AN INTERSECTIONAL ANALYSIS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES FOR WOMEN OF LOW-INCOME HOUSEHOLDS

A CASE STUDY OF THE ABERDEEN COMMUNITY, SIERRA LEONE

A master's thesis report
by
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Master of Management of Development

Specialization: Social Inclusion, Gender, and Youth

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A research project submitted to Van Hall Larenstein University of Applied Sciences in partial fulfilment of the requirements for the degree of Master in Management of Development, specialisation of Social Inclusion, Gender and Youth

By Mustapha Abdul Fofanah

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Dedication

This work is dedicated to all the development initiatives genuinely seeking to make the world a better place for the less privileged and marginalized persons.

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Definition of some key terms and abbreviations

TERMS	DEFINITION
SRHR (Sexual and Reproductive Health and Rights)	Refers to the right of individuals to make decisions concerning their sexual and reproductive health, free from discrimination, coercion, and violence.
Low Income	This term refers to the economic status of individuals or households characterized by limited financial resources. Low-income household for this study, is defined as households where the combined regular income of its members is 100 USD and below per month.
Marital Status	In this work, marital status indicates whether an individual is married or single.
Age	Age refers to the number of years a person has lived and it was categorized into groups such as young adults, adults, and older adults.
Religion	Religion signifies a system of beliefs. This work only involved Islam, Christianity and traditional faith.
Education	Education refers to the level of formal learning and knowledge an individual has acquired. Here it was categorised into educated or little to no education.
Disability	Disability indicates a physical or mental impairment that may limit a person's activities.
Intersectionality	The interconnected nature of social categorizations and their impact on an individual's experiences and opportunities, concerning discrimination and privilege.
Healthcare	The organized provision of medical services, including prevention, diagnosis, treatment, and recovery, aimed at maintaining or improving people's health.
Access	The ability of individuals to obtain and use healthcare services, including factors that facilitate or hinder their utilization.
Utilization of SRHR	The extent to which individuals or communities make use of Sexual and Reproductive Health and Rights (SRHR) services, encompasses various aspects such as frequency of use, types of services used, and reasons for use or non-use.
Opportunities and resources	The available means, support, or initiatives, that contribute to improving access and utilization of SRHR services.
Aberdeen community	The specific geographical and social community located in Sierra Leone is the focus of the study.
SSI	Semi-Structured Interviews
KII	Key Informant Interviews
FGD	Focus Group Discussions

Abstract

Sierra Leone confronts severe difficulties in providing comprehensive sexual and reproductive health and rights (SRHR) services (WHO, 2021). The provision of proper SRHR services faces significant obstacles due to the nation's difficulties with some cultural norms, poverty and scarce healthcare resources (MoHS, 2017). These obstacles are particularly acute for women from low-income backgrounds, who encounter intersecting attributes and disadvantages that further hinder their access to essential SRHR services. The challenges in accessing SRHR have resulted in the prevalence of—increased risks of STIs, unwanted pregnancies, unsafe abortions, female genital mutilation, teenage pregnancies, and sexual assault against women etc., (WHO, 2021).

With a focus on the Aberdeen community of Sierra Leone, this study has explored the concept of intersectionality as a tool to analyze and understand the intersection of low income with other identities such as religion, age, education, marital status, and disability in the context of access to SRHR services. The report examines the impact of the above-mentioned intersecting identities (age, religion, marital status, education, and disability) on the ability of women who are already identified as coming from low-income backgrounds to access SRHR services, as well as the importance of 'by and for' organizations in addressing the needs of marginalized women who face difficulties in getting the much-needed access to SRHR.

A total of twenty-nine (29) individuals plus five (5) key informants were included in the data collection processes, which consisted of two (2) focus group discussions (FGD) with four (4) participants each, and twenty-one (21) semi-structured interviews (SSI). These individuals consist of participants who represented a variety of intersecting characteristics, including disability, age, education, marital status, and religion, all of which manifested in the results as the most common combinations of intersectional attributes among these participants that had a big impact on how they accessed SRHR services. The KII—including a community leader, an SRHR advocate and three SRH workers with one of them working in the private sector.

The results show the importance of using intersectionality as a tool to understand and analyse access to SRHR for women. It shows how the various factors studied impact women's access to SRHR services in Aberdeen. The study used low income as the main factor, along with religion, age, disability, marital status, and education. The results highlight that religion is a key factor for the women when accessing SRHR services, as faith often influences preferences for SRHR services and the degree of their religiosity shaping their views on SRHR services such as pregnancy prevention, sexual abuse and abortion. Marital status revealed a significant difference between those who are married and those who are single. Single women were shown to have more autonomy while married women often need their spouse's approval to access some SRHR services. Education level affects health-seeking behaviours, with educated women being more proactive and less educated women being less so. Disability creates challenges with access and mobility, and age groups have different SRHR needs and barriers. Younger women (18-25) seek sex education, modern contraception, emergency contraception, menstruation, testing and treatment, abortion (despite its illegality), and STD/STI prevention and treatment. Older women (36-40) mainly seek prenatal and postnatal care and STI/STD prevention. The findings also show how the intersection of these identities with low income impacts these women's utilization of SRHR services and their perception of the available opportunities and resources for promoting access to SRHR services. The research report's recommendations urge the commissioners to develop intervention strategies that recognize the complexity of the identities of these marginalized women and to proffer solutions that do not see them only, as a homogenous group within the community.

Chapter one

1.1 Introduction

This document represents the research report completed as part of the requirements for the Master of Applied Sciences in Management of Development, with a specialisation in Social Inclusion, Gender, and Youth, at Van Hall Larenstein University of Applied Sciences. The research project has been commissioned by the Sierra Leone Netherlands Business and Culture Council (SLNBCC), an organization that, among other crucial activities, promotes and coordinates the implementation of development initiatives in Sierra Leone, including access to SRHR for marginalized groups.

In contemporary society, access to adequate sexual and reproductive health and rights (SRHR) has been highly regarded as a fundamental human right. This status accorded to SRHR, was first echoed by the 1994 Cairo International Conference on Population and Development (ICPD) – in which they emphasised the need for men and (especially) women, "to have access to safe, effective, affordable and acceptable methods of their desired sexual and reproductive health and rights" (International Conference on Population and Development, 1994).

The event was groundbreaking as it marked a significant moment when participating states recognized that sexual and reproductive health is of paramount significance to the well-being and advancement of individuals, couples, and families, as well as the broader social and economic development of communities and nations (Hunt & Mesquita, 2007). By acknowledging this critical interconnection, the conference underscored the importance of addressing sexual and reproductive health needs as integral components of human rights and comprehensive development strategies.

Despite the significant numerous efforts to promote SRHR, many obstacles still exist, primarily preventing marginalized populations from obtaining sexual and reproductive health and rights services (UNESCO, et al., 2018). Among these marginalized groups, women from low-income backgrounds face diverse challenges that significantly hinder their access to sexual reproductive health and rights. The objective of this report is to explore access to SRHR for women residing in the Aberdeen community of Sierra Leone through an intersectional lens.

Specifically, this study explored the concept of intersectionality as a tool to analyse and understand the intersection of low income with other identities such as religion, age, education, marital status, and disability in the context of access to SRHR services. The study assesses how the intersecting identities (age, religion, marital status, education, and disability) affect the SRHR access of women already identified as low-income. Additionally, it highlights the significance of 'by and for' organizations in addressing the challenges faced by marginalized women striving to access essential SRHR services.

The rationale for the focus of this study stems from the recognition that numerous initiatives have been implemented by the SLNBCC and other organizations to enhance access to sexual and reproductive health and rights (SRHS) for women from low-income backgrounds in Sierra Leone. However, despite these efforts, women in such circumstances continue to experience low rates of access. The findings advanced in this study posit that intersectionality plays a role in shaping access to SRHR for women in low-income settings. Therefore, comprehending the intricacies of this issue is vital, and the study results will inform the development of future interventions aimed at effectively addressing this matter.

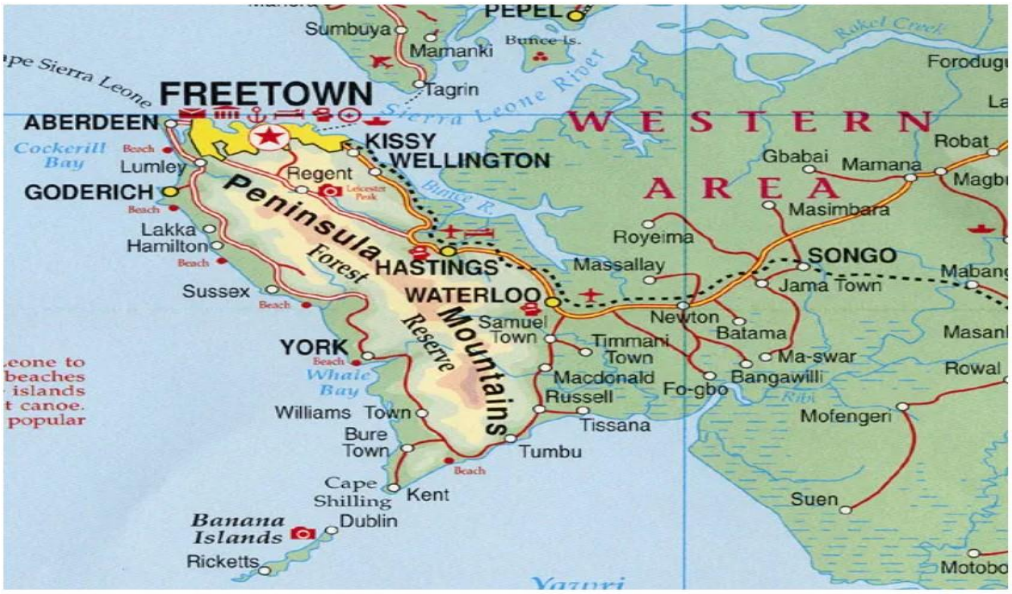
1.2 Country profile and study area

Sierra Leone is a country in West Africa with a population of more than 8 million people (World Bank, 2021). According to Statista, the total population of the country consists of approximately 4.2 million females and 4.22 million males (Statista, 2021). In the Housing and Population Census conducted in 2015 by Statistics Sierra Leone, the youth population makes up 39.4% of the national population. The female youth population is higher than the male youth population at 52.8% and 47.2% respectively – the sex ratio of the youth population is 89.2 which means that for every 100 female youths, there are 89.2 male youths (Statistic SL, 2015). This difference in the youth population has been largely attributed to the growing population of the country wherein, more men migrate and die earlier than women. The statistics mentioned are crucial in understanding the dynamics of the country's population and composition. A large number of the more than 8 million population lives in the rural areas which are marred by poverty and thus, are deprived of good health services. Of these populations, women make up the bulk of it and have limited access to sexual reproductive health and rights services in Sierra Leone (Statistic SL, 2015).

This study was conducted in the Aberdeen community which is located in the northwestern part of Sierra Leone's capital, Freetown. It is an attractive coastal community with a range of upscale restaurants, hotels, nightclubs, and other tourist amenities.

The Aberdeen community exhibits a notable prevalence of commercial sex activities that are largely regarded as unsafe. This situation has, among other consequences, led to an increased incidence of sexually transmitted infections (STIs) and diseases (STDs), unintended pregnancies, and unsafe abortion cases within the community (Menzel, 2019). The community also hosts pockets of other slum-like communities that largely consist of a sizable population falling within the low-income brackets.

Figure 1 Map of Freetown, Showing the location of the Aberdeen community



Credit: Impression of Sierra Leone

The Aberdeen community has been specifically selected by the commissioner for this study since it has undertaken development activities there in the past, and its population, which is deemed to comprise the desired respondents capable of providing the necessary results for the research and also because the commissioner in partnership with other organization has previously undertaken interventions initiatives aimed at improving SRHR in the community—and there is interest to further improve access to SRHR in the area.

1.3 Sierra Leone's healthcare system and sexual and reproductive health

Sierra Leone's healthcare system plays a vital role in providing essential healthcare services to its population. According to the country's Ministry of Health and Sanitation (MoHS), "access to sound health is a human right and its vision is to ensure a functional national health system delivering efficient, high-quality health care services that are accessible, equitable and affordable for everybody in Sierra Leone" (MoHS, 2018). As a commitment to ensuring that they are true to the statement, the ministry has and is still partnering with key players in the health sector and engaging in numerous initiatives to promote health in the country.

In the past years, the MoHS in a bid to enhance sexual and reproductive health and rights services through a series of programs, policies, and strategies, collaborated with international organizations and NGOs, and they have been steadfast in expanding access to these services and reducing health disparities (Rashid, et al., 2017). However, despite these advancements and ongoing efforts, Sierra Leone still faces considerable challenges. The country had a civil war that lasted for more than a decade and it almost destroyed its health infrastructure. The aftermath of Sierra Leone's civil war weakened the health sector of the country and the 2014 Ebola outbreak further exposed the weakness of the

health sector—with the recent COVID-19 pandemic also having a detrimental impact on the health infrastructure of the country (Lauren E. Parmley, et al., 2021).

The above-mentioned situation has contributed negatively to the country's push for progressive development in the health sector and the impacts it has on individuals residing in remote areas and low-income households are overwhelmingly negative. Other factors exacerbating these challenges include poverty and intersectional identities which manifest as societal norms, cultural beliefs, and gender inequalities (Moussaoui, et al., 2022). These factors contribute significantly to the existing gaps in sexual and reproductive health rights in Sierra Leone.

Despite multiple efforts and initiatives from the government, NGOs and other partners, Sierra Leone remains among the list of countries with limited access to health care primarily hindered by locational hindrances, exorbitant out-of-pocket expenses, a scarcity of qualified medical staff, and low-quality healthcare services. (Caviglia, et al., 2021). In the context of sexual and reproductive health, the situation is further complex and challenging. To address the healthcare requirements of women residing in low-income households and facilitate fair access to sexual and reproductive health and rights services, it is essential to comprehend the strengths, limitations, and distinct challenges encountered by women in accessing the system itself.

The healthcare system in Sierra Leone consists of a mix of public and private providers, with varying levels of accessibility and quality across the country. The country possesses a sizable public healthcare system, with the government owning and operating 94% (1,203 out of 1,284) of the registered health facilities. The remaining 6% (81 facilities) are privately owned and primarily located in urban areas, where services are typically funded through user fees at the point of service. (MoHS, 2021).

The public health system policy in Sierra Leone has been the subject of reform in recent years. It has been restructured into three tiers, namely primary, secondary, and tertiary levels of care (MoHS, 2021). Primary care focuses on peripheral health units (community health care), secondary care focuses on districts and specialist services and tertiary focuses on national and regional levels, including the fostering of research and training (MoHS, 2021). This research will focus on the impact of intersectional identities on access to primary health care. The strengths of the healthcare system include the presence of dedicated healthcare professionals and the implementation of policies and programs aimed at improving overall health outcomes. However, significant weaknesses persist, including limited healthcare infrastructure, inadequate funding, a lack of SRHR policies that promote inclusivity/poor implementation of SRHR laws and policies, and a shortage of skilled healthcare professionals. These shortcomings pose particular challenges when it comes to the provision of comprehensive sexual and reproductive health and rights services.

1.4 Presentation of the Commissioner

The Sierra Leone Netherlands Business and Culture Council (SLNBCC) is the organization that has commissioned the research project. SLNBCC amongst other initiatives, has been actively involved in implementing development programs aimed at improving access to Sexual and Reproductive Health and Rights (SRHR) in Sierra Leone. Established in 2016 through a collaboration between the Embassy of the Kingdom of the Netherlands in Accra and the Ghana Netherlands Business and Culture Council (GNBCC), the SLNBCC is dedicated to promoting sustainable development initiatives, fostering a favourable business environment, and providing support to local entities, investors, and businesses from Sierra Leone and the Netherlands.

The SLNBCC recognizes the strong connection between SRHR and sustainable development, and thus, that has been driving its efforts to facilitate SRHR projects in Sierra Leone. The organization has been instrumental in promoting the Netherlands' Aid to Trade policy and advancing partnership interests, leveraging its position to implement SRHR initiatives in collaboration with local stakeholders. Through capacity-building projects, networking initiatives, and the dissemination of valuable insights, the SLNBCC has made significant contributions to drive sustainable development by enhancing access to SRHR services and other development initiatives in the country.

1.5 The relevance of this research on access to SRHS for SLNBCC

The research on sexual and reproductive health and rights (SRHR) holds great significance for the Sierra Leone Netherlands Business and Culture Council (SLNBCC) in its pursuit of promoting sustainable development and fostering an inclusive environment in Sierra Leone. By providing valuable insights into the challenges faced by women of low-income households in accessing SRHR, this research directly informs and shapes the intervention initiatives and programs of the SLNBCC.

In addition to its role in advocacy and policy development, the SLNBCC collaborates closely with the Netherlands Embassy in Accra to coordinate the roll-out of development assistance to Sierra Leone. Promoting healthcare, including comprehensive SRHR, is an area of utmost importance for both the SLNBCC and the embassy. The research findings will serve as crucial evidence for the development and implementation of targeted interventions, policies, and programs aimed at improving SRHR outcomes in the country.

1.6 Problem statement

Numerous organizations, including the SLNBCC, have launched initiatives to enhance the accessibility of sexual and reproductive health and rights services (SRHR) for women from low-income backgrounds. However, despite these commendable efforts, women in this demographic still encounter significant barriers to accessing essential SRHR services. This restricted access can be attributed to the intersec-

tion of additional factors, namely religion, age, marital status, education, and disability. These intersecting elements collectively exert a substantial influence on these women's capacity to access sexual and reproductive health and rights services.

The study's location which is the Aberdeen community lacks adequate information to guide the commissioner in creating and implementing programs and interventions addressing SRHR access through an intersectional lens. Hence, it has been undertaken to provide the commissioner with the necessary knowledge and insights required for developing interventions that enhance access to SRHR for women, considering the intersecting factors that were identified.

1.7 Research objective

The core objective of this study is to explore the use of intersectionality as a tool for understanding and analysing how low income intersects with factors such as religion, marital status, age, education, and disability to impact the accessibility of sexual and reproductive health and rights (SRHR) for women in the Aberdeen community of Sierra Leone—to enable the commissioner of the research to formulate interventions strategies that address the issue through an intersectional standpoint.

1.8.1 Main research question

How does the use of intersectionality as a tool improve the understanding and analysis of the impact of low income and the factors of marital status, age, education, religion and disability on access to SRHR for women in the Aberdeen community of Sierra Leone?

1.8.2 Sub-research questions

1) What are the personal experiences of women in the Aberdeen community, when accessing sexual and reproductive health and rights?

2) What is the contribution of low income and the factors of marital status, age, religion, education, and disability in shaping access to SRHR for women in Aberdeen?

3) How do the combined effects of low income, marital status, age, religion, education, and disability impact the utilization of SRHR services by women in Aberdeen?

4) What are the perceptions of women in the Aberdeen community on the existing opportunities and resources that support access to SRHR?

Chapter Two

2.1 Literature review

This chapter presents an overview of several author's perspectives on access to sexual and reproductive health services and the factors associated with it. It presents conceptual frameworks that make clear the crucial components of access. The chapter also outlines clear definitions for the key terms and concepts that are essential in forming the study's research design.

2.2 Overview of literature review

There have been several studies that try to address the issues of social or intersectional identities serving as barriers to sexual and reproductive health services. The studies featured in this section reveal that socio-cultural and socio-economic factors play significant roles as barriers to sexual and reproductive health and rights (SRHR). According to (Tripathi, 2021), demographic and socioeconomic disparities affect access to family life, and sex education among young unmarried women in India. He revealed that “less educated women from the poorest wealth quintiles and religious and social minorities face greater challenges in receiving mainly sex education” (Tripathi, 2021). Similarly, in Iran, (Shahnaz Kohan, et al., 2017), mentioned that cultural and contextual factors influence the access of single women to reproductive healthcare services. They further argued that family attitudes, sociocultural norms, and the overall cultural context shape their experiences and hinder access.

In Maldives (Hameed, 2018) highlights how sociocultural factors and small island communities create barriers to SRHR for young unmarried women. Non-marital sexual activity is illegal in Maldives and carries different societal expectations for men and women, leading to stigma and isolation for sexually active unmarried women. The inward-looking culture of small island communities exacerbates these challenges, particularly for rural young women who face heightened scrutiny and limited confidentiality (Hameed, 2018). In such a climate, unsafe abortion becomes a common recourse due to the need to avoid public scrutiny and humiliation, thereby hindering access to SRHR.

The findings from these three studies underscore the importance of addressing socio-cultural and socio-economic factors to enhance access to SRHR. It helps in tailoring interventions, programs, and strategies that are bent on improving access for marginalized groups. Most profoundly, it highlights the essence of interventionists to understand that intersecting factors are crucial to ensuring equitable access and improving sexual and reproductive health outcomes. By addressing these barriers, policymakers, healthcare providers, and researchers can work towards overcoming the challenges posed by socio-cultural norms and economic disparities in accessing SRHS for all individuals with limited access.

While the above studies provide crucial information about social factors hindering access to SRHS for marginalized groups, there is however, a study gap existing in the context of social identity such as

marital status, religion, age, education and disability in influencing access to SRHR, especially for women from low-income background and as well the propose study area which is Sierra Leone in general and the Aberdeen community in particular. As stated previously, the study exhibits a notable prevalence of commercial sex activities that are largely regarded as unsafe thus creating a situation that has caused—among other consequences, an increased incidence of sexually transmitted infections (STIs) and diseases (STDs), unintended pregnancies, and unsafe abortion (Menzel, 2019).

2.3 Sexual and reproductive health in low-income settings

Sexual and reproductive health and rights services play a crucial role in promoting individual well-being and contributing to the overall development of communities (WHO, 2023). Access to comprehensive sexual and reproductive healthcare is not only a fundamental human right but also a key determinant of health and social rights (WHO, 2023). However, in low-income settings, numerous challenges persist, hindering the accessibility and utilization of these essential services, (Natasha Davidson, et al., 2022).

Low-income communities encounter a wide range of challenges when seeking access to sexual and reproductive health services. According to the World Health Organization, “Half of the world’s population lacks access to essential health services, and about half a billion have been pushed into extreme poverty because of catastrophic health expenses” (WHO, 2022). This issue is further exacerbated for individuals and families, with limited resources.

Individuals and families, with limited resources struggle to afford the costs associated with consultations, medications, contraceptives, and reproductive procedures. The limited healthcare infrastructure in low-income and middle-income countries compounds the issue, as it results in a scarcity of clinics, skilled healthcare professionals, and specialized services (Liu, et al., 2017). These deficiencies pose significant challenges, especially for those living in remote or underserved communities.

In addition to financial and infrastructural challenges, cultural and societal barriers further impede access to sexual and reproductive health services in low-income settings (Natasha Davidson, et al., 2022). Deeply ingrained cultural norms, values, and taboos surrounding sexuality and reproductive health often lead to stigma, discrimination, and social exclusion (Husseina & Ferguson, 2019). These factors contribute to a climate of silence, where discussions on sexual and reproductive health are considered taboo, limiting education, awareness, and open dialogue. Moreover, gender inequalities prevalent in many low-income societies restrict women's autonomy and decision-making power over their reproductive health, further impeding their access to services (Osamor & Grady, 2016).

The consequences of inadequate access to sexual and reproductive health services in low-income settings are far-reaching and have significant implications for maternal and child health outcomes, overall

population health, and gender equality (Desrosiers, et al., 2020). Limited access to family planning services and contraceptives contributes to unintended pregnancies, resulting in higher rates of maternal and infant mortality, unsafe abortions, and adverse health outcomes (Desrosiers, et al., 2020). The lack of comprehensive sexual education and preventive measures perpetuates the spread of sexually transmitted infections, including HIV/AIDS, leading to a higher burden of disease and impacting the overall well-being of communities (Desrosiers, et al., 2020).

2.4 The value of intersectionality in understanding access to SRHR services

Understanding the complex relationships of access to Sexual and Reproductive Health and Rights (SRHR) services necessitates a thorough investigation of the various identities and situations that people bring to the table. This is where the idea of intersectionality manifests as a potent analytical tool for understanding access. Individuals' experiences of their identities are not isolated but rather interrelated and mutually influencing, and intersectionality recognizes this.

Intersectionality has gained significant attention in academic and public health discourse for its capacity to unearth the complexities surrounding SRHR access. As Crenshaw originally conceptualized, intersectionality exposes how systems of power and privilege operate simultaneously, impacting individuals differently (Crenshaw 1991). For instance, women from low-income backgrounds might face distinct barriers to SRHR compared to women with higher socioeconomic status due to economic constraints. Also, even women from a low-income background who experience some form of disability will have another layer of barriers compared to those who are not experiencing disability.

Furthermore, intersectionality promotes a deeper comprehension of healthcare disparities. Studies (Kapilashrami, 2020) show that by looking at SRHR access with an intersectional lens, we can spot differences that might not otherwise be seen when looking at single identities in isolation. This refined viewpoint can aid organisations and policymakers in developing interventions that are specifically tailored to the needs of underrepresented populations. Also, by acknowledging the value of intersectionality in understanding access to SRHR services, healthcare providers can employ a more inclusive and effective attitude towards SRHR programs that ensures no woman is left behind in her pursuit of essential healthcare services.

Definition of key concepts

2.5.1 Access to health care

The process of providing sustainable access to healthcare, especially for underserved or marginalized groups has been a key activity of at least many international organizations, some state institutions and academic and healthcare professionals. This is because “access is central to the performance of health care systems around the world” (Levesque, et al., 2013). According to (Cu, et al., 2021), the Levesque framework has been successfully used in research that explored, assessed, and measured access in

various healthcare services and settings. The framework introduced in 2013 offers a captivating and inclusive viewpoint by encompassing five dimensions of access and five abilities of the population to obtain healthcare services (Cu, et al., 2021). The five dimensions of access are approachability, acceptability, availability and accommodation, affordability and appropriateness. The five dimensions through which the population interact with five corresponding dimensions to generate access include; the ability to perceive, the ability to seek, the ability to reach, the ability to pay; and the ability to engage (Levesque, et al., 2013). Through these, access to healthcare is determined and it helps identify the factor that is perpetuating the lack of access.

Levesque et al., in their framework, define access to health care as “the opportunity to reach and obtain appropriate health care services in situations of perceived need for care” (Levesque, et al., 2013). In analysing the framework, (Cu, et al., 2021) explain the definitions further as the opportunity to identify, seek, reach, obtain, or use healthcare and to ensure the fulfilment of the needs for these services”. This concept of access to healthcare is crucial to this study. Elements of it will be used to define what access would be for the respondents during the process of defining the tools for data collection. Access is the concept being studied, except through an intersectional lens, thus, an understanding of it is an essential component of the conceptual framework and the research question.

2.5.2 Intersectionality

“Intersectionality is a concept that describes how systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination “intersect” to create unique dynamics and effects” (Center for Intersectional Justice, 2022). Kimberlé Crenshaw, an American scholar and lawyer, coined the term "intersectionality" after being inspired by the Black feminist movements in the United States. Through one of her latest works on the concept, she emphasised how intersectionality highlights the effects of multiple forms of discrimination combining, overlapping, or intersecting to shape especially, the experiences of marginalized individuals or groups, (Crenshaw, 2017).

Intersectionality which sometimes encompasses social identity is a powerful psychological and physical resource that has an important role to play in managing and improving health (Jolanda Jetten, et al., 2017). It contains the elements that describe, define and shape one’s relationship and interaction in any given society as well as how one may access opportunities, resources and facilities. It goes beyond the usual idea of economic disadvantage. According to (Balasubramanya, et al., 2021) “communities with least access are not necessarily the most economically disadvantaged, indicating that relying solely on traditional economic indicators to target programmes and interventions may not be sufficient to improve equity in access to public health services”.

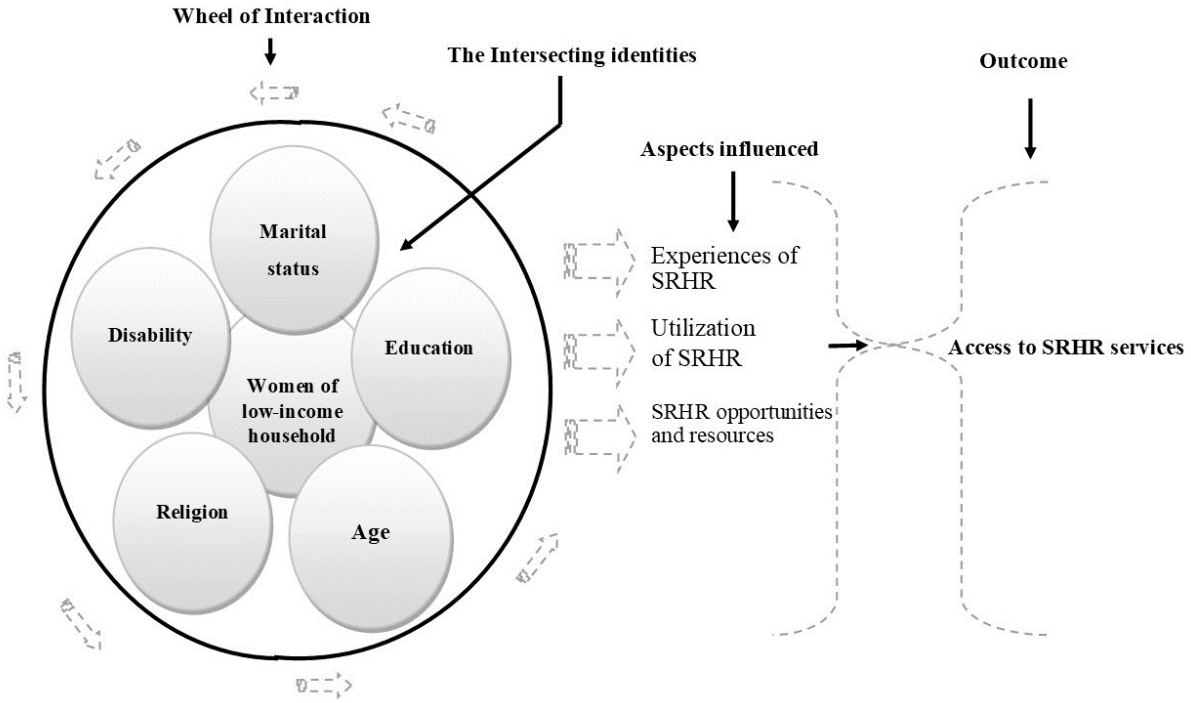
In the context of Sierra Leone, many initiatives such as the free healthcare initiative launched in 2010 – which abolished fees for pregnant women, lactating mothers, and children under five years of age have been instituted yet still, yet the problem of access is still prevalent among that group (Moussaoui, L. S. et al., 2022). This points out the fact that significant gaps and limitations still exist in addressing the healthcare needs of the population in low-income settings, especially women in low-income households. The intersectionality of individuals using public services plays a significant role in creating disparities in access to different services, (Pal, 2022). Intersecting identity has been used as a tool for social exclusion. In the conceptual framework for intersectionality, one's biological (female) and social characteristics (low income, marital status, age, education and disability) are key influencing factors shaping one's access to opportunities and outcomes.

2.5 Conceptual framework

The conceptual framework for the study has been developed by the author using the theoretical framework of intersectionality. The intersectionality framework acknowledges that social identities, including race, marital status, economic status, religion, age, ethnicity, etc., intersect and interact to shape individuals' experiences and their access to resources and opportunities. It emphasizes the interconnections among different social categories and how they intersect to create unique reexperiences of privilege or marginalization, (Bowleg, 2012).

Using elements of the framework, the study aims to explore intersectionality as a tool for understanding the impact of low income, and the factors of marital status, age, education, disability and religion on access to sexual and reproductive health services. The diagram below shows how the mentioned identities interact and intersect to shape the experience of accessing SRHR for women in low-income households in the Aberdeen community of Sierra Leone.

Figure 2 Conceptual Framework



Credit: the author

The diagram visually demonstrates the factors of religion, age, education, marital status and disability and how they interact and intersect with women's low-income identity in shaping their access to SRHR. This framework aligns with the sub-research questions, emphasizing the intersections and interactions that the study explores to understand the use of intersectionality as a tool to understand and analyse access to sexual reproductive health and rights for women in the Aberdeen community of Sierra Leone.

The circle (wheel of interaction) contains the factors or intersecting identities being studied. The arrows going around the circle suggest the turning of the wheel to directly influence the aspects of a person's experiences of SRHR, their utilization of SRHR and their SRHR opportunities and resources—eventually generating the outcome of their access to SRHR services.

Chapter three

3.1 Research Methodology

This chapter provides an overview of the study procedure, outlining the key steps that were completed. These steps include defining the research design, specifying the data collection techniques, determining the sample size, offering explanations of data collection processes, outlining the data analysis methods and addressing ethical issues.

3.2 Research design

The research strategy for this study used a qualitative approach, which was selected to help advance a thorough grasp of the sub-research questions that complemented the primary research question and to record the experiences and perspectives of those who responded. The use of a qualitative approach was specifically selected because the research deals with concepts of social phenomenon—and they are not easily quantifiable. Qualitative research is a method of inquiry that focuses on collecting and analysing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences (Pritha, 2020).

During the data collection stage, two female research assistants were recruited to address the delicate nature of the subject and the opportunity for respondents to share personal and intimate experiences. The research assistants were crucial in creating a setting for the participants that was safe, and encouraging, and guaranteed their comfort and anonymity.

3.3 Data collection methods and data source

The methods used to collect the data for this study were Key informant interviews (KII) to collect data from those working in the field of SRHR and an individual with knowledge of the community – while focus group discussions (FGD), and semi-structured interviews (SSI) were used to gather the data from the primary respondents. The report also used secondary data which consists of the review of literature to understand the concepts identified in the study and which also form parts of the discussion of the findings.

As indicated previously, the report is designed to probe into concepts that deal with perceptions, opinions and experiences of individuals and due to that reason, a deliberate decision was made to use semi-structured interviews since it does not restrict one's response like structured interviews tend to do. It was for the same reason the focus group was done.

However, the FGD and the KII also serve the purpose of data triangulation as the information across the three methods used were compared to identify converging and/or varying patterns.

3.4 Data collection tools

For the semi-structured interviews (SSI), the data collection tool involved the use of an interview guide that was developed to streamline the process. This guide contained open-ended questions covering

various aspects related to the use of intersectionality as a tool for analysing and understanding access to sexual and reproductive health and rights services. It provided the flexibility needed to explore respondents' experiences, perceptions, and challenges in accessing these services. (See annex for the tool)

In the case of the focused group discussions (FDG), the questions in the interview guide were used as a moderator's guide to facilitate group conversations. This guide included a series of topic areas and questions designed to stimulate discussions among the participants. The moderator played an active role in encouraging participation and ensuring that all participants had the opportunity to share their perspectives and insights on the research topic. (See annex for the tool)

For the key informant interviews (KII), the interview guide was developed was used as well with some questions targeting individuals with specialized knowledge and expertise in the field. This guide contained questions tailored to extract detailed information about how intersectional attributes impact access to sexual and reproductive health services.

3.5 Sample selection, sampling size and description of respondents

The study's targeted population for the primary data comprised women residing in low-income households within the Aberdeen community of Sierra Leone. A purposive sampling strategy was employed to select participants using the specific criteria in the table below as the primary requirements for the sampling selection for both the FGD and the SSI. For KII, influence (leadership ability) in the community and expertise on the topic were the only sampling criteria.

Table 1 Participants selection criteria

Sampling selection criteria (SSI and FGD)	Description
Low-Income Households	Participant households are classified as low-income based on their income level or socioeconomic status. Low-income household for this study, is defined as households where the combined regular income of its members is 100 USD and below per month.
Location	Participants are selected solely from the Aberdeen community, Freetown, Sierra Leone. (Only urban area)
Gender	Only individuals who identify biologically as women and are of reproductive age selected. Note: The commissioner decided that the research only focuses on women.
Intersectional attributes	Intersectionality recognizes that individuals have multiple intersecting identities that shape their experiences and access to resources. In the study, participants from low-income households with factors such as age, religion, marital status,

	education and disability status were documented.
Sampling selection criteria (KII)	**Description**
Influence in the community and Expertise on the topic	Respondents' influence (leadership ability) in the study area, knowledge and/or professional experience (working in the field of SRHR) of the topic was prioritized.

The sample size was determined based on the principle of data saturation, which indicates that data collection continued until no new insights or themes emerged. In utilizing this principle, the data was collected one after the other within fifteen days with an average of two respondents per day for the KII and SSI. The two FGDs were conducted in two days.

Initially, it was anticipated that a sample size of approximately 35–40 participants would be necessary to achieve data saturation. However, the point of saturation was reached after conducting two (2) FGD and twenty-one (21) SSI interviews, with primary respondents along with five (5) KII interviews. It became evident that further data collection would not yield additional insights. Consequently, the final sample size for the research was set at twenty-nine (29). When the KII was added, it brought the total number of participants to thirty-four (34).

3.6 Description of respondents featured in the semi-structured interview and focus group discussion

Among the twenty-one (21) respondents for SSI and eight (8) respondents for the combined FGD, fourteen (14) were enlisted as married whereas fifteen (15) indicated they were single, highlighting a deliberate attempt to balance the distribution of marital characteristics.

The age distribution is broken down into three stages. Each stage and the number of respondents is coded as thus ten (10) respondents are 18–25 hereby referred to as young adults, ten (10) are in the 26–35 age bracket, referred to as adults and nine (9) are in the 36–40 age bracket, referred to as older adults. This wide range of ages makes it possible to thoroughly explore the difficulties and points of view present at these selected stages of life for women of reproductive age.

The participants' diversity in terms of religion was also documented, with an equal number of respondents, ten (10) identifying as Muslim (IS), ten (10) as Christians (CH), and an extra nine (9) who adhered to traditional beliefs (TB). This fair portrayal guarantees that experiences are understood holistically in the context of these three religious viewpoints.

The last two intersectional attributes considered in this study are educational background and disability. Fourteen (14) participants had a formal education (educated) and fifteen (15) had little to no formal education (L-to-NO-Ed). Notably, within the total number of respondents, seven (7) were identified as

having some form of disability (DIS). (See table in the annex for more details on the description of respondents).

Figure 3 the Author and a KII interviewee

Credit: the author

3.7. Description of Key Informant Interviewees

One of the five KII respondents, a recognized local leader, provided an individual perspective on local cultural factors and community-based SRHR practices. She was also instrumental in being the resource person and she created ease of access to the community's respondents. Another respondent for the KII was an SRHR advocate with years of experience in the difficulties and possibilities for advocacy activities in the context of the community, on access to SRHR.

The KII group also included three SRHR experts who represented different aspects of the healthcare system. Two were community health workers who were employed by the government and worked in the community's health facility and the last one had expertise from a private healthcare facility. A broad understanding of SRHR accessibility and community dynamics was made possible because of the various perspectives offered by this group of KII respondents, who collectively enhanced the research. (See table in the annex for more details on the description of respondents).

3.8 Data analysis

The data collected from the semi-structured interviews, focus group discussions, and key informant interviews were analysed using a qualitative data analysis approach. The data collected were systematically and thoroughly explored to identify themes, patterns, and relationships concerning the impact of intersectionality on access to sexual and reproductive health and rights for women in low-

income households within the Aberdeen community. The data analysis process commenced during the data collection phase, with responses being transcribed. The following methods were employed to analyse the data:

3.8.1 Coding, Categorization and Analysis

In the initial stages of data analysis, the transcripts from the semi-structured interviews, focus group discussions, and key informant interviews were meticulously reviewed and coded to identify meaningful units of information. The coding process included labelling specific segments of the data with descriptive codes that encapsulated the key ideas, concepts, and themes present in the respondents' answers. These include respondents' identities, accounts of the experiences of access, the utilization of access etc.

The thematic analysis was drawn from the coded data and utilized in the presentation of the findings. They were derived through an iterative process of reading, coding, and categorizing the data. All aspects of the data and the themes that were driven from it were tailored to facilitate an effective exploration of the research questions and the research objectives.

3.8.2 Interpretation and Integration

Following the identification of themes, the data were further analysed to gain a deeper understanding of how intersectionality influenced access to sexual and reproductive health and rights. The data were interpreted and synthesized, taking into consideration the unique perspectives and experiences of the participants. The analysis explored connections and relationships between the themes, enabling the development of a comprehensive analysis.

3.8.3 Validation and Triangulation

To ensure the reliability and validity of the findings, a triangulation process was employed. The data was compared and contrasted through semi-structured interviews, focus group discussions, and key informant interviews. Patterns differences and contradicting statements were key elements sought after in this process. However, no statement across all the methods was found to be directly opposed to each other in the discovered themes. Nonetheless, the triangulation process identified converging patterns in the data.

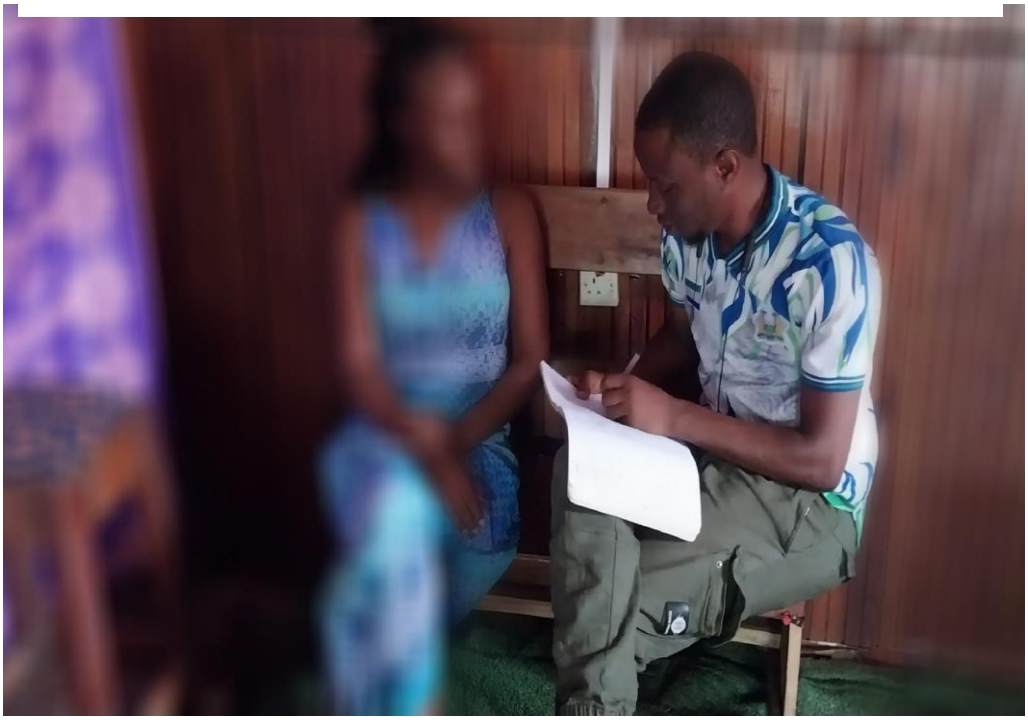
3.9 Ethical consideration

Throughout the study, ethical considerations were paramount, particularly due to the sensitive nature of the topic. Measures were implemented to protect the rights and well-being of all participants. Informed consent was obtained from each participant, ensuring their full awareness of the study's purpose, objectives, and their rights as participants. Detailed informed consent request statements were provided, explaining the confidentiality measures in place and addressing any concerns or questions raised by the participants.

To maintain confidentiality and ensure the safety and privacy of each participant, the research team, consisting of the researcher and research assistant, handled all data with the utmost care and discretion. Participants' identities were safeguarded through the assignment of codes and pseudonyms, with no personally identifiable information used in the final report. All research materials, including audio recordings, transcripts, consent forms, and digital data, were securely stored on a dedicated, password-protected Drive accessible only to the researcher.

During the data collection process, participants were allowed to ask questions and seek clarification regarding the study. The research team provided oral explanations of the consent form, ensuring that participants fully understood their rights and the confidentiality measures in place. Any concerns or issues raised by participants were promptly and appropriately addressed to uphold the ethical integrity of the study.

Figure 4 the author and an SSI interviewee



Credit: the author

Chapter Four

4.1 Presentation of Findings

This section contains the study's findings including the use of intersectionality as a tool to understand and analyse access to SRHR for women in the Aberdeen community of Sierra Leone and how their low-income backgrounds intersect with factors of religion, marital status, age and disability to impact their access. The findings are presented through various themes that emerged from the responses of the respondents.

4.2 Understanding Sexual Reproductive Health and Rights, in the Low-income Households of the Aberdeen Community: participants' perspectives

The phrase "sexual and reproductive health and rights" is commonly used in today's health discussions, encompassing many aspects of personal well-being. However, access isn't equal for everyone hence this study. Understanding SRHR is crucial because it equips individuals with the proper knowledge and understanding that enables them to actively pursue and utilize the available SRHR services. Based on the results of the data collected, all the respondents, including those who participated in the SSI and FGD demonstrate some understanding of what SRHR is and what it entails nonetheless, many believe the 'right' part of the term is context-based, meaning it entirely depends on the type of sexual health the individual is seeking or whom the individual knows within the health eco-system of the community and also the individual's financial means.

Collectively, the respondents mentioned that *"For us women in this community, sexual and reproductive health and rights mean taking care of our bodies and emotions when it comes to our intimate lives and our ability to have children. It's about us knowing what's best for our health as well as having the right services available to us regarding our sex lives".* - [FGD, 1]

They also mentioned that *"for the 'right' part we believe it is tied to your financial status or who you know at the health facility or the type of sexual and reproductive health you are seeking because the laws in our country do not permit certain sexual health services. You can only have rights based on those things."*- [FGD, 1]

The respondents that participated in the KII, affirmed the understanding of SRHR demonstrated by those that were featured in the SSI and FDG, with one stating that *"every woman in this community whether old or young, knows what SRHR is all about. There is a lot of information available to us about things to do or what not to do to protect one's sexual health. Advocacy groups do a lot about Pregnancy prevention and care and there are some community initiatives to make sure that people are aware of their sexual reproductive health. Regarding rights, it is not accessible by everyone because some aspects of SRHR are banned in this country while some are available only to those who have the means which most of the women that have very little income do not have."* - [R4, community leader, KII]

4.3 The experiences of women in the Aberdeen community, in accessing sexual and reproductive health and rights services

The study findings regarding the experiences of women from the Aberdeen community in accessing SRHR painted several pictures that confirm the numerous challenges often seen to impact their ability to access the much-needed SRHR services. Among the respondents, eighteen (18) mentioned that their experiences have not been good as they often struggle with factors attributed to (household decision-making wherein the manner and ways of their access are partly or wholly regulated by senior household members) and external barriers (societal norms and healthcare providers' indifferent attitudes towards them). Six (6) detailed their experiences as mixed, meaning their experiences have not been all good or all bad while five (5) stated that they have not had any bad experiences yet.

Experiences relating to internal barriers resulting in their 'not good' experiences in accessing SRHR were well captured by the comments of an SSI respondent explaining that, *"for me, I cannot just go to the clinic by myself even if I need some care. I do not live alone; I need to check with my people"*. – [R9, Adult, SSI]

A similar statement corresponding with the above was also mentioned in one of the focus group discussions whereby the participant stated, "*SRHR is a big thing and I do just wake and go to the clinic because I need some treatment, that decision has to be made not by me alone because I do not have the powers to decide just like that—in case something happens, I cannot be blamed"*. – [CH, Adult, FGD 2]

The participants went on to recognise that having to navigate such circumstances in itself presents a challenge. Adding that *"Matters relating to one's health should not be left in the hands of any member of the household to decide in consensus on when and how they should seek care"*. – [IS, Young Adult, FGD 2]

Regarding experiences relating to external barriers, the respondents mentioned*, "Getting SRHR services here sometimes is very challenging and it feels like you are trying to become a politician when you are poor. You have to navigate through, stereotypes, long waiting times, and stigma just to get the care you need."* – [R15, Young Adult, SSI]

"Sometimes, I often feel invisible when it comes to going to the clinics to access SRHR services. The facilities are not always accessible, and providers rarely consider our unique needs" another participant mentioned. - [DIS, Older Adult, FGD 2]

"It is a fact, that women in this community face both physical and attitudinal barriers. Sometimes, healthcare facilities aren't even physically accessible maybe because it is closed or there are not enough drugs or staff present at the time and some of the staff are not professional. Sometimes also, people are just not able to make the decisions for themselves" An SRHR advocate reaffirming some of the experiences of the respondents. – [R13, Advocate, KII]

To conclude this segment of the results presentation, it is worth noting that the study findings attributed the experiences of the respondents with the majority indicating that they have not had good experiences when accessing SRHR in the community. Internal barriers, which are found to be influenced by the dynamics of household decision-making are a key challenge. This suggests that some of the women felt their autonomy constrained, echoing the sentiment that SRHR decisions couldn't be made in isolation; they were deeply embedded within a larger social context.

External barriers were tied to long waiting times, social stigma, and inaccessible healthcare facilities which all featured prominently in their experiences. It was evident that these external barriers compounded the challenges posed by internal dynamics, creating a complex and often challenging environment for women seeking SRHR care.

Others stated the opposite experiences however, their numbers were too minimal to tilt the results in their favour. Therefore, the findings have shown that a strategy ought to be developed that provides a solution for these women to improve their access to SRHR from both their internal and external challenges. It is worth noting that the respondents' underlying identities were not accounted for in this result.

4.4 The contribution of low income and the factors of marital status, age, religion, education, and disability in shaping access to SRHR for women in Aberdeen

As was previously mentioned, coupled with their low-income background, five typical intersectional attribute combinations—religion, age, education, marital status, and disability—that significantly affect respondents' access to SRHR formed the focus of this report. The findings on how these five occurring factors intersected with the respondents' low-income backgrounds to shape their access to SRHR have been presented below.

Based on the findings, an interesting pattern emerged from the examination of the respondents' overlapping characteristics. Notably, seven (7) individuals exhibit all five of the key intersectional attributes that were recorded while twenty-two (22) share four of these intersecting identities. This was because only seven (7) of the twenty-nine respondents that constitute the primary respondents identified as having some form of disability.

This intersection draws attention to the wide diversity of experiences that respondents have, as well as how these characteristics have a big impact on how they perceive the accessibility of sexual and reproductive health and rights in their community. Below is an analysis of the responses of the respondents on how the key intersecting attributes that were recorded, shape their access to SRHR in the Aberdeen community. It is worth noting that the results below have been deliberately designed to show how each of the five factors intersects with the respondents' low-income background to impact their access to SRHR. This means that each of the factors—religion, marital status, education, age and disability—have been analysed against the respondents already having the identity of coming from a low-income background.

4.4.1 Religion and its Contribution to Access to SRHR Services in the Aberdeen Community

Religion was the foremost identity intersecting with the respondent's low-income background was identified from the data as having an impact on the accessibility of Sexual and reproductive health and rights for women in the Aberdeen community.

The data show that all of the respondents belong to one of these three religions—Islam, Christianity and traditional faiths. During the data collection phase, respondents conveyed beliefs that provided insights into their perspectives on access to sexual reproductive health services within their communities.

A prevalent sentiment was the prioritization of their faith, which influences their preferences for specific types of SRHR services. From the data collected, it was noted that the respondents characterized SRHR into two types which are Western-oriented (SRHR) and traditional practices (SRHR). Seventeen (17) comprising six Muslims, eight (8) following traditional beliefs, and five (5) Christians expressed support for traditional SRHR practices while the rest were strongly in favour of Western-oriented SRHR practices.

The respondents defined western-oriented SRHR practices as the use of advanced care such as contraceptives, STD/STI prevention and treatments that require the use of tablets and Abortion care through pills and other advanced means. They defined traditional practices as the use of sexual abstinence until marriage, herbs to care for both pregnancy prevention and care pregnancy and to treat infections. The above underlying findings show that the sentiment of which SRHR the respondents will pursue is largely dictated by their belief system. This means that their faith determines whether they opt for Western-oriented SRHR services or those rooted in traditional practices.

Another interesting pattern that emerged among the respondents is the fact that the extent of their religiosity determines their approach or zeal towards accessing SRHR. For example, six (6) Christians,

seven (7) Muslims, and four (5) traditional faith believers who expressed that they are religious, meaning they practice their faith teachings regularly, generally voiced endorsement for existing laws prohibiting practices like abortion and exhibited resistance towards pregnancy prevention care. On the other hand, those who identified as less religious consisting of the bulk of the remaining respondents, displayed a range of perspectives—some were undecided while others advocated for unrestricted access to the full spectrum of sexual and reproductive health and rights benefits. Here are some of the notable mentions by respondents on religion and its influence on Access to SRHR in the Aberdeen Community.

"My faith guides every aspect of my life, including my health choices. I seek SRHR services that align with my religious values." - [R11, CH, SSI]

"As a strong believer, I'm against practices that go against our beliefs, and certain SRHRs are against my belief. We should focus on other aspects of SRHR, not ones that are not relevant." - [R14, IS, SSI]

"I follow a religion but my approach to SRHR is based on common sense and respect for personal choices. It's not just about religion, our choices are because of our circumstances so it is not fair that people judge us because we want to access a particular SRHR." - [R16, IS, SSI]

"For me, my traditional beliefs shape my decisions when it comes to accessing SRHR– I like to stick to our traditions for SRH services, It's very effective whether I am using it to treat infections, or to prevent or for some other sexual health related issue" - [R7, TB, SSI]

"I've seen how religious beliefs can sometimes limit choices. In this community, faith is not just a belief; it's a way of life and it deeply impacts SRHR decisions from personal to communal level and it often guides individuals towards culturally aligned services." - [R20, community health worker, KII]

The accessibility of sexual and reproductive health and rights (SRHR) within the Aberdeen community is revealed to be significantly impacted by religion as an intersectional identity. Some of the respondents' views on SRHR access are significantly influenced by their religious beliefs, which include Islam, Christianity, and traditional faiths. The importance of faith determines preferences for particular SRHR service kinds, directing decisions between Western-oriented strategies and conventional methods. It's interesting to note that a person's level of religiosity affects both how eager they are to use SRHR services and how they feel about things like abortion and pregnancy prevention care.

4.4.2 Marital Status and its Contribution to Access to SRHR Services in the Aberdeen Community

The marital status of women from low-income households in the Aberdeen community is the second most significant factor the results show to be intersecting with the low-income identity of the respondents to shape their access to SHRS. In comparison to those who were listed as being married,

those who were single had distinct viewpoints and experiences about access to SRHR. The results of the study show that married people constituting fourteen (14) of the total primary respondents have an added burden of contacting their spouses; more than half of them ten (10) mentioned that they rely on their husbands' consent to receive some type of SRHR, which mainly includes pregnancy prevention, antenatal care, STI/STD prevention and treatments and as well as issues relating to sex education and sexual violence.

Of the fifteen (15) who have been identified as singles twelve (12) assert that access to any type of SRHR is completely up to them and that they are the only ones who can decide whether they want to do so while the rest three (3) indicated that they need some form of consent from their family members (i.e., parents, guardian).

Based on these findings, it is evident that Married women, coupled with their low income, face an additional layer of complexity, often requiring consultation with their spouses before seeking certain SRHR services. More than half of the married respondents – ten (10) said they must get their partner's consent, for things like abortion or prenatal care – meaning, they require full spousal authorization while the rest five (5) only had to consult their partner but do not need full authorization. This emphasizes the importance of marital ties in SRHR decisions and emphasizes the impact of spousal dynamics on decision-making.

In contrast, single women assert their autonomy, with twelve (12) of the respondents maintaining sole decision-making authority over their SRHR choices while the rest three (3) only seek minimal consent from relatives. This freedom underscores the distinct advantage that single women have in seeking SRHR services, undeterred by the need for spousal approval. This insight raises critical questions about the dynamics of agency, empowerment, and autonomy for married women in low-income settings regarding their access to comprehensive SRHR services.

In one of the focus group discussions a respondent stated, *"When you're married, it's not just about you. You have to consider your partner's views, and sometimes that can affect whether you can access certain services or not."* - [A married adult, FGD 2]

"Spousal consent often becomes a hurdle for married women. It's a complex issue, balancing individual needs with marital dynamics." – [R8, community health worker, KII]

"Being single in this community does have its benefits. You're in charge of your own decisions, and you can access the services you need without anyone else's approval." - [R15, Single young adult, SSI]

"I've seen friends struggle because they needed their husbands' permission for medical care. Being single gives you more control over your own health decisions." [A single, older adult, FGD 2]

This finding shows that women who are single or married will see things differently as a result of their marital identities. The requirement for spousal approval and consultation for married women adds complications, especially when it comes to delicate services like pregnancy prevention, antenatal care, STI/STD prevention and treatments as well as issues relating to sex education and sexual violence. Contrarily, a majority of unmarried women have more autonomy and the freedom to make their own SRHR decisions.

4.4.3 Education and its Contribution to Access to SRHR Services in the Aberdeen Community

According to the findings, the accessibility of sexual and reproductive health and rights (SRHR) for women who already are grappling with the factor of low-income, in the Aberdeen community is found to be significantly impacted by education. The study shows the stark differences in SRHR access between people with formal education and people with little to no formal education.

Of the respondents, fourteen (14) had a formal education, which they, the respondents associated with more familiarity and understanding of SRHR. This group of respondents mentioned that the empowerment of education allowed them to make decisions about their reproductive health with more knowledge. They showed a tendency to look for complete SRHR services. Access to SRHR was expressed to be more difficult for fifteen (15) respondents who had little to no formal education. The research reveals that low awareness is frequently the result of little education, which limits their ability to make wise SRHR decisions.

Different opinions on the impact of education on SRHR access within the Aberdeen community were noted from the perspectives of two key informants. A dedicated advocate of SRHR underscores the transforming potential of education, stating *“People with formal education are likely to demand their rights and/or use their little earnings to pursue all-inclusive SRHR services that are protected by the laws of the country”.* - [R13, Advocate, KII]

A health worker in a private clinic offers perceptions of the actual world, noting a link between formal education and the use of their facilities. The health worker stated that he had noticed that *“those who have received formal education are more likely to use their services which comes with a cost.”* – [R17, Community health worker, KII]. This statement provides insight into the fact that women from low-income backgrounds – education plays a huge role in their proactive health-seeking behaviour.

In one of the focus group discussions, it was asserted that *"Education opens doors. I know my rights; I know why it is important for me to prioritize my sexual health and I know where to find help when I need it. Education empowers us to take charge of our health and be aware of what matters in our lives."* - [[A single, older adult, FGD 1]

Adding to that statement, it was also stated that, *"Lack of education can leave you vulnerable. I've seen friends struggle because they didn't know where to go for certain SRHR services."* - [R18, adult, SSI]

"For those with education, accessing SRHR is a given. But for others, it's not that simple." - [R24, young adult, SSI]

Within the community of Aberdeen, the influence of education on the accessibility of sexual and reproductive health and rights (SRHR) stands out as a critical factor. The research investigation underlines the substantial disparities between people with formal education and those with little to no formal education. The study findings expose the fact that education encourages proactive SRHR choices and informed decision-making among people with higher levels of education however, it presents a barrier for individuals with lower levels of education, thereby restricting their awareness and eventually access to SRHR. All those who had some form of formal education expressed the desire to actively pursue SRHR while nine (9) of those who had little to no education mentioned that SRHR is not that much of a priority thereby indicating that they are not that much interested in actively pursuing SRHR.

4.4.4 Disability and its Contribution to Access to SRHR services in the Aberdeen Community

Seven respondents acknowledged having a disability of some kind during the data collection. Five took part in the semi-structured interviews, while the other two separately participated in the focus group discussions—one in each of the two sessions. Their experiences showed how access to SRHR is impacted by disability, especially for low-income women.

For people with disabilities, mobility is a problem that makes, access to some healthcare facilities more difficult. All of the respondents who were identified as having some form of disability mentioned the issue of mobility as adding to the factor of them coming from low-income households.

Additionally, they expressed the difficulty of receiving the needed assistance due to the lack of specialized care or assistance for disabled people. They mentioned that everyone undergoes the same process when attempting to access SRHR, which all the respondents, agree should not be the norm. they also argued that having a disability affects their willingness to seek out SRHR assistance. Everyone, in qualifying the statements of those affected, mentioned that regardless of one's social or economic standing, using SRHR in our cases might lead to stigma in some situations and for those with disabilities, it is even worse.

The constraints on mobility that people with disabilities must deal with are the first issue that was mentioned during that aspect of the data collection phase. Collectively, they mentioned that access to vital SRHR services is hampered by the difficulty of getting to healthcare facilities with one stating that, “Whether you are visually impaired or are suffering from the use of your body parts, you are often in

need of assistance. Either you need someone to take you to the clinic or you have to go there yourself – the fact that we are not rich makes it very hard for us". – [R12, DIS, KII]

To this argument, even the non-disabled respondents agree, saying that current institutions in the community don't provide the specialized assistance needed to meet their needs. *"Transportation in these times is a daily struggle for everyone, let alone for people who are physically or even mentally challenged. It makes access to SRHR very hard for them."* - [NON-DIS, FGD 2]

The absence of specialized care tailored to individuals with disabilities emerges as a critical concern from the data collected. Respondents emphasised that general health facilities often lack the necessary accommodations to address their unique needs, resulting in compromised care and attention. *"When everyone has to go through the same process to access SRHR, it becomes problematic for us. We are all the same people but our needs are not the same, we need care that caters to our disadvantages but we do not get it here."* - [R5, DIS, SSI]

The impact of disability on self-confidence is a serious realization for this study. Respondents feel that the stigmatization of disability that already exists in society hurts their confidence in obtaining SRHR assistance. Self-confidence, which is frequently weakened by societal attitudes, is recognized as a crucial element for gaining access to SRHR. *"People with disabilities already struggle with confidence because of how society perceives them and because they believe they have limited opportunities in life. They find it more difficult to approach SRHR services because they do not want to be portrayed in a manner that is frequently associated with stigmatization as a result of their current circumstance."* - [R13 Advocate, KII]

The experiences of respondents who have disabilities disclose the significant effects of disability on access to sexual and reproductive health and rights (SRHR) services. For women from low-income households, I imagined the impact to be more severe. Challenges linked to mobility surfaced as a major hurdle, making it difficult to reach essential SRHR services. These experiences resonate even with those without disabilities. The lack of specialized care at general health facilities further compromises their access to SRHR services. And conclusively, the stigma around disabilities erodes self-confidence, and that discourages these women from seeking SRHR assistance.

4.4.5 Age and its Contribution to Access to SRHR Services in the Aberdeen Community

The wide range of ages seen in the study reveals distinct effects on women's access to sexual and reproductive health and rights (SRHR) who are already impacted by their low-income status in the targeted area. Grouped into three categories, the findings reveal some patterns. Women aged 18-25 emerge as the most proactive in pursuing SRHR services, primarily focusing on sex education, modern contraception, emergency contraception, menstruation, testing and treatment, abortion (despite its

illegality), and STD/STI prevention and treatment. One thing that most of them allude to is that they prefer seeking SRH care and they will go the length it takes to secure the SRHS they need. The 26-35 age group follows suit, with a significant portion indicating that they mostly seek pre-pregnancy and pregnancy care and other SRHR services such as consulting on issues of sexual base violence, STD/STI prevention and treatment etc. In contrast, the 36-40 group primarily engages in prenatal and postnatal care and STI/STD prevention and treatment.

Furthermore, in this section, the study findings show that the unique needs of these different age groups have a significant impact on how people can have access to sexual and reproductive health and rights (SRHR) services. Notably, the age group of 18 to 25 claimed that despite actively seeking SRHR, they experience significant obstacles. Stigmatization brought on by misunderstandings about their intentions, combined with financial limitations and family-related repercussions, which occasionally result in disownment, forces them to prioritize survival over comprehensive care thereby affecting their access to SRHR. However, due to partner reactions, domestic duties, and the inadequacy of the health facilities, such as lack of drugs, and medical staff, the 26–35 and 36–40 age groups claim that they struggle with increased sexual violence worries and other domestic-related issues like taking care of the house.

Here are key statements that were made during the data collection process.

"As you grow older, new worries come up. I have a family so it is not just about me anymore; I have a family to care for so that makes SRHR access complicated because I have to consider the cost, also my time." - [R2, Older Adult, SSI]

"When I go to the clinic to get pills or treated for some infections, I sometimes get comments from people who think I'm just being reckless—that I am too young to be going for such care. I have a friend who was thrown out because she got pregnant—she went to live with her boyfriend but because they are poor, she had to spend her time doing some petty trading to survive and would rarely go for medical check-ups." - [R24, young adult, SSI]

"Youth are actively seeking care for their sexual and reproductive health, yet ironically, they continue to be the most vulnerable. Many lack access because of their inexperience and as well as their financial limitations. For those who are older, the burden of their families' demands, the epidemic of sexual assault, and poverty make it difficult for them to prioritise SRHR even when it matters. What I can say is that ages really matter and more so for women who earn very little, their age has an impact on how they are perceived by the society when they are seen to be actively seeking access to SRHR" - [R13, Advocate, KII]

4.4.6 Analysis of the Interplay of Low-Income and the Factors of Marital Status, age, disability, education and Religion in Shaping SRHR Access for Women in Aberdeen

In this segment of the presentation of the findings, the results of the factor of low income acting as a central thread that weaves together with religion, age, disability, and marital status to shape the landscape of SRHR access for women in Aberdeen are analysed.

Indeed, factors included in the study do not function in isolation. Based on the data collected, twenty-two (22) of the respondents shared four of the factors (age, religion, marital status, and education) adding to the factor of low income. The remaining seven (7) shared all five of the factors also adding to the factor of low income.

Interestingly, despite the respondents sharing these factors, when their identities are further categorized into different age groups, religion, marital status, educational backgrounds and disability status, it was understood that their access to SRHR is shaped differently. What was even more interesting to note is that seldom do these respondents share converging sub-identities. For example, respondents two (2) and ten (10) both identified as having some form of disability and are both married and of the same age group, however, in religion and education, they differ. Based on that aspect, the data shows that they experience access to SRHR differently. Respondent two (2) was among those who expressed support of Western-oriented SRHR while respondent ten (10) was on the other side of the aisle. This difference in the opinion expressed by these respondents pointed out the reality that an individual's needs are unique and that one size does not necessarily fit all.

Throughout the data, the factors of age, religion, marital status, education and disability intersect with low-income creating in some cases a convergence and in other cases a divergence of experiences. What was common in the findings was that the factors each intersect with low income to shape the experiences of women in the Aberdeen community.

Based on the results, religious beliefs were shown to significantly affect women's SRHR choices. Some align with Western-oriented practices, while others adhere to traditional methods, dictated by Islam, Christianity, or traditional faiths. The degree of religiosity also plays a role, in influencing the extent to which individuals engage with SRHR services. Marital status introduces another layer of complexity. Married women often require spousal consent for certain SRHR procedures, while single women have greater autonomy in their choices.

Education emerges as a pivotal factor, with formal education empowering women to make informed SRHR decisions, while those with limited education face barriers due to a lack of awareness. Disability further complicates the issue, affecting mobility and perpetuating stigma, which hinders SRHR access.

Finally, age plays a role, with younger women often more proactive but facing stigma, while older women grapple with domestic responsibilities, and sexual violence risks, affecting their SRHR priorities.

In summary, study findings have shown that women's access to SRHR in Aberdeen is intricately shaped by the intersection of low income with religion, age, disability, marital status, and education. These factors create a multifaceted landscape where access is neither uniform nor straightforward. Using intersectionality as a tool for analysing and understanding access to SRHR is crucial for designing targeted interventions that cater to the diverse needs of women in the community.

4.5 The implication of low income, marital status, age, religion, education, and disability and their impacts on the utilization of SRHR services by women in Aberdeen.

The use of Sexual and Reproductive Health and Rights (SRHR) services by women in the Aberdeen community of Sierra Leone is a complex narrative that is seen from the data to be strongly influenced by a variety of circumstances. The constraints and opportunities created by low income combined with marital status, age, religion, education, and disability have been shown to have a substantial impact on how these women utilized SRHR services. The findings show that the factors in focus do not only contribute to shaping the respondent's access to SHRH, but they also strongly shape the ways these women use SRHR. Most notably, it impacts their ability to use SRHR in terms of influencing—the frequency of use, their desire to use and the services used.

4.5.1 Impact of the frequency of use

An example of how it influences their desire to use is shown in the result. Of those who indicated that they are married and shared a mix of adult and older adult age groups, eight (8) of them expressed that they do not feel the need to utilise SRHR very often, except when they experience complications with their sexual health. The remaining five (5) who are of the same description with two identified by the data as a young adult, say the contrary, indicating that they often do check-ups to determine their sexual health status. Those who are unmarried, all mentioned that they check their status at least once a month and four (4) mentioned that they are on pregnancy prevention pills.

4.5.2 Impacts on their desire to use and the services used

When the group of the primary respondents are further broken down to assess the utilization of SRHR services, another pattern emerged which shows that those with strong affiliations to their religions, comprising Muslims, Christians and traditional faiths, eighteen (18) do not desire to use certain SRHR services, (abortion, pregnancy prevention). They feel, there are other things worth focusing on and that aspects of SRHR are not that relevant. One of these respondents stated that *"even if those aspects are free, I will not seek to use them."*- [R18, Adult, SSI]

When these group of women were asked a follow-up question about SRHR services such as reporting, seeking protection and counselling for sexual violence, whether it is a service they will utilise, eleven (11) of them were identified as having little to no education stated that it depends on circumstances such as the relationship the victim has with the perpetrator other factors. If it is a close relative, like one's partner, then they said they will think twice about reporting but might do it but will not seek counselling. Of the rest, who identified as educated fourteen (14), including three (3) that fall in the little to no education category stated that they would report, and if need be, they will also seek counselling and protection.

For those with disabilities, the utilization of SRHR services is influenced by their unique challenges. All of them that the results show as having some kind of disability mentioned that their disability coupled with other intersecting factors including their low income, age, education and faith significantly shape their desire to utilise SRHR and certain services. One stated *"When I cannot easily go to the clinic, why would I desire to go there? I will do that only when it might be urgent for me to go there. People like us, even when we go there, we do not always get the treatment we deserve"* – [DIS, Adult, FGD 1]

The above findings show that the different factors, age, marital status, disability, education, low income and religion have a compelling impact on the respondents' frequency of using SRHR as well as their desire to use SRHR and the type of services used. Such knowledge is vital and it gives insights into the value of the use of intersectionality as a tool to understand access to SRHR.

4.6 Analysis of the Available Opportunities and Resources Facilitating Access to SRHR

In the aspects of the findings of existing opportunities and resources that support access to SRHR in the community, the research's results show that government and non-governmental-led initiatives are supporting the promotion of access to SRHR and also, there are community-driven approaches. This finding is crucial as it helps to understand the respondents' perspectives on the existing opportunities and resources and how they can be used to better design intervention strategies.

4.6.1 Government-led initiatives as existing opportunities and resources that support access to SRHR

Government-led programs significantly influence Aberdeen residents' access to SRHR. Giving pregnant women and young children access to free healthcare is a significant initiative that drew praise from respondents during the data collection process. However, despite being viewed as a positive step by the respondents, they still mentioned that there are still difficulties with that program. As one respondent shared in an SSI, *"We appreciate the government's efforts, especially the free healthcare for pregnant women and young children. It's a step in the right direction, but the challenge is that*

sometimes there are medicine shortages, so we still end up spending our own money because they will only provide us with prescription lists." - [R3, Adult, SSI]

Several viewpoints arose during semi-structured interviews (SSI), a key informant interview (KII), and focus group discussions (FGD) to clarify this complex aspect of government-led initiatives as existing resources that support SRHR.

One SSI participant noted, *"There's a growing awareness in our community about SRHR, and it's thanks to government initiatives on raising awareness. There are billboards in some areas to raise awareness of STDs/STIs, and we now have a dedicated SRHR unit within our health facility. It might not be much when we consider what we need but it is a step in the right direction."* - [R20, Community Health Worker, KII].

Conversely, another KII respondent highlighted a different issue, saying, *"While government efforts are appreciated, there are limitations. The services are sometimes overwhelmed, and waiting times can be lengthy. This is a big problem and serious barrier for women who need immediate care but fall within the low-income category in the community."* - [R13, Advocate, KII].

4.6.2 NGO-Led Initiatives as existing opportunities and resources that support access to SRHR

The results of the findings reveal that non-governmental organizations (NGOs) play a crucial role in filling some of the gaps that exist in the promotion of access to SRHR. Respondents indicated that they provide specialized SRHR services. The Aberdeen Women's Center was cited as an example of such an organization that is seen as an existing resource to the respondents. They offer free SRH care for pregnant women and those affected by SBV as well as support for conditions like fistula. Marie Stopes was another organisation stated by the respondents which offers comprehensive SRHR services in the community. Participants expressed gratitude for the services non-governmental organisations are providing.

A participant in a focus group discussion articulated this sentiment, saying, *"Organizations like the Aberdeen Women Center and Marie Stopes are a lifeline for us. The Aberdeen Women's Center offers free healthcare for pregnant women and support for conditions like fistula. And Marie Stopes provides comprehensive SRH services including education and some medications. It's reassuring to have these options."* – [Adult, FGD, 1]

One key resource that was also pointed out from NGO-led initiatives was the sense of privacy and emotional support they provide. This was emphasized during one of the focus group discussions, one participant said, *"Marie Stopes, for instance, offers emotional support especially when we are going through issues related to our sexual health. With them, I know my privacy is protected, which is*

important to me. Sometimes, it's a big comfort just to know that you can speak honestly about your situation without fear of being judged."- [Young Adult, FGD 1]

4.6.3 Advocacy Groups as existing opportunities and resources that support access to SRHR

The research unveiled advocacy groups as key resources available in the Aberdeen community that support access to sexual and reproductive health and rights (SRHR). The respondents see these groups as catalysts for many changes that have occurred in that aspect. Their key activities have been raising awareness about SRHR issues, advocating for policy reforms, and amplifying the voices of women.

These activities have been translated into awareness campaigns, workshops, and educational sessions that have equipped some women with knowledge about their sexual and reproductive health. A participant in a focus group discussion highlighted, *"Some of these groups teach us things we didn't know. They explain our rights and options to us and that has helped us to become more informed and confident."* – [FGD, 2]

These groups according to the respondents, have been instrumental in actively engaging with policymakers and advocating for changes in SRHR policies that have impeded the SRH rights of women in general around the country. They play a vital role in bridging the gap between the community's needs and government actions. During the SSI, one respondent stated, *"These groups are tireless in their efforts to influence policies like the anti-abortion laws of the country and other practices like FGM. They're our representatives on a bigger stage, fighting for our rights."* – [R6, Young Adult, SSI]

Lastly, the results indicated that they have helped boost the voices of some of the women by creating a platform for them to speak up and demand their SRHR. A respondent in the SSI remarked, *"When you see others like you talking openly about SRHR, it gives you the courage to do the same. These groups make us feel like our experiences and concerns matter."* – [R27, Adult, SSI]

4.6.4 The community: as an existing opportunity and resource that supports access to SRHR

The community itself was identified by the respondents as an existing opportunity and resource that supports access to SRHR. The results reveal that there are support groups that have come up with educational initiatives that contribute to SRHR access in the Aberdeen community. These grassroots efforts include the transfer of knowledge and information about their sexual health and rights. However, a notable constraint these initiatives faced has to do with the limited logistical support they have. They mentioned that they would like to have at least monthly campaign events where they will share information and materials relating to SRHR but they lack the logistical support for such initiatives.

During the focus group discussion, a participant pointed out, *"We have had support groups that have done great in educating us. When we share ideas, it is better because we know ourselves. Such activity*

is something that we would love to do even if it is just every month but we lack the logistical support are need to reach everyone effectively." – [Adult, FGD, 2]

A major opportunity that the results uncovered was an initiative the respondents had initiated in the past which was identified as peer education strategies. A few of the members of the community were trained to serve as peer educators. From time to time, they conduct informative sessions and workshops, that impart SRHR knowledge in a relatable and culturally sensitive manner. This was mainly carried out by those who have strong affiliations to traditional beliefs. However, they suggested that it is something that could be replicated and popularized in the communities. A reference to this was highlighted by the community leader who acted as a KII. She said, *"Peer educators are individuals who are within our community, households and faiths and they speak our language. They understand our daily struggles and can explain SRHR issues in a way that resonates with us."* – [R4, Community Leader, KII].

Chapter Five

5.1 Discussion of findings

In this chapter, the findings from the preceding chapter are analysed and interpreted. Additionally, it incorporates analyses of these conclusions in light of the literature review that is pertinent to the themes investigated.

5.2 Sexual and Reproductive Health and Rights (SRHR): A Contextual Understanding

As revealed by the study, SRHR is a word that is frequently used in discussions of current health issues and it reflects the many facets of individual well-being. But as this study makes clear, not everyone has access to SRHR, particularly in low-income areas like Aberdeen. According to the results, SRHR and its importance are understood by the respondents in general, although a complex viewpoint does come into focus. Many believe that the 'RIGHTS' part of SRHR depends on the situation and is influenced by things like the kind of sexual health services required, one's connection to the healthcare system, and one's financial resources. This notion was similarly expressed by (MajMcGranahan, et al., 2020) who stated that the exercise of SRH rights has been seen as context-specific.

The findings show that the women of Aberdeen, view SRHR as fundamentally about caring for their intimate physical and emotional well-being and their ability to make choices regarding reproduction. It embodies the idea of having access to services that safeguard their sexual health. However, the concept of 'rights' within SRHR is perceived as tied to socio-economic status and the prevailing legal restrictions. In a stark realization, respondents believe that the extent of one's rights in respect of SRHR depends on their financial standing and familiarity with influential individuals within the healthcare system.

There's a wealth of information available, with advocacy groups and community initiatives actively promoting sexual health awareness and pregnancy prevention. However, this awareness doesn't always translate into equal access to rights. Legal restrictions and financial barriers create disparities in accessing certain SRHR services, disproportionately affecting those with limited means. Such revelation is crucial and demands action in that direction more so when SRHR is deemed to be a human rights issue.

5.3 The difficulties women in the community of Aberdeen have in exercising their rights to sexual and reproductive health

The results of the study provided insight into various experiences that women in the Aberdeen community have while seeking to access Sexual and Reproductive Health and Rights (SRHR) services. These experiences, as outlined by the respondents in the findings presented, revealed a mixture of challenges, barriers, and occasional positive encounters. The results categorised the challenges into internal (household barriers) and external barriers.

The internal barriers were rooted in household decision-making dynamics. The data show many women especially those who are married expressed that they couldn't make SRHR decisions independently, even if they felt the need for care. This highlights the societal norms and power structures within households that often limit a woman's autonomy when it comes to their sexual and reproductive health. This finding is consistent with the findings of (Garrison-Desany, et al., 2021) which show that women often lack the autonomy to decide on their SRH, requiring permission from their husbands/partners.

External barriers also played a significant role in the experiences of these women. The narrative of navigating SRHR services feeling like trying to become a politician when you are poor vividly captures the challenges they face. Long waiting times, stereotypes, and social stigma all contributed to a sense of invisibility and frustration when seeking SRHR services. Moreover, the inaccessibility of healthcare facilities and a lack of consideration for women's unique needs further compounded these challenges. This finding was also highlighted in a report by ((UNFPA, 2020), and they emphasize the structural and systemic issues that women encounter when attempting to access SRHR services. From the findings, it's clear that the healthcare system's shortcomings, combined with social stigma, create formidable obstacles for women in the Aberdeen community.

Lastly, this study underscores the urgent need for comprehensive interventions that address both the internal and external barriers women face in accessing SRHR services. Efforts to promote women's autonomy within their households and communities should go hand in hand with initiatives to improve healthcare infrastructure and reduce social stigma. The most interesting thing to note is that women from low-income backgrounds are not a homogenous group, thus, tailored approaches that consider the diverse identities and circumstances of women in the Aberdeen community are essential to ensuring equitable access to SRHR services for all.

5.4 The complex interplay of intersectional identities and their impact on access to SRHR services

The study's findings offer a comprehensive view of how various intersecting factors, including low income, religion, age, disability, marital status, and education, shape the access to Sexual and Reproductive Health and Rights (SRHR) services for women in the Aberdeen community. This discussion goes into greater detail about these results, emphasizing the importance of the use of intersectionality as a tool in understanding and analysing access to SRHR for women in Aberdeen.

Interplay of Multiple Factors

The study underscores the complexity of SRHR access for women who share the same low-income background. It reveals that women in the Aberdeen community do not experience these services in isolation. Instead, the intersection of multiple identities influences their perceptions, choices, and

challenges related to SRHR. As defined in the literature review, “Intersectionality is a concept that describes how systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination “intersect” to create unique dynamics and effects” (Center for Intersectional Justice, 2022). It is essential to recognize that these factors identified in the findings are not mutually exclusive, and the results indicate that individuals may share some while differing on others, leading to unique experiences.

Religion's Impact

Religion was seen as a crucial identity intersecting with low income and other factors. According to the results, the respondents' faith strongly influenced their preferences for SRHR services, categorizing them into Western-oriented and traditional practices. Moreover, the level of religiosity, whether deeply religious or less so, significantly impacted individuals' views on specific SRHR practices, such as abortion and other SRHR services. This finding was also highlighted by (Cense, et al., 2018) in a Rutgers position paper, noting that religious, values, are frequently the recurring reason for governments to oppose abortion and the rights of other people.

Marital Status Complexities

Marital status according to the findings introduced a layer of complexity, especially for married women. They often required spousal consent for certain SRHR services, emphasizing the importance of considering marital dynamics in SRHR interventions. This aspect of the findings is also consistent with the findings of (Garrison-Desany, et al., 2021). In contrast, single women demonstrated more autonomy in their decisions. This disparity in agency based on marital status raises questions about empowerment and control over one's health choices within the context of marriage and access to SRHR for women from low-income backgrounds.

Educational Divide

The results show a stark contrast between the two divides when analysing the impacts of education on SRHR access. Respondents with formal education displayed better awareness and understanding of SRHR, enabling them to make informed decisions. In contrast, those with limited education faced barriers due to a lack of awareness. This highlights the role of education in empowering individuals to prioritize their sexual and reproductive health. Any intervention directed towards the alleviation of the challenges the group in question faces, but prioritised education, particularly SRHR education.

Disability Challenges

The finding shows that women with disabilities face unique challenges, particularly regarding mobility. The study revealed that the physical constraints of reaching healthcare facilities added to the difficulties created by low income. Furthermore, the lack of specialized care for disabled individuals

highlighted the need for inclusive healthcare services. The stigma associated with disability also hindered their confidence in seeking SRHR assistance. This evidence was also backed by a study that assess the issue of SRHR and disability concluding that persons with disability face numerous challenges, including structural inaccessibility, communication barriers and negative attitudes from service providers (Hameed, et al., 2020).

Age-Related Nuances

Age was a significant factor influencing SRHR access. Younger women aged 18-25 demonstrated proactive engagement with SRHR services but coupled with their low-income background, meaning compounding their financial limitations, they faced societal stigma and guardian/parent consent. On the other hand, older women, especially those aged 36-40, often had different SRHR priorities, such as prenatal and post-natal care but they too had their unique challenges such as family worries, sexual-based violence etc. These age-related variations emphasize that a one-size-fits-all approach is ineffective and that age-related needs are to be understood and accounted for when designing interventions.

Intersectionality Matters

The study's most critical insight is the recognition of intersectionality's impact on SRHR access. Different combinations of these factors result in diverse experiences and needs within the community. Recognizing and understanding these intersections is essential for crafting targeted and effective interventions. In conclusion, it has underscored that SRHR access is not solely determined by a woman's low-income status but is intricately woven with multiple intersecting factors. To address the diverse needs of women in the Aberdeen community adequately, interventions must consider these complex dynamics. Policymakers, healthcare providers, and community advocates should adopt a holistic and inclusive approach that accounts for individual choices, beliefs, and circumstances, ensuring equitable access to SRHR services for all women in the community.

5.5 SRHR in Aberdeen: Opportunities and Resources

The results also draw attention to the participant's perception of the wide range of opportunities and resources that are currently available to enhance access to sexual and reproductive health and rights (SRHR) in the Aberdeen community. Government-led programs, such as free medical care for pregnant women and infants, were acknowledged as helpful measures toward enhancing SRHR access. However, respondents cited enduring difficulties that could undermine the efficacy of these initiatives, such as a lack of drugs and protracted wait times. Other studies included in the literature review have also hinted at the issue of lack of medications and other essentials. (See Chapter Two). Adding to that,

the result brought up the consensus among the respondents that government initiatives to increase SRHR awareness and set up specialized SRHR units inside healthcare facilities were necessary but occasionally insufficient to satisfy the demands of the community.

By providing specialized services, privacy, and emotional support, non-governmental organizations (NGOs) have emerged as key participants in closing access gaps to SRHR. The comprehensive SRHR services provided by organizations like Marie Stopes and the Aberdeen Women's Center, which include care for pregnant women and prenatal care, were praised. These NGOs not only offer crucial healthcare, but they also foster a secure and encouraging environment for people looking for SRHR services. likewise, advocacy organizations were acknowledged as change agents for their active awareness-raising, support of legislative changes, and amplification of the voices of local women. They function as a bridge between the needs of the community and the activities of the government, promoting laws that are more in line with the SRHR rights of women in the area. It was understood also from the findings that the community itself was identified as a resource and an opportunity. Their grassroots activities and peer education strategies were clearly shown to advance SRHR knowledge and awareness. However, it was noticed that it was often hard for these initiatives to successfully reach everyone due to logistical issues.

5.6 Reflection on research limitations and mitigating strategies

During this study, several limitations were encountered. While there were other logistical challenges, such as the need to provide incentives for participants' transportation and refreshment and the eventual breakdown of the recording phone used, as well as issues related to adverse weather conditions, the research team adapted, redefined strategies, and readjusted the entire process to successfully collect the data. The primary limitations encountered and the corresponding mitigation strategies are detailed below.

Sensitivity of the Topic

Due to the prevalent societal and cultural attitudes in Sierra Leone, the topic's sensitivity—sexual and reproductive health services—posed a barrier. People's reluctance to discuss sexuality in public has been affected by the predominant cultural and religious views, (that sex shouldn’t be discussed in the open, women’s private parts are sacred, women should not talk about sex to mainly males, non-partner/husband) makes it a no-go-area. As a result of this, during the first round of data collection, getting people to participate in conversations about this issue proved to be very difficult. The first few who through the help of the community leader agreed to participate in the research—when talking about their own experiences with sexual and reproductive health, showed hesitation and uneasiness. It was anticipated that this behaviour would result in underreporting or biased responses, which could affect the study's overall quality and thoroughness.

To address this limitation, two female research assistants, along with an influential community figure considered trustworthy, were used by the researcher to create a secure and confidential environment for participants. The community leader created ease of access to the respondents in the community while the two research assistants, along with the researcher interacted with the respondents to collect the data.

The data ethical considerations section outlined detailed measures taken to protect the rights and well-being of the respondents. Key elements, such as obtaining informed consent (see annexe), ensuring confidentiality, and preserving anonymity, were identified as crucial means of soliciting respondents' cooperation and thus actions were taken to that effect. By reassuring participants about their privacy and providing a clear explanation of the study's purpose and objectives, through the two research assistants and the community figure, a supportive atmosphere that encouraged openness and honesty was achieved. In conclusion, these strategies were successfully implemented during the research to overcome the limitations posed by the sensitive nature of the topic and to ensure the integrity of the data collected.

Gender bias

Another limitation that emerged was rooted in the gender of the researcher, who is male. It was recognized that this factor could potentially introduce a gender bias, either consciously or subconsciously, which might affect participants' willingness to share intimate and personal information. During the research, some respondents openly conveyed their discomfort in discussing such sensitive topics with a male researcher. They expressed a preference for engaging with a female researcher, perceiving that she would have a better understanding of their unique challenges and concerns regarding sexual and reproductive health. This gender mismatch posed limitations mainly throughout the focus group discussions and certain aspects of the semi-structured interviews, potentially impacting the depth and authenticity of the data collected.

To mitigate this limitation imposed by gender bias introduced by the lead researcher being a male, the deliberate decision was taken to ensure that the two research assistants were both females as well as the community leader. Also, besides the two assistants being female, the decision was taken to ensure that both of them possess the necessary knowledge, cultural competence, and sensitivity skills to navigate the successful collection of data on the topic. They were instructed to prioritize the establishment of rapport with participants, foster trust, and create a comfortable environment for discussing sensitive topics related to sexual and reproductive health. Through this approach, the diverse perspectives and experiences of women from low-income households were effectively and comprehensively represented in the study.

Political instability

The research was conducted in the aftermath of a tense and highly contested election period in Sierra Leone, which significantly disrupted the data collection process. Political instability posed substantial threats. The government arrested top military personnel, which suggested the potential for a coup, led to the dispersal of gatherings and heightened security concerns. As a result, engaging with respondents became challenging. Some individuals were reluctant to participate due to their fear of engaging in discussions with strangers, as they suspected these individuals might be associated with sensitive security apparatuses monitoring dissenting views. These circumstances also had an initial notable impact on the sample size and representativeness of the study regarding intersectionality.

To mitigate these challenges during the research, several strategies were employed. Some interviews were conducted over the telephone, bypassing security concerns and movement restrictions. Additionally, the respected community leader played a crucial role in enhancing participants' confidence and allaying their fears. She generously offered her home as a secure meeting point for data collection. Collaborating closely with the two research assistants, these measures effectively navigated the limitations imposed by political instability and security concerns. Throughout the process, there was ensured maintenance of smooth communication channels between the researcher, the two assistants and the community leader to make room for the adaptability to changing situations. These strategies ensured the continuity of data collection efforts despite the limitations posed by political instability and security concerns.

5.7 Methodological considerations and the research implications

The qualitative methodology formed the key and the only approach to the study. To collect data for this approach, KII, SSI and FGD tools were employed. Throughout the process of collecting the data, the researcher adopted a flexible approach, allowing for necessary adjustments to ensure the collection of high-quality data. A clear example of this occurred when on several occasions the researcher had to endure the heavy downpour of rain to collect data instead of postponing. Initially, the researcher intended to conduct only one FGD, however, out of necessity because it was becoming a burden on both the assistant researcher and the respondents to hold more SSI, the researcher decided to conduct two FGD sessions. Eventually, one of the focus group discussions was delayed significantly because of an illness contracted by one of the research assistants and the respondents were compensated for their time.

This research marks a significant step in exploring the use of intersectionality as a tool for understanding and analysing access to sexual and reproductive health and rights (SRHR) in the Aberdeen community. It is the first of its kind to explore the issue of SRHR from that perspective. The

study provides these women with a vital platform to express their experiences, challenges, and potential solutions. It's not just about gathering data; it's also about amplifying their voices.

The study findings probe deeper into the factors studied and have provided new perspectives on the particular opportunities and limitations brought about by elements including age, religion, marital status, education, and disability. This deeper understanding is crucial as it sets the stage for targeted interventions tailored to these specific challenges as well as further studies of the same nature. It's a significant contribution with far-reaching implications for improving the lives of these women.

Chapter Six

Conclusion and Recommendations

6.1 Research Conclusion

The conclusion of the research summarizes the key findings from the results section of the report. It does so by answering the sub-research questions that contribute to the main research question. In other words, it recaps the most important discoveries made throughout the study and explains how they enhance our understanding of the overarching research inquiry.

The research findings begin with the views of the women in the study area on sexual and reproductive health and rights (SRHR). The findings show that these women have a good understanding of SRHR, but they perceive the 'right' aspect of SRHR as context-dependent. This means that it depends on the type of SRHR service the individual is seeking, whom the individual knows within the health system of the community, and the individual's financial resources. This finding was crucial for the study as it provided the basis for answering the sub-research questions. It gives an insight into what the experiences of the women in Aberdeen might have been when accessing SRHR services.

The first sub-research question in this report aimed to explore the experiences of women in Aberdeen when accessing SRHR services. The research findings revealed that these women had varied experiences. The majority described their experiences as 'not good', while the others reported mixed or good experiences. The main reason for the 'not good' experiences was the presence of two types of barriers: internal barriers (household decision-making that restricted or controlled their access) and external barriers (societal norms and health care providers' attitudes towards them.

The second sub-research question in the study explored how low income and the factors of marital status, age, religion, education, and disability contribute to the access to SRHR for women in Aberdeen. The research findings addressed this question by showing the impacts of how each of the factors intersects with the participants' low-income background. This allowed for a clear application of intersectionality as a tool to understand and analyse how low income and other factors affected access to SRHR. The results of these findings indicated that the respondents' intersecting identities were important in shaping their access to SRHR services. For instance, it revealed that women from low-income households had different experiences depending on their marital status. Married women faced more challenges, especially when they needed spousal approval or consultation for services such as pregnancy prevention, antenatal care, STI/STD prevention and treatment, sex education, and sexual violence. Unmarried women had more autonomy and freedom to make their own SRHR decisions.

The findings also show a significant difference between those who have formal education and those who have little or no education. It is evident that education levels strongly influence SRHR access among women from low-income backgrounds in the study area. Women with formal education have

more knowledge and confidence in making informed SRHR decisions. They seek comprehensive SRHR services and understand their rights. However, women with little or no formal education often lack awareness and face difficulties in accessing SRHR. Likewise, the results reveal that age is another factor that affects the preferences and challenges of the respondents regarding the SRHR services they seek. Younger women (18-25) are more proactive in seeking SRHR services, but they mainly focus on sex education, modern contraception, emergency contraception, menstruation, testing and treatment, abortion (despite its illegality), and STD/STI prevention and treatment. Women in the 26-35 age group seek a different range of SRHR services, such as pre-pregnancy and pregnancy care, and also consult on issues of sexual violence, STD/STI prevention and treatment. Older women (36-40) mostly engage in prenatal and postnatal care and STI/STD prevention. It shows that each age group has distinct needs, although some needs overlap, and they face different challenges, such as societal perceptions, domestic responsibilities, and healthcare system shortcomings (poor facilities, lack of staff and drugs).

The results also highlight the intersection of low income and disability, showing that women with disabilities face unique challenges in accessing SRHR services. The results reveal that mobility issues limit their ability to reach healthcare facilities, and the lack of specialized care worsens their situation. The results also show that stigmatization lowers their confidence in seeking SRHR services. Regarding the intersection of low income and religion, the results show that religion plays a significant role in shaping women's choices and preferences for SRHR services. Some women prefer traditional-oriented SRHR services, while others choose more Western-oriented approaches. The level of one's religiosity also affects attitudes toward practices like abortion, with more religious individuals often rejecting them. This intersection demonstrates the impact of faith on SRHR decisions. These results reveal a complex interplay of factors that shape women's access to SRHR services. By using low income as the main factor, intersecting with religion, age, disability, marital status, and education, the results answer the sub-question on how low income and other factors influence access to SRHR for women in Aberdeen. It also shows the importance of using intersectionality as a tool to understand and analyse access to SRHR services thereby, effectively contributing to an understanding of the main question.

The results answer the sub-question on how low income, marital status, age, religion, education, and disability affect the utilization of SRHR services by women in Aberdeen. The results show the complex ways in which these factors collectively influence how women in the Aberdeen community of Sierra Leone use SRHR services. These factors not only affect access to SRHR but also shape its utilization. The findings indicate that the frequency of SRHR service use differs among different groups, with unmarried women often seeking regular check-ups, including pregnancy prevention methods, while some married women only seek SRHR services when they have sexual health problems. Furthermore, the preference for specific SRHR services is strongly influenced by religious beliefs and educational

background. Those with strong religious ties tend to avoid certain SRHR services, believing they have more important matters to attend to. On the other hand, education plays a crucial role, with more educated women showing more interest in accessing a wider range of SRHR services. Finally, women with disabilities face additional challenges, such as mobility issues and inadequate care, which affect their desire and ability to use SRHR services.

The results answer the sub-question on the perceptions of women in the Aberdeen community on the existing opportunities and resources that support access to SRHR. The results reveal a diverse landscape of opportunities and resources that influence access to SRHR in the Aberdeen community of Sierra Leone. Government-led initiatives, such as free healthcare for pregnant women and young children, are important in supporting access to SRHR services. However, challenges such as medicine shortages and long waiting times remain. NGOs provide specialized SRHR services and emotional support, filling critical gaps in the community. Advocacy groups are seen as vital agents for change, raising awareness about SRHR, advocating for policy reforms, and empowering women to voice their concerns. Moreover, the results show that grassroots efforts within the community, such as peer education strategies and knowledge-sharing initiatives, also contribute to access to SRHR services. Although this sub-question and its answer do not directly relate to the main research question, they present this research and the commissioner with the insight that the respondents' perceptions of the existing platforms and spaces are crucial launch pads for interventions aimed at improving access to SRHR services for low-income women.

6.2 Research recommendations

The SLNBCC should develop a targeted intervention plan with an intersectional outlook for improving access to SRHR services in the Aberdeen community. Meaning, that the plan should not consider women from low-income households to be a homogenous group and thus, the overlapping identities that significantly shaped their accessibility to SRHR services must be entirely recognised in the plan. Also, it is recommended that SLNBCC conduct a study aimed at exploring men's role in shaping access to sexual reproductive health and rights services for women within the Aberdeen community.

The intervention should be tailored to address some of the specific issues that the findings of the report have unveiled in the community. It must incorporate regular periods for progress assessments to measure the impact of the intervention. For this process, SLNBCC should collaborate with local health authorities, NGOs, and community leaders to ensure the intervention's feasibility. Lastly, the organisation must set a timeline for the intervention, including milestones for each phase.

SLNBCC should also develop an intervention plan targeting the enhancement of healthcare providers through training on SRHR services and attitudes towards women seeking care. The intervention should

focus on assessing the change in healthcare providers' attitudes and knowledge through pre- and post-training evaluations. For this intervention, the organisation should partner with medical institutions and organizations to conduct training sessions. The training should enhance the healthcare provider's understanding of the differences embedded within the identities of these women and focus on providing tailored SRHR services for them.

Lastly, the SLNBCC should Partner with local schools, religious organizations, and community groups to create and disseminate information with customised content addressing the varying needs of different identities studied. To complement this effort, SLNBCC should also conduct regular workshops and seminars, aiming to reach a specific percentage of the target population but mostly including community-based groups and men within the community.

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Annexes

Introduction statement, consent request and interview guide questions

Good afternoon/morning. My name is Kemurl Fofanah—this is Ms. Bah and Ms. Tommy. I am currently pursuing a Master's degree in Management of Development with a specialization in social inclusion, gender, and youth at Van Hall Larenstein University of Applied Sciences. My university is based in the Netherlands but I am a Sierra Leonean and live and work here. I am conducting independent research on the topic of Access to Sexual and Reproductive Health and Rights (SRHR).

I/We would like to discuss the issue of your social identities and their impact on access to SRHR. The purpose of this research is to gain knowledge from you and formulate recommendations that will facilitate the improvement of access to SRHR, particularly for women in low-income households.

You have been selected to participate in this research because you reside in the targeted community for this study, and you fit the description of the respondents needed. Your opinion and experiences are crucial to the research, and we encourage you to freely express yourself and provide honest feedback.

Please be assured that we will ensure the confidentiality and anonymity of your participation and the information you provide. The interview will last approximately 30 minutes, and you are free to participate at your convenience. You also have the right to stop the interview or decline to respond to any questions.

Before I proceed, I would like to formally ask for your permission to record the interview and take a picture.

Respondents agreed to both: ☐

Respondents did not agree to both: ☐

Respondents agree only to be recorded: ☐

Interview questions for the study on 'an Intersectional Analysis of Access to Sexual and Reproductive Health and Rights (SRHR)'.

Question topic: Experiences in accessing Sexual Reproductive Health and Rights

1. How would you describe your experience of accessing sexual and reproductive health and rights services in the Aberdeen community?

2. Can you share any specific experiences you have had when seeking sexual and reproductive health services here?

3. What challenges have you faced or observed in terms of accessing these services?

4. Have you encountered any barriers related to your age when seeking sexual and reproductive health services? Can you provide examples?

5. How has your marital status influenced your ability to access sexual and reproductive health and rights services?

6. Has your level of education affected your experiences in accessing these services? In what ways?

7. Are there any religious beliefs or practices that have influenced your decisions or experiences regarding sexual and reproductive health?

8. If you or someone you know has a disability, can you share the unique challenges faced in accessing these services?

9. How do societal norms and community attitudes impact you as a woman, accessing sexual and reproductive health services in Aberdeen?

10. Are there specific services or aspects of sexual and reproductive health care that you believe are underrepresented or inadequately addressed in the community?

11. What resources and opportunities do you think k are available to you in this community that promote your (or women's) access to SRHR services?

12. Have you or anyone you know encountered stigma or discrimination while seeking sexual and reproductive health services?

Question topic: The contribution of low income and the factors of marital status, age, religion, education, and disability in shaping access to SRHR for women in Aberdeen

1. How would you describe the relationship between low income and the ability of women in Aberdeen to access sexual and reproductive health and rights (SRHR) services?

2. Can you share examples of how (your) marital status impacts the SRHR choices and experiences of women in the community, especially those with low income?

3. In your opinion, what role does age play in shaping the accessibility of SRHR services for (you or) women of different age groups, and how does it overlap with low-income?

4. How do your faith) and religious beliefs (within the community) affect women's decisions regarding SRHR services, particularly for those facing economic challenges. (As a Muslim, or a Christian or someone who believes in traditional faith) What do you think about SRHR services?)

5. What differences have you observed in access to SRHR services between women with varying levels of education, especially when combined with low income? (What differences do you think education levels make with regard to the access to SRHR services?)

6. For women with disabilities or those you know, how does their disability intersect with low income in terms of SRHR access? What challenges do you face because of your situation?

Question topic: The utilisation of SRHR services and the understanding of SRHR

1. Can you tell us how often you access SRHR services in the Aberdeen community? Are there specific services you use regularly, and if so, how frequently?

2. Could you share your thoughts and feelings regarding your desire to use SRHR services? Are there any particular reasons or needs that drive you to seek out these services?

3. Which SRHR services have you used or do you use? Please describe the services, and can you explain why you choose or chose them over others?

4. Have you encountered any obstacles or challenges in accessing SRHR services, if so, can you explain those challenges?

5. How does the Aberdeen community react to women who use SRHR services often? (Do you perceive any societal attitudes or expectations as to how you may use SRHR service?)

6. What is your experience with healthcare services and the attitudes of the staff in facilitating your utilization of SRHR services?

7. Can you describe how residents in low-income households of the Aberdeen Community perceive and define sexual reproductive health and rights (SRHR)?

8. What are the common misconceptions or gaps in knowledge about SRHR that you have observed within the low-income households of this community?

Thank you for your valuable insights and participation in this study

NOTE to the research assistant: The questions were to be asked based on the type of respondents being interviewed. Some of the questions are specifically meant for certain respondents/interview sessions, i.e., Key Informants and focus group discussions. If you have any issues, please contact the researcher.

Respondent Demographic Information Form

1. Respondents number: [……]

2. Age: […….]

3. Marital Status: Single [ ] Married [ ]

4. Education: [Specify your highest level of education]
   - [ ] No formal education
   - [ ] Primary school
   - [ ] Secondary school
   - [ ] Vocational/Technical school
   - [ ] College/University

5. Religion: [Specify your religious affiliation]
   - [ ] Christianity
   - [ ] Islam
   - [ ] Traditional African religion

6. Disability: [Do you have a disability?
   - [ ] Yes
   - [ ] No

7. Income Level: [Specify your approximate monthly household income]
   - [ ] Less than $100
   - [ ] More than $200

Please only tick what applies to you Thanks

The table below illustrates the codes and categorisation of the respondents.

Respondent	Low-Income	Location	Gender	Religion	Education	Age range	disability	Marital status	Data Collection Method
R1	LI	AB	F	TB	Educated	Adult	NON-D	Single	Semi-Structured Interview
R2	LI	AB	F	TB	L-to-NO-Ed	Older adult	DIS	Married	Semi-Structured Interview
R3	LI	AB	F	CH	Educated	Adult	NON-D	Married	Semi-Structured Interview
R4	Not available	Not available	NA	Not available	NA	Not available	Not available	Not available	Key Informant Interview
R5	LI	AB	F	IS	Educated	Young Adult	DIS	Single	Semi-Structured Interview
R6	LI	AB	F	CH	L-to-NO-Ed	Young Adult	NON-D	Single	Semi-Structured Interview
R7	LI	AB	F	TB	Educated	Older Adult	NON-	Married	Semi-Structured Interview
R8	Not available	Not available	NA	Not available	NA	Not available	Not available	Not available	Key Informant Interview
R9	LI	AB	F	IS	educated	Older Adult	NON-D	Married	Semi-Structured Interview
R10	LI	AB	F	IS	Educated	Older Adult	DIS	Married	Semi-Structured Interview
R11	LI	AB	F	CH	L-to-NO-Ed	Young Adult	NON-D	Single	Semi-Structured Interview
R12	LI	AB	F	CH	Educated	Adult	DIS	Single	Semi-Structured Interview
R13	Not available	Not available	NA	Not available	NA	Not available	Not available	Not available	Key Informant Interview
R14	LI	AB	F	IS	L-to-NO-Ed	Older Adult	NON-D	Single	Semi-Structured Interview
R15	LI	AB	F	TB	L-to-NO-Ed	Young adult	NON-D	Single	Semi-Structured Interview
R16	LI	AB	F	IS	Educated	Adult	NON-D	Married	Semi-Structured Interview
R17	Not available	Not available	NA	Not available		Not available	Not available	Not available	Key Informant Interview
R18	LI	AB	F	TB	L-to-NO-Ed	Adult	NON-D	Married	Semi-Structured Interview
R19	LI	AB	F	TB	educated	Young adult	NON-D	single	Semi-Structured Interview
R20	Not available	Not available	NA	Not available	NA	Not available	Not available	Not available	Key Informant Interview
R21	LI	AB	F	CH	L-to-NO-Ed	Adult	NON-D	Single	Semi-Structured Interview
R22	LI	AB	F	CH	Educated	Older Adult	NON-D	Married	Semi-Structured Interview
R23	LI	AB	F	IS	L-to-NO-Ed	Young Adult	DIS	Single	Semi-Structured Interview
R24	LI	AB	F	IS	L-to-NO-Ed	Young adult	NON-D	Married	Semi-Structured Interview
R25	LI	AB	F	IS	educated	Young Adult	NON-D	single	Semi-Structured Interview
R26	LI	AB	F	CH	L-to-NO-Ed	Adult	DIS	Married	Semi-Structured Interview
R27	LI	AB	F	IS	Educated	Adult	NON-D	Single	Focus Group Discussion
R28	LI	AB	F	CH	L-to-NO-Ed	Adult	NON-D	Single	Focus Group Discussion
R29	LI	AB	F	TB	Educated	Older Adult	DIS	Married	Focus Group Discussion

R30	LI	AB	F	TB	Educated	Young Adult	NON-D	Single	Focus Group Discussion
R31	LI	AB	F	CH	L-to-NO-Ed	Older Adult	NON-D	Married	Focus Group Discussion
R32	LI	AB	F	TB	Educated	Adult	NON-D	Married	Focus Group Discussion
R33	LI	AB	F	CH	L-to-NO-Ed	Young Adult	DIS	Single	Focus Group Discussion
R34	LI	AB	F	IS	L-to-NO-Ed	Older Adult	NON-D	Married	Focus Group Discussion

In the table above:

- Respondents: (R) indicates the respondent
- Low-Income (LI): Indicates that the household is classified as low-income.
- Location (AB): Represents the Aberdeen community in Freetown, Sierra Leone.
- Gender (F): Indicates that the respondent is biologically female.
- Intersectional Attributes: Abbreviations or codes representing various attributes such as:
- Age: young adult for those between 18-25, Adult for those between 26-35 and older adult for those between 36-40.
- Religion: CH Christians, IS Islam and TB traditional belief (faith)
- Education: Educated and L-to-NO-Ed: little to no education.
- Marital status: Married or Single
- Disability: NON-D: non-disabled and DIS: disabled
- Data Collection Method: Codes indicating the method used to collect data - Semi-Structured Interview (SSI), Key Informant Interview (KII), or Focus Group Discussion (FGD).

Research timeline

Months	*May*		*June*				*July*				*August*				*September*			
Weeks	*2nd*	*3rd*	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Activities																		
Planning & defining the research topic with the commissioner																		
The drafting of the research proposal																		
Designing and redefining research tools (SSI, FGD and KII guides)																		
Fieldwork																		
Data analysis process																		
Finalizing data analysis and presentation of results (thesis)																		