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Rapid Gender Analysis

TO SUPPORT THE GOVERNMENT OF SIERRA LEONE TO STRENGTHEN ITS HEALTH SYSTEM

The Rapid Gender Analysis was conducted in November - December 2023 across eight districts of Sierra Leone: Falaba, Kambia, Bonthe, Tonkolili, Kenema, Karene, Kailahun, and Pujehun.

APRIL 2024

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The views in this analysis are those of the author and do not necessarily represent those of CARE or its constituent programs.

CONTENTS

LIST OF ACRONYMS

CARE	Cooperative Assistance and Relief Everywhere
ANC	Antenatal Care
CEFM	Child, Early, and Forced Marriage
CHC	Community Health Centre
CHP	Community Health Post
CHW	Community Health Worker
DHMT	District Health Management Team
FGD	Focus Group Discussion
FLHW	Frontline Health Worker
FMC	Facility Management Committee
FP	Family Planning
GBV	Gender-Based Violence
GoSL	Government of Sierra Leone
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IPV	Intimate Partner Violence
KII	Key Informant Interview
MCHP	Maternal and Child Health Post
MoGCA	Ministry of Gender and Children's Affairs
MoHS	Ministry of Health and Sanitation
NHSP	National Health and Sanitation Policy
PNC	Postnatal Care
PHU	Primary/Peripheral Health Unit
PIQ	Personal Interview Questionnaires
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SRH	Sexual Reproductive Health
THE	Total Health Expenditure
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
VSLA	Village Savings and Loan Association

EXECUTIVE SUMMARY

This Rapid Gender Analysis (RGA) report presents findings from the gender and power analysis carried out in November and December 2023 in **Falaba, Kambia, Bonthe, Tonkolili, Kenema, Karene, Kailahun, and Pujehun** districts of Sierra Leone. The purpose of the RGA is to understand how gender and social norms, roles, relationships, and dynamics influence health outcomes and health-seeking behavior in Sierra Leone, especially for vulnerable populations. The report will inform the development of CARE's future health programming and proposed interventions for health funding opportunities.

The document is structured into four primary chapters – Background, Methodology, Findings: Results and Analysis, and Recommendations—each containing sub-chapters. The background section outlines the study's purpose, objectives, and underlying rationale. The methodology section describes the research design, applied approaches, data collection methods and participant information. The study's key findings are categorized into distinct thematic areas aligned with CARE's Good Practices Framework for Gender Analysis and includes the following **Core Areas of Inquiry:**

- Household decision-making, division of labor and control of productive assets
- Control over one's body
- Access to public spaces and services
- Claiming rights and meaningful participation in public decision-making

The RGA also applies the above domains related to health outcomes, behaviors, and health-seeking behavior, including gender dynamics within the Sierra Leone health system with recognition that unequal gender dynamics gaps impact health care providers and their ability to deliver quality services. Finally, the recommendations section outlines actions or interventions CARE should consider in future programming.

Key Findings

- Men have more influence over decisions for the household than women—including the seeking of healthcare—and women lack control over key decisions related to sex, marriage, and children, including if and when to use contraception. Women's mobility is limited by social norms which require male permission for movement.
- Contraceptive use is low. Despite around 70% of people knowing about contraceptives and where to get them, only 50% are currently using them. Many community members believe modern forms of family planning are *haram* or unhealthy, with anecdotal evidence suggesting there is perception that it promotes extramarital affairs.
- Front Line Health Workers (FLHW) face major barriers to effective service delivery: almost half of FLHWs interviewed are unpaid, effectively operating as volunteers, struggle with difficult living conditions and lack of supplies, and report inequitable treatment between male and female workers.
- There is a lack of evidence-based health information for pregnant women: only 27% of pregnant women in the study reported having received any information related to sexual and reproductive health or associated risks.
- Despite generally positive health-seeking behavior, both women and men are concerned by lack of availability of medicine.

- Despite community efforts to reduce sexual and gender-based violence, Gender-Based Violence (GBV) continues to be prevalent in studied communities, with the majority of study participants agreeing that Intimate Partner Violence (IPV) is an issue, and that GBV contributes to adolescent pregnancy.
- Participation in decision-making structures at the community and public level is influenced by age and gender, with women and youth less likely to hold positions of power and influence key decisions.
- At a policy level, the various gender equality policies lack adequate gender mainstreaming and integration training at central and decentralized levels and are not addressing deep-rooted gender inequalities embedded in social norms and practices.

Recommendations

1) **Address harmful social norms at the household and community levels –** engage with community leaders, both women and men, in dialogue that aims to shift the power dynamics and increase acceptability of less traditional roles for both women and men in the household and community.
2) **Engage with men and boys to address the harmful social and cultural norms –** both in their own lives and across formal structures.
3) **Promote the leadership of women and youth –** to increase their participation and representation across the health system.
4) **Address GBV –** roll out evidence-based prevention programming targeting the root causes, including power imbalance, of prevalent forms of violence and increase the number of community engagement and feedback structures to facilitate reporting and access to justice.
5) **Ensure programming methodologies and interventions are appropriate for rural, agricultural populations with low literacy and numeracy –** utilizing literacy trainings and farmer business management methodologies as delivery mechanisms for health and norms change content.
6) **Support supply chain management** to address inconsistent availability of medicines, which is the most pressing concern both women and men have regarding access to healthcare.
7) **Address the high prevalence of unpaid health care workers** and develop key incentive packages to retain and motivate health care workers, taking into consideration the needs of female health care workers, particularly those posted in hard-to-reach and isolated communities.
8) **Strengthen or introduce Community-based Health Service Delivery Accountability and Feedback Mechanisms** to ensure that community members can accessibly share feedback on service provision concerns and priorities for improvement. Ensure this mechanism includes a feedback loop back to the community on actions taken.
9) **Support the Ministry of Health and Sanitation (MoHS) to review its Human Resource policies and practices** to ensure male and female health workers are treated equitably with a focus on equal pay.
10) **Implement professional development and continuous learning curriculum with community level health workers** to refresh and/or upgrade technical knowledge and skills including new protocols and policies and support evidence-based community health education.

BACKGROUND

Gender inequality presents a significant barrier to social and economic progress in Sierra Leone. The country is ranked 162 out of 170 on the United Nations Development Programme's (UNDP) Gender Inequality index in 2021, placing it among the least equitable countries in the world. Harmful gender and social norms, especially those that inhibit women's and girls' education and decision-making, pose significant obstacles to advancing reproductive, maternal, newborn, child, and adolescent health (RMNCAH), including access to modern contraceptives, and reducing the prevalence of malaria.

Sierra Leone's population is very young, with approximately 60% of the population under the age of 25[1]. The sexual and reproductive health education they receive is often from their parents and informed by stigma and misinformation about sexuality and contraception. The median age at first marriage among women aged 20-49 is 19.8 years[2], indicating high rates of child, early, and forced marriage (CEFM). These factors contribute to high rates of adolescent pregnancy and poor health, education, and livelihood outcomes for women.

Traditional norms around household and childcare responsibilities and decision-making have started to shift in response to awareness campaigns and an increased number of women taking up leadership roles both in public and private spheres[3]. However, women only hold 18% of elected seats in deliberative bodies of local government and only 12% at the national level[4].

The Government of Sierra Leone (GoSL) is aware of the challenges regarding gender issues and has articulated the need for continued integration and mainstreaming of gender in all development programs and projects at national and local levels – including having specific objectives and targets under Policy cluster 5 in the Sierra Leone's Medium-term National Development Plan 2019–2023[5]. The Ministry of Gender and Children's Affairs (MoGCA) have the mandate to ensure the oversight of the implementation of gender-related laws and policies – like the Gender Equality and Women's Empowerment Act which became law in 2023 and the Sexual Offences Act of 2012. The MoHS Gender Desk under the Directorate of Policy and Planning is responsible for ensuring quality of care. This is laid out in several policy documents, including Framework for Life Stages Approach to Service Delivery, RMNCAH and Nutrition Strategy 2017-2025, RMNCAH Policy, and Strategy, Quality of Care and Patient Safety Policy.

However, many of these centrally agreed policies and laws remain aspirational, having little meaningful impact on the lives of women and girls in Sierra Leone. Rather, entrenched stereotypical attitudes toward women and girls in the family, school, and society continue to hinder progress towards the ambitions laid out in the above listed policies and laws. A significant gap remains in actualizing gender equality and eliminating discrimination and GBV in Sierra Leone.

Specific to health, Sierra Leone's Total Health Expenditure (THE) remains low despite the National Health and Sanitation Policy (NHSP) goal of 15% of gross domestic product and international and regional standards required to provide universal health coverage (UHC). In 2021, Sierra Leone released a National Community Health Worker (CHW) Policy, which lists providing gender-sensitive services as part of the CHW program mission but is not yet adequately funded.

There is a need for robust, evidence-based programming that mainstreams gender equality and inclusion. This RGA was commissioned by CARE to ensure future health programming continues to address the evolving gender and power dynamics relevant to the most vulnerable target groups.

[1] Sierra Leone Population and Housing Census 2015.
[2] Sierra Leone Demographic and Health Survey 2019
[3] CARE SL Flood RGA 2021
[4] https://data.unwomen.org/country/sierra-leone
[5] Sierra Leone's Medium-term National Development Plan 2019–2023. pp 136

METHODOLOGY

The RGA was conducted using tools and approaches of CARE's Good Practices Framework for Gender Analysis[6]. As much as possible, the analysis applies an intersectional lens to identify how components of one's identity (age, marital status, etc.) influence the domains. The aim of the RGA is to provide practical programmatic recommendations to identify the differing needs of women, men, boys and girls and the most vulnerable populations, ensure we 'do no harm', and identify opportunities to transform inequitable gender and social norms through future health programming.

The team used a range of primary and secondary information gathering methodologies, including a mix of **qualitative and quantitative methods,** to understand local gender and social norms and how they influence women's and men's roles and relationships. Qualitative tools included Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) (see Annex I for guides). The quantitative tool was a Personal Interview Questionnaire (PIQ). Qualitative questions were formulated for KII discussions for flexibility in discussion with target stakeholders, and to allow for probing of certain critical issues reported during interviews by various respondents.

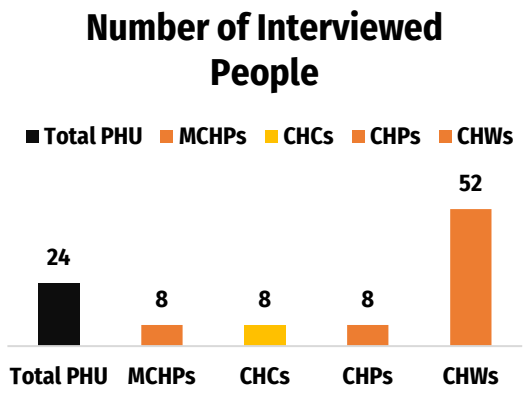
Using two-stage cluster sampling methods, the assessment targeted **8 districts** out of 16 total (Kailahun, Kenema, Kambia, Karene, Falaba, Tonkolili, Bonthe and Pujehun) and **24 catchment facilities** in **4 regions.** The chiefdoms were randomly selected using a multi-stage cluster sampling selection method.

KIIs were conducted with 24 randomly selected staff members of 24 Peripheral/Primary Health Units (PHUs) (one staff per facility): 8 Maternal and Child Health Posts (MCHPs), 8 Community Health Posts (CHPs), and 8 Community Health Centers (CHCs). In addition, 52 CHWs and District Health Management Teams (DHMTs) took part in KIIs.

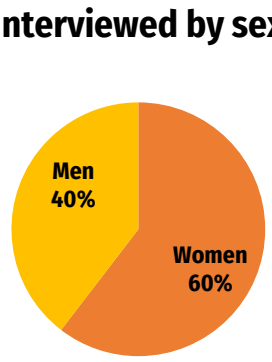
In total 24 **FGD** sessions were held with a minimum of eight people per group.

A total of 720 individual respondents (435 females, 285 males) from different households were interviewed using the PIQ across the 24 selected catchments. The PIQs were conducted in communities that are 2-8 kilometers away from PHUs. Data gathering and analysis was done using the KoboCollect mobile data collection app and Excel spreadsheets.

BAR CHART 1. NUMBER OF INTERVIEWED PEOPLE BY HEALTH UNITS



PIE CHART 1. NUMBER OF INTERVIEWED PEOPLE BY SEX



To minimize poor or low quality of data, supervisors accompanied each enumerator during data collection; supervisors reviewed data, identified inconsistencies, extreme values or invalid codes prior to data being uploaded online. The data was collected using tablets which enabled additional data verification including length of time for completion of questionnaires and verification of interview locations through geolocation coordinates.

[6] genderinpractice.care.org/wp-content/uploads/2019/12/GEWV_gender-analysis-good-practices_2012.pdf

Research limitations include challenges to data collection stemming from cultural sensitivities around discussing GBV and religion, both of which are important determinants to health uptake, but which could not be investigated in depth. Additionally, the survey design also included numerous demographic questions which provided data which, while rich, did not directly relate to the specific focus of this study. In the future, more targeted questions will ensure the possibility of deeper analysis into the core areas of inquiry.

FINDINGS: RESULTS AND ANALYSIS

Socio-Demographic Characteristics of Respondents

Socio-demographic characteristics of respondents formed the basis of social stratification in the analysis. As argued in existing literature (Rosemary Morgan, Asha George, Sarah Sali, Kate Hawkins, Sassy Molyneux and Sally Theobald, 2016)[7], using socio-demographic indicators as social markers or stratifiers in gendered power analysis can serve as a way of identifying intersections that influence an individual's vulnerability, for which the project can use to target groups that face the most barriers to accessing health services improved health outcomes.

TABLE 1: Social and demographic characteristics of respondents interviewed

Indicators/ household characteristics	Disaggregation	% of sample	
Sex of respondents	Male (n=285)	40	
	Female (n= 435)	60	
Religion of respondents	Muslim (N=565)	78	
	Christian (N=155)	22	
Average household size	7 people		
		% Female	% Male
Age category of respondents	15-24 years (n=137)	24.1	11.2
	25-49 years (n=403)	56.3	55.4
	50 years or above (n=180)	19.5	33.3
Marital status of respondents	Married Monogamous (n=307)	39.8	47.0
	Married Polygamous (n=139)	16.6	23.5
	Single (n=132)	18.2	18.6
	Widow/Widower (n=66)	12.6	3.9
	Co-habiting (n=44)	7.1	4.6
	Divorced (n=18)	3.2	1.4
	Separated (n=9)	1.8	0.4
	Don't know (n=5)	0.7	0.7

[7] See 'How to do (or not to do) …gender analysis in health systems research'. Downloaded from https://academic.oup.com/heapol/article/31/8/1069/2198200

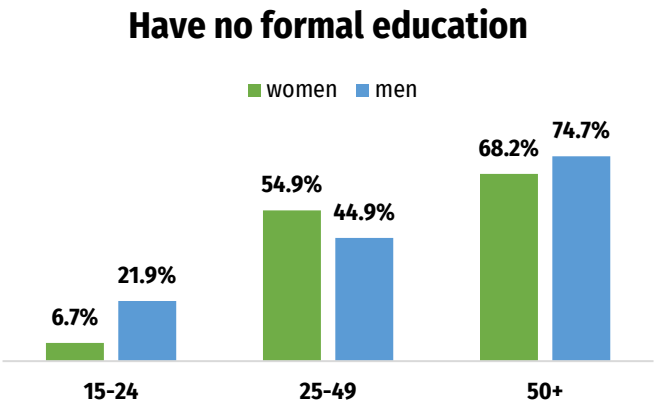
Were married before 18 years	Percent of ever-married respondents (n=52) 4 48	12%	1.7%
Highest level of education	No formal education (n=348)	45.7	52.3
	School aged with some formal education, but out of school (n=23)	3.7	2.5
	Some primary education (n=44)	6.4	5.6
	Completed primary education (NPSE certificate) (n=25)	3.7	3.2
	Some JSS (n=51)	9.4	3.5
	Completed JSS (n=52)	8.3	5.6
	Some SSS (n=82)	11.7	10.9
	Completed secondary education (WASCE certificate) (n=61)	7.6	9.8
	Tertiary (college/university) (n=17)	2.1	2.8
	Tertiary (tech/vocational) (n=17)	1.4	3.9
Current fertility status (women only)	Neither pregnant nor a mother (n=208)	39.5	
	Has biological child(ren) but not lactating (n=192)	36.5	
	Lactating mother (n=84)	16.0	
	Pregnant (n=42)	8.0	

The surveyors intentionally interviewed significantly more women (435) than men (285) for two reasons: (1) understanding women's experiences and perceptions was a key aim of the assessment and (2) when the survey was being conducted, more women than men available to spend time with the survey team.

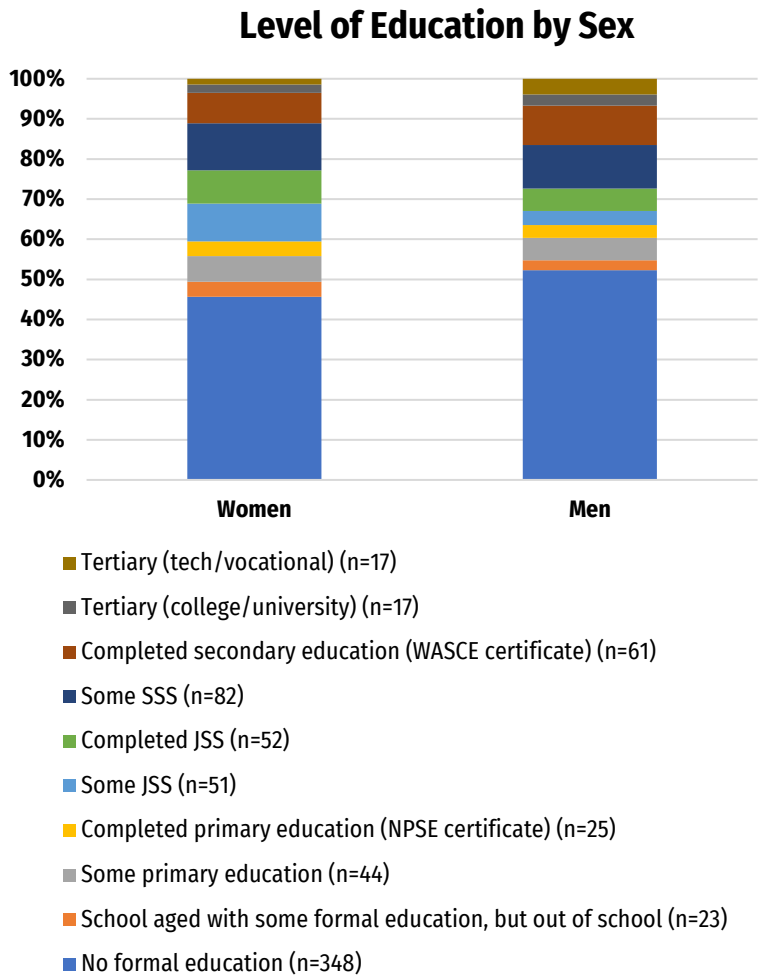
The majority of those interviewed sit at the bottom end of the formal education spectrum, with 46% of women and 42% of men reporting they have not had formal education. This is significantly higher than the national averages captured in the 2019 DHS, which recorded 39% of women and 29% of men as having no formal education but noted that the DHS 2013 founds levels were higher, and therefore closer to the rates found in this RGA (51% women, 41% men).

On average, the data shows that women are receiving less education than men, with higher percentages for 'highest level achieved' at every level except Senior Secondary School (SSS) completion and above. This finding seems to undermine the claim of PIQ respondents – 88% of whom said boys and girls are given equal access to education.

BAR CHART 2. PERCENT OF PEOPLE WITH NO FORMAL EDUCATION BY SEX



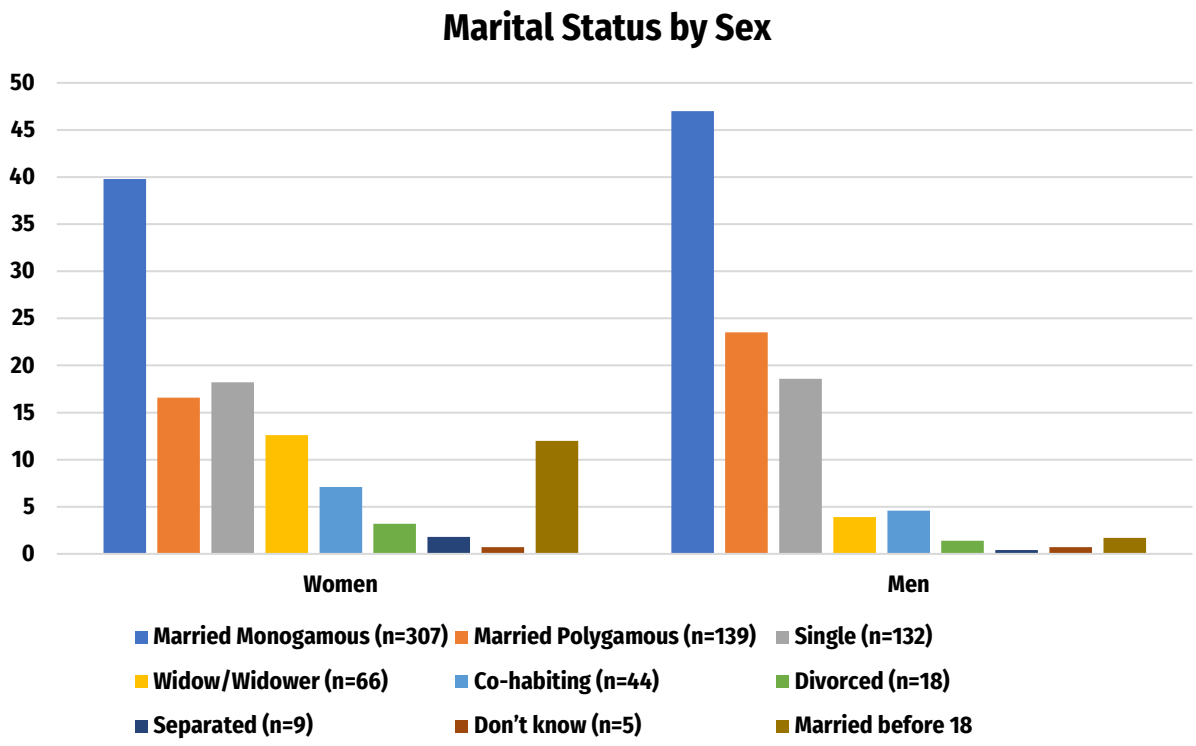
BAR CHART 3. PERCENT OF LEVEL OF EDUCATION BY SEX



However, when the data is divided out by age (see below), the proportion of individuals who have had no formal education dramatically increase with age, showing that youth have much higher rates of starting, and staying in school, than their parent and grandparents. However, rate for both men and women are low when it comes to post-secondary education, with fewer than 7% of men and 3.5% of women completing some kind of post-secondary degree.

The majority of respondents were either married or cohabitating (female 63.5%: male 75%), with just over 18% of respondents identifying as single. Among the ever-married respondents, 12% of women were married before turning 18, which is in contrast with 1.7% of male respondents who married before age 18.

BAR CHART 4. MARITAL STATUS BY SEX



Household decision-making, Division of labor and Control of productive assets

Although monthly income was not provided by respondents, the PIQ and FGD participants agreed that the primary livelihood activity of most families is agriculture/farming: 83% of women and 86% of men PIQ respondents reported some level of involvement in these activities. This is far higher than the national average (54% women, 49% men), which is likely a reflection of the difference between urban centers and the rural areas selected for the RGA. According to the 2019 DHS, men and women in the lowest wealth quintile are most likely to be employed in agriculture, which implies that most RGA respondents are amongst the poorest in Sierra Leone.

Of those respondents engaged in farming/agriculture, 66% of women and 72% of men reported spending four or more hours per day on agricultural activity. When PIQ participants were asked to describe the agricultural activities in which they are involved, the answers given by men and women are almost identical with no discernible gender gap in labor responsibilities. However, when FGD participants were speaking about men's farming activities they used the terms "farming" and "labor" most often, but when speaking about women, "gardening" was used but "labor" was not.

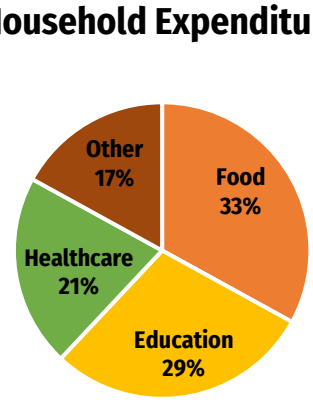
This difference in language could reflect the different value placed on labor inputs by men and women. When asked what else they contribute to the family's farming activities, 8% of women responded, with petty trading, livestock, and cooking being the most common answers. Less than 5% of men listed any additional activities, with livestock activities most mentioned.

In total, 65% of FGD respondents listed petty trading or business as an income source for women while only 25% mentioned trading or business as a source of income for men. This warrants further exploration, given restrictions noted with respect to women's mobility and household decision-making discussed in this report.

In the PIQ 10% of women and 12% of men reported they are engaged in a job outside of their domestic role: of those, 59% of women are paid for that work, compared with 80% of men. A total of 29% (31% women, 25% men) of PIQ participants said they are members of Village Savings and Loans Associations (VSLA).

When discussing the roles of men's and women's responsibilities around household expenditure, several FGDs assigned percentages – men are expected to cover 70-80% of expenses, including major purchases, healthcare, school fees, whereas women are expected to contribute 20-30% and cover food, medicines, and household items.

PIE CHART 2. HOUSEHOLD EXPENDITURE



Households tended to spend a third of household income on food (33% of total expenditure) and nearly a third on education (29% of total expenditure), as compared to healthcare (21% of total expenditure) and other expenses (17% of total expenditure) across the study districts.

The RGA found that men and women agree that men have more influence over decisions for the household than women. When presented with a list of decisions and asked who decides within a household, 48% of respondents said male heads of household control decisions around income use, borrowing money, and selling assets while 34% reported that husbands and wives make those decisions together. Women's control over financial decisions is more varied, but relatively low overall: 23% noted wives can make decisions on purchasing

daily needs, 11% noted they can make large purchases or borrow money, and 17% noted they can sell assets.

The pattern is similar for decision-making around when and where to seek healthcare for both themselves and their children. In total, 39% of respondents noted men make the decisions and an equal number noted husbands and wives decide together, with the exception that 50% of men say they make the decisions related to seeking their own healthcare alone. In all aspects of household decision-making, including seeking healthcare for themselves, less than 20% of women said they controlled those decisions (range from 8% selling assets to 19% seeking healthcare for themselves). Men reported that women only control 2-7% of household decisions, marking a disparity in perception which warrants further exploration.

In terms of division of household labor, the majority of PIQ respondents report that women and girls are primarily responsible for cooking (77%) and cleaning (56%), though 26% of respondents say boys and girls work together to clean. In total, 69% of respondents reported that children collect water, but overall respondents agreed children are not responsible for childcare. Most households (78%) responded that childcare is the mother's responsibility while (38%) noted that it is held jointly between parents. Care for the sick was noted by half the respondents as carried out jointly by husbands and wives, while 30% of respondents noted it was done by the husband alone. This finding warrants further exploration but was anecdotally linked to increased involvement of husbands related to the need to make decisions around seeking health care and the accompanying expenditure.

When FGDs discussed the responsibilities of men and women in the home and community, responses validated a strong gendered division of labor with cooking, childcare, and domestic work women's domain and decision-making, finances and role of breadwinner, protector men's domain. There was not a significant difference in responses for different age groups across the FGDs.

Control over one's body

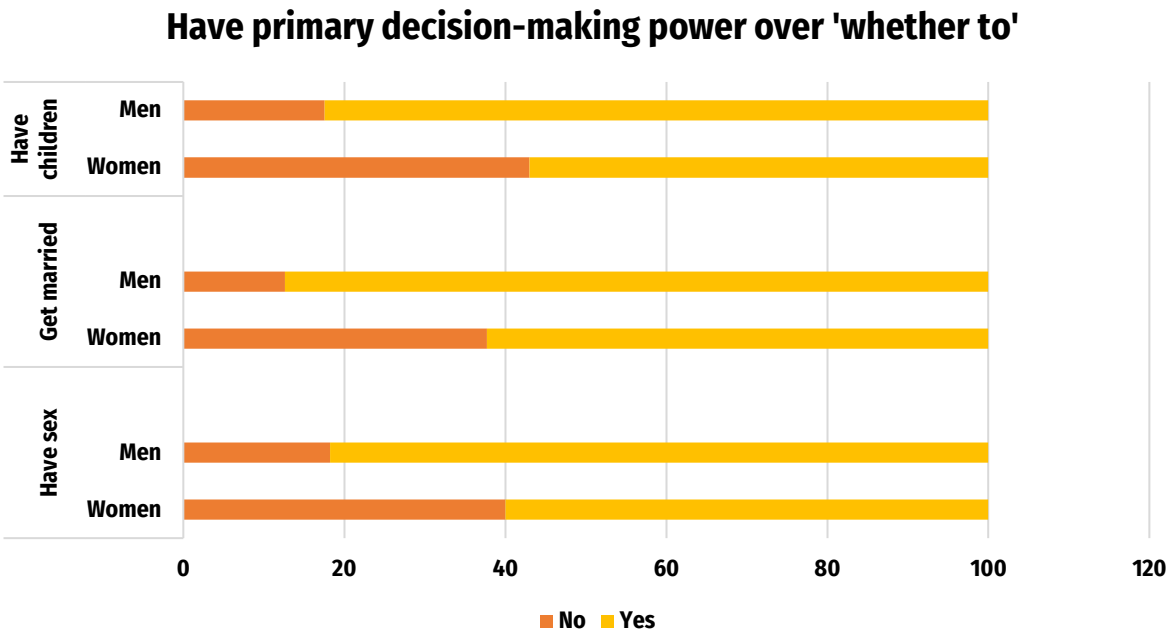
Being able to make decisions about your own body, life, and future, without coercion or violence is an essential human right. This RGA found that in Sierra Leone, more men than women report having primary responsibility for decisions related to sex, marriage, and children. The table below shows the responses from women and men to specific questions related to bodily autonomy.

TABLE 2: Responses from women and men to specific questions related to bodily autonomy

	% Women	% Men
Report that they have primary responsibility for deciding whether, when, and who to marry	65	88
Report that they have primary responsibility for deciding whether, when, and with whom they will have sex	64	82
Report that they have primary responsibility for deciding whether, when, and how many children they will have	56	85
Report that they have primary responsibility for deciding whether and when they use contraceptives	56	90
Report that they allow or advise their partners to use contraceptives to prevent pregnancy or disease transmission	58	66
Are currently using a modern form of contraceptive	51	50

On the health system side, 96% of health workers interviewed noted they would provide contraceptives to unmarried women while 8% said they would require a male relative's permission before providing health services to women.

BAR CHART 5. PERCENT OF PEOPLE WITH PRIMARY DECISION-MAKING POWER



Of the 49 pregnant women interviewed, 16 (33%) said they did not want to get pregnant when they did and only 13 (27%) reported having received any information related to sexual and reproductive health or associated risks.

When FGDs discussed local beliefs and practices related to marriage, pregnancy and family planning, the issue that came up most frequently was that community members believe modern forms of family planning are *haram* or unhealthy. The virtues of herbal forms of family planning were discussed by around 10% of participants. Pregnancy was spoken about as being a gift from God and therefore should not be interfered with. Local beliefs are strongly in favor of marriage as an institution, including polygamy, with a few groups saying girls should get married as soon as they hit puberty. FGDs confirmed the importance of conforming to traditional roles: men were considered the head of household and that women should be subservient, including with respect to sex.

When FGD groups were asked whether women in their communities experience GBV, almost one third of groups agree there is sexual violence, exploitation, and physical abuse in their community, with 60% of respondents agreeing there is IPV and that GBV contributes to adolescent pregnancy. A quarter of groups agreed CEFM is an issue. In total, 12% of the FGD respondents identified situations where GBV is acceptable. These included when a woman does not complete her duties such as cooking, when a woman disrespects her husband, and when a woman commits adultery.

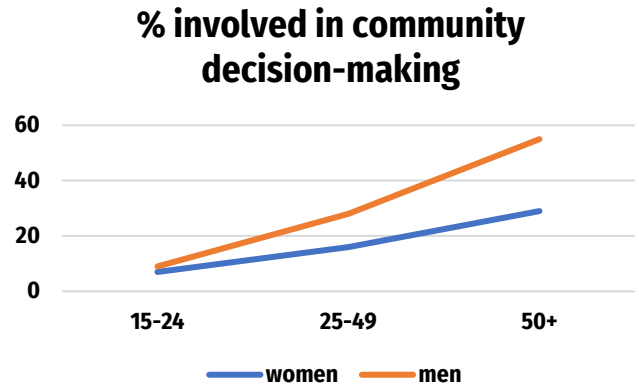
In terms of how the community responds to GBV or IPV, 46% of PIQ respondents said their community has GBV services available. The majority of FGDs agreed that using the law, police, or chiefs are the main pathway to community response (though this is an area for further exploration on the quality of survivor response). There was no mention of working with boys and men to change their behaviors or shifting community perception around the root causes of GBV.

Access to public spaces and services

Only 8% of PIQ respondents said a woman can make the decision independently to visit a relative – 81% say that husbands or couples decide.

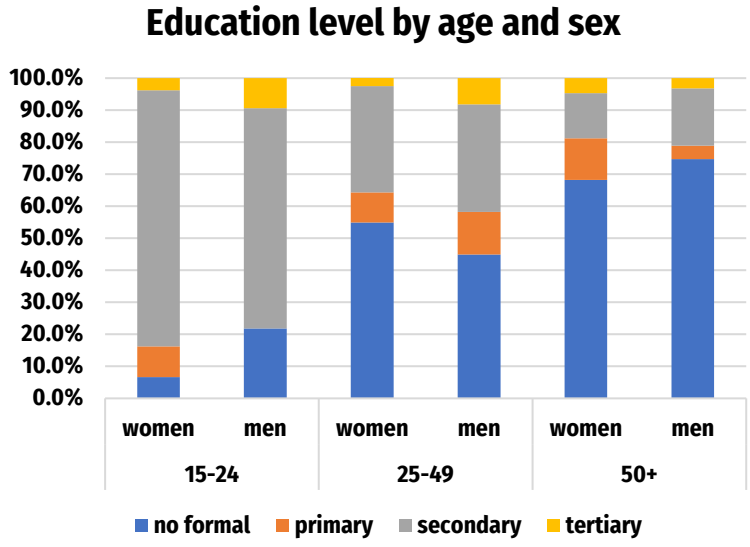
Community decision-making

BAR CHART 6. PERCENT OF PEOPLE BY SEX INVOLVED IN COMMUNITY DECISION-MAKING



Almost twice as many men (34%) as women (16%) report they are members of a power structure responsible for decision-making in their community, chiefdom, or district. Age is also a strong determinant of involvement in community-level decision-making: only 7% of youth 15-24 responded yes (7% women, 9% men), compared with 21% (16% women, 28% men) of people in the 25-49 age category and 43% (29% women, 55% men) aged 50+. This data shows that the rate of women's participation in community decision-making is much lower than men's as they age – women increase 22% between youth and elder, while men increase 46%. If 55% of men over the age of 50 are in decision-making positions, it's clear where the community power lies. Given this same demographic (men over 50) is the least likely to have had formal education, this suggests the community values age-related experience over formal education.

BAR CHART 7. EDUCATION LEVEL BY AGE AND SEX



Women are most often involved in decision-making through Village Savings and Loan Associations (VSLAs) (27%), village heads (19%), or member of Community Teachers Associations (19%). Men are most often Village heads (21%), Community Development Committee members (20%), or traditional leaders (15%).

Those not currently involved in community power structures were asked if they were confident in their ability to participate. Men and women's answers were very similar with 72% somewhat to very confident, and 28% feeling not at all confident.

Health services

Between 87% (Kailahun District) and 100% (Falaba District) of individuals report their community has a local community health center and most people live less than 2km from a health facility. This PIQ data is validated by FGDs, which all agreed there are health services in their community and those services are accessible and affordable for most people, verifying that there are fees for some services. An average of 95% of respondents believe those facilities are safe for women, men, boys, and girls, and 83% of respondents reported knowing the CHW for their community.

When asked what extra factors influence women's access to healthcare, men and women agreed that lack of finance was the most significant issue (61% agreed or strongly agreed), followed by the attitudes of health care workers (43% agreed or strongly agreed). Respondents were split on their opinion of whether male partners' decisions were barriers (41% strongly agreed and 41% strongly disagreed). Just over a third (36%) of respondents noted that bad roads and household chores were barriers to access health services for women.

Results from an assessment of the human resource capacity across the sample of 24 health facilities showed that, on average, 74% of the staff are female. However, 46% (42% women, 50% men) of the 175 health workers in the 8 districts are currently not on regular payroll, working as volunteers. This may be a driver in community members being asked to pay fees for services that they are entitled to receive for free.

From the interviews with health care providers, 46% believed there is a payroll policy/practice to provide equal pay for female and male workers, 58% believe there is an internal document (such as a code of conduct, employee's guidebook) that outlines equal treatment and support for diversity amongst its staff; 83% report there is a policy or practice to assist staff who are survivors of GBV/IPV; and 58% report that there is a mechanism to report sexual harassment or discrimination. However, when asked if the service package for staff provided different provisions for male and female health care providers, 100% of staff said 'no', though 92% believed female health care workers are entitled to maternity leave. When asked what factors discourage them in their workplace, health workers listed their top 5 concerns as.

TABLE 3: Top 5 concerns from health workers in the workplace

Factor	% Women	% Men
1. Difficult living conditions	88	88
2. Lack of materials	75	100
3. Poor functioning health system	75	87
4. Poor management	75	63
5. Inequitable compensation	69	75

Even though they are not ranked among the most common concerns, 50% of both women and men included gender discrimination and sexual harassment amongst their concerns, a finding worth further exploration.

Health-related knowledge, attitudes, and practices

As this RGA is intended to feed directly into the development of CARE's health programming, which is targeted at the most vulnerable last mile population groups, including women and girls, the RGA focused on reproductive, maternal, adolescent and child health and malaria knowledge, attitudes, and practice.

Overall, the respondents in all eight regions noted positive health seeking behavior. The PIQ found that when people are sick, 89% of respondents (90% women, 87% men) seek the attention of health care professionals – either CHWs or at the PHU; and 8% (7% women, 9% men) will go directly to a pharmacy or kiosk to buy medicines without a prescription; and 3% (2.5% women, 3.5% men) will first try to treat their illness with herbs or traditional medicine. Those over 50 years of age are slightly less likely than average to go to a health facility (87%) and slightly more likely to buy medicine directly (10%) than other age groups.

When caring for a sick child, the same number of women and men will seek professional advice (89%). When treating children without medical supervision, 4% of respondents will try herbs and traditional remedies on children (2.5% women, 5% men): and 6.4% will buy medicine for a child directly from a kiosk or pharmacy (6.2% women, 6.7% men).

Community perception of the quality of health services provided by both CHWs and PHUs, is generally favorable with 57.5% (53.5% women, 62.5% men) of respondents rating the services as very good or good. However, 20.5% (24% women, 15% men) rated the services as poor or very poor. The remaining 20% were neutral on the issue.

When PIQ participants were asked their opinion on the problems they saw in relation to healthcare service delivery at the primary health facility, the top five issues that came out were (based on who ranked this as a problem or a serious problem):

1. **Affordability**, 34.5% (34% women, 35% men)
2. **Long wait times**, 29% (28% women, 30% men)
3. **Discrimination**, 27% (27% women, 27% men)
4. **Attitude of the health worker**, 24.5% (25% women, 23.5% men)
5. **Distance of the health facility**, 23.5% (26% women, 20% men)

In addition, 23% ranked transport (25.7% women, 18.9% men), 20% ranked sex of the healthcare worker (22% women, 17% men), 19% getting permission to access healthcare (22% women, 14% men), and 16% going alone (18% women, 12% men) for healthcare as barriers to care. Very few respondents in the FGDs felt the sex of the health worker was a barrier to access services.

When FGDs were asked what the community considers essential for quality healthcare, the most common responses were:

1. Consistent supply of medicines, especially for malaria
2. A good quality facility with sufficient equipment
3. Qualified staff with good attitudes towards the community

The FGDs had moderately positive views on the quality of maternal care (antenatal care [ANC], delivery, postnatal care [PNC], family planning [FP]) being provided in their communities. The same FGDs were strongly positive in their views on the quality of malaria testing and treatment services. FGDs were evenly split in their opinions (positive and negative) on the quality of medicine availability and the affordability or services and medicines.

The RGA limited health knowledge questions specifically to sexual and reproductive health (SRH) – summarized in the table below. More men than women reported that they know the function of contraceptives, where to get contraceptives and where HIV/AIDS services are available. Despite 70% of people knowing about contraceptives and where to get them, only 50% were currently using them.

TABLE 4: Knowledge about contraceptive methods and HIV/AIDS testing by sex

	% Women	% Men
Know about contraceptives that prevent pregnancy	67	72
Know where to get modern forms of contraceptive	68	73
Are currently using a modern form of contraceptive	51	50
Know where to go to get HIV testing and treatment	80	88

Of those respondents who reported they are not currently married (n=225), 44% of the women and 55% of the men report that they are currently using contraceptives to prevent pregnancy and disease,

while 34% of women reported their contraceptive needs remained unmet. A further 19% of women in this group do not know where to go when they need a modern contraceptive. In total, 38% of male respondents and 25% of female respondents in this group do not allow their partner to use contraceptives to prevent pregnancy or infection.

RECOMMENDATIONS

The following recommendations should be considered in designing future health programming in Sierra Leone:

1. **Address harmful social norms at the household and community levels** – In order to address the restrictions on women's agency and rigid gender and social norms, programming should engage with community leaders, both women and men across all ages, in a long-term, iterative dialogue. The process should aim to explore local norms to guide decisions about which are harmful and in need of change; support community action to change local norms; build the acceptability of less traditional roles for both women and men in the household and community; and shift the power dynamics towards more inclusion, from the interpersonal level up to the government.

2. **Intentionally engage with men and boys** – Evidence has shown that shifting gender norms to increase women's agency and autonomy needs the buy-in of the men in their lives. Interventions should be designed that engage with men and boys, both in their own lives and across formal structures, to explore different forms of masculinity and work with young men as change agents. In particular, establishing community structures that can serve as safe spaces for young men will allow them to question norms of masculinity, and learn alternatives through group activities and processes.

3. **Promote the leadership of women and youth** – In ways that will enable structural change to their participation and representation in the community and across the health system. This could mean bringing together existing and emerging leaders for capacity strengthening that includes socially progressive themes and content, including sexual and reproductive health and malaria. With the support of the existing leadership structures, programming can then progress to initiatives that build up and support diverse voices to engage in decision-making. Specifically, the data above identified a need to intentionally address barriers to women taking up CHW role in their health catchment areas, which will require working with health systems and structures at all levels.

4. **Address Gender-Based Violence** – Roll out evidence-based, trauma-informed, and survivor-centered prevention and response programming targeting prevalent forms of violence such as IPV that were identified as problematic by participants in the RGA. Programming should engage households in dialogue aimed at shifting towards more equitable power in decision-making, paid and unpaid labor, and caring responsibilities. Transformative change in how men and women communicate, negotiate, and work together in their home and community will have broad reaching impacts, including on the sexual and reproductive health of both women and men. Other programming possibilities include increasing the number of community engagement and feedback structures and conducting further research on accessibility and quality of survivor support services.

5. **Ensure methodologies and interventions are appropriate for rural, agricultural populations with low literacy and numeracy**. Data from the RGA has shown that many of the healthcare access and uptake issues faced by study participants are influenced by their basic demographic characteristics, notably, low levels of literacy and numeracy, dependence on agricultural livelihoods, and for women, time poverty due to disproportionate burden of care responsibilities. Providing adult literacy and numeracy skills training, which includes socially progressive themes and content, including on SRH, is highly recommended, and can also increase the chances of women to taking up the CHW role in their health catchment areas. Additionally, embedding SRH and social norms change messaging in programming that participants will be highly incentivized to join for economic reasons, such as farmer business management trainings and village savings and loan associations, can begin to address some of the underlying economic barriers to health. At the same time, programming should be organized and scheduled around community members agricultural and caring schedules, recognizing the disproportionate domestic and caring labor undertaken by women.

6. **Support supply chain management** – To address the most pressing concern both women and men have, which is the inconsistent availability of medicines. This may require working the health facilities on their stock management, with the Logistics department of MoHS on stock and supply management, and the central level teams responsible for ensuring stock is available to be sent when requested.

7. **Address the high prevalence of unpaid health care workers** – Having unpaid staff contributes significantly to issues within the health facilities and between facility staff and the community. Consider developing key incentive packages to retain and motivate health care workers, taking into consideration the needs of female health care workers, particularly those posted in hard to reach and isolated communities. Implementing short-term solutions, via stipends or honorariums, while a long-term solution can be found will support other efforts to improve health care services and the community's perception thereof. This may require engaging private sector stakeholders.

8. **Strengthen or introduce Community-based health service delivery accountability and feedback mechanisms –** There was an observable disconnect between communities, community-level health service providers, and the central level health system. To ensure that community members can accessibly share feedback on service provision concerns and priorities for improvement, build an inclusive and transparent feedback mechanism, which could start to restore trust between the health care system and the communities it serves.

9. **Support the MoHS to review its Human Resource policies and practices** to ensure male and female health workers are treated equitably with a focus on equal pay.

10. **Implement professional development and continuous learning curriculum with community level health workers** – While the quality of services is generally well-regarded by RGA participants, health staff performance and motivation will improve with more support for their professional development. Implement a package of training that refreshes their

technical knowledge and skills, introduces new protocols and policies, and build soft skills like provision of adolescent-friendly services, provision of respectful client-centered maternal health services, making men feel welcome and comfortable getting involved in the health care of their wives and children.

CONCLUSION

While Sierra Leone is making progress integrating gender equality into strategies, programs, projects and activities, there remains significant opportunity to support gender transformative programming at the community level focused on equal access to, and involvement in, decision-making; women's bodily autonomy; and preventing gender-based violence. Within the health system, there is an opportunity to unpack and address the gendered barriers that health care providers face, including regular payment, and supporting an enabling environment to do their jobs effectively.

This RGA has surfaced the need for more research on several key areas, including how gaps in the training, education and support received by health workers influence community health seeking behaviors. In particular, the finding that 50% of both women and men health workers included gender discrimination and sexual harassment amongst their concerns, warrants further exploration. Additionally, more research and investigation into the relationship between GBV and health seeking behavior is needed, with trauma-informed, survivor-centered culturally sensitive research methodologies needed to ensure research does no harm.,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