



The  
University  
Of  
Sheffield.

**Experiences of Ebola survivors on healthcare access  
in Bombali District, Sierra Leone**

**Registration number: 150127851**

**Dissertation presented for the degree of  
MPH in International Development and Public Health**

**University of Sheffield**

**2016**

**Word Count: 15,000**

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## **PREFACE**

‘So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand.’

– Isaiah 41:10

First of all, I thank God for completing my Master’s dissertation. With his presence and faith on me, I was able to work hard whenever I faced difficulties during working on the dissertation. With his wisdom and encouragement made me strong enough to finish the work with success.

I would not be able to complete this piece of work by myself without supports from my parents, family, supervisors, personal tutors and course mates. I would like to sincerely express a huge thanks to my supervisor Dr. Robert Akparibo for all the supports and motivation whenever I had trouble with working on the assignment.

In addition, my parents – also my role model – who have always encourage me to work hard and given me great opportunity to study abroad.

Last but not least, my fellow course mates, it was grateful to study with you in the Department of Geography. You always challenged me to work more and hard but each one of you inspired me throughout the course.

**ABSTRACT**

The key aim of the research is to explore Ebola survivor's experiences of accessing healthcare in Bombali District, Sierra Leone. The latest Ebola outbreak in 2014 brought international attention toward since the beginning of the disease outbreak. Now, Sierra Leone is declared free from Ebola. However, there are almost 5000 survivors suffering post-Ebola symptoms and poverty. The research trying to identify the challenges those survivors are suffering and more specifically in term of medical help. In order to achieve the key aim, a qualitative approach was used and semi-structured interviews were conducted with 33 Ebola survivors and 8 health workers. The interviews focused on investigating whether survivors face any challenges accessing healthcare and what are their views toward traditional healers. Moreover, it also examined what are the key factors impacts on delivering quality healthcare for those survivors within perspective of health workers working in the survivor's clinic.

## **CHAPTER 1 - INTRODUCTION**

### **Background**

The total population of Sierra Leone is 7,076,641 in millions. The official language of the country is English but locally Krio and Temne is widely spoken (UNDP, 2015b). The life expectancy at birth is 50 years both male and female (WHO Sierra Leone, 2016a). Historically, before the end of the civil war in 2002, there has been over 11 years of armed conflicts. Due to long ongoing conflicts, there is lack of infrastructure in most of sectors and especially for healthcare system (UNDP, 2015b).

Sierra Leone ranked 181 out of 188 countries in 2014 Human Development Index (HDI). It is indicated as the world's poorest country (UNDP, 2015a). More than 60% of total population is living below US \$ 1.25 a day (UNDP, 2015b). Economically, the country is highly dependent on foreign aids. Almost 50% of public investment programmes are conducted and financed by externally. The growth of economy is unlikely to be changed with low productivity and 46% GDP in agriculture sector (UNDP, 2015b).

The education level is also low, only 10% of adult female completed up to at least secondary education where 21.7% of adult male (UNDP, 2015a). In addition, female participation in labour market is relatively high by 65.7% whereas 69% of male (UNDP, 2015a). Due to the linkage with low education level, most of labour force is concentrated in agricultural sector as the main growth of economy.

The country's public health expenditure rate in percentage of Gross Domestic Product (GDP) is approximately 11.8%. The percentage of expenditure is relatively high compared to other countries (UNDP, 2015a). However, the healthcare system is very poorly structured. The country has high percentage of communicable burden of diseases by 70% and 30% of non-communicable diseases (WHO Sierra Leone, 2016a). Number of doctors is significantly low. There are only 4 out of 100,000 people (WHO Sierra Leone, 2016a).

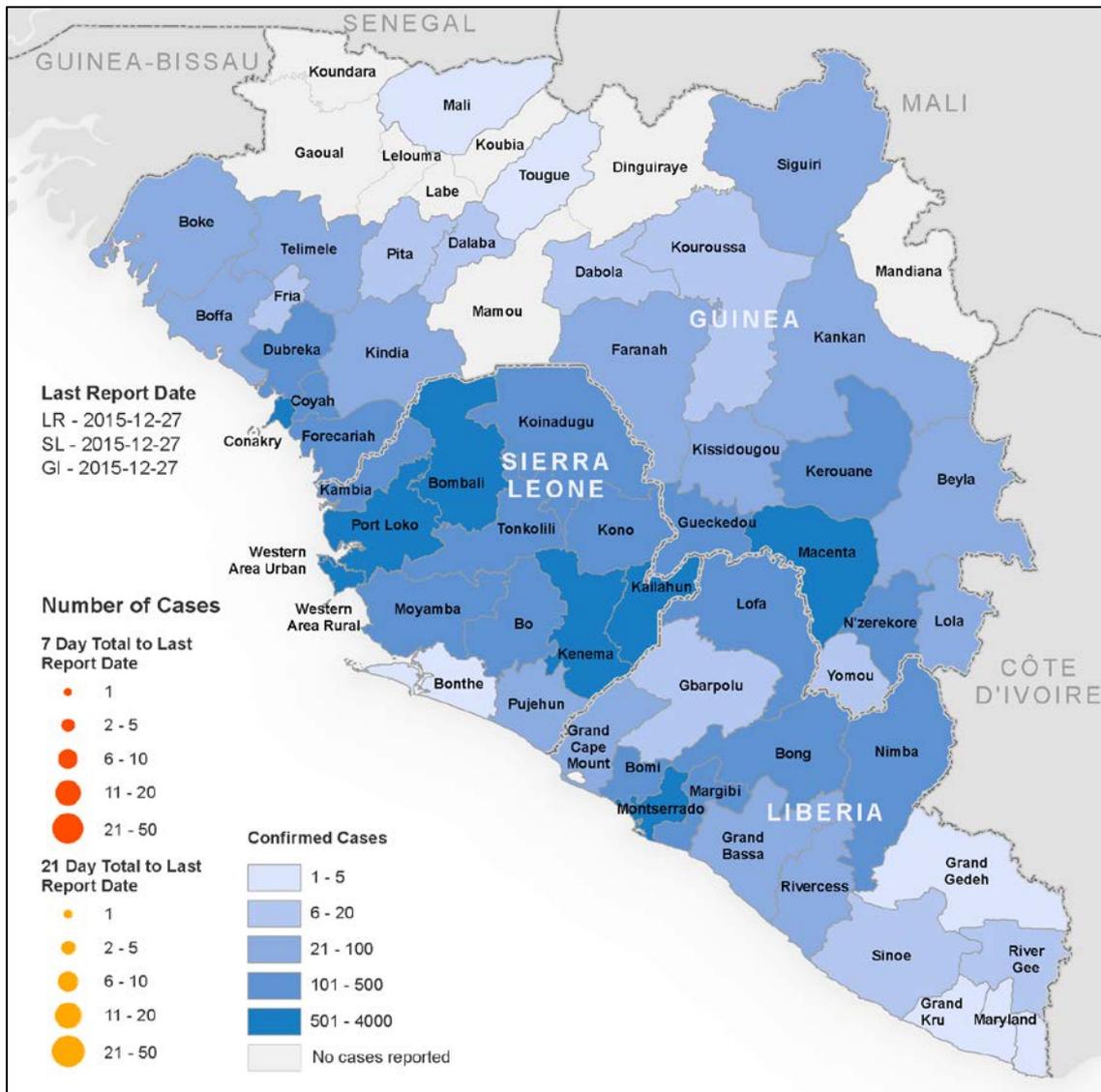
**Brief summary of latest Ebola outbreak in 2014**

The Ebola disease virus transmits through human to human direct contact with infected people this also includes any contaminated surfaces and materials. There is no proven treatment available for Ebola but there is few potential treatments still undergoing with evaluation. Officially there are no licensed vaccines but two of possible vaccines are still testing for human safety (WHO Sierra Leone, 2016b). The symptoms are high fever, headache, muscle pain, fatigues and sore throat in early stage. These symptoms are very common as getting cold or some other disease; therefore it was hard to identify who actually have inflected Ebola. The early symptoms build up with vomiting, diarrhoea, bleeding and impaired kidney and liver functions (WHO Sierra Leone, 2016b).

According to <Figure 1>, in Sierra Leone, cumulative confirmed cases are 8,706 and registered deaths are 3,590 from the data recorded until 27<sup>th</sup> March 2016 (WHO Sierra Leone, 2016b). There are approximately 5,116 estimated survivors only in Sierra Leone (WHO Sierra Leone, 2016b).

The very first confirmed case in Sierra Leone was found on 24<sup>th</sup> Mary 2014 (WHO Sierra Leone, 2016b). By the 7<sup>th</sup> November 2015, there was the first declaration of official over of Ebola after 22 months of Ebola outbreak. The declaration was made after 42 days with no new confirmed case (WHO Sierra Leone, 2016b). However, in January 2016, there was flare-up of Ebola after declaration. The flare-up was ended by 17<sup>th</sup> March 2016 and officially until now Ebola was defeated in Sierra Leone (WHO Sierra Leone, 2016b). Besides, the country is still in high risk because of potential Ebola virus persistence in those over 5000 survivors.

<Figure 1> Cumulative number of cases in Sierra Leone



(Source: WHO, 2015)

**Ebola survivors’ access of healthcare**

Ebola survivors are suffering post-Ebola syndrome which cause long-term disability including eye sight problem, body and joint pain, headache and fatigue. It makes them difficult to work and keep their livelihood ongoing (WHO, 2014). Most of them worked in labour sector with high demand of physical activities now lost their jobs because of their health conditions.

Another problem survivors are suffering is stigma within their communities and even in regional healthcares. In order to decrease stigmatisation of Ebola survivors, there

is available place where those survivors freely share their own experiences with other fellow survivors. The headquarter of the Sierra Leonean Association of Ebola Survivors (SLAES) is based in Freetown the capital and each districts had own branch of association which normally organise regular meetings and gather ups (Acland, 2016). On the other hands, the government failed to provide previously promised free healthcare and medication for Ebola survivors and comprehensive package for survivors. Due to this the government turned to charitable agencies for implementation. There is also very low trust of government providing supports for Ebola survivors (Acland, 2016).

Survivors also suffer psychological trauma as many of them lost family and friends during the outbreak. The mental health problems are another key issue to be considered among survivors. WHO and other partner NGOs have been establishing essential care unit for survivors including developing primary health care and adapting referral system to governmental hospitals. So far, they have set up 20 survivor's clinics and 4 referral clinics (WHO, 2016b).

The establishment of Ebola survivor's clinic in Bombali District was mainly contributed by World Hope International (WHI), Ministry of Health and Sanitation, WHO and Sierra Leone Association of Ebola Survivors (Bombali District). The clinic first opened in late May 2015. It can provide acute care and ongoing management for survivors. It also has a mobile clinic and outreach programmes to make easy access of healthcare even survivors living in rural areas in Bombali District (World Hope International, 2016).

During the Ebola outbreak, there were issues with people accessing traditional healers in their communities and avoiding to come to hospitals. It was from rumours around people which were wrong information saying that hospital is the one spreading Ebola virus and health workers will stigmatise patients. There was a case of a single traditional healer near Guinea border spread 14 women infected at funeral (Robinson, 2014). The local belief and traditional medical practice was the key source of transmission of diseases. Especially during the Ebola outbreak, in process of nature of burials washing infected dead body was the majority case of how it transmitted. Without knowing the fact that the person is infected Ebola virus, people tend to go to

traditional healers for medical treatment. This caused delay of presenting early stage in hospital and high possibility of death even after treatment (Grant, 2014a).

There is need for long-term available funding and research on medical supports for Ebola survivors. Those funding is required for maintain laboratory and survivor's clinic capacity, training for health workers and improvement for Disease Surveillance and Response strategies (WHO, 2016a). In terms of access of healthcare for survivors, not only primary medical care for post-Ebola symptoms but also specialised service such as eyesight problems and mental health counselling will be also required to facilitate the needs. Furthermore, the healthcare services need to provide both registered and unregistered survivors to be able to monitor their health conditions as in long-term (WHO, 2016a).

### **Structure of dissertation**

The key aim of the research is to explore experiences of Ebola survivors accessing healthcare in Bombali District. Through three key research questions, it will investigate whether survivors face any challenges seeking medical care and their views of traditional medicine practices. Furthermore, it will also examine on the perspectives of health workers working in the survivor's clinic. It will also identify whether health workers face any barriers working in the clinic and what could be improved to deliver quality healthcare to survivors.

## **CHAPTER 2 – LITERATURE REVIEW**

This chapter will explore relevant literatures of the research. Specifically it will examine current research based on healthcare access on Ebola survivors. In terms of access of healthcare, there are several factors which would impact on those survivors accessing healthcare facilities. Through the literatures, it will identify what has been done through previous research and find the gap between literatures.

### **Ebola outbreak in Sierra Leone**

During the Ebola outbreak, one of the key issues was that from the first stage of infection, many people were not aware of the disease. Since it was the first time when Ebola outbreak happened in Sierra Leone, most of people thought it is Cholera or another disease since the symptoms were quite similar (Bolten, 2014). In addition, since people were not fully aware of it, infected patients was hiding from hospitals and following their own way of treating disease such as going to traditional healers or herbalist for medication (Quist-Arcton, 2014). Not only the behaviour of population avoiding hospitals, there was lack of healthcare facilities in Sierra Leone during the Ebola outbreak and nothing was prepared to fight against Ebola. Therefore, even for patient who willing go to go to hospital find it difficult to seek medical help (Swartout, 2014).

### **Post-Ebola symptoms**

Survivors suffer challenges involves both physical and psychological problems. Furthermore, due to their health condition, it brings hardship on their livelihood as well (Nanyonga et al. 2016). Most common post-Ebola symptoms can be listed joint pain, headache, eyesight problem and muscle pain. Psychologically, most of them suffer from trauma and stigma from their communities (WHO, 2016d). Especially for trauma, for those survivors went through life threatening illness, they need support groups and mental health counselling sessions (Locsin et al. 2003). However, there is not sufficient support available for survivors. Due to severe post-Ebola symptoms which survivors find it very difficult to handle, WHO and other partner NGOs allocated essential package of health service to more than 10,000 survivors in Guinea, Liberia and Sierra Leone (WHO, 2016d). With international aid and supports, over 2600 survivors were able to received general health assessment and eye exam (WHO, 2016d).

### **Survivors in Sierra Leone accessing healthcare facilities**

There are key factors which will influence accessing healthcare facilities which are: distance, cost, stigma, rumours and traditional healers. These are the also factors which could delay adequate treatment for patient to access to hospitals.

#### **Distance of available healthcare facilities**

According to previous research done in Wunde Chiefdom, there was no regular transportation available and the road condition was very poor. The Chiefdom did not have healthcare facilities not even in nearby neighbouring village. The only option for that population was the outreach programme which health workers frequently visit the area once in a month (Ferme, 2014). Since there was no choice of healthcare around the area, people would prefer to go to traditional healers where those traditional practices are in their communities. Even if they are willing to go to hospital due to poverty, distance and poor transportation, they have no other option to find alternative ways (Richards et al. 2015).

#### **Cost of treatment and medication**

In order to go and get medical help from hospitals, it requires private transportation for both sick person and accompanied person. Not only transport but there is also expenditure which involves medical supplies and foods even if the treatment and medication is free (Ferme, 2014). However, for survivors there are number of free healthcare available from the government. First of all, 'project shield' provides semen testing to check on health status of survivors and psychosocial counselling every time they visit the healthcare facilities. Secondly, Ministry of Health and Sanitation provided Comprehensive Programmes for Ebola Survivors (CPES). This aimed to provide sustainable healthcare with quality and sufficient support of their livelihood. Finally, the government and Chief Medical Officer promised to survivors to provide free healthcare service in all public healthcare facilities (Government of Sierra Leone Ministry of Health and Sanitation, 2015).

#### **Stigmatisation**

Survivors are suffering community stigmatisation even from their own family members. Some of them neglected and not willing to talk or share food with them even if they

are not declared virus-free after they discharged (Mark, 2014). The only reason is that they have infected Ebola and some of them still think that it is dangerous to contact them with any chance of transmission. According to previous Ebola outbreak in Uganda during 2000-2001, most of survivors experience stigmatisation after a month when they discharged from treatment centres (Davtyan et al. 2014). It depend of degree of stigmatisation, some of them suffer intense stigmatisation which involves not allows to come back home, burning all their stuffs and family members abandoned them. Due to the rejection from their community after they have discharged and survived from Ebola, there was few cases of survivors committed suicide (Hewlett and Amola, 2003). Going back to normal lives just like before Ebola is difficult for survivors. It involves emotional distress; lost livelihood and rejection from their communities (Harries et al. 2016). Due to social stigma, survivor's quality of life is diminishing with rejection and even violence (Davtyan et al. 2014).

### **Community rumours**

Community rumours and mistrust on healthcare facilities was also another issue which influenced accessing healthcare during Ebola outbreak. When medical workers wearing protective gears, some of them find it very suspicions and brought fear to the community (Quist-Arcton, 2014). International aid health workers also faced challenging to delivery healthcare to patient because some of patients believed that those foreign health workers are the source of Ebola disease and they refuse to go to hospitals due to this misunderstanding of diseases (Nossiter, 2014). Even some of family members tried to break out their isolated families from treatment centres because they believed that the disease is treatable at home with faith of traditional healers (Mark, 2014). Therefore, those who refused to go to hospital for medical help, they relied on herbalists and herbal expertise who frequently move around the communities (Ferme, 2014). These misunderstanding rumours were started to decreased when most of communication with issue of Ebola was done by chiefs, representatives and ministers. This was due to people trust and respect in authority (Harries et al. 2016). With numbers of sensitisation and ongoing community intervention to deliver correct information, the community rumours were started to decrease.

**Traditional healers**

Most of people trust more traditional healers than health workers in the hospitals (Nossiter, 2014). This is due to they have lack of trust in governmental healthcare facilities and avoid to go to hospitals. As a result, during the Ebola, it failed to manage further spreading of disease and preventative strategies (Ferme, 2014). Statistically, over 80% of population is depend on traditional medicine for medical purposes and 90% have received mental health treatment in the past (Boakye et al. 2014). Traditional healers became people's first choice of healthcare when there are no available healthcare facilities and affordability of treatment and medication fees (Boakye et al. 2014). Moreover, traditionally, there was superstition and tribal belief of seeking healthcare from traditional healers (Goodwin et al. 2012).

**Summary and rationale**

Through the literatures, it was possible to examine possible factors which could influence access of healthcare among Ebola survivors. The key factors were distance, cost, stigma, rumours and traditional healers. However, there are significant gap between those possible factors and what has been done through previous research. Overall, research literature handle only factors around healthcare access with general population not specifically for survivors. Furthermore, there was very limited relevant literature around current situation of Ebola survivor's clinic in each district in Sierra Leone. This is need for research to investigate how survivors are accessing healthcare through those existing clinics specifically for survivors and whether they face any barriers or difficulties within the clinics. In terms of traditional healer, it needs to identify whether there has been any behavioural change after experiencing the latest Ebola outbreak. Overall, what needs to be done for survivor's to get sufficient treatment for post-Ebola symptoms and support for their livelihood.

**CHAPTER 3 – RESEARCH AIM AND OBJECTIVES**

The aim of the research is to explore the experience of Ebola survivors on healthcare access in Bombali District, Sierra Leone.

In Bombali District, there is an Ebola survivor's clinic located nearby Makeni town (the capital of Bombali District). Almost 400 registered survivors are frequently using the clinic for medical purposes. The clinic itself provides primary healthcare especially for post-Ebola symptoms, regular check-ups and running outreach programmes for survivors in rural areas in Bombali District.

There has been not enough research on Ebola survivors accessing healthcare in post-Ebola era and to explain current situation. Through the research, it would offer starting point of identifying challenges for those Ebola survivors accessing healthcare and what needs to be done for the future.

I aimed to understand Ebola survivors' experiences of accessing healthcare specifically in Bombali District and fulfil the following objectives:

1. Understand whether Ebola survivors face any challenges accessing healthcare in Bombali District in Sierra Leone
2. Explore whether Ebola survivors in Sierra Leone would access traditional medicine for their health conditions, and explore their views regarding traditional medicine practice.
3. Understand whether health workers face any barriers providing quality healthcare in the post-Ebola era.

In order to meet the above aim and objectives of the research, it will answer following key questions:

1. What challenges do Ebola survivors face in accessing healthcare in Bombali District in Sierra Leone?
2. What are views and perception among Ebola survivors regarding use of traditional medicine in treatment of health conditions?
3. What are the perspectives of health workers regarding factors impacting on quality healthcare delivery in post-Ebola era?

## **CHAPTER 4 – RESEARCH METHODOLOGY AND ANALYSIS**

### **Research design**

This study has adopted a qualitative approach. The aim of the project is to understand

their experiences of accessing healthcare after the latest Ebola outbreak in 2014 and their own perception of traditional healers for medical purposes and a qualitative approach using semi-structured individual interviews is considered most appropriate.

A qualitative method will be helpful for both a research and interviewees to informally have conversations within semi-structured set of questions. It will be very flexible with follow up questions based on answers from interviewees (Gill et al. 2008). Semi-structured individual interviews will take around 30 minutes with a set of 20 questions. For the survivors, the interview questions will be related to how they get medical help when they are sick and their own perception of traditional healers versus western medical care. The study also aims to recruit and interview health workers to investigate whether they have any challenges of delivering healthcare for those Ebola survivors after the Ebola outbreak. The question will be related to whether there are any challenges or barriers delivering healthcare service to Ebola survivors.

### **Methods originally proposed and change of methods**

Originally, before I was in the field site, I have planned to conduct focus group interviews for in-depth understanding of the experience of accessing healthcare of Ebola survivors. However, after few days of collecting data and conducting individual interviews with survivors, I decided not to have focus group interviews because through individual interviews, I was able to get enough information. One of the concern and reason I decided to have focus group was to make comfortable environment for survivors to share their own experiences with their fellow survivors in the case when they feel any discomfort during individual interviews (Harrell and Bradley, 2009). However, during the individual interviews, when I explained the aim and purpose of the research, most of survivors were willing to share all of their experiences with me.

### **Research location**

**<Figure 2> Map of Sierra Leone**



(Source: UNOCHA Sierra Leone)

<Figure 3> Map of Bombali District division of 13 chiefdoms



(Source: UNOCHA Sierra Leone)

Bombali District is located in the Northern Province of Sierra Leone. The district is the second largest district in the country. The capital of Bombali District is Makeni. Makeni

is also the largest city in the Northern Province. The Bombali District is divided into thirteen chiefdoms. According to Population and Housing Census, there are approximately total population of 368,621 including 175,657 male and 192,964 female (Statistics Sierra Leone, 2006). The district's poverty rate is 57.9%. The main livelihood in the district is agriculture by 60.5% (The World Bank and Statistics Sierra Leone, 2013). Due to former conflicts for long period of time, the district has experienced considerable displacement and destruction. Therefore, satisfaction of social service and economic recovery is still underdeveloped compared to other districts. Outside the capital – Makeni Town – there are lack of basic service like water and power supply and poor road conditions (UNOCHA Sierra Leone, 2015).

Healthcare services are provided by government, private and NGOs. After the end of civil war in 2002, the Ministry of Health and Sanitation (MoHS) shifted decentralised health system in order to expand coverage. So far, Bombali District has 16 community health centres, 1 government hospital, 3 mission hospitals, 1 community hospital and 3 private clinics (Ministry of Health and Sanitation, 2016). In addition, tradition medicine practices are also providing primary healthcare as an alternative source. The district experienced the last Ebola case on 13<sup>th</sup> September 2015 (National Ebola Response Centre, 2015).

### **Data collection**

I have managed to have 33 interviews with Ebola survivors and 8 interviews with health workers working in the survivor's clinic in Bombali District. The local Ebola survivor's association took led in the process of recruiting Ebola survivors and health workers for interviews. Since the association has all contacts with survivors and survivor's clinic. Through the connection with placement organisation (the University of Makeni) and survivor's association, I was able to recruit participants for interviews. For health workers, they were recruited after investigating where those interviewed survivors often go for medical help. It also led by association executive members to be the first contact with health workers working in the survivor's clinic.

All the interviews were held in the place where Ebola survivor's Association normally have weekly meetings. It is close to Makeni town (the capital of Bombali District) where

majority of survivors have easy access and well aware of the place. Since the interview was held in specific place, after the interview return transport fee was provided according to where each participant was coming from. For health workers, the interview was held in the local survivor's clinic during their free time with advance meeting arrangements.

The language used during the interviews was mainly English. I was accompanied by a local translator helping with translating my questions and answers from the participants in the case if any participants willing to use local language.

In order to make interview environment comfortable and informal, I decided to use voice recorder and just take some notes if it is necessary. There were advantages and disadvantages of using voice recorder. For advantage, the interview can flow very naturally without pausing and writing down details it was more likely to be daily conversation (Patton and Cochran, 2002). On the other hand, after interview during the process of transcribing it was hard to identify any body language or facial emotion of survivors. It was only able to catch some tonal change from their responses (Markle et al. 2011). Furthermore, some of interviewees found voice recording very strange at the first time. It highly requires trust and permission from interviewees before using the voice recorder.

### **Sampling methods**

I used a convenience sampling method to recruit Ebola survivors for conducting interviews. This choice of sampling method allowed me to collect and generate relevant data for the research (Patton and Cochran, 2002). Since recruitment process was led by Ebola Survivor's Association, I was not able to control this measure. Recruitment was based on whoever is available on the day for interview and who has easy access to the clinic on the day. In order to reduce low credibility of the data, I tried to analysis data considering gender, age, occupation and area of living to make comparison of different experience of accessing healthcare and find out any key challenges among them. This was necessary both for the first and second research question because it aims to investigate Ebola survivor's experiences of accessing healthcare and views and perception of traditional healers. For the interviews with

health workers, I also used convenience sampling methods. On the arranged day, I recruited health workers who were working on that day in the clinic (Patton and Cochran, 2002). For health workers, I tried to analysis based on their role and duration of work in the clinic to make any comparison on their response during the interview. In order to minimise bias in the research, I always emphasised to interviewees that they have right to opt out of the study whenever they want to. This would have reduced any risk of anyone who might felt compelled to take part (Patton and Cochran, 2002).

### **Data analysis**

The data analysis is based on voice recorder during the interview, interview notes and reflection from field diary. Both inductive and deductive approach is used in order to refine research question and test in the field site. The transcription was done once all the interviews are done for each day of research. At the end of each day, recorded file was transfer to personal laptop and transcribed into Word documents. During the process of transcription, all of survivors and health workers are randomly marked as S1 or H1 (Patton and Cochran, 2002). Once all the transcription is done, based on grounded theory approach, it is coded within each research question sections (Patton and Cochran, 2002). For those socio-demographic and socio-economic statuses which can be easily gathered are collected and used spread sheet in Excel. The reason why I collected those data separately is that it is much easier to see them through a table with interviewed survivors and health workers detail during analysis process. After all the transcription was coded and it separated with relevant themes based on coding (Patton and Cochran, 2002). Those themes are founded by reading through the interview transcription and highlighted the patterns for each section and grouped into same themes. Once this is all done, I have created separate Word document clearly showing codes, themes and original text from response for each research question.

### **Positionality and power**

During the research there was definitely imbalance of power relations especially during interviews with survivors and health workers (Bourke, 2014). There were high expectations from interviewees and Ebola survivor's Association. This was because they already had numbers of interviews from other NGOs and government before I

conducted the interviews with them. They were quite well aware that after interviews they will gain some benefits as being participate as a part of research. They even told me what previous researchers or organisation helped them with food, finance and others. Due to this high expectations, I had to keep emphasis them that I am not from neither NGOs nor governmental organisation for research but I am a university student (Ganga and Scott, 2006). I had to tell them before I start on my interviews with them to keep them in mind that I am a research student not professional or a part of NGOs. For better understanding for those interviewees, I was always with translator to clarify on this issue.

There was one day of interview when I felt very uncomfortable when interviewees asked me specific benefit of being a participant of the research (Chereni, 2014 ). The participant was emphasising the fact that her and her family is suffering very difficult situation and she was asking for some help from me. She lost her husband during the Ebola outbreak and she was with infant crying because she could not feed the baby since breast milk is not enough. As a researcher, I had to explain there will not be direct benefit through the research but I would try my best to bring some indirect benefits but this is not promised but possible benefits. On the other side, I felt really bad I was not able to directly help them since they are suffering financial problems and cannot even sustain their livelihood for herself and her family.

### **Ethical considerations**

The research has fully approved by the University of Sheffield. After recruitment, I have explained details with participant information sheet and written inform consent was sought from all participants individually. In the case of when participants are not capable of writing their own names and signature, local translator helped them write their names and alternatively finger print was collected. During the interviews with survivors and health workers anonymity and confidentiality was kept and even during data analysis process. Since the recruitment of participants was led by Ebola survivor's Association as the gatekeeper, I had to assure all the participants are able withdraw at any time during the research process: before, during and after interviews have been conducted (Farber, 2006). I have used voice recordings in order to have normal conversation environment without stopping. In prior to start the interviews, I

have consent from interviewees to use voice recordings. After when the interview is done, I transcribed the interview without their name and randomly marked each interviewee such as S1 for survivors and H1 for health workers. The research will be shared with the University of Makeni, Sierra Leone for further research on Ebola survivor's access of healthcare and improvement of future projects for survivor's supports.

### **Limitations anticipated**

There were numbers of limitations in the field during research. Considering the fact that the research has done in West Africa, Sierra Leone, there were practical issues such as limited access of internet use and frequent electricity cuts due to rainy season (Begley, 2009). Besides these practical issues, adapting in new environment was a big challenge for me since it was the very first time conducting research and spending 6 weeks in Africa.

Furthermore, due to academic schedule in the University of Makeni, I was not able to start research for over 2 weeks (Begley, 2009). During the time I arrived, it was the end of term exam and marking period for all the students and academic staffs. My supervisor in the field was not able to take me to Ebola survivor's Association to arrange introduction meeting since he was really busy. Therefore, I had to spend over 2 weeks adapting myself with the new environment and individually getting some cultural context and understanding some of aspects of latest Ebola in the area.

There were also language barriers with translators and association members. Since English is my second language and even for them they are familiar with local language. With translators sometimes I had some difficult time to communication with them delivering the needs during the interviews. Sometimes, they was not able to understand what exactly I wanted to do and just do what they thought it was right. I had to keep make it clear what I would like to do and discuss with them why I think this is right to do (Larkin et al. 2007). For instance, during the interview, when they were translating Krio to English and the other ways, I felt they are adding some of their aspects since I am just asking questions without any influenced questions. I asked them just to translate my questions rather than adding some your own perspectives

when phrasing the questions in Krio. At first, they told me that it if for good understanding for interviewees but I had to make sure to reduce any influence or intervention during the interview in order to gather survivor's own opinions (Temple and Young, 2004). Through several discussion and communications, translators and I had agreement of how this could be improved. By the end of the interviews, we became a good team and gathered good values of data from survivors.

When recruiting survivors and health workers for conducting interviews, there were miscommunications with executive staffs in the association. Arranging meetings and interviews considering their schedule was not well confirmed in the first place. I had to make sure to make frequent calls to them to confirmed dates of interviews and if I am not available for some unexpected reasons I had to notice them in advance (Nes et al. 2010). In the beginning, I was not familiar with the time keeping with them since I had to wait a long time even we had made meetings with them. After understanding that it is one of their cultures to take some time to do some meeting, I was able to adapt with the situation.

Furthermore, after 4 weeks of spending time in Sierra Leone, I was starting to not feeling well. Since, the area was quite common with communicable diseases especially Malaria and Typhoid, I thought I was caution to keep myself safe by using mosquito repellents, sleep under nets and always drink bottled water. However, I had to go to hospital since I was severely not feeling well with high fever, joint pains and upset stomach. After blood testing, I got Malaria and had to spend almost a week with treatment and medication. I was not able to continue with my interviews with survivors during that time (Begley, 2009). Even worst, after a week of suffering with Malaria, I also got Typhoid in the following week. Due to illness of Malaria and Typhoid, there was limited time for me to collect data and conduct more interviews with both survivors and health workers. Even when I got back from my research field, due to that illness I was not perfectly feeling well after few weeks.

## **CHAPTER 5 – GENERAL FINDINGS**

The aim of my research in Bombali District is to explore the experience of Ebola survivors on healthcare access. In order to achieve the aim, I set out three related

research questions to answer.

1. What challenges do Ebola survivors face in accessing healthcare in Bombali District in Sierra Leone?
2. What are views and perception among Ebola survivors regarding use of traditional medicine in treatment of health conditions?
3. What are the perspectives of health workers regarding factors impacting on quality healthcare delivery in post-Ebola era?

Accessing healthcare could be into two perceptions in Ebola survivors and health workers. Therefore the research questions included both aspects of Ebola survivors and health workers in Bombali District. Considering issue with traditional healers during Ebola outbreak, one of the research questions also includes views and perception of traditional healers among Ebola survivors. Each research question will have several emerged themes based on data collected through interviews.

This chapter entails overall summary of respondents based on socio-demographic details and socio-economic status. For socio-demographic detail, the <Table 1> of interviewed survivors are listed with age, gender, occupation and current area they are from. For socio-economic status of Ebola survivors are compared their current occupation and previous occupation before Ebola outbreak. Through these data, it will identify how Ebola survivors are suffering under difficult situation of their livelihood. Furthermore, from the current location of their community will also provide information whether they have experienced stigma from their community after Ebola outbreak. This will broadly explore life of survivors in Sierra Leone and whether there are any challenges before analysing healthcare access.

For the second part of this chapter, a table of interviewed health workers currently works in Ebola survivor's clinic with their socio-demographic information, their roles and duration. Brief background of information about the clinic will we also presented such as how the clinic established, currently ongoing programmes and relationship with Ebola survivor's association.

&lt;Table 1&gt; Details of interviewed survivors

	Age	Gender	Occupation		Area
			Now	Before Ebola	
S1	27	M	None	Little business	Pate Bana
S2	48	M	None	Power operator	Pate Bana
S3	60	M	None	Trader	Pate Bana
S4	19	F	None	Farmer	Pate Bana
S5	22	F	None	Petite trader	Pate Bana
S6	36	M	None	Bike trader	Masuba
S7	35	F	Petite trader	Trader	Makeni Town
S8	35	F	None	None	Masuba
S9	38	M	None	Private business	Masuba
S10	28	M	None	Student	Pate Bana
S11	45	M	Driver	Driver	Makeni Town
S12	30	F	Health worker	Healthworker	Makeni Town
S13	22	F	None	Clothes trader	Bangola
S14	27	F	Nurse	Nurse	Makeni Town
S15	43	F	Teacher	Teacher	Makeni Town
S16	31	F	Teacher	Volunteer	Yoni
S17	39	F	None	Private business	Makeni Town
S18	32	F	Nurse	Nurse	Makaba
S19	27	F	Petite trader	Trader	Makeni Town
S20	38	F	None	Nursing aid	Makeni Town
S21	35	F	Teacher	Teacher	Masuba
S22	30	F	Health worker	Healthworker	Kabala
S23	31	M	Farmer	Farmer	Pate Bana
S24	36	M	None	Private business	Makeni Town
S25	26	M	None	Student	Makeni Town
S26	33	M	Farmer	Porter	Cubarak
S27	47	F	Petite trader	Petite trader	Masuba
S28	20	F	None	Farmer	Masuba
S29	24	M	Petite trader	Student	Makeni Town
S30	35	M	Family work	Porter	Masuba
S31	28	F	Petite trader	Petite trader	Masuba
S32	27	M	Petite trader	Driver	Makeni Town
S33	37	M	Petite trader	Petite trader	Makeni Town

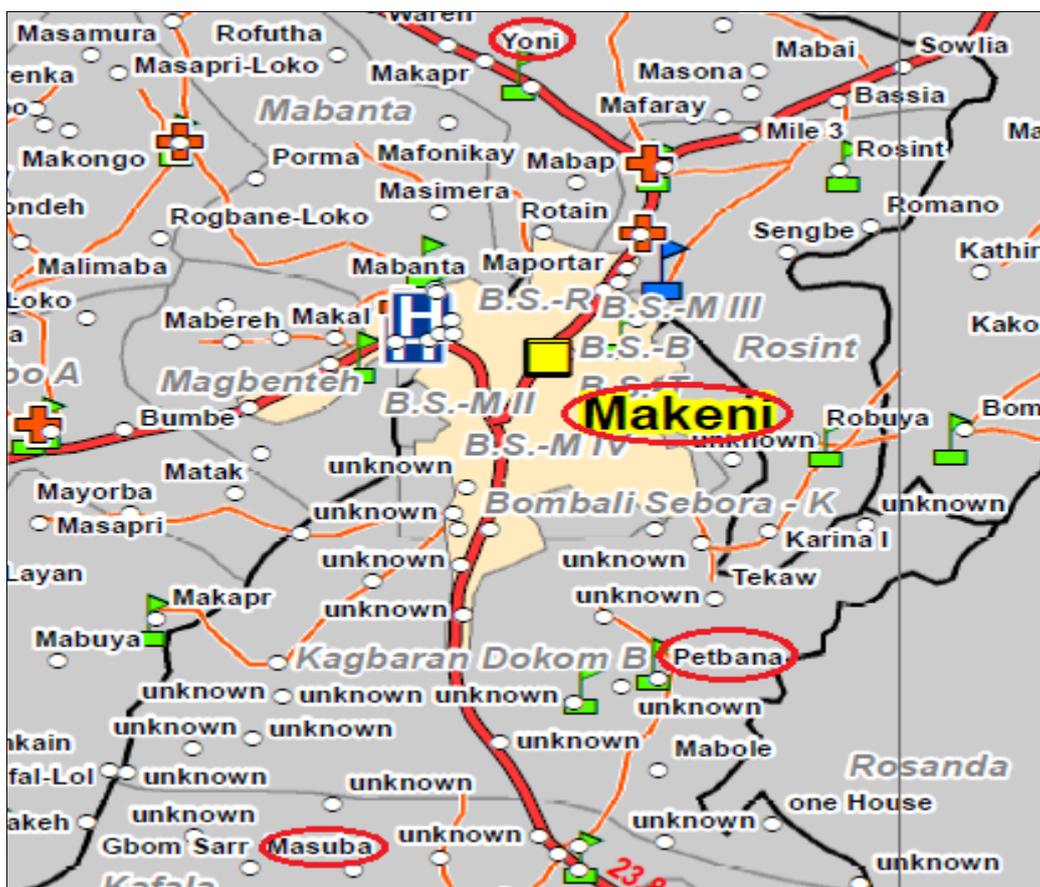
According to <Table 2>, most of survivors who interviewed are coming from Makeni town (the capital of Bombali District) and followed by Masuba and Pate Bana which are also surrounding area of Makeni town. Others area includes Bangola, Yoni,

Makaba, Kabala and Cubarak.

<Table 2> Distribution of interviewed survivors by areas

	Areas			
	Makeni Town	Masuba	Pate Bana	Others
Number of Survivors	13	8	7	5

<Figure 3> A map of Bombali District



(Source: Revenue Development Foundation, 2013)

After figuring out the number of survivors from same area, it was really hard to find detailed map of Bombali district. The <Figure 3> was the most detailed map but still most of area is indicated as 'unknown'. I was only able to find Makeni town, Pete Bana, Masuba and Yoni. Through this four red circled area, survivors were coming from pretty close areas.

**Difficult livelihood for Ebola survivors**

A large number of survivors lost their job after Ebola outbreak due to their health conditions and stigma from their communities. According to <Table 1>, even for those who are still working, there is also change of job to petite trader or agricultural work. The livelihoods for survivors are in very difficult situation. There are few quotes during the interviews:

*'Before Ebola, I was a trader. But afterward, because of health condition, I rarely work in these days.'*

*(S3, M, 60 years old, Pate Bana)*

Due to post-Ebola symptoms and the age of S3 survivors, he was not able to get back to his job after Ebola outbreak.

*'I was doing a private business before Ebola. Now I do not have job because I was not able to continue the business due to lack of resources and finance.'*

*(S17, F, 39 years old, Makeni Town)*

Besides health condition, some of them find it difficult to go back to their job due to lack of resources and financial problems.

*'I used to go to school. I was in senior school. Because I cannot afford the fee, so I could not graduate the school yet.'*

*(S29, M, 24 years old, Makeni Town)*

During the Ebola outbreak, most of survivors also lost their family. S29 also lost his parents because of Ebola and he is now only one to earn money for support his siblings. Therefore, he has no choice to work rather than go back to school.

Through the quotes from survivors, it can be seen that most of survivors are having very difficult situation without sustainable livelihood and cannot able to get back to normal life just like before Ebola outbreak.

### **Stigmatisation in communities**

Some of survivors had to move their houses due to stigma in their previous community after when they discharged from treatment centres. Here are some of quotes from survivors:

*'Since Ebola outbreak occurred and I got infected, the landlord asked him to move out.'*  
(S11, Male, 45 years old, Makeni Town)

According to S11, he was forced to move out of the previous house and he had to find another place to live.

*'After I was discharged, because of stigma, I had to move. When I was in treatment centre, my husband found out that the stigma on survivors was very bad.'*  
(S21, F, 35 years old, Masuba)

During the stay in treatment centre, her husband also experienced stigma from their community and they had to move out of the village when she was about to discharged from the treatment centre. In this case, this is not forced but they voluntarily moved out from their community.

*'People are still saying about be but I do not care much now.'*  
(S22, F, 33 years old, Kabala)

Even though some of survivors forced or voluntarily moved out from their previous communities, they are still suffering stigma in the new communities. There is still ongoing stigmatisation of Ebola survivors. Through the experience of stigmatisation in communities and even in healthcare facilities, they are now kind of used to what others saying about them. This is happening because they cannot do anything to change to better situation with no stigma on Ebola survivors. It seems that now they do not care much as long as when they discharged and voluntarily moved out from their previous communities.

	Age	Gender	Role	Duration of work
H1	30	F	Associate nurse	Almost a year
H2	30	F	Nurse	Almost a year
H3	28	M	CHO (Community Health Officer)	1 month
H4	32	F	Fully trained nurse	Over 2 years
H5	48	F	Hygiene cleaner	9 months
H6	27	F	Associate nurse	9 months
H7	36	M	Driver	6 months
H8	28	F	Financial officer	Over 2 years

Above <Table 3> indicates interviewed health workers socio-demographic details, their role and duration of work in the Ebola survivor's clinic in Bombali District. Besides Community Health Officer (CHO), most of them started to work in the clinic from the beginning. The CHO recently changed due to emergency leave of previous CHO in the clinic.

### **Ebola survivor's clinic in Bombali District**

According to their record, there are currently 355 Ebola survivors are frequently using the clinic. The clinic currently provides primary healthcare for survivors including post-Ebola symptoms. If the health condition of patients requires advance treatment or medication, the clinic will refer them to governmental hospital in Bombali District which is also nearby the clinic. The main reason why they refer to governmental hospital is that it is the only place providing free healthcare for Ebola survivors.

The clinic first established in June 2014 with intervention from World Hope International and then currently Medical Research Committee (MRC) is running the clinic for 1 year project. The key aim of the clinic is to decrease stigma and discrimination of Ebola survivors in regional hospitals when they require medical help. In order to achieve the aim, they also employed survivors as health workers to interact with fellow survivors and provide comfortable environment for them.

The survivor's clinic was first established in Freetown (the capital of the country). It aimed to provide psychological assessment with mental health counsellor sessions and support group sessions (Tiffany et al. 2016). However, the situation in Bombali

District is somehow different from the clinic in Freetown. There is no available mental health counsellor with psychological professionals rather there is only some of health workers who are also survivors are voluntary counselling survivors with mental health problems.

The clinic is also working on outreach programme to provide easy access for survivors living in rural area in Bombali district. In <Table 4>, there are key outreach spots decided by the number of survivors in the village. A team of CHO and at least 3 nurses from the clinic normally go out both Tuesdays and Thursdays to those areas. For each area, they will regularly visit each village at least once in a month. For the survivors living nearby the outreach spots are also welcomed to come for medical help. In that case, the clinic will provide return transport fee only for those patients.

**<Table 4> Outreach programme spots**

<b>Name of cluster</b>	<b>Days of visit</b>	<b>Total population of survivors</b>
Tamibiama	Thursday	7
Kamalo	Tuesday	16
Makomp Doron	Thursday	5
Pate Bana	Tuesday	32
Robuya	Thursday	15
Rosanda	Tuesday	18
Romanoh	Thursday	41
Kolisokoh	Tuesday	7

Through the outreach, they provide medication and feeding for all patients. Feeding is provided because of effectiveness of medication and treatment. The key aim of the outreach programme is to reach survivors who do not have easy access to the clinic in Makeni town and regularly check their health condition. The health workers are also sensitising survivors with not to go to traditional healers but to come to hospitals for medical treatment.

### **Relationship with Ebola Survivor's Association**

The relationship with Ebola survivor's association is more likely partnership and cordial. The association is monitoring the clinic and through survivor's meetings they check

whether survivors are receiving adequate healthcare. The feedback of survivors will be delivered to the executive members of the association and will be discussed with the clinic health workers for further improvement. Moreover, through regular association meetings, the updated information is normally delivered by those executive members to survivors. Therefore, both clinic and the association are important for both of them.

### **Closure of Ebola survivor's clinic**

By the end of this September, the currently project with MRC will be ended. Therefore, both survivors and health workers are concerning what is going to happen next for the current survivor's clinic in Bombali district. There has been still ongoing discussion of what will happened next and how survivors will be able to get medical help after September. According to health workers, there will be new project of Comprehensive Programme for Ebola Survivors (CPES) will take over the clinic and provide healthcare to survivors. However, the clinic will be closed and all the survivors will be directed to nearest regional hospitals for medical treatment. In other words, there will not be separate clinic for survivors just like the current one but to go to general hospitals around their area. Due to this new programme, both survivors and health workers are concerning with stigma and discrimination of treatment in regional hospitals. They wish the clinic to sustain at least 6 months to 1 year.

## **CHAPTER 6 – FINDINGS AND ANALYSIS 1**

This chapter will focus on the first research question (What challenges do Ebola survivors face in accessing healthcare in Bombali District in Sierra Leone?) and relevant literature discussions.

**Choice of survivor's clinic**

There are various ways why survivors choose to come to the clinic majority of them were directed, given information from treatment centres and association. Some of survivors decided to come to the clinic because of financial problems and survivors are working in the clinic.

*'Because this is for survivor's hospital and assigned hospitals for survivors.'*

*(S4, F, 19, Pate Bana)*

*'I was instructed by my chair and representatives and radio to come here for medical help.'*

*(S31, F, 28, Masuba)*

Majority of survivors were either assigned to the survivor's clinic when they discharged from treatment centres or delivered information through Ebola survivor's association weekly meetings and outreach programmes.

*'When I discharged, there are no alternative free treatment is available.'*

*(S5, F, 22, Pate Bana)*

Besides this clinic, there were no other healthcare facilities where survivors can get free treatment and medication. The situation was even worst when it was before the survivor's clinic was first established in Bombali District.

*'Because I can get free treatment for Ebola survivors.'*

*(S8, F, 35, Masuba)*

The most frequent response from the survivors was the clinic provides free treatment and medication for them. This was the main reason why they choose to come to the clinic.

*'Because survivors are working here.'*

(S19, F, 27, Makeni town)

Another key aspect was that survivors prefer to come to healthcare facilities where survivors are working as health workers. Since the clinic has several nurses who are also survivors, survivors feel comfortable to talk to them and share their health problems.

### **Geographical and financial access**

Most of survivors are spending about an hour for return trip from their house to the clinic and it is approximately on average of 9 miles for return. When they come to the clinic, they normally take motorbikes and spend on average of 5000 Leones (0.70 British Pounds) for return trip.

**<Table 5> Transport cost to the survivor's clinic**

	Transport cost (single trip), Currency = Leones						
	0 (on foot)	1000	2000	3000	4000	5000	5000+
<b>Number of survivors</b>	4	5	12	3	2	4	2

According to <Table 5>, for single trip to come to clinic, most of them spend around 2000 to 3000 Leones. Considering the period of them when the interview was held, during the rainy season, they have to spend more money on transport because of poor road condition. Especially for survivors who spend over 5000 Leones for single trip, they had to spend extra during rainy season and spend more time to come to the clinic.

### **Stigmatisation in regional hospitals**

Before the clinic was established, some of survivors who were discharged from treatment centres, they had no choice to go to regional hospital for medical help. During that period of them, most of them experienced stigmatisation from health workers.

*'It is because of stigma. I will not be comfortable to go to hospital not for survivors. During the treatment centre and hospitals, some of the nurses ignored me. Even doctors did not want to treat me. I felt very bad.'*

(S21, F, 35, Masuba)

Due to past experiences, the main reason they prefer to come to the clinic is that it is specifically for survivors and there are health workers who are also survivors. For instance, during Ebola epidemic in Democratic Republic of the Congo in 1995, survivors also experienced reluctance of hospital personnel at the beginning of epidemic. Due to denial from healthcare facilities, some of them also considered hospital with fear (Roo et al. 1998).

### **Survivors working in healthcare facilities**

Due to stigmatisation experiences, most of survivors think that health workers who are survivors are working in healthcare facilities is very important.

*'Sharing testimonies of survivors would make succeed in project for survivors' supports. Therefore, making unity of survivors and share with colleague survivors to get information of where we could get medical help.'*

(S16, F, 31, Yoni)

It does not only make comfortable environments for those survivors who come to the clinic but also sharing their experiences and delivering correct information to fellow survivors would be very effective.

**<Table 6> Views of survivors working in healthcare facilities**

	Comfortable		Preference	
	Yes	Do not mind	Survivors	Do not mind
<b>Number of survivors</b>	19	14	28	5

According to <Table 6>, 19 out of 33 survivors feel comfortable to share their health problems with health workers who are also survivors in the clinic. In addition, if they have choice to go to hospitals with same condition but one with survivors and the other without survivors working, they would go to the one with survivors. 28 out of 33 survivors preferred to go to hospital where survivors are working.

In terms of stigmatisation, it would be very effective to hire survivors to work with health workers in multi-level of community intervention. This will include delivering correct information and counselling through sharing testimonials (Davtyan et al. 2014). As one of the key clinical service for psychological problems and stigmatisation, risk communication strategies will also be very effective with survivors working as a communicator with fellow survivors suffering difficulties with their health conditions (WHO, 2016c).

### **Key challenges with current survivor's clinic**

Even though there is survivor's clinic in Bombali District, there is key challenge for those survivors in term of not enough medication especially injective and limited choice of medication.

*'I trust injects for treatment but they only gave me medication. I prefer to have injection in order to feel better within short time.'*

*(S13, F, 22, Bangola)*

Some of survivors prefer to have injective medication due to severe pain and they want to get better as soon as possible. However, because there are limited injective medication is available in the clinic; the priority treatment is tablet medication.

*'The medication they gave me did not work. Instead, I was not feeling better. It also happened to my husband as well. So, we tried to get medication from outside the hospital. I had to pay 25,000 Leones for test and for medication it cost me 180,000 Leones.'*

*(S15, F, 43, Makeni Town)*

Furthermore, some of survivors found that the available medication in the clinic did not work for them. In order for them to feel better, they had to spend extra money and get them from outside the clinic.

With current survivor's clinic, survivors are easily getting access whenever they need medical help. They are well aware that there is available clinic specifically for survivors

in Bombali Distirct and information delivery is well structured through Ebola Survivor's Association regular meetings. In terms of distance, those who interviewed were able to get easy access by riding bikes and relatively survivors were living surrounding area of Makeni town. Since survivors can get free treatment and medication from the survivor's clinic, there is not extra spending when they come to the clinic except for transport fee. Most of them have experienced stigma either in their community or regional hospital and they prefer to go to hospital or clinic where survivors are also working. There was also some issue with the clinic with not sufficient medication is available especially injective and limited range.

## **CHAPTER 7 – FINDINGS AND ANALYSIS 2**

This chapter will focus on the second research question (What are views and perception among Ebola survivors regarding use of traditional medicine in treatment of health conditions?) and discussion with relevant literatures.

### Direct / indirect or both experiences of accessing traditional healers

According to <Table 7>, most of survivors have indirectly experienced traditional healers but only few of them prefer to go to traditional healers for medical purposes. For those survivors who directly experienced visiting traditional healers, most of them had negative views on traditional healers.

**<Table 7> Experiences of visiting traditional healers**

	Experiences of visiting traditional healers		
	Direct	Indirect	Preference
Number of survivors	7	15	3

*'I think they cannot cure medical problems. If I go there, I believe there will be more problems and cause delay of treatment.'*

*(S2, M, 48, Pate Bana)*

*'The main problem would be the amount of medication they are giving to the patients. Overdoes of medication will cause another problem.'*

*(S10, M, 28, Pate Bana)*

The main reason why survivors do not prefer to go to traditional healers is that they do not believe on traditional medicine and measurement of medication. Going to traditional healers would bring them another problem and not receive treatment and medication which would make them feel better. There are strong negative views on traditional healers.

*'In fact, if I have been to native doctors, I would not be survived. My belief is that if I go to native doctors, there is more chance for me to die. Therefore, I will not risk myself to go there.'*

*(S16, F, 31, Yoni)*

Some of them even think that if they go to traditional healers, they would die and less chance to survive. There is a huge trust on hospital rather than traditional healers.

*'They are good at taking care of diseases such as Malaria.'*

*(S30, M, 35, Masuba)*

On the other hand, some of them believe that traditional healer is good at treating Malaria and Typhoid using specific herbs. For only Malaria and Typhoid, they prefer to go to traditional healers rather than hospitals. Besides the disease, for general medical help, they prefer to go to hospitals.

*'When I was in the native doctor, they would lock me in a room. So, I had to get out of there and never go again.'*

*(S10, M, 28, Pate Bana)*

*'One of my cousins went to native doctor before. They told me that it caused another problem after he went there.'*

*(S18, F, 32, Makaba)*

Even though they have experienced either directly or indirectly, most of them have negative views on traditional healers.

*'When there were not enough healthcare facilities around nearby communities, people tend to go to native doctors more often. However, now there is enough healthcare facilities available, people only go to native doctors for spiritual problems.'*

*(S32, M, 27, Makeni Town)*

The main reason why survivors went to traditional healers for medical purpose was during the time when there were not enough healthcare facilities around where they live. However, since they have easy access to hospitals, some of them only use traditional healers for spiritual purposes not medical purposes.

### **Availability of traditional healers**

Most of survivors did not have traditional healers around they live since they are from Makeni town. Besides for the survivors from Makeni town, there were number of traditional healers in their villages and communities.

**<Table 8> Availability of traditional healers in community**

	Availability of traditional healers					
	0	1	2	3	4	5+
<b>Number of survivors</b>	17	1	4	6	1	4

Even though, they had easy access of traditional healers especially for those who are from villages, they did not choose to use traditional healers for medical purposes. They had strong belief that when they are not well, they should go to hospitals not to traditional healers.

### **Differences between hospitals and traditional healers**

Survivors were well aware of key differences between hospitals and traditional healers. The most response was in terms of medical facilities and available medical service. Traditional healers do not have adequate equipments and they do not do lab testing after consultation. In terms of medical service, traditional healers cannot do operation and they do not consult patient and give treatment. Rather, they would just give medication without measurement. For other aspects, survivors recognised traditional healers as not fully trained and not qualified health workers. Finally, survivors see hospitals more structured whereas traditional healers are doing what they wish to do without structured system. Overall, survivors have high trust on hospitals rather than traditional healers in terms of medical help.

### **Behavioural change after the latest Ebola outbreak**

There has been behavioural change after the latest Ebola outbreak in terms of patients going to traditional healers for medical purposes. During Ebola outbreak, there was rumours spread around communities that hospital is the one spreading the Ebola and once you go there you will not able to survive. Furthermore, if you go to hospitals health workers will stigmatise you and they will not treat you. Due to this rumours some of survivors were avoiding to go to hospitals but alternatively they preferred to go to traditional healers. Through huge sensitisation by government and partner NGOs and experience of Ebola outbreak, now survivors realised where to go for medical help. They would go to hospitals for medical help not to traditional healers.

The local belief and practices around illness and the decision-making procedure of healthcare choice is mainly based on fatalism in Sierra Leone. People have strong belief that there is no need to go to healthcare facilities and it will soon get better after wait in place and consult with traditional healers (Grant, 2014b). Some of them consider infection of diseases as punishment and warning which could last death if the diseases do not cure after all. Based on this traditional belief and health seeking behaviours in the community, it was very difficult to acknowledge Ebola outbreak and sensitising people to come to the hospital (Grant, 2014b).

Compared to previous literatures, most of interviewed survivors have negative view toward traditional healers and they prefer to go to hospitals instead. Even though direct or indirect or both experience did not caused behavioural change. Besides, Malaria and Typhoid, they said they would straight report to the hospital for medical help. Majority of them were also well aware of the key differences between hospital and traditional healers and also providing those traditional healers are not equipped and not qualified to provide medical help. I assume through continuous sensitisation and through experience of Ebola outbreak, survivors realised that traditional healers cannot heal Ebola and also other severe diseases. There is definitely change of behaviour before and after Ebola outbreak.

## **CHAPTER 8 – FINDINGS AND ANALYSIS 3**

This chapter will focus on the last research question (What are the perspectives of health workers regarding factors impacting on quality healthcare delivery in post-Ebola era?) and discussion on relevant literatures.

### **Key challenges and barriers**

The key challenges for the clinic involve with lack of medication especially injective and there is need for improved medical facilities and equipment to deliver quality healthcare for survivors. For health workers, there is no available training programmes and lack of professional personnel in the clinic.

*'There are no available trainings to improve on skill development for health workers to gain more knowledge.'*

*(H1, F, 30, Associate Nurse)*

At the moment, there are no trainings for health workers in the clinic. Most of them are depending on their own knowledge. According to Ebola emergency response situation report in Bombali District, there is prioritised training programmes for health workers. It is only prioritised for investigation and surveillance officers not for health workers currently working in the clinic (Ministry of Health and Sanitation, 2015).

*'Treating patients especially suffering depression or mental problems they create unnecessary situation and not even able to talk to them properly. If there is a professional counsellor who knows what needs to be done with those patients, it will be better.'*

*(H4, F, 32, Nurse)*

When health workers are screening and consulting survivors, some of them suffer psychological problems which are also a part of post-Ebola symptoms. Since the clinic does not have professional psychological health worker, the existing health workers are finding difficult to treat those survivors. In Sierra Leone, there is only a single practicing psychiatrist and few mental health nurses available (Shultz et al. 2015). There is highly absence of mental health and psychosocial support system not only for Ebola survivors but in the entire health system.

*'The main challenges for me is that transport to come to work. I have to pay 6000 Leones everyday in order to come to work. Compare to my salary I am paying high amount for transport.'*

*(H6, F, 27, Nurse)*

Furthermore, the health workers are having difficulties with transport especially during rainy season. Since the condition of road is very poor, if it rains hard, sometimes they cannot come to clinic to work. Moreover, compare to the monthly salary for health workers, they have to spend more on transport fee. There is not enough salary for them excluding transport which they need to spend every day to work.

### **Facilitators after the latest Ebola outbreak**

After experiencing Ebola outbreak, healthcare facilities are equipped with better medical equipments and improved facilities. The overall healthcare system became structured and emphasising on preventing strategies. For health workers, they were not aware of how to protect themselves before Ebola and they were not fully prepared for it even during the Ebola outbreak. During the outbreak, local health workers were the one who got hardest hit. Nearly 200 health workers got infected and died because of Ebola. In addition, there was a huge loss of co-workers in healthcare facilities (Shuchman, 2014).

*'There was not enough and adequate facilities and equipment. After Ebola, there was a lot of things has been put thing in the place. Especially, in terms of washing hands, wearing PPEs, aprons and gloves.'*

*(S2, F, 30, Nurse)*

After Ebola outbreak, through continuous training for health workers, they are now know how to protect themselves from any infected patients and wearing Personal Protective Equipment (PPE).

With support and intervention from WHO, expertises of Infection Prevention and Control (IPC) were training and providing direct support for health workers with waste management, laboratory testing and contact tracing. There was also available publication of guidelines (WHO, 2015b). The other partner NGOs, UNICEF, WFP and WHO supplied one million sets of PPE and extensive trainings for health workers (WHO, 2015b). Therefore, health workers were able to protect themselves when they are accounting patients or visiting patient care areas (WHO, 2015a).

*'It is prioritised in all Infection Prevention and Control (IPC) in the hospitals. I think they should still continue to train surveillance officers. Sensitisation for people to lead them to come to hospitals. They should also avoid visiting traditional healers.'*

*(H3, M, 28, CHO)*

IPC in hospital was highly prioritised and sensitisation became very important to bring people to the hospitals to reduce any delay of treatment and further spread of diseases (To et al. 2015). For survivors, sensitisation also made through outreach programmes in rural villages. It aimed to deliver information that survivor's clinic is available and if survivors suffering any medical problem, they should all come to the clinic for treatment not to traditional healers.

### **Recommendations to improve quality healthcare**

In order to deliver quality healthcare to survivors, there are number of elements which needs to be improved in the clinic. According to interviewed health workers, motivating health workers, facilitating sufficient medication, sustaining the clinic and sensitisation are the key elements which need to be improved.

*'Just motivate health workers. Everything in health sector will be okay. Providing more trainings and improvement on welfare systems for health workers.'*

*(H2, F, 30, Nurse)*

Motivating health workers would be very important in the clinic. Since there is lack of professional personnel, no available staff trainings and insufficient salary and lack of supports, health workers are de-motivated at the moment.

*'They should provide enough drugs to the healthcare facilities.'*

*(H3, M, 28, CHO)*

There is also need to be sufficient amount of available medication in the clinic.

*'The survivors' clinic and sustaining them is the key element for survivors.'*

*(H4, F, 32, Nurse)*

Especially for survivor's healthcare delivery, sustaining the current clinic would be the best way and to employ more survivors working as health workers.

*'Huge sensitisation through radio and hire some health workers to talk with community. Community mobilisation and community outreach. Giving them examples and correct information, we would accompany with survivors. Sensitising them to go to hospital. Then, people started to go to hospitals.'*

*(H4, F, 32, Nurse)*

Finally, continuous sensitisation is highly required through outreach programmes. Delivering correct information to survivors and sensitising where to get medical help would make them to avoid traditional healers. WHO has been working hard on community engagement programmes in order to counter with misinformation and misinterpretation of previously delivered information. They also worked with community religious leaders to address fear, worries and stigma of Ebola outbreak (WHO, 2015b). They also emphasised and encouraged to go to hospitals for if there is any need of medical help.

The factors impacts on delivering quality healthcare in the perspective of health workers in the survivor's clinic can be conclude, motivate health workers, sustain the current clinic and sensitisation. Even after Ebola outbreak, with great help from international organisation, there are now essential equipment and trainings are well in place such as IPC and wearing PPEs. However, there is still need for sufficient medication and improved facilities and equipment to deliver quality healthcare especially for Ebola survivors.

## **CHAPTER 9 – CONCLUSION AND RECOMMENDATIONS**

The study identified Ebola survivor's experience of accessing healthcare in Bombali District, Sierra Leone. It is important to note that the experience of accessing healthcare does not involve with a single challenge. There were underlying factors which also influencing access of healthcare such as extreme poverty, underdevelopment, weak health systems and social customs. These made difficult to break further human to human transmission of Ebola (WHO, 2015b).

Choice of healthcare was also influenced by traditional belief around illness and seeking medical help. Most of people preferred to use traditional healers or herbalist around their communities during the first stage of Ebola outbreak. When there are available healthcare facilities especially for Ebola survivor's providing free treatment and medication, people tend to come to the clinic whenever they do not feel well. In order to deliver available healthcare for survivors and avoid going to traditional medical practices, social mobilisation will be effective with community based care through outreach programmes (Pronyk et al. 2016).

Through experiencing Ebola outbreak there has been many improvement in terms of facilitating improvement medication and equipment available in clinics and huge sensitisation results people to realise when seeking medical help, go to hospital not to traditional healers. There is still need for improvement in order to deliver quality healthcare for survivors. The priority will be motivating health workers and provide enough support for them to comfortably work in the clinic. In addition, sufficient medication and improved facilities are also required in the clinic.

The current clinic will be closed due to the end of contracted project from MRC, however, in order to provide quality healthcare for survivors, sustaining the clinic would be the best way. In addition, employing survivors as health workers would be another important to note. It would be effective to sensitise fellow survivors in rural areas in rural communities by sharing testimonials. It is one of essential clinical care 'risk communication' for survivors in order to treat psychological problems and stigma relief (WHO, 2016). Furthermore, it will also make comfortable environment for survivors to get healthcare without stigma.

Recommendation based on the findings and analysis from the research as follows:

- 1) Sustaining the current survivor's clinic in Bombali District
  - This will requires on-going discussion with the government and partner NGOs who will take over CPES project from September. In this case, the role of the Ebola Survivor's Association and health workers working in the

current survivor's clinic would play important role in order to sustain the clinic.

- 2) Facilitate enough medication and improved equipments in the clinic
  - The clinic needs to have sufficient amount of medication with wide range of option to provide to all survivors. Especially, there is high demand of infective medication from survivors. In addition, for some of them there is case which some of provided medication does not work. Preferably, expanding range of medication will be also required.
- 3) Motivate health workers by providing more financial support and available trainings
  - There is also need to improve on welfare of those health workers working in the clinic both financial and skill development.
- 4) Sensitisation through outreach programmes
  - Continuous sensitisation to bring people to come to the hospital not to traditional healer when they need medical help. Moreover, through outreach programmes, deliver correct information in case of community rumours with misunderstanding and misinterpretation of information.
- 5) Recruit survivors as health workers to provide comfortable environment for fellow survivors in the clinic
  - Especially for healthcare facilities targeted for Ebola survivors, it would be better to have survivors working as health workers in order to provide comfortable environment and also a source of treatment with mental health problems.

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## **APPENDICES**

### **Appendix 1 – Questionnaires for Ebola survivors**

#### **\*Challenges of accessing healthcare\***

1. Name / Age / Gender
2. What do you do for living?
  - Before / after Ebola, any difference?
3. Do you have family living with you?
  - Are there any other Ebola survivors beside you?

4. Which area or village are you from?
  - Have you recently moved your house after Ebola?
5. After Ebola, when you are sick, where do you get medical help from?
6. Are there any specific reasons you choose to go to that healthcare?
7. Where did you get the information that the healthcare (of your choice) is for survivors?
8. What kind of medical help can you get from (your choice of) the healthcare?
9. How long does it take you to go to (your choice of) healthcare from your house?
  - Do you walk or pay for motorbikes?
  - How much do you pay? (Single and return)
10. When was the last time you visited (your choice of) the healthcare?
11. What was your health problem at that time?
12. Did you have to pay for treatment and medication?
13. Do you think you did get enough help and support from (your choice of) the healthcare?
14. Is there anything you want more or any need for improvement?
15. Have you heard of outreach programmes or mobile clinic around where you live?
  - Have you used it before?
  - How often they come to your area or village?
  - What kind of medical help can you get there?
  - How was your experience?
  - Would you go there again?
  - Would you recommend to others?
16. Beside your choice of healthcare, are there anywhere else you can get medical help?
17. Do you know any other clinics or hospitals for Ebola survivors in Bombali District?
  - Have you used it before?
  - How far is it from your house?
  - How was the experience?
  - Did you have to pay for treatment and medication?
  - Would you recommend to other survivors?

18. Do you know this clinic (Ebola Survivors' Association) has few health workers who are also survivors?
19. Do you feel comfortable to share your health conditions with them?
20. Reversely, if health workers are not survivors, would you feel the same?
21. Do you think it is important to employ survivors as health workers in clinics and hospitals for survivors?
  - Why do you think it is important?
22. I am going to give you two examples, Hospital A has health workers who are also survivors and Hospital B has no health workers who are survivors. Both hospitals have same treatment, medication, facilities and distance. Where would you prefer to go?
23. Do you aware that this clinic (Ebola Survivors' Association) will be closed in this September?
24. After September, when this clinic is closed, if you are sick, where would you go for medical help?

\*Views / perception of traditional healers (native doctors)\*

25. Have you ever been to native doctors before?
26. Are there native doctors around where you live now?
27. How many are there?
28. Have you heard any stories from your friends and families who went to native doctors before?
  - Did they say anything about the native doctors?
  - Did they have to pay for treatment and medication?
  - Would you go when you are sick?
29. What do you personally think about native doctors?
30. Would you recommend to someone else?
31. What could be the main differences between hospitals and native doctors?
32. Do you think Ebola survivors often to go to native doctors before they come to hospitals?

**Appendix 2 – Questionnaires for health workers****\*Challenges of delivering healthcare to Ebola survivors after Ebola outbreak\***

1. Name/Age/Gender
2. Which clinic are you currently working for?
3. What's your job title?
4. What's your role in the clinic?
5. How long have you been working in the clinic?
6. Are you also survivor?
7. Were you also working as a health worker before Ebola?
8. How this clinic became healthcare for survivors in Bombali District?

- Since when?
  - How? (NGOs intervention, Governmental initiatives)
  - For how long is this clinic is for?
  - Fundings?
  - After closure, what is going to happen next?
9. Are there any other Ebola survivors' clinics in Bombali District?
- Where is it?
  - How many are there in total?
10. What kind of medical help can survivors get from the clinic?
- Is there referral system available?
  - To which hospital treat Ebola survivors?
11. Besides medical help, are there any other supports and help available in this clinic?
- Working with Ebola Survivors Association?
12. Do you think this clinic is providing enough help and supports to the survivors?
- What could be done more?
  - What are the barriers delivering more supports?
13. Does this clinic has any outreach programmes or mobile clinic for survivors?
- How often?
  - Where is prioritised area?
  - What kind of medical support can survivors get?
  - Any education programmes? Or delivering information?
  - How many health workers are involved?
14. Is there anything which can be improved in this clinic?
- Such as what?
  - Why do you think those are important?
15. How many survivors are working as health workers in this clinic?
- Health workers?
  - Volunteers?
  - For volunteers, do they get paid as well or any supports available?
16. Do you think it is important to employ survivors as health workers in the clinic and hospitals?
- Why do you think so?

17. Do you have any challenges or constrain working as a health worker in the clinic?
- How about before Ebola outbreak?
  - How about afterwards?
18. What could be the main difference of working as a health worker before and after Ebola for you?
19. What do you think of latest Ebola outbreak as a health worker?
- What went wrong?
  - What could be done for the future?
  - What needs to be done now?
  - Traditional healers?
  - Patients avoiding hospitals?
  - Any challenges or constrain achieving improvements?
20. What do you think of key elements impacts on delivering good healthcare to survivors?
- Do you think it is enough now?
  - What else can be done?
  - List 5 things which could be essential to deliver the good quality of healthcare.
  - What should be prioritised for survivors?

### **Appendix 3 – Transcribed interview with an Ebola survivor**

#### **#23**

R – Could you tell me your age?

P – 31 years old.

R – What do you do for living?

P – Farming.

R – How about before Ebola?

P – I was also farming.

R – Do you have families living with you?

P – I have 2 wives before but one died because of Ebola. Total 7 children.

R – Are there any other Ebola survivors?

P – I am the only one.

R – Which area or village are you from?

P – Pate Bana

R – Have you recently moved your house after Ebola?

P – No, I am staying in same place.

R – When you are sick, where would you go for medical help?

P – Here.

R – Do you have specific reasons to come here?

P – Because it is for survivors and it is free treatment.

R – Where did you get the information from?

P – Through the association meetings, the chairman informed me.

R – What kind of medical help can you get here?

P – Medication, free consultation.

R – How long does it take you for come?

P – More than 15 miles. 10,000 single and 20,000 return.

R – When was the last time you visited here?

P – Two months ago.

R – What was the health problem?

P – Joint pain, headache and back pain.

R – Do you think you did get enough help?

P – No.

R – Is there anything you want more?

P – Yes. Improvement of health facilities. Assist with shelters. Access the clinic easily because I am from far away.

R – Have you heard anything about outreach programmes?

P – Yes. They come to our village.

R – How often?

P – Twice in a week.

R – Have you used it before?

P – Yes I have. They were there yesterday but I did not need it.

R – What kind of medical help can you get?

P – Consultation and medication.

R – Do you think it is enough? Is there anything you want more?

P – No. Education support is needed and enough medication.

R – Are there any other places where you can get medical help?

P – No. But may be some pharmacies.

R – Do you know any other hospitals for survivors?

P – No. This is the only one.

R – Do you know that this clinic has health workers who are also survivors?

P – Yes.

R – Do you feel comfortable to share your health problems with them?

P – Yes.

R – Reversely, if they are not survivors, would you feel same?

P – Yes. Even though they are not survivors, I would share.

R – Do you think it is important to employ survivors as health workers?

P – Yes.

R – Two examples. Hospital A health workers are survivors and Hospital B they are not. Both of them have same treatment, facilities and distance. Where would you prefer to go?

P – Hospital A.

R – Do you aware that this clinic will be closed in September?

P – No, I did not know.

R – After September, when you are sick, where would you go for medical help?

P – I will have to look out for another solution.

R – Now, I am going to ask you few more questions about your own perception of native doctors? Have you ever been to native doctors before?

P – No.

R – Are there any native doctors around where you live?

P – No.

R – Have you heard any stories from your friend, families who went to native doctors before?

P – No. There is are native doctors available where I live.

R – What do you think of native doctors?

P – They are not telling truth. They are liars and exploiters.

R – What do you think the main differences between hospitals and native doctors?

P – In hospitals, consultation before medication but native doctors no consultation but only medication. They are the source of spread of infection. If patients come to hospitals there will be no infection. That is the main reason why the epidemic became a huge one especially for Ebola. The main reason why I was able to survive is that I came straight to hospitals.

R – Would you recommend to anyone else?

P – No.

R – Do you think survivors prefer to go to native doctors?

P – Well, everyone have their own choice. For me, I would not go.

#### **Appendix 4 – Coded and themed for views and perception of traditional healers**

##### (1) Personal view and perception

S1	For me, I do not trust them at all. I only trust hospital. Also, when I went there I did get healed but when I come to hospital I always get healed. So, I trust the hospital.
S2	I think they cannot cure medical problems. If I go there, I believe there will be more problems and cause delay of treatment.
S3	Well, they cannot provide medical help. I doubt that they are not professionals.

S4	Well, I trust hospitals are doing right thing.
S5	I do not have trust with them. I am not sure what they are doing. Because when I go there, their demand is too high. I cannot afford it.
S6	I do not trust them. When I come to the hospital, they examine my health condition and advice me to take appropriate tablet for treatment.
S7	I think they are liars. I do not trust them. Therefore, I do not want to go to native doctors. I would prefer to go to hospitals.
S8	It is not good. Some of them will not give right medication to treat the medical problems.
S9	I think they are just liars because when you go to native doctors, instead of solving the problem, they will cause more problems which will cause even death. That is why I do not trust them and I do not like it.
S10	After the experience of using native doctors, I would always go to hospital whenever I feel sick. Even to others, I will tell them to go to hospital not native doctors. The main problem would be the amount of mediation they are giving to the patients. Overdoes of medication will cause another problem. Therefore, I would not use it and tell others to go to hospital instead.
S11	I do not trust them.
S12	They are not good at all. They cannot treat Ebola.
S13	I know one good native doctor. For others, I do not trust them. I appreciated that good native doctor but in generally I do not trust them.
S14	But I do not think that would work. So, I do not go there. Also, as a health worker in the hospital, I cannot go to there. Some of people said that they can treat you but for me I do not think that would work.
S15	The medicine what they are using, they do not have measurements. It will cause other problems when you use their medicine. Therefore, I would not use them at all. I will just go to hospitals.
S16	In fact, if I have been to native doctors, I would not be survived. If I have symptoms, I prefer to go straight to hospital. Reporting as soon as possible will not delay treatment. My belief is that if I go to native

	doctors, there is more chance for me to die. Therefore, I will not risk myself to go there.
S17	I just prefer to go to hospital when I am sick.
S18	For me, native doctors do not know how to diagnosis patients.
S20	I do not prefer to go. They do not have measurements.
S21	They have no measurement and prescription. It is very low possibilities to get treatment. They tell lies. They have no solutions. They are if I have opportunity to tell the government, I would like to tell them to stop the native doctors. Because they have no solutions to treat people. If they can make it stop, people will not waste their time with them and just come to hospital and get treated.
S22	I personally do not like them. They have no measurement of medication. If you have problems with stomach, they would give you a whole one bottle of medication to drink it all. It will affect your body system.
S23	They are not telling truth. They are liars and exploiters.
S24	For me to come here in hospital, it is the best way. I would never go to native doctors. Hospitals would give you right medication.
S26	It is like game of chance. Some of them will work but some others will cause another problem. Even I am a native doctor for myself. I know some of herbs which can work for diarrhea. Only for that one.
S27	I prefer hospital better because they can treat me.
S29	Sometimes, I think some of them are good. I would report to hospitals and if they cannot treat me, then I would go to native doctors.
S30	They are good at taking care of diseases such as Malaria. I would go to hospital. When I go to hospital, they would go investigation and then give medication.
S31	It is not good. Because they are not professionals.
S32	Because distance and transport issues, when I have malaria, I would go to one of my cousin who sell some herbs for malaria. I believe for malaria it works for me.

## (2) Past experience

## - Direct

S1	When I was young, my parents forced me to go to traditional healers. Because they thought being ill means there is devil attacking you.
S10	When I was in the native doctor, they would lock me in a room. So, I had to get out of there and never go again.
S24	My grandmother was also native doctor. When I was young, my grandmother would give me some leaves and rub them on body. I started to sweat and felt better.
S29	I went there. They managed to get some leaves in bushes and I had to eat it. And then, I was covered by some blankets behind bushes. I reported myself to hospital.

## - Indirect

S1	Some of them in the village went to the traditional healers when they are not feeling well.
S18	One of my cousins went to native doctor before. They told me that it caused another problem after he went there. Because there is not required dose of medication and they do not know right amount of medication. He had to go to hospital afterward.
S19	During the Ebola, those native doctors were source of infection. They did not have safety equipment and they touch dead body of infected and that is how Ebola virus spread. Most of them died who did not rush to hospital.
S22	They would offer to refer the man to big hospital for treatment. But they said they do not have money for treatment and ran away from the hospital. Instead, they are still with native doctor's treatment and his condition is getting worst than before.
S30	Before, there were no healthcare facilities but now every community have healthcare facilities so that people can go there easily.
S31	Most of them lost their lives and also lost their families by drinking this

	traditional herb from the native doctors. Therefore, people now know that through the experience of others, if you go to native doctors you would not solve your problem but rather you would get other problems.
S32	Some people are satisfied with treating malaria from native doctors. In the past, when there were not enough healthcare facilities around nearby communities, people tend to go to native doctors more often. However, now there is enough healthcare facilities available, people only go to native doctors for spiritual problems who are not Christians.

### (3) Differences between hospitals and traditional healers

S1	Well, for me, hospital is 100% trust. But I do not trust traditional healers.
S6	In terms of operation, when you need to have operation, in hospitals they can straight away take action and precede operation. But from my father's experience with native doctors, they do not preceded operation even though it is necessary.
S7	If you go to hospital you can get treatment. But if you go to native doctors it will end up coming back to hospitals. So, I do not waste my time for getting treatment.
S8	In the hospital, they to lab testing but in native doctors they just give medication as their will.
S9	I feel good when I come to hospital because I trust them.
S10	Clinic, they will counsel you first. Understanding the fact that what have you been going through and what cause the problem. But in native doctors they do not have idea what is their problem but instead they will charge you first. They are not knowledgeable of medical conditions.
S12	In the hospital, they will do the test and find what the problem is but native doctors they just give you medication without test and appropriate amount.
S13	Native doctors are more likely possibilities without adequate measurement of treatment and medication. But, in hospital, they examine your condition first and give you medication and injection.
S14	When you go to hospitals, they will do lab testing and know the

	problem. But when you go to native doctors, they will give you medication with inadequate doses without checking your health problems. But in hospitals, they would give you drugs according to presentation of patients' conditions.
S15	Hospitals can diagnosis your condition and give you adequate amount of medication. But native doctors would give you medication without right measurements.
S16	The main problem with them is that there is no measurement for medication. Overdoes of medication will make you die. In addition, there is no test of medication whatever they are using. That is why I am not interested.
S17	In hospital, they do test and then give you medicine. But native doctors, they just give me medication without test.
S18	Hospitals are very structured and medication is very effective based on the diagnosis. Native doctors they just predict.
S19	If you go to native doctors it will cause another problem. Also, they cannot handle serious problems.
S20	In hospitals, they would check you and test you but in native doctors they would not have measurement and just ask you what is wrong and give medication.
S21	Hospitals are structured organisations but native doctors are not structured. Even hospitals give solution to your problem but native doctors are opposite.
S22	Hospitals they do physical examination and test them would look and tell you the right thing and give you treatment. Native doctors, they do not have qualification. They cannot do as same as doctors in hospitals. They will just give some herbal medication. Some of them have poisons. And they do not know how to treat patients.
S23	In hospitals, consultation before medication but native doctors no consultation but only medication. They are the source of spread of infection. If patients come to hospitals there will be no infection. That is the main reason why the epidemic became a huge one especially

	for Ebola. The main reason why I was able to survive is that I came straight to hospitals.
S25	Hospitals are better than native doctors. Because they will be able to understand your health problems. In native doctors will not understand of health conditions.
S26	For me, the difference is that hospital they do consultation and investigation but native doctors cannot do that.
S28	I would prefer to go to hospital. Because, they investigate and they do what is right. Native doctors are guessing what they can do.
S29	Hospitals they are all trained but native doctors are not qualified as health worker.
S30	Hospital they are correct but native doctors are just giving medication.
S31	For delivering babies and surgeries, those native doctors do not have facilities for this. Also, there are no alternative medications for other health problems.
S32	Native doctors do not have enough medical equipment.

#### (4) Behavioural change after Ebola

S1	When there is not enough healthcare access of hospitals, they often go to traditional healers.
	When there was Ebola outbreak, the government stopped those traditional healers and telling us that they are not perfect and not to use them. Some of them who have experienced traditional healers, they also think that those traditional healers cannot heal Ebola at all, to only use hospitals when you are sick.
S10	There were some rumours around people. Ebola is spread through hospital, and people are afraid to go to hospital when there was Ebola outbreak. Instead they go to native doctors. In the hospital, even nurses and doctors were afraid of treating us because of chance to get infected. As a result of that, people often seek native doctors when they are not feeling well. That caused spread of disease since they are contacting others.

	There have been different sensitisation from different NGO partners, they normally visit the town and educate people. Try not to use native doctors because they are not qualified.
S19	People now know that if you go to native doctors you would die.
S24	Survivors prefer native doctors because they do not acknowledge what is going to happen. But after Ebola, they now know that they are the source of infection, therefore they would prefer to come to hospital when they are not well.