We Lead by Sabi (We Lead by Example)

CAUSE Canada and CAUSE Canada Sierra Leone Partnership

With support from the Fund for Innovation and Transformation, the Inter-Council Network, and the Government of Canada

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Wi Lead by Sabi (We Lead by Example) is a gender-transformative innovation seeking to address gender and disability discrimination as an important intersection of a woman's identity. The project was designed by CAUSE Canada and CAUSE Canada Sierra Leone Partnership (CCSLP) and supported by the Fund for Innovation and Transformation (FIT), the Inter-Council Network, and the Government of Canada. It was tested in rural communities in the Koinadugu and Falaba districts (the Northern region) of Sierra Leone between April 1, 2022, and March 31, 2023. The following sections will describe the innovation's testing and present the main results, learnings, and conclusions.

Context

Sierra Leone is ranked 162 out of 170 in UNDP's Gender Inequality Index. Women and girls suffer high levels of gender inequality including gender discrimination and marginalization. Women's access to sexual reproductive health and rights (SRHR) is low: only 53% of women have their need for family planning fulfilled with modern methods (UN Women, 2019). Women in Sierra Leone are also more vulnerable to violence: 62% of women ages 15-49 report having experienced either sexual or physical violence (UNFPA, 2020).

According to the UN, 10% of Sierra Leone's total population has a physical disability and 35.3% of all people living with a disability live in the Northern region (Sierra Leone 2015 Population and Housing Census), which is also considered the country's poorest region. As in many countries, in Sierra Leone, people do not generally understand disabilities, and cultural and religious beliefs exacerbate misconceptions about disabilities, resulting in extreme abuse and discrimination. Common beliefs about the causes include blaming the misdeeds of parents and/or ancestors; as a punishment from God; and demons/spirits who have possessed the person. People with disabilities are often considered a source of family shame and as "not quite human" (Rohwerder, 2018). In Sierra Leone, these fallacies result in extreme abuse of people with disabilities including not allowing them to leave their homes, increased physical and sexual abuse, lack of access to education, infanticide, paternal abandonment, lack of civic registration, among other forms of discrimination and abuse. In Northern Sierra Leone, myths exist about the magical powers of having sex with virgin girls with disabilities, resulting in undocumented high levels of rape for women and girls with disabilities.

The 2015 census revealed that in Sierra Leone, 63% of the persons with disabilities above the age of three years never went to school. While 24.1% of boys and men with disabilities have attended formal schooling, only 13.2% of women and girls with disabilities had this opportunity.

Koinadugu is one of the districts with lower school age population densities, with approximately 37 to 62 school age children and youth per square kilometre. With lower number of students, fewer resources are allocated, undermining the cost of supervision, the transport of learning materials through areas with difficult terrain, and the number of personnel required. (UNICEF, IIEP-UNESCO, 2020). This also means that schools in Koinadugu have limited resources to do the necessary adaptations to facilitate the access and permanence of girls and boys with disabilities.

Women with disabilities report a higher exclusion from activities during menstruation than women without disabilities. 23.6% of women with disabilities versus 19.7% of women without disabilities aged 15-49 who reported menstruating in the last 12 months did not participate in social activities, school, or work due to their last menstruation (MICS report, 2017). Although schools in Koinadugu have more cubicles for menstruating girls that the national averages (13% in primary schools, 18% in Junior Secondary schools and 30% in Senior Secondary Schools – compared with 4%, 13% and 20% respectively on a national level), there is no information available on whether these cubicles are adapted for girls with disabilities.

Although there is no available information on violence against women with and without disabilities in Sierra Leone, nor its districts, girls and young women with disabilities may face up to 10 times more violence than women and girls without disabilities (World Bank, 2019).

The testing

In response to this context, We Lead by Sabi wanted to put women with disabilities at the centre as a way of transforming the negative pattern of exclusion into a positive one in which women with disabilities lead sustainable changes in their communities.

Our hypothesis was that if women with disabilities are empowered to be leaders and role models in their communities, they will have a greater impact in empowering and influencing other women and girls with disabilities as well as their families and communities to take action to improve their access to rights.
This hypothesis was based on two main assumptions: 1) women can be inspirational to other women and girls; 2) by taking an active role in the community, women with disabilities are showing that inclusion is possible.

The testing methodology was the "Most Similar Systems Design/Mill's Method of Difference". We compared similar cases (communities) which only differ in the outcomes to analyze: 1) changes in knowledge, awareness and attitudes among girls and women with disabilities, families of girls with disabilities and the communities; 2) action plans designed by each of the families and the community working groups. These changes were assessed using pre- and post-tests, interviews, and focus groups with stakeholders in different stages of the intervention.

During a 10-month testing period, women with and without disabilities, appointed as "Champions" worked with out-of-school girls with disabilities, their families, and the entire community to identify and plan specific strategies towards an improved access to rights. Specifically, their rights to education, sexual and reproductive health, and protection from sexual and gender-based violence were prioritized according to the needs already identified during consultations with the community.

First, seven women living with disabilities and seven women living without disabilities from 14 different communities were targeted and invited to be Champions. They received intensive training on gender equality and rights, and on strategies to raise awareness, build capacity and lead change among families and communities. Each Champion worked in their own community however were divided into two intervention groups: Champions living with and without disabilities for intervention group one and two respectively.

During their assignment, each of the Champions identified four out-of-school girls with disabilities in their communities and worked with them and their families. Through home visits, the Champions focused on ensuring the girls' and their families' understanding of the rights entitled to girls living with disabilities. Thereafter, Champions supported each family to identify their specific needs and the risks that prevent the family member living with a disability from having their rights met. Each family built a tailored plan according to their capacity to progress towards access to rights and to protect her from the identified risks. Champions encouraged this change, and supported the families during the entire process, including the plan's implementation.

In parallel, the Champions conducted engagement events for the entire community to raise awareness on the rights and needs of women and girls living with disabilities. They promoted two messages: first, that discrimination and segregation harm the entire community; and secondly, that communities have the capacity to identify, create and implement specific strategies to protect and include women and girls living with disabilities. Champions invited community members to create a Community Working Groups (CWG) to undertake this task and build a plan. As with the families, Champions supported and monitored the creation and implementation of these plans. As a way of ensuring the plans' sustainability, families and communities were supposed to provide the resources to implement their plans.

In addition, the Champions conducted workshops and focus group discussions (FGD) for women and girls living with disabilities to learn and reflect about their rights and needs as they were expected to be key contributors in the development of both the family and the community action plans.

A steering committee was also created to assess the feasibility of the strategies contained in the family and community action plans. The committee was composed of members from different organizations and institutions[1] to bring different criteria to the assessment.

In addition, baseline, midterm and endline surveys were implemented in the 14 communities.

Differences between the outcomes in the communities, with special emphasis on the action plans designed in the communities with Champions with and without disabilities were analyzed to determine if there are significant differences in the effectiveness to create change. Main findings are presented in the following section.

Main Results

Remarkable achievements in women and girls living with disabilities' access to rights were observed in both intervention groups. These changes resulted from their families' improved practices and an increased social action among communities to increase girls living with disabilities' access to rights.

Increased access to rights (education, SRH, protection from GBV) of women and girls with disabilities

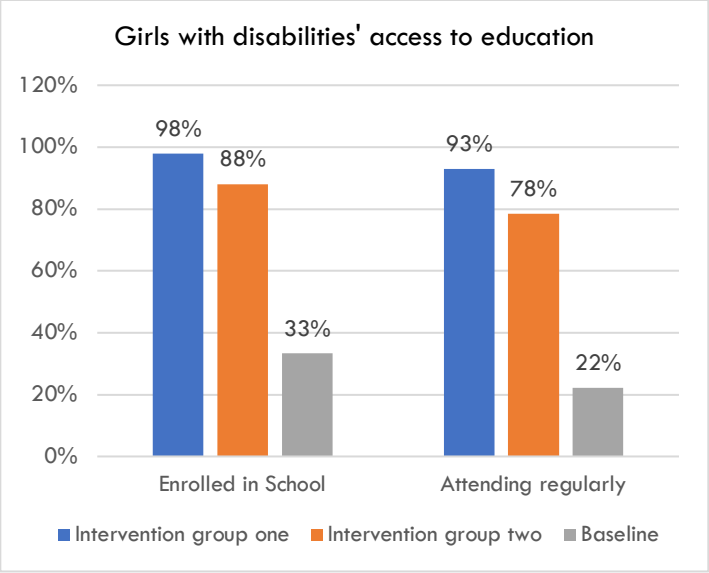
Access to education

Girls with disabilities improved access to education was one of the intervention's most impressive achievements. Based on the baseline findings and the short duration of the intervention, it was estimated that 35% of the out-of-school girls with disabilities targeted by the innovation would be enrolled in school by the end of the testing, however, as shown in the chart below, enrollment rates were considerably higher. The circumstances leading to an increased enrollment in school vary. On the one hand, there were out-of-school girls specifically targeted by the Champions who were enrolled to school as a result of the intervention. Most of these girls (96% in intervention group one and 74% in intervention group two) were enrolled in school because their family prioritized their education as part of their action plan and worked towards achieving that goal. The remaining girls were enrolled in school afterwards even when their families had not prioritized their access to education when designing their action plan. This is explained by the fact that the right to education was also being promoted during the trainings for girls with disabilities and the community engagement events, for which education was being seen not only as necessary but also as possible for the girls living with disabilities and increasingly more by their families.

On the other hand, the enrollment in school of other girls who were not receiving home visits from a Champion, was attributed to the girls' increased knowledge and awareness resulting from their participation in the trainings and the CWGs' actions. The intervention's staff has knowledge of 33 girls (21 in intervention group one and 12 in intervention group two) who were not attending school before the intervention and were enrolled after attending the training workshops. Likewise, there is evidence of 14 girls in intervention group one and seven girls in intervention group two who were enrolled in school as a result of the CWGs' actions.

In addition, reported school attendance among the newly enrolled girls was high as shown in the chart. All the cases of irregular or interrupted attendance were due to mobility limitations either because the girls did not have someone to walk with them to school every day and/or their families were struggling to purchase a mobility device.

[1] Members included the Local Council, Ministry of Education, Ministry of Children and Gender Affairs, Social welfare, DHMT (District Health Medical Team), SLUiDI (Sierra Leone Union on Disability Issues), Girls Education Movement (GEM), Women's Advocacy Network (WAN), One Stop Centre, Women's Network, and Radio Shalloma and Radio Bintumani.



Base: girls with disabilities surveyed at endline

Access to Sexual Reproductive Health and rights (SRHR)
While in the baseline surveys only 3% of the women and girls with disabilities were aware of their SRHR, during the endline surveys, 74% of the women and girls in intervention group one and 62% in intervention group two demonstrated having access to SRHR by acknowledging the availability of contraception and/or because they had visited a health center to receive a service related to their menstrual health or hygiene.

Also, during the FGDs, women showed that they were exercising their SRHR. Some participants shared their stories about taking care of their health as well as exercising their reproductive rights when deciding not to have more children and demanding free contraception at the health centre.
This change is mostly attributed to women and girls' increased awareness about their SRHR as assessed through the post-training surveys where 82% of the participants in intervention group one and 80% of the participants in intervention group two demonstrated an increased awareness about their rights and needs. Also, the CWGs in most of the targeted communities worked to increase girls and women living with disabilities' access to SRHR, mainly by sensitizing and educating the communities about girls and women living with disabilities' SRH rights and needs.

Protection from SGBV
As SGBV was so prevalent and normalized in the targeted communities, women and girls with disabilities were not able to identify situations or risks of SGBV. In fact, during the baseline surveys, none of the girls with disabilities and only 3% out of the women with disabilities mentioned situations of SGBV when they were asked if there were any places or activities in the community where they felt unsafe. During the endline survey, 81% of women and girls with disabilities in intervention group one and 79% in intervention group two recognized feeling vulnerable to SGBV.
Starting to talk about SGBV and raising awareness not only among women and girls living with disabilities, but also their families, and the entire community, was the first step to start addressing and preventing situations of SGBV. Women living with disabilities were able to disclose situations of violence they were experiencing during the FGD as well as reporting their situation to the CWG and community leaders. Also, the families targeted during the intervention improved their practices to stop and prevent situations of violence. As for the CWGs, while the prevention of SGBV was prioritized, they also intervened in the response to SGBV cases. Further evidence on the improvement of family practices and increased social action to protect women and girls with disabilities from SGBV will be presented in the following sections.

<u>Families' improved practices to increase girls living with disabilities' access to rights</u>

In order to improve girls living with disabilities' wellbeing, it was paramount to improve their families' practices. With this end, Champions first pursued an increased awareness about the rights and needs of girls with disabilities among the families and then supported them to build a tailored action plan to improve their practices.

As assessed by the pre- and post-surveys, 96% of the families in intervention group one and 86% in intervention group two increased their awareness.

100% of the families from both intervention groups designed and implemented an action plan.

Working with the Champions enabled the families to realize that they could do better in terms of the attention and care they were providing to their girl living with a disability. Although all the actions in their plans were directed towards this final goal, more specific actions related to an improved care were implemented by some families. Some examples include holding family meetings to appoint members to support her during daily activities, provide enough food and decent accommodation.

At the endline, all 55 family representatives surveyed said that the sentence that best describes the way they and their family relate with their girl living with a disability is: "We have been integrating her more into our family and doing more things to improve her life". Likewise, all 55 girls agreed that the best way to describe the changes in their families is: "My family is including me more and taking better care of me".

The main area in which families improved their practices was education. All the girls in intervention group one and 93% of the girls in intervention group two were either enrolled in school or in skill trainings. Only two girls in intervention group two were neither enrolled in school nor skill training due the severity of their disability.

The second area mostly commonly prioritized by the families was health. 52% of the families in intervention group one and 46% in intervention group two reported that the girl's access to health services had improved as a result of their action plans.

Although health care is supposed to be free for all people living with a disability in Sierra Leone, most of the families were paying medical bills. In some cases, they were able to get some of the services for free after being sensitized about this right by the Champion, however, in most of the cases, the families continued to struggle to find the funds to cover medical expenses. Most of their strategies were oriented towards that end.

Among the families changing their practices to improve access to health, six families (three per intervention group) included specific actions to improve the girl's access to SRHR. These actions were setting as a priority the access to contraception, educating their girl on SRHR or addressing the girl's menstrual health and hygiene.

The third main area prioritized by the families was protection from SGBV. At the beginning of the intervention SGBV was largely hidden and normalized by many, however, as the champions continued talking about SGBV with the families to increase their awareness of the need to protect their girls from SGBV, more families started to address this issue. One of the most remarkable achievements was that two early marriages were prevented by families who were receiving direct support from a Champion in intervention group one. In addition, three families in intervention group one and one family in intervention group two identified that their girls were experiencing or had experienced SGBV and consequently included specific actions to address those situations. In addition, one family established specific actions focused on sensitizing the family on the negative effects of early marriage to stop a family member from giving the girl in child marriage. Also, two families in intervention group two decided to undertake actions to protect their girl from SGBV as a preventive measure. In one case, the family focused on educating the extended family while in the other, the family focused on promoting and supporting the awareness raising efforts among the community. Lastly, four families (three in intervention group one and one in intervention

group two) included the protection from all types of violence through improved supervision and protection measures for the girl during various activities.

Although the remaining families did not include specific actions to protect the girl from SGBV, their awareness of the girl's risk of experiencing SGBV increased during the intervention. While 26% of the families in intervention group one and 39% of the families in intervention group two recognized that their girls were at higher risk of experiencing SGBV during a survey conducted at the end of the second home visit, in the endline survey, 74% of the families in intervention group one and 72% of the families in intervention group two expressed that they were aware of the girl's potential exposure to SGBV.

Increased social action among communities to increase girls with disabilities' access to rights.

Increased social action is now being achieved in all the targeted communities. Actions are being led first by the Champions and by the CWG, but then supported by community members as expected. Somehow unanticipated, women and girls with disabilities, especially in intervention group one, are now having a stronger role as advocates for their rights.

Champions
Champions from both intervention groups successfully positioned themselves as agents of change in their communities. Although all the Champions completed the assigned tasks, resulting in the positive results presented in the first part of this section, Champions with disabilities stood out in the achievements in the following ways:

1. Champions in intervention group one were able to engage more women and girls with disabilities than the Champions in intervention group two by being creative and sensitive to the needs of women and girls living with a disability. Examples include implementing outreach/motivational strategies such as door-to-door notification and giving girls and women living with a disability a say in the selection of the training venues.
2. Champions living with disabilities promoted and supported the role of women and girls living with disabilities as active advocates of their rights. Although it was planned that the main actors of social action would be the families and communities, Champions with disabilities also ensured that women and girls living with disabilities were encouraged to use their voices and actively support actions that would be of benefit to them. Further detail is provided below.
3. Champions in intervention group one achieved more participation during the community engagement events and were more effective in increasing support for the implementation of the community action plans with 285 (154 women, 131 men) community members willing to support the action plan vs 150 (73 women, 77 men) community members in intervention group two.
4. Champions in intervention group one advocated before the local Peripheral Health Units (PHUs) and the government hospital in Kabala for the free access to medical care of women and girl with disabilities. For example, one of the Champions reported having built relationships with nurses at the hospital who never charge her for treatment, to ensure that the hospital does not charge other women or girls living with a disability.

During the endline surveys, all 14 Champions said they will continue taking action to improve the wellbeing of women and girls with disabilities.

Community Working Groups
In coordination with community leaders, the Champions led the creation of the CWGs. 14 CWG were formed with an average of 15 members including the town chief, mammy queens, youth leaders, town speaker, School Management Committee (SMC), chairman, mothers' club chairlady, nurses, religious leaders, head teachers, among others.

All CWGs committed to monitoring all forms of discrimination of women and girls with disabilities, mitigating challenges faced by families in terms of accessing education and SRHR, monitoring SGBV cases in their respective communities, and supporting families to implement the strategies from their action plans.

Likewise, all CWGs designed and implemented their action plans. In both intervention groups, the plans included strategies to improve women and girls living with disabilities' access to education, SRH and protection from SGBV. In some communities, actions to address discrimination and neglect were included as well.

- The strategies are comprehensive. Some examples include:
  - Working directly with families with girls living with disabilities to monitor and support them.
  - Raising awareness among all community members on relevant topics such as teenage pregnancies and the use of contraception.
  - Liaising with school authorities to wave admission charges for girls with disabilities.
  - Advocacy to the health centres to guarantee free access to healthcare for people living with disabilities, as required by law.
  - Creating/strengthening community by-laws regarding SGBV.
- Some of the results achieved by the CWG are:
  - 21 girls with disabilities were enrolled in school directly as a result of the CWGs' actions.
  - Three child marriages of girls with disabilities who were not being targeted by a Champion were cancelled because of the CWG's intervention.
  - CWGs strengthened the monitoring and response mechanisms to SGBV cases in their communities.

Women and girls living with disabilities

An unexpected result was that women and girls' empowerment went beyond the family and community action plans. Although the actions plans were crucial to improving their access to rights, women and girls were also acting independently, without necessarily channeling their needs through the plans. For example, some girls attending the workshops were able to talk to their families to enroll them into school. Likewise, women and girls started to address situations of violence and to exercise their SRHR.

Champions from intervention group one led the creation of awareness-raising teams composed of five women and three girls in each of the seven communities. The purpose of the teams was to identify and engage more women and girls living with a disability. All the groups were formally registered because it was necessary so as to be recognized by the community and to organize and hold meetings with other community members. The teams' first achievement, resulting from their coordination with other community leaders, made it compulsory to address the needs and rights of women and girls living with disabilities in all community gathering. Now, the awareness-raising teams are being consulted and included in any issue related to women and girls in their communities. Following the intervention, in some communities, addressing the needs and rights of women and girls with disabilities at all community gathering is a by-law enforced by the chiefs.

Conclusions

Both Champions with and without disabilities were successful in improving the capacities (knowledge and awareness) of girls and women with disabilities, families of girls with disabilities and the entire communities. Consequently, changes in behaviour, including social practices, were realized in the action plans designed by each of the families and the community working groups, were observed in both intervention groups. However, Champions with disabilities achieved an unexpected outcome: women and girls living with disabilities positioned themselves as leaders of change, and, thanks to the Champions' initiative, established themselves as active advocates for their rights. This validates the hypothesis as the use of role modeling by women with disabilities to inspire and empower women and girls with disabilities and help them break down barriers that challenge them and others in their communities proved to be very effective. Furthermore, Champions with disabilities were more effective in engaging communities, resulting in a higher number of community members supporting the efforts to improve women and girls with disabilities' inclusion and overall wellbeing. Lastly, Champions with disabilities demonstrated a sensitivity, motivation and enthusiasm that led them to undertake additional actions such as personally advocating to the health centres for the right to free medical care for people living with disabilities.

Nonetheless, achievements in the communities led by Champions living without disabilities also confirmed the effectiveness of women's leadership, which is extraordinary in a country marked by a deeply rooted gender inequality.

Recommendations:

1. While women living with disabilities are important leaders who are role models that inspire and empower women and girls with disabilities, it is also critical to have them lead projects such as "We Lead by Sabi" as they are essential advocates of change for themselves and others in their communities.

2. Empowering women living with disabilities to be advocates and positioning them as role models for other women and girls with disabilities is an effective strategy to impacting both individuals' wellbeing as well as changing the mindset of the community.

3. Intensive and comprehensive training should be offered to all the Champions at the beginning of the intervention as a key component to their empowerment. Likewise, refresher trainings, together with ongoing one-to-one support from the staff and counselling were important supports for Champions' performance as leaders of change.

4. Although the main objective was to improve the practices of the families of girls living with disabilities and mobilizing communities, it is remains critical to help position women and girls living with disabilities as leaders of change, and active advocates for their rights.

5. Educating women and girls living with disabilities, their families and the entire communities is key to mobilizing towards improving the wellbeing of girls and women living with disabilities.

6. While the access to education was families' main priority when seeking to improve girls living with disabilities' lives and future, with changes that were both remarkable and evident, finding feasible and sustainable solutions to improve the access to SRHR among women and girls with disabilities was challenging, as foreseen. Given this, access to SRHR as a more challenging barrier should be prioritized in training for the Champions as well as in other activities in the intervention.

7. As SGBV was considerably normalized and invisible in the communities, empowering Champions and involving key partners were fundamental strategies in changing communities' mindset. The most outstanding outcome related to SGBV was that all CWG were active in the sensitization and awareness raising on SGBV and creation/strengthening of community by-laws. As a result, resources to prevent SGBV should be focused on educating and mobilize communities towards this end.

8. Champions living with a disability promoted the creation of the awareness-raising teams in their communities, thus granting a recognized space for women and girls with disabilities to advocate for their rights. Providing space for Champions to implement their own creative and innovative solutions is important.

9. The CWG were engaged in monitoring and supporting the families in the different actions to improve girls with disabilities' access to education, SRHR and protection from SGBV. Given this, connecting the families with the CWG is useful to improving the outcomes of the family action plans.

10. Involving key stakeholders and presenting the community action to them is a good strategy for connecting the CWG with key decision-makers at the district level and to engaging these stakeholders in supporting all efforts to improve women and girls with disabilities' access to rights.