definitively agreed that sexual harassment, intimate partner violence, rape, and other types of GBV are present in the chiefdoms. One key informant from the District Council said, for example that: "*we know it is there. Maybe we can't say for sure how much of a problem [GBV] is, but it is there. Cases of beating, neglect, harassment, and even rape can happen in this district*".

To respond to the effects of the GBV, Sierra Leone has a four-phased national referral pathway.[97] At the time of the *Gender and Protection Analysis*, the referral pathway in Bonthe was **yet to be mapped**. Still, this study indicated that response services along the pathway are **affected by a number of challenges**. As mentioned, survivors' access to health services may be limited due to distance, poor roads, costs, etc. Until recently, almost no health staff were trained in providing MHPSS. What is more, few survivors take their cases to the police, instead of addressing GBV cases within the informal system. Recent data regarding GBV reporting in Sierra Leone indicates that 28 per cent of women would not report an incident of GBV to the police.[98] Responses given during the *Gender and Protection Analysis* suggest that the percentage of women in Bonthe that choose not to report cases to police is actually probably much higher than just 28 per cent. Where cases are taken to the justice system, few are prosecuted. In an effort to help address some of these challenges, the GoSL, led by MoGCA, has adopted *One Stop Centres* (OSCs) for response to sexual violence. This includes an OSC in Bonthe to provide **survivor-centred case management**, including psychosocial support, **as well as medical treatment** (for example: emergency medical care, including post-exposure prevention of HIV/AIDS, other sexually transmitted infections (STIs), and unwanted pregnancy, when drugs are available), and **legal services and referrals to safe housing**, all in one location. While establishing an OSC in Bonthe is an important step towards providing GBV response services in the district, the centre is experiencing a number of issues: there is little awareness of the OSC in the district, it is run by a single full-time staffer, it has frequent stock-outs of drugs, and it is house in a small space without regular electricity.

96 UNDP, 2022, *Capturing the Socioeconomic and Cultural Drivers of Sexual and Gender-based Violence in Sierra Leone.*
97 GoSL, 2022, *National Referral Protocol on SGBV: Pathways to Service Provision for Survivors of Gender-Based Violence.*
98 UNDP, 2022, *Capturing the Socioeconomic and Cultural Drivers of Sexual and Gender-based Violence in Sierra Leone.*

4.6.1. Select Types of Gender-based Violence

4.6.1.1. Denial of Resources

GBV can also be economic in nature, stemming from the control that husbands have over household finances. This study found that many husbands use control over household income to perpetuate economic violence against women by denying them income, food, and other necessities. This is done as a way of asserting and maintaining masculine power in the home. Study participants said that it is especially used as a way of punishing women for speaking up about cases of domestic violence that occur against them or when they contest their husband's power in other house in other ways. As one women noted, "*a wife might speak out against her husband beating her one time. Maybe she will not eat the next day [because her husband refuses her income]. Definitely she will not speak out again*". "*Even if the man does not beat you, there are other things he can do, like deny the wife money for food for the day. Then she will learn to listen to him*", said another woman. **Denial of resources is especially challenging in a context where poverty and food insecurity is already such an overwhelming problem for many.** In addition to the effect is it has on the lives of women, it can also have **considerable impacts on the well-being of their children**, as denial of resources to the mother will also usually mean that her children are deprived of food, health care, and other necessities too.

4.6.1.2. Sexual Harassment

This study suggests that although women of all ages[99] are subject to sexual harassment – unwanted sexual remarks or advances – it is girls and young women that are most likely to be victimised. Young women participating FGDs indicated that they usually experience **harassment from their peers of the same age**. This most often occurs at school, but also in public spaces such as streets, markets, and their community. **When sexual harassment occurs at school,** some female learners take their complaints to their teachers first, and sometimes to their parents if the problem persists. However, **the responses they can expect from authority figures vary greatly**. Troublingly, many girls said they are accused of having encouraged the harassment, and subsequently nothing is done to discipline the offenders or protect the girls from further harassment. When action is taken, the boys that perpetrated the harassment might have their parents involved in the matter or be physically punished by teachers.

When cases of harassment take place in the community girls may complain to their own parents or the parents of the perpetrating boy. In an effort to maintain community relationships most matters remain between families, and few are ever taken to police. For similar reasons, parents of perpetrators do encourage their sons to stop. However, older participants in FGDs also **often suggested that harassment can be prevented by exerting more control on girls' lives**, restricting where they go and what they do, without a similar emphasis on preventing the abusive behaviours undertaken by boys. From their perspective, most girls that were interviewed **believe that boys are unaware of the harm caused by their actions**, indicating how entrenched are the norms that underpin such unwanted sexual remarks or advances. In the opinion of one female focus group discussant, "*for the boys, its is just normal. They do not even think about it at all. They just do it believing it is normal*".

99 Sexual harassment can and does also happen to older women, especially around streets and market areas. Cases of harassment are generally not reported. These women instead either tolerate it or confront their perpetrators directly.

4.6.1.3. Domestic Violence

Domestic violence was another form of GBV that was frequently mentioned during the *Gender and Protection Analysis*. As with other forms of GBV, some study participants insisted that domestic violence does not occur in their communities, while others were more forthcoming saying that it happens. This was a topic that respondents sometimes spoke about using the euphemism '*quarrel*', which is a term that denote acts that span from threats to denying food to physical violence. **This is another example of how GBV might remain hidden in communities, this time through language that is used to normalise it and diminish its severity.** Male respondents sought to normalise and minimise domestic violence in other ways, saying that incidents that do not leave physical injuries are not severe enough to be considered as violence. "*We do beat the women here, but not to wound them – not to remove their teeth [for example]*", said one man. Similarly, a traditional leader also excused violence perpetrated against a wife that continually countered her husband's authority, saying that "*a man does not have the right to beat his wife. But let me ask you: if he tells her, and tells her, and she does not listen, what is he to do?*" These are just two of numerous examples that show how the problem of domestic violence can be diminished and made to seem normal. Qualitative data from this study indicated that **men often justify domestic violence** committed against so-called "*stubborn women*" who "*do not listen when told to do something*" by their husbands. In particular, the women's refusal to have sex, may lead to physical violence (or denial of food or money).

Table 3: Types of Violence Experienced by Ever-married Women in Bonthe[100]

Type of Violence	Percentage
Emotional	37.8%
Physical	23.1%
Sexual	0.5%
Any type	41.7%

Secondary research presented in the table provides a sense of **the scale of the problem of domestic violence**. It indicates that 41.7 per cent of ever-married women in the district have ever experienced emotional, physical, or sexual violence committed by a husband or partner. Many males and females **accept harmful attitudes and violent practices**, as shown in *Table 4*.[101] Interestingly, more women than men are likely to agree that domestic violence is justified in one of the five instances given. Therefore, many females are themselves socialised into accepting violence practices, and subscribe to the belief that indicate that physical violence perpetrated against them by their male partners is **acceptable and expected under some circumstances**.

Table 4: Justifications for Domestic Violence[102]

Justifications for Domestic Violence	Females	Males
Burns the food	5.5%	9.2%
Argues with husband	22.9%	22.7%

100 DHS, 2019, *Sierra Leone DHS 2019*.
101 Interestingly, the proportion of women in the Bonthe the DHS reported to believe in justifications for domestic violence is lower than the national average of 48.6 per cent, while the proportion of men in Bonthe that believe this is considerably higher than the national average of 29.9 per cent.
102 DHS, 2019, *Sierra Leone DHS 2019*.

Goes out without telling husband	22.6%	16.7%
Neglects the children	39.7%	20.7%
Refuses husband sex	32.3%	9.6%
Agree with any reason above	45.4%	41.9%

Cases of domestic violence are seldom prosecuted. Authorities at all levels believe domestic violence to be family matter, and rarely promote punishment of perpetrators. As mentioned below, FSUs investigate all cases of sexual violence, and are mandated to also investigate cases of domestic violence, but rarely do so. Instead, they seek **private resolutions** in order to compromise such cases. Officers interviewed at the SLP's FSU in Mattru Jong reported that all cases of domestic violence that were brought to them were compromised; see *Text Box E* for more information on customary law and GBV. Even for those cases that are not compromised, it is very challenging for survivors to see legal recourse. Prosecution of domestic violence requires **a completed medical certificate** that is endorsed by the health facility. The certificate costs around SLL 150,000 – an amount that few people can afford. As well, although community leaders are technically responsible for notifying state authorities of cases of domestic violence and physical abuse, most support a local or private resolution. The tendency for traditional authorities to seek informal resolutions to domestic violence is an extension of social pressures present in Sierra Leonean society, whereby family and friends are likely to advocate that survivors stay with their partners due to the high value that Sierra Leonean society places on the family unit.[103]

TEXT BOX E: CUSTOMARY LAW AND GBV

Much of the population in Bonthe District – especially the population living outside of Mattru Jong – falls under the jurisdiction of local courts and the system of customary law. Customary law is protected by the Constitution under "*the rules of law by which customs are applicable to particular communities in Sierra Leone*".[104] **The result is that even though women have certain rights in Sierra Leone under formal law, but the customary system often upholds patriarchal social structures that discriminate against females.** In actuality, women and girls rarely pursue recourse against perpetrators of GBV due factors such as: stigma, fear of retribution, costs, pressure from family and community, lack of familiarity with legal structures and processes, lack of awareness about what rights they have, impunity of perpetrators, etc. In many matters there is a tendency for communities to resort to the **informal justice system**, where decisions are made by chiefs and other traditional leaders. Survivors of GBV and their families often seek alternative justice through customary law due to its proximity, accessibility, affordability, and **a traditional belief that marital violence is something that occurs within the private domain and should therefore be resolved informally**. Addressing cases of GBV through informal systems can lead to impunity, leaving women isolated and coping with the effects of violence alone.

103 Denney, Lisa, and Aisha Fofana Ibrahim, 2012, *Violence against Women in Sierra Leone: How Women Seek Redress*.
104 Barnes, Karen, and Peter Albrecht and Maria Olson, 2007, *Addressing Gender-Based Violence in Sierra Leone: Mapping Challenges, Responses and Future Entry Points*.

Men in the districts studied rarely come forward as victims of domestic violence. Indeed, each time the topic of male victimisation was raised during FGDs, its was met with **laughter and derision**. When one man shared a story of abuse the group laughed, mirroring the treatment he received by police who advised him against taking him to court saying "*look at you as a man taking your wife to court of her slapping you, nobody will believe it*". Although it is mostly women and girls that are affected by GBV, there may be unique elements that contribute to the particular experiences of male survivors, especially **the reluctance of men and boys to come forward and seek assistance**. Part of the reason is a lack of awareness and stigma related to GBV perpetrated against males. "*There is still not a clear understanding for people and organisations that men and boys can be affected by GBV. When it happens it is seen as a joke*", said one male key informant. Though the *Gender and Protection Analysis* did not study this directly, there is good reason to believe that sexual violence committed against men and boys might especially be taboo, given that same-sex sexual relations between men in Sierra Leone remain illegal and highly stigmatised.[105]

4.6.1.4. Sexual Violence

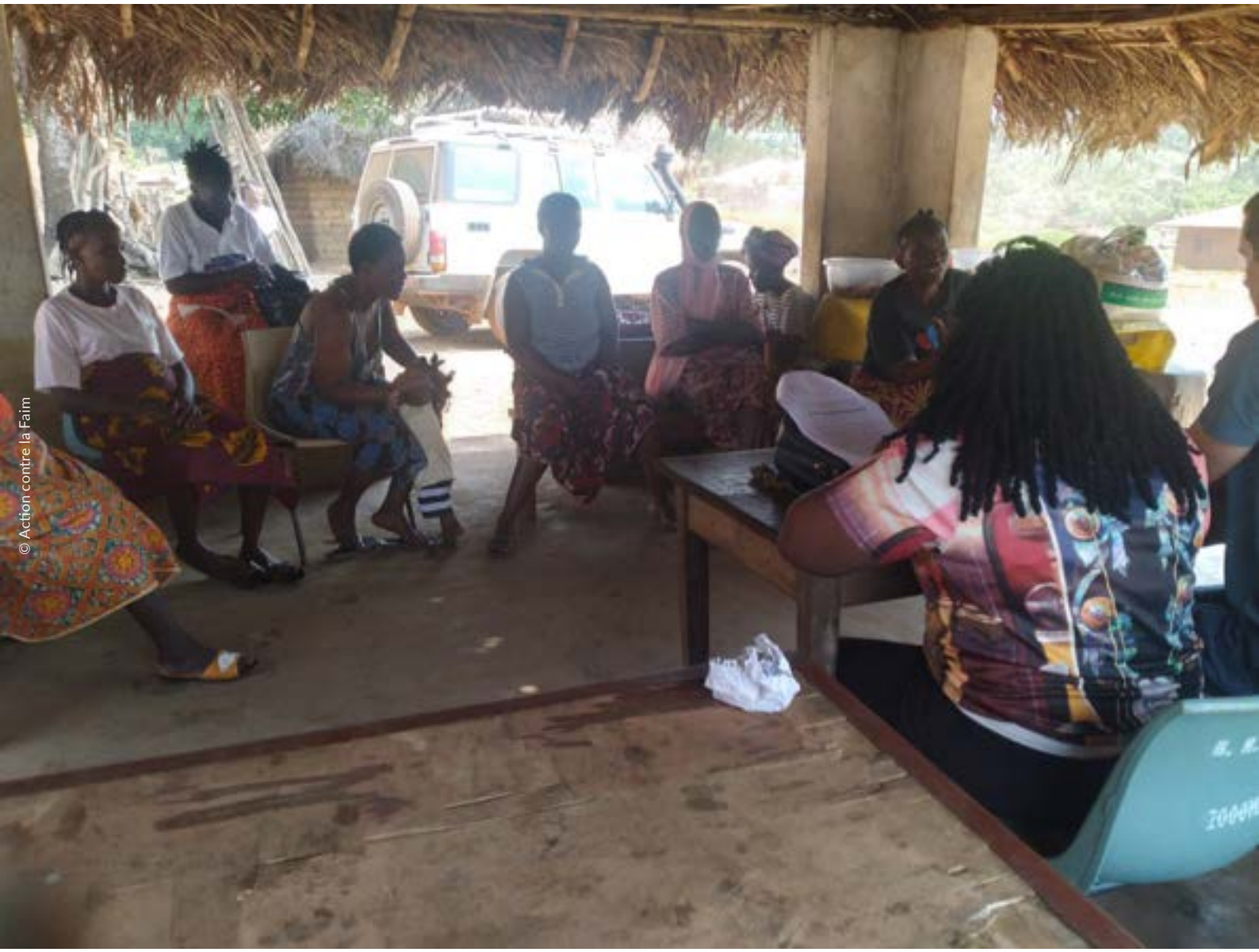
Sexual violence was not frequently reported among respondents in the *Gender and Protection Analysis*. Most said that they had not heard of recent cases, and did not believe that sexual violence happens with frequency in their communities. The DHS also found that only 1 per cent of all women in Bonthe District have experienced some form of sexual violence since age fifteen;[106] in 85.9 per cent of instances a past or present husband or partner perpetrated the act. Study participants suggested that the main reason sexual violence was decreasing was due to harsher penalties imposed under Sierra Leonean law. Under Sierra Leone's revised *Sexual Offences Act*, **rape is considered a felony and carries a sentence of fifteen years to life imprisonment**.[107] In an opinion typical of those expressed during the study, one traditional leader said: "*there is not much rape here like it was before. There has been a lot of sensitisation about the new laws on the radios, and this has made the people scared to die in prison*".

The *Sexual Offences Act* also criminalises '*compromise*' **actions designed to prevent sexual violence cases from going to court**, by paying or pressuring victims to drop their complaints.[108] For this reason the FSU reported that all rape cases that it sees are sent to the high court for prosecution and perpetrators are often imprisoned. That being said, it is recognised that many rape cases probably continue to be thrown out of court for **lack of adequate evidence**. Nationally, out of the 120,522 cases recorded by the SLP in 2018, only 1,334 went to court and only convictions were reached (reflecting a conviction rate of less than 2 per cent.[109]

Many study participants also maintained that cases of sexual violence continue to be resolved outside of the formal justice sector, within family and community structures. This is especially true in remote areas, or in cases of sexual violence within intimate partner relationships, which are often considered a private matter, where family cohesion should be first rather than risking long-term imprisonment of the family's main breadwinner. Indeed, even those working to bring cases forward may be susceptible to social pressures that silence survivors. As one key informant noted, "*one woman's group leader in Kpanda Kemo-has relaxed in filing cases of GBV because the people are making me look bad as one of the persons bringing trouble to the community*".

105 Human Dignity Trust, "Sierra Leone", https://www.humandignitytrust.org/country-profile/sierra-leone/ (11 March 2023).
106 The corresponding national average is 7.4 per cent.
107 M'Cormack-Hale, Fredline, and Josephine Appiah-Nyameke Sanny, 2021, "Most Sierra Leoneans Approve of Measures against Sexual Violence, Want More to Be Done", *Afrobarometer Dispatch* No. 424, Feburary.
108 M'Cormack-Hale, Fredline, and Josephine Appiah-Nyameke Sanny, 2021, "Most Sierra Leoneans Approve of Measures against Sexual Violence, Want More to Be Done", *Afrobarometer Dispatch* No. 424, Feburary.
109 GoSL, 2022, *National Referral Protocol on SGBV: Pathways to Service Provision for Survivors of Gender-Based Violence*.

The study also finds that another type of sexual violence that is being underreported is forced sex within marriage. Many study participants expressed a belief that martial rape is prevalent, but is generally dealt with as a family matter. "*We have not heard about a situation of rape [in the community] for about a year. But you know there are still husbands who will force their wives to have sex with them*", explained a government key informant. Less than two-thirds of married women in Bonthe believe can say '*no*' to their husband if they do not want to have sexual intercourse.[110] In fact, women across FDGs suggested that **forced sexual intercourse within marriage was still a problem for them**, saying for instance that: "*husbands here do not believe that a wife can refuse them [sex]. It can make a problem for some women. So some are forced. Some can still refuse. But this makes a quarrel in the marriage and sometimes you have to bring in the [husband's] family to try to make peace*".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110 The DHS also states that 0.5 per cent of ever-married Bonthe women have ever experienced sexual violence – that is, with threats or with physical force being made to have sexual intercourse or another other sexual acts when she did not want to; see: DHS, 2019, *Sierra Leone DHS 2019*.

4.7. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The need for MHPSS is high across Sierra Leone. The memory of the civil war and the Ebola outbreak are still very traumatic, revivified by the current COVID-19 pandemic. The limited evidence-base suggests that 13 per cent of the total burden of disease and 31 per cent of all health-related disabilities are attributable to mental illness.[111] **Nationally, care and response services are missing**, with scarce mental health workers and only one psychiatric facility in the country.[112] MPHSS services in Bonthe are also severely lacking. While mental health is included as an essential service in the Sierra Leone *Basic Package of Essential Health Services*,[113] there are **no psychiatrists or psychologists in the district**, and only one mental health nurse. Interviews with health personnel found that the expansion and deepening of mental health skills was generally considered to be an important contribution to health system in Bonthe.

There still exist considerable misconceptions about mental issues in the district, like the widespread belief that mental illnesses can be caused by witchcraft or spiritual issues that require spiritual remedies. This prevents many people from seeking health professional, opting for **traditional medicine or religious intervention** instead. Secondary research also points to a belief that mental health issues are caused by abuse of narcotics, demon possession, and involvement in religious cult activities,[114] reinforcing the considerable **stigma and negative attitudes** existing towards persons with mental health issues, who were referred to during interviews and discussions as "*mad*" or "*crazy*". **The disparaging attitudes of others** have been found to discourage people with mental health issues from seeking treatment – for many, there is perceived shame associated with mental illness.[115] Because **stigmatisation and exclusion** are major contributors to the burden for those living with mental health issues,[116] reducing the stigma is key to improving quality of life for this vulnerable population.

Although men undoubtedly also experience stress due to their impoverished economic circumstances, **women's relatively more vulnerable position makes it even more likely that they will be affected by mental health issues**. In fact, women included in the in the study frequently reported **high levels of distress and anxiety** from poverty. In instances when women have no or insufficient funds for food, because their husband has not given or does not have any money to give, women will have to spend their own earnings, buy food on credit, or forage for foodstuffs. "*We always stress where our next meal will come from. There is not enough money, not enough food, which makes you not sleep, and it can be too much sometimes*", said one woman, adding that: "*it is up to the wife to get the food, even if there is no money*". Women's economic dependency on men also means that they are greatly affected emotionally, as well as in practical ways, when a relationship ends. For this reason, **widowed women** have an increased risk of developing adverse psychosocial consequences, given their economic vulnerability.

Financial stresses in the home are also a flashpoint for domestic violence, which women are much more likely to be victims of. As was noted before, financial dependency also decreases the chances that wives will report GBV and increases the likelihood that women will remain trapped in abusive relationships. Survivors may experience severe physical injuries, unwanted pregnancies, and exposure to STIs. Staff at the OSC in Bonthe noted that survivors of GBV, but **especially survivors of sexual violence**, experience numerous psychological issues that include: stress, anxiety, depression, and in some severe cases even suicidal ideations. Currently, there are **no formalised support groups at community level** people to seek for emotional or psychosocial support. Some women seek support from female family members or friends. Cases of intimate partner violence may also be addressed by speaking to in-laws, in an attempt to get a husband's family to change his behaviour. For other stresses, women may also turn to religious communities and other social networks at community level.

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111 Bah, Abdulai Jawo, *et al.*, 2018, "A Scoping Study on Mental Health and Psychosocial Support (MHPSS) in Sierra Leone",
112 WHO, 2016, "Improving Access to Mental Health Services in Sierra Leone", 30 August, https://www.afro.who.int/news/improving-access-mental-health-services-sierra-leone (20 March 2023).
113 GoSL, 2015, *Sierra Leone Basic Package of Essential Health Services*.
114 Palmer, Lynette, 2013, "Perceptions of Mental Health in Sierra Leone – A Family Doctor's View", https://www.commonwealthhealth.org/wp-content/uploads/2013/07/Perceptions-of-mental-health-in-Sierra-Leone_CHP13.pdf (21 March 2023).
115 World Health Organization, 2017, *Improving Access to and Appropriate Use of Medicines for Mental Disorders*.
116 de Boer, Hanneke, 2010, Epilepsy Stigma: Moving from A Global Problem to Global Solutions, *Seizure* 19.

4.8. WATER, SANITATION, AND HYGIENE

Adequate WASH is a challenge across district. As was stated above, **less than half of the population of Bonthe has access to an improved source of drinking water** and only 37.3 per cent has access to an improved sanitation facility.[117] Communities also have **low knowledge on hygiene practices**. The MICS 2017 indicates that only 6.1 per cent of Bonthe households have handwashing facilities with water and soap, one of the lowest performing districts in this regard and far lower than the national average of 23.5 per cent.[118] Gap analysis found that access to water services in Mattru is higher when compared to rural towns, though even in the district capital there are **differences in access between wealthy and poor households and between different geographical areas**. Most communities in Mattru have pumps and toilets. Although broken pumps are common, the density of the population means that it is easier to access pump water from neighbouring areas. Residents of peri-urban areas around Mattru are more likely to **go to streams for drinking water** because they live further away from access to neighbouring communities that have working pumps and in closer proximity to streams and rivers. **The burden for drawing water falls overwhelming to women and children.** In addition, many key informants indicated that **access to improved water facilities is seasonal**, and that shallow wells and even shallow groundwater is increasingly not providing water year-round. This is true both in Mattru Jong and in rural communities. It is alarming that less than 30 per cent of the dug wells in Sierra Leone are delivering water year-round.[119]

Access to WASH resources for residents of rural communities in Bonthe District is relatively much worse than in the district capital. Again, to the extent that a accessible water resources do no exist in a community, it will increase workload on the women and children that will ultimately have to walk – sometimes for kilometres – to collect water from streams, rivers, and other water sources. Remote communities depend on unprotected hand dug wells for drinking water. Those that have wells indicate that these wells are frequently broken. Most communities reported pooling funds to fix broken pumps, but eventually abandoning these efforts after pumps repeatedly broke again. As a result, **pumps remain unfixed and unused** throughout communities sampled.

Communities remain dependant on government and development partners for maintaining WASH facilities. "*If you go into the communities to ask how much money you have put aside [for maintenance of water sources], they will say* 'we are waiting for Council, or we are waiting for the NGO'", stated a key informant from the MoWR. While it is part of the MoWR's mandate to help ensure *"that the population is provided with adequate and reliable potable water supply*" and "*that the country's water resources are properly managed*",[120] representatives of the ministry in Bonthe said they have "*too few staffs and too little funds to meet the great need of communities in Bonthe when it comes to water [resources]*". Another problem is the **shortage of qualified technicians** working within the private sector to repair water resources in the district. Few such technicians currently exist, and many qualified and uncertified technicians reportedly purposely **engage in partial repairs of water facilities to create more business** for themselves. Ultimately, water pumps using boreholes are more technical and expensive to repair. There are models that are very good for water points. For instance, **personal waterholes** creating small hand pumps using plastic piping have been successful in some areas.[121]

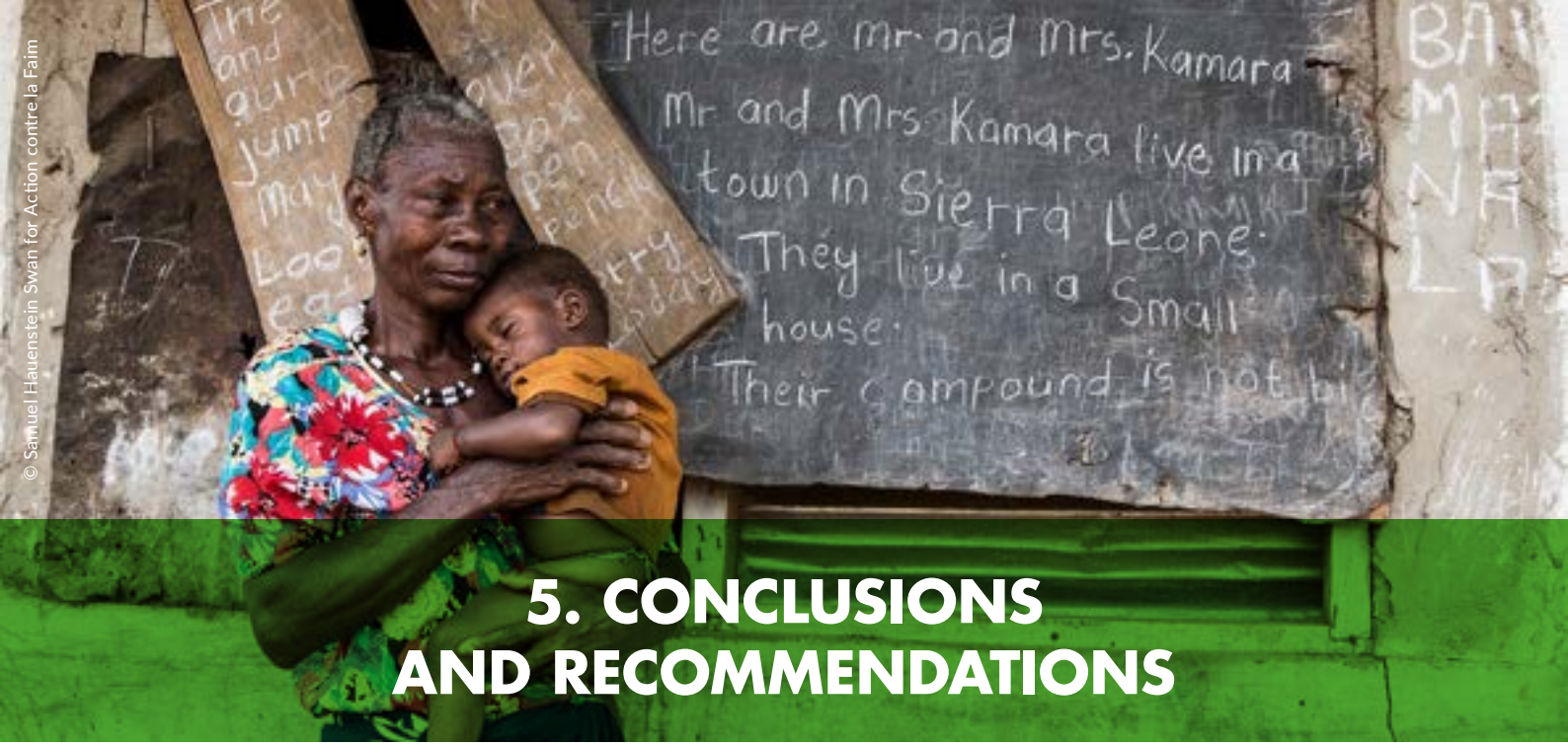
Lack of adequate WASH in healthcare facilities remains a particular challenge in Bonthe. Many health facilities also had broken pumps, meaning that staff often used well or stream water for activities there. This poses a threat to both the patients and clinical staff. Thus, significant gaps remain in the delivery and maintenance of WASH

117 DHS, 2019, *Sierra Leone DHS 2019.*
118 UNICEF, 2017, *Sierra Leone MICS 2017.*
119 GoSL, 2018, *Water, Sanitation and Hygiene Sector Performance Report 2017.*
120 MoWR, "Vision, Mission & Mandate", https://mwr.gov.sl/mandate-mission-vision/ (7 April 2023).
121 See for instance those used as part of Promotion of Nutrition Sensitive Wash Self-Supply In the Sherbro Island in Bonthe District (https://sendsierraleone.com/promotion.html (9 April 2023). Similar pumping technology was used in some communities in the chiefdoms of Jong, Kpanda Kemoh, and Yawbeko.

within the health sector in Bonthe. Key informants from the *Ministry of Basic and Senior Secondary Education* stated that **many schools in Bonthe do not have access to basic water**, handwashing facilities, or menstrual hygiene management. Substantial work needs to be done still by the GoSL and its partners in the development of resources, standards, and guidelines for WASH in schools. **One notable success is the provision of latrines for schools.** This was declared a GoSL priority, with the government mandating that schools cannot be approved to open unless they have working latrines for boys and girls. Today, the goal of providing latrines in schools in Bonthe has mostly been met.

Rural communities also lack adequate latrines, with most communities digging latrines for themselves. However, these are usually not deep enough and are not reinforced by cement. Community latrines are frequently get flooded during the rainy season, leading to the dissemination of pathogens that increases diarrhoeal diseases, and related illnesses. **A large percentage of communities also rely on open defecation.** The DHS indicates that 41.1 per cent of the district engage in open defecation.[122] Open defecation creates many problems. Typhoid, cholera, and other diarrhoeal diseases – illnesses closely linked with water and sanitation – were reported to be a problem during the *Gender and Protection Analysis*. **The high prevalence of diarrhoea and other infectious diseases amongst the under-fives** only highlight the severity of the situation. But adults can be affected as well. For instance, in one remote intervention community five people **died of cholera** last year – two adults and three children. "*Last year, the cholera situation was bad here. Some people delayed to get treatment on time and only went when it is very serious, and by that time it might be too late. Because there is no mobility the people delayed [seeking care], but now due to the deaths they know better to go early*", said one resident of the community. Another community had an estimated 25 cholera cases of cholera last year. One resident from the community said, "*there were many cholera cases after the rains. More the children get affected, the older people only get sick once in a while. But it is mostly the 2-5 years old that can play in the dirty areas*". While waterborne illnesses like these affect both sexes equally, as children and other family member fall sick, **caring for them will become the responsibility of women**. This increases the amount of time women must devote to their caring roles, in addition to all of the other farming, household, and parenting duties they already perform.

122 DHS, 2019, *Sierra Leone DHS 2019.*



5. CONCLUSIONS AND RECOMMENDATIONS

This study illustrated outlined a number gender and protection issues across different sectors in Jong, Kpanda Kemoh, and Yawbeko Chiefdoms in Bonthe District. Poverty is an overarching development challenge throughout the district, which as has high food expenditures as a percentage of total income. This makes households in the district vulnerable to very high inflation, especially as rising prices of staple foods have further deteriorated nutrition. Although poverty is challenge for all, women may feel it most acutely, as women are much more likely to do unpaid work, which cuts into the time they can spend on productive paid work. The result is that women are often dependent on their husbands for money for food and other household expenses. Most wives must even ask their husbands for money to access health services. Another controlling behaviour by husbands is to attempt to deny their wives contraception use, even if many women eventually access it independently in secret anyway. In general, the presence of GBV is still taboo among many people in communities, and not easily discussed. Still, this study found that denial of resources, sexual harassment, domestic violence, and sexual violence are occurring in the chiefdoms sampled. Among the many drivers of GBV are the discriminatory social norms, which also affect the roles and responsibilities of men and women, their decision-making power, and the types and amount of resources they can access and control. Another key issue identified through this study is that many people do not have improved source of drinking water and access to improved sanitation facilities.

5.1. PROGRAMMING RECOMMENDATIONS

Taking into consideration some of the issues just mentioned, **this study outlines a number of recommendations** below for ACF programming in the district.

5.1.1. Food Security and Livelihoods

→ Sensitising men as part of MSGs

The project must ensure the **proper sensitisation of males about support given to MSGs** through alternative income-generating activities, so as to help ensure these activities are understood and supported by males. Females that challenge male authority, accept non-traditional jobs, or break other social taboos can be perceived to be '*going against the grain*' creating relationship tensions that can accompany male frustration

when gender roles shift. Worse still, violence against women might perversely increase in the short-run if women begin to challenge the reigning distribution of economic power in the household. **Including men into project activities**, can help sensitised them to some of the key benefits of female empowerment, so as to **encourage more equal gender dynamics** within households and at the community level. One way to do this is to create **separate activities** for the male partners of MSG participants, perhaps forming **additional male dialogue groups** around certain issues. The men that are engaged in these activities can become male '*champions*' for gender equity and women's empowerment in project communities. They can encourage **male-to-male accountability for gender transformative change** in a society where men still hold most of the power and control over resources and decision-making at household, community, and national levels.

→ Complement food security and livelihoods activities with training on gender norms

Equalising the economic opposition of men and women is not sufficient in itself to achieving gender equity and women's empowerment. Just increasing the women's income is insufficient to meaningfully impact their decision-making and control of household resources. Some might not even be able to control the income they earn, as it is usually the man as the head of the household that has the final say when it comes to big decisions in the house. Therefore, economic advances need to be **paired with social initiatives** that working with men and women to help ensure that latter have a greater say in controlling household finances, as well as in making decisions about accessing contraception, household investments, major decisions about their children's future, etc. **Groups like *SEND-SL* are already implementing methodologies** that are impactfully affecting positive change between men and women in Bonthe. *SEND-SL's Gender Model Approach*[123] is a gender transformative approach that focuses on **transforming the power relations and structures** that reinforce gender inequity to achieve both gender equality and development outcomes, including economic transformation within families. In this way, *SEND-SL* is **a potential implementing partner** with an already tested methodology that could be leveraged by ACF within this project, or for a future one.

5.1.2. Health

→ Work with health personnel on communication and improving patient-health provider relationship

Doing so can boost the utilisation of healthcare services by women by **reducing stigmatising behaviour by healthcare professionals** to make facilities more friendly and welcoming. This will increase trust of communities towards health staff through **respectful behaviour** by: sensitising staff towards disrespectful behaviour, defining such behaviour, listing examples of the many forms it can take, and establishing an action plan that specifies how to identify disrespectful behaviour and respond to it. Responsibility for addressing the problematic behaviour belongs to health staff, who need to **raise awareness of the problem and hold each other accountable** in communicating respect as a core value. Some options forward this regard is **to create a specific facility-driven '*pledge of conduct*'** that serves as a model for patient interactions, by clearly articulating the standard of behaviour desired, as well as acceptable and unacceptable behaviours, and a feedback mechanism for patients to access. This can come with contingencies for the Officer in Charge of each facility to consistently **address complaints** of disrespectful behaviours. Taken together, the recommendations listed here can help build community trust in public health and push back against negative community attitudes towards health facilities that discourage attendance.

123 SEND-SL, *Gender Model Approach*, available at: https://sendsierraleone.com/Assets/documents/Gender%20model%20family.1ai.pdf (accessed 20 March 2023).

→ Establish *Village Savings and Loan Associations* (VSLAs) to support emergency transport and health care access

VSLAs are a useful mechanism for **accumulating local savings by groups and associations** that mobilise and manage their own financial resources in the form of savings. Given the problems faced in accessing health facilities, VSLAs might especially be **used for emergency transport**, offering no-interest loans for the transportation of serious health cases. FGDs revealed that in some cases lack of access to transportation due lack of access of financing results in more severe health outcomes, and even death. In other cases, the time it takes to find and secure borrowed funds may exacerbate a health situation that is highly time-sensitive. Even if funds are secured, they might be accompanied by high interest rates. Contributions to a VSLA scheme might take the form of small household donations, with a final amount decided by the each community. The pool of funds used for the scheme should be grown, and when it has reached a sufficient amount might be used for **purposes that cut across other sectors** – like repair of WASH resources, capital for petty trading, food purchases when families are food insecure, etc. The scheme could be **managed through MSGs, but made available to all community members**, so that it enjoys broad-based local support. The VSLA should be managed transparently according guidelines regarding how much money must be maintained by each community, when funds must be repaid, how much can be reinvested for community development, etc.

→ Explore innovative ways of promoting family planning

Radio can play a role in increasing knowledge about contraception, by combatting prevailing myths and misinformation that still exist about family planning methods. In doing so, it can increase the uptake of family planning methods by **providing accurate information and promoting messages** that support the use of modern contraceptives. **More targeted messaging** through innovative methods will be necessary as well. For instance, involving adolescent girls to facilitate discussion issues related to teenage pregnancy with to their peers through **school clubs** might prove more effective than radio-based messaging. This might include engaging modes of message delivery like **theatre and role-playing**. Activities around family planning should also **include parents**, who still tend to see family planning as best addressed by controlling the sexual activities of young people. In this regard, **intergenerational dialogues** between parents, teens, and community can be conducted around family planning, increasing awareness among parents about the issue from the perspective of young, so that young persons' sexuality is not seen as a morale issue.

→ Include religious leaders in health messaging, especially about family planning

Religious leaders and other community leaders groups could be engaged further in dialogues around family planning, using targeted messaging that incorporates religion in its argument for increased family planning. Such work could particularly focus on those groups – like *imams* – who are more likely to hold negative views towards the use of modern contraception. Including these influential stakeholders can help create additional dialogue about family planning and contraception use within **religious communities**, and generate additional buy-in among a group that has previously been opposed to these issues.

5.1.3. Nutrition

→ Promote cultivation and cooking of cassava leaves

Given that Bonthe has considerable cassava cultivation, there is an opportunity to also **promote cultivation of nutritious cassava leaves** among farmers. Unlike the roots that are essentially carbohydrates, leaves are

a good source of protein and Vitamins A and C. **Concurrent training** will also be required on processing and cooking techniques that reduce losses in nutrition associated with common preparation methods. Prolonged boiling involved in making typical Sierra Leonean soups or stews, for example, results in considerable losses of Vitamin C.[124]

→ Incorporate sensitisation against misinformation and myth into nutritional work

Conduct community dialogues and cooking demonstrations on the lead mothers and MSGs should also include **sensitisation about how to counter harmful myths** about different types of food. Not only will this programming activity expand awareness and skills about how to incorporate a cooking demonstration on how to select and prepare nutritionally balanced meals, it can directly demonstrate to community members that myths and misinformation they hold about certain foods – eggs, chicken, pumpkin, and others – are false. Community cooking events can also demonstrate **diverse recipes** that use adequate amounts of such foods to meet the particular nutritional requirements of groups like PLW and boys and girls. Again, such demonstrations **should not neglect men**, as they often have the final say about the foods consumed in the household, in this way encouraging them to take on more responsibilities around caregiving.

5.1.4. Mental Health and Psychosocial Support

→ Engaging community groups in mental health messaging

For example, religious leaders may participate in training and/or sensitisation around health and MPHSS issues to reduce misconception around mental health representation and hence stigma. Again, religious leaders might be **sensitised on basic information** on mental health, mental illness, and stigma, as well as how to help identify individuals in emotional distress to appropriate referral mechanisms. They might also be **encouraged to implement anti-stigma activities** as part of their usual responsibilities at community level by including mental health messaging in their religious activities. Those sensitised/trained could include: pastors, priests, imams, traditional healers, traditional midwives, etc. **Other key actors** like community leaders, CHWs, and adolescents – may be trained as well. This can help to further roll out mental health messaging at the community level, and **create additional avenues for targeting messaging at particular groups**. For example, adolescent girls may find it easier to be approached with messages about mental health issues by peers that are going through similar life experiences.

→ Peer support groups may be formed in project communities

Because there are not enough MHPSS services available at health facilities currently, **peer support groups can serve as community-based MHPSS** that help respond the needs of communities. Participation in support groups can be **led by service-users and supported by health staff** at nearby facilities. Such groups must receive the **requisite training and resources** to provide peer-to-peer MHPSS for common mental health issues such as stress and anxiety, which are common throughout project communities. The support they give might have a **thematic composition of topics** that varies depending on the needs and preferences of participants. Discussions might range from the sharing of mental health experiences, discussing effects, coping mechanisms, peer education, and support and encouragement for service usage. Developing and strengthening innovative responses should **focus on women's groups and networks** that provide peer support for

124 WFP, 2021, *Home-grown School Feeding Value Chain Assessment*.

alternative forms of MHPSS can also create greater awareness around mental health at the community level. Given that most cases of GBV are addressed informally, there exists an opportunity to **promote help-seeking support at a community level**. In particular, peer support structures can also be **trained on the referral pathway**, to help create awareness among survivors of GBV about available services and to better educate them about how to seek out such support. In this way, more serious cases, such as those dealing with the interconnected web of physical, social, and emotional traumas resulting from GBV, can be increasingly referred to more specialised service providers like the OSC.

5.1.5. Water, Sanitation, and Hygiene

→ Rehabilitation for water points in communities and at health facilities should take into account sustainability

Few communities take ownership over their water resources, and as a result many pumps remain broken and used because they have not been repaired. Often community members wait on government or development partners to carry out these repairs on their behalf. More can be done to **engage community leadership in the governance of WASH facilities**, promoting a sense of ownership among community leaders and members and encouraging them to put plans and resources in place for maintenance and repair. In this regard, there may be an opportunity to **integrate this water into the CLTS** to make sure that the same sort of **community-led programming model** is leveraged, to help achieve common health and nutritional goals by making sure all communities have sustainable access to basic WASH services. Community ownership can further fostered by **encouraging communities to proactively collect funds to repair water pumps** in the eventuality that they break. Again, the VSLA model mentioned above could be leveraged for this purpose, so funds are always set aside for repairing broken water points.

→ Develop a network of high-skilled rural water supply technicians

Increasing the functionality of water facilities across the district requires attention, and additional focus is needed on capacity building for community management and government/private sector maintenance services. **Creating a roster of certified rural water supply technicians** could fill this need. In particular, there is an opportunity to **work with the MoWR to train and certify** more individuals specialising in pump repair, including within this **strong representation of women**. The technicians could be private for-profit individual operators, who should benefit from standard training, accreditation, and subsidised for tool kit. The technicians would provide **routine preventative maintenance**, together with **repairs** and potentially **source construction/installation services**. Taking time to ensure that such **repair people are geographically dispersed** in a way that makes them accessible to most communities can help secure access to such expertise across the three chiefdoms the project is working in.

5.1.6. Cross-cutting Gender and Protection

→ Create easy to communicate gender and protection messaging tools that can be used by all ACF staff and partners for sensitisation across sectors

Such messaging should be **easily communicated in summary format** for individual sessions with WASH Committees, FMCs, MSGs, and other support groups. This might be **a single tool** for communicating messages on gender and protection to all groups, or it could be adapted (where needed) to mainstream messages that exist for each sector.

→ Ensure that gender and protection is mainstreamed into all ACF activities throughout the project management cycle

This starts with **developing monitoring, evaluation, and learning systems** that explicitly incorporate gender and protection into all outcomes, outputs, and indicators. This also means that **all data collected in support of programming must have strategies** to collect and disaggregate data properly – by sex, age, disability, etc. – to make sure there is useful data to monitor, evaluated, and inform programming. Data that is being collected for programming activities, for instance data on GBV cases, child protection issues, and human rights abuses, can also help create a knowledge base in this area for ACF and it's partners, helping each to profile incidents – types, place, victim, perpetrator, etc. – to what inform programmes of ACF and others.

→ Ensure all ACF staff receive adequate training on gender and protection issues

This will mean **training staff on important aspects** of *'do no harm'*, security protocol, referral pathway, gender sensitisation, etc., to give each the **information and skills necessary** to always act in ways that are gender sensitive, and to promote gender equality daily through their professional roles and responsibilities.

→ Implement gender-related programming models focused on social transformation

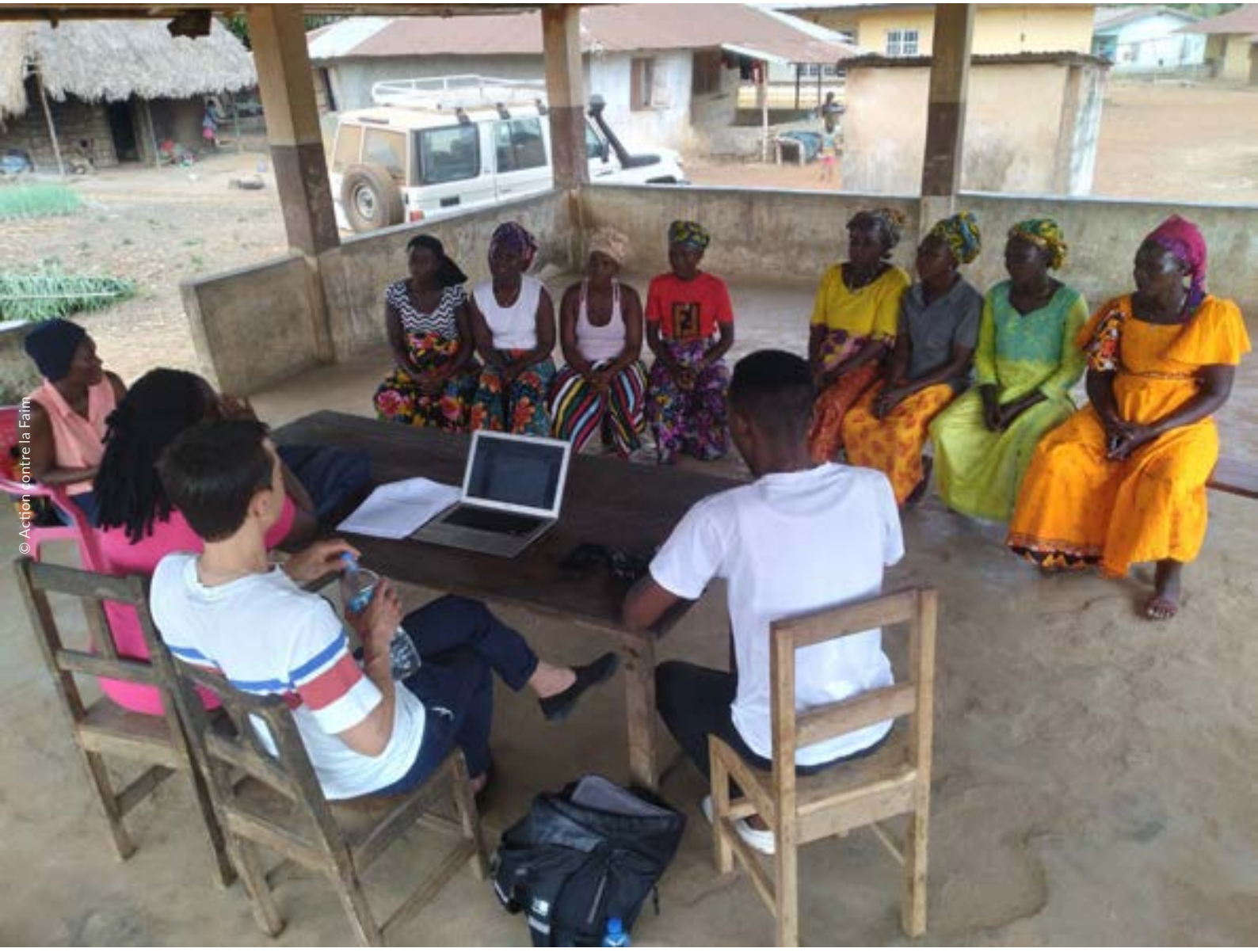
The *Gender and Protection Analysis* shows that gender norms are deeply entrenched. Thus, it should be expected that promoting gender equality and normative change in any context is a long and difficult process. Social learning and social sanctions are both embedded in community and occur over time. *Start, Awareness, Support, and Action* (SASA!) is one such model. *SASA!* is designed to **address a core driver of violence against women**: the imbalance of power between women and men, girls and boys in a way that **inspires and enables communities to rethink and reshape social norms**.[125] This technique has been applied and evaluated, having been found to decrease GBV in frequency and severity, and reduce the risk of new onset of GBV.[126] Interventions that shift harmful gender norms and increase gender equality are likely to generate multiple outcomes, as gender equality has been shown to be correlated with wider indirect benefits such as: economic, health, and educational outcomes.[127] Thus, while effective normative change requires broad action, the benefits of such change are also to be widely felt, creating positive economic and social externalities for men, women, girls, and boys.

→ Gender programming targeted at men/men's groups

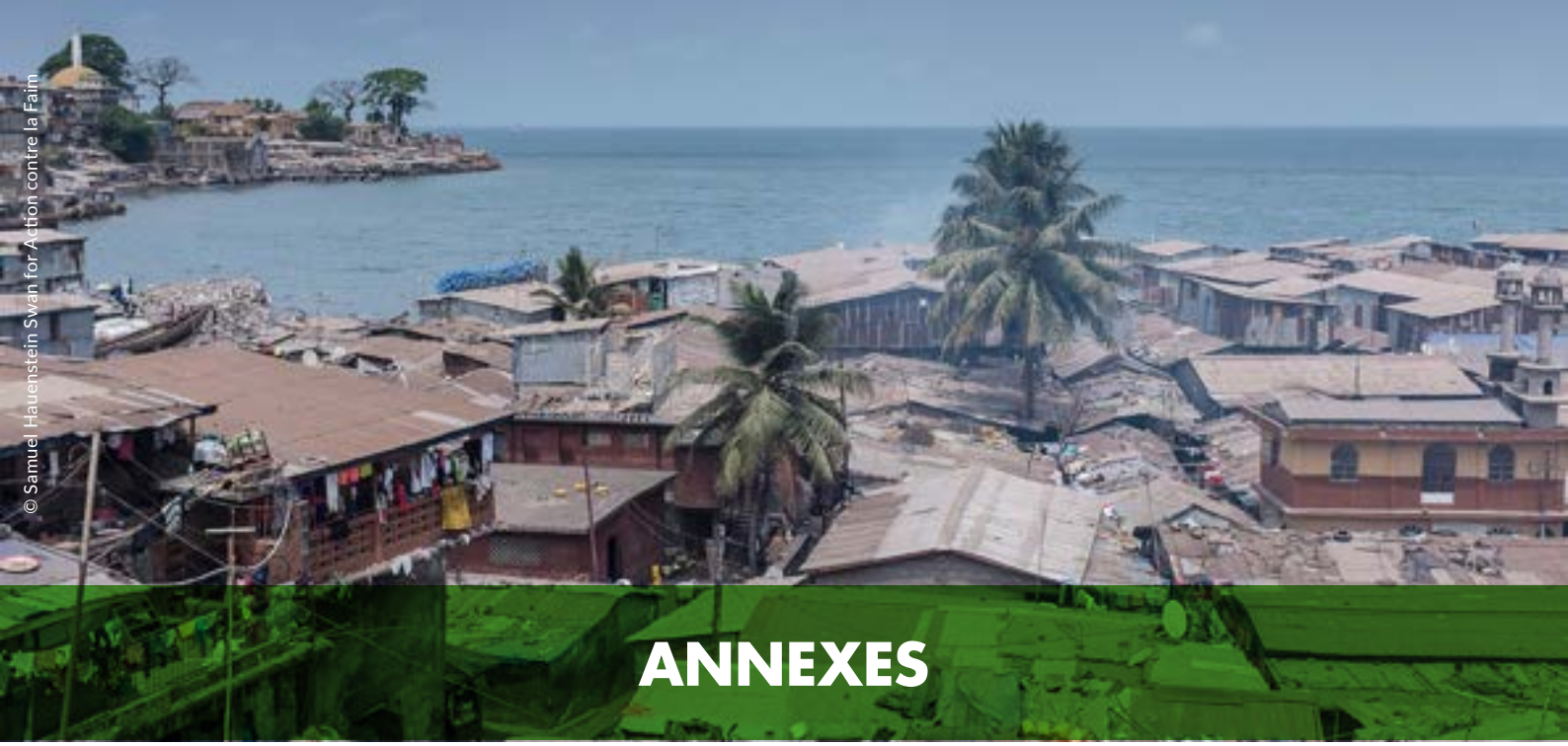
Given the inter-gender dynamics of how norms function and the power that men hold in Sierra Leonean society, **it is critical to not limit gender transformative interventions to women and girls**. Evidence suggests that interventions working with males, as well as females, are more effective at reducing violence than single-sex interventions.[128] Indeed, there is a growing acceptance that men and boys must be included in interventions aimed at GBV, especially given the role of males in the perpetration of violence, and recognition that masculinity and gender-related social norms are implicated in GBV.[129]

125 Raising Voices, "SASA!," http://raisingvoices.org/sasa/ (accessed 6 March 2023).
126 Abramsky *et al.*, 2016, "The Impact of SASA!, A Community Mobilisation Intervention, on Women's Experiences of Intimate Partner Violence: Secondary Findings from a Cluster Randomised Trial in Kampala, Uganda," *Journal Epidemiologic Community Health* 70 (8).
127 Michelle Remme, Michelle, Christine Michaels-Igbokwe, and Charlotte Watts, 2014, *What Works to Prevent Violence against Women and Girls?* Evidence Review of Approaches to Scale up VAWG Programming and Assess Intervention Cost-effectiveness and Value for Money, n.p.
128 Jewkes, Rachel, Michael Flood, and James Lang, 2015, "From Work with Men and Boys to Changes of Social Norms and Reduction of Inequities in Gender Relations: A Conceptual Shift in Prevention of Violence against Women and Girls," *The Lancet* 385 (9977).
129 Ricardo Christine, Marci Eads, and Gary Barker, 2011, *Engaging Boys and Men in the Prevention of Sexual Violence*, Pretoria: Sexual Violence Research Initiative and Promundo.

One internationally recognised model of intervention that as mentioned in this regard was: *Engaging Men in Accountable Practice* (EMAP). *EMAP* offers an **innovative model for working constructively with men** to examine the gendered impact of conflict and how they have been socialised, which are crucial steps in creating a world where women and girls are valued, equal and free from violence.[130] Such a methodology was found to be effective in reducing some forms of GBV in other contexts.[131]

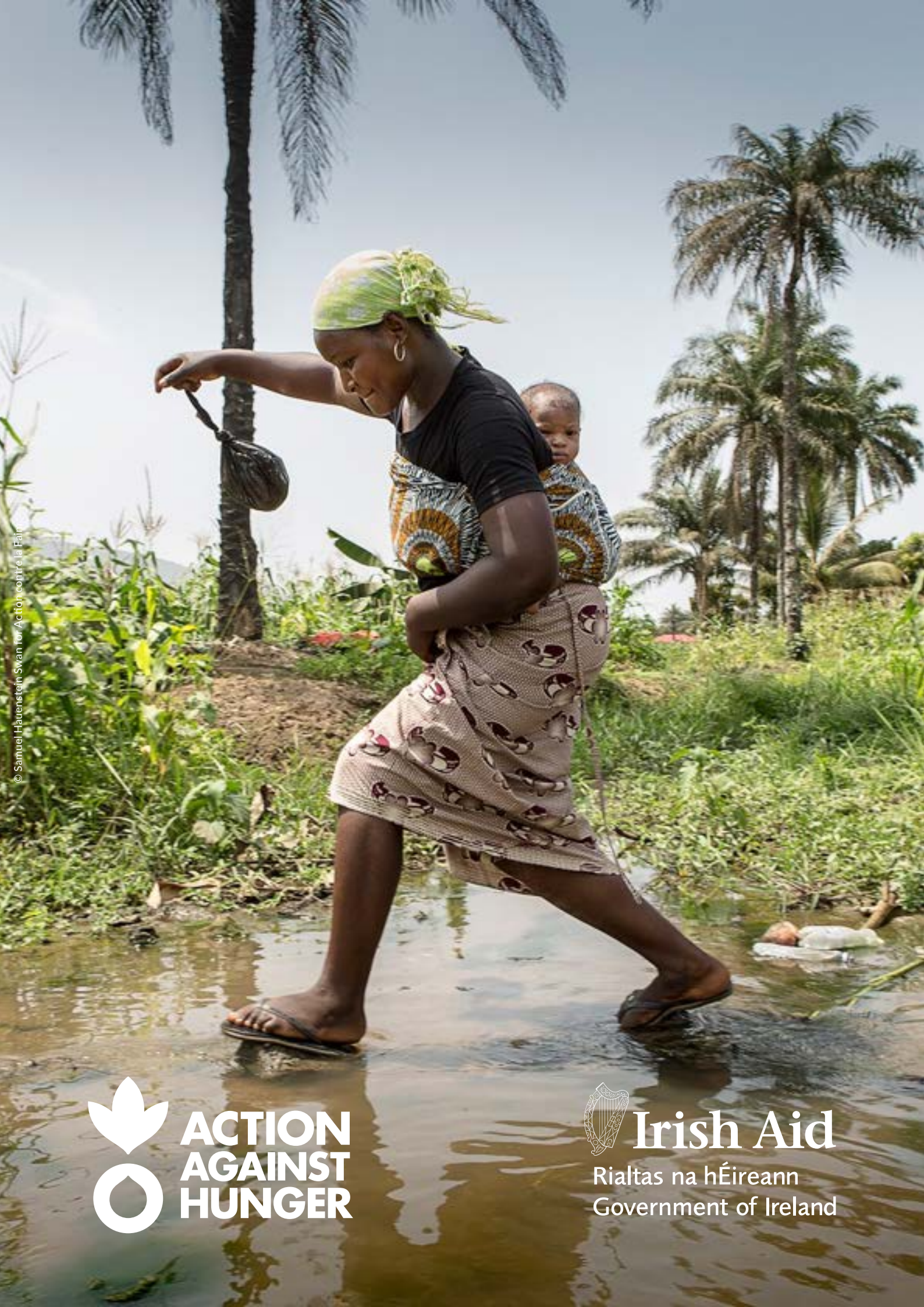


130 IRC, 2013, *Part 1: Introductory Guide Preventing Violence Against Women and Girls: Engaging Men Through Accountable Practice*, New York, NY: International Rescue Committee.
131 IRC, 2013, *International Rescue Committee – Liberia, Men's Dialogue Group Endline Study.*



ANNEXES

Annexes available upon request



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