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Worlds Apart?
Health-seeking behaviour and strategic healthcare planning in Sierra Leone

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Abstract

In 2010 Sierra Leone introduced Free Health Care for pregnant women and children under-five. In the first five months usage increased dramatically but has since steadily declined. This dissertation uses theoretical models and existing literature, as well as interviews and a survey, to investigate health-seeking behaviour. It finds that treatment is sought from a number of different sources and identifies cost, access, service quality and belief as critical factors in decision-making. It highlights the omission of belief from healthcare planning and argues that lack of research on health-seeking behaviour could explain decreasing utilisation of government health facilities.

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Acronyms

ARI	Acute Respiratory Illness
CAM	Complementary and Alternative Medicine
CHO	Community Health Officer
DHMTs	District Health Management Teams
FHC	Free Health Care Initiative
GoSL	Government of Sierra Leone
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSB	Health-seeking behaviour
MDGs	Millennium Development Goals
MHP	Maternal Health Promoters
MoHS	Ministry of Health and Sanitation
NHSSP	National Health Sector Strategic Plan
NGO	Non-governmental organisation
PHU	Peripheral Health Unit
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
WHO	World Health Organisation

Glossary of Terms

Allay

- Krio word for a spiritual or unnatural illness.

Alternative Medicine

- Term used to describe health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system (WHO). In this dissertation it is mainly used to refer to traditional and faith healing.

Biomedicine

- Medicine that uses the scientific study of biology to understand and treat illness.

Community Health Office

- Paramedics working in Community Health Facilities

Complementary and Alternative Medicine

- Term used to describe types of traditional medicine in some countries. It refers to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system (WHO).

Faith healing

- Healing achieved by religious belief and prayer rather than by medical treatment (Oxford Dictionary).

Gbambaba

- A root which is boiled and then drunk or inhaled in order to treat malaria. (Gbambaba was the most common spelling given)

Orthodox Medicine

- A term used for Western Medicine or Biomedicine.

Provinces

- Used to describe places outside Freetown or Western Area (see map on page 8).

Traditional Birth Attendant

- Usually a woman who assists mothers in delivering their babies. Skills are learned from other traditional birth attendants or from delivering babies by themselves (WHO).

Traditional Healer

- General term that encompasses a broad variety of indigenous healing roles including herbalists, spiritualist, diviners, midwives amongst others (WHO).

Traditional medicine

- The sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (WHO).

Upcountry

- Used to describe any province outside Freetown or Western Area (see map on page 8).

Western Medicine

- Another term used to describe biomedicine that is the most common form of medicine in North America and Western Europe.

Witch gun

- Gun-like object used to shoot people with unnatural illnesses, usually administered by traditional healers on behalf of clients. Symptoms can include but are not restricted to; fever, headache, pain and vomiting, which will result in death unless treated by a traditional healer.

Tables and Figures

Figure 1: Map of Sierra Leone

Source: CIA World Fact Book

Figure 2: Map of Sierra Leone Provinces

Source: www.leonedirect.com

1. Introduction

Sierra Leone has long featured at the bottom of development indices. It has been dubbed the 'worst place to be a woman', 'the worst place to have a child' and even 'the worst place to live' (Afrol News 2012; Africa News 2012; National Geographic 2010). High youth unemployment, rural impoverishment, poor infrastructure and a fledging health system were already problematic before the 10-year civil war, which ended in 2002, that set the country back even further. With the highest under-five mortality rate in the world, one of the highest rates of maternal mortality and a life expectancy of just 49 years, Sierra Leone's health environment is one of the country's greatest challenges (WHO 2012: 1; WHO 2009: 1). Poor health infrastructure and a lack of trained personnel, combined with a heavy disease burden, make health care planning particularly challenging.

Despite this, significant steps have been taken to improve health services. In April 2010 the Government of Sierra Leone (GoSL) introduced a Free Health Care Initiative (FHC) that removed user fees for pregnant and lactating women and children under-five (GoSL 2011:1). Healthcare utilisation increased dramatically in the months following its introduction, yet since September 2010 government statistics report a steady decline in usage (GoSL 2011:3). This study aims to shed some light on why utilisation has declined by analysing health-seeking behaviour (HSB) in Sierra Leone. It addresses three central questions:

1. What treatment do people seek when they feel ill?
2. What factors influence their decision?
3. Does the Ministry of Health and Sanitation (MoHS) take these factors into account in their strategic healthcare planning?

Understanding where and why people seek health care in Sierra Leone is crucial for two main reasons. Firstly, failure to understand HSB and perceptions of health can result in rejection of health care initiatives. This was the case during a mass drug administration campaign in Northern Uganda, which aimed to control schistosomiasis and soil-transmitted helminth. Parker et al detail how failure to understand local perceptions of disease resulted in rejection of the campaign by local residents (Parker

et al 2008). With the estimated cost of FHC for 2010 alone at almost $36 million (GoSL 2011:2), rejection of the initiative could result in huge wastage of funding for the GoSL, which is particularly critical given Sierra Leone's low resource setting.

Secondly, health is an integral part of development. Whether you take Amartya Sen's expanded conceptualisation of development as a process of 'expanding the real freedoms that people enjoy' or a more limited view of development as related to economic growth, health can play a crucial role. For Sen, expansion of peoples' freedom is both the means and the end of development, thus improved health is both a constitutive and instrumental element (Sen 1999: 36). Yet even for those that take a narrower view of development, health can still play a critical role. Jeffery Sachs argues that poor health can lead to poverty and using the case of malaria he asserts that countries with high disease burdens have lower economic development due to less foreign direct investment, lower human capital investment and increased absenteeism from schools and workplaces, all the result of poor health (Sachs and Malaney 2002). Whilst this theory is highly contentious it is likely that at the micro-level at least, poor health impacts on household income, either through forgone income or expenditure on health care (Packard 2009: 79). Understanding HSB and implementing successful health care programmes is therefore crucial to Sierra Leone's general development and, potentially, it's economic development too.

Whilst HSB analysis has been carried out in many developed and developing countries, research on Sierra Leone is lacking. GoSL has investigated barriers to accessing government health facilities but they have not conducted full HSB research. Based on preliminary investigations, this study finds that Sierra Leoneans seek health care from a number of different sources; public, private, formal and informal, and finds that the main factors affecting decision making include; cost, access, service delivery and belief. It suggests that the MoHS have acknowledged and are attempting to address cost, access and service delivery, but are yet to adequately account for belief in their healthcare planning. Whilst this study is limited in scope, it aims to demonstrate that further research into HSB in Sierra Leone is necessary in order to build an effective public health strategy.

This dissertation proceeds as follows: Chapter 2 outlines the methodology, Chapter 3 reviews existing HSB models and literature on HSB in sub-Saharan Africa (SSA) before drawing literature-informed hypotheses. Chapter 4 uses data collected during field research to assess where people go for treatment in Sierra Leone and what factors influence their choices. Chapter 5 assesses whether the MoHS's healthcare planning incorporates these HSB and Chapter 6 offers some concluding remarks.

2. Methodology

The aim of this dissertation is to assess where people seek treatment for illness in Sierra Leone, why they choose particular treatment options and whether the government adequately takes these behaviours into account. Hypotheses were drawn from existing research and academic literature on HSB before fieldwork was conducted to offer insights into HSB in Sierra Leone. Field research included qualitative semi-structured interviews and a quantitative survey. Both were carried out over a two-week period in Freetown, Sierra Leone in June and July 2012. Government reports and other grey literature were also used to evaluate whether HSB had been taken into account in Sierra Leone.

The data presented in this dissertation does not purport to be a comprehensive analysis of HSB and merely seeks to highlight that further research is necessary. The topic of health was therefore kept broad to ensure a generalised picture of HSB could be understood, as well as to ensure sufficient data could be collected within a short timeframe. Respondents were asked to comment on their HSB when they felt 'ill', rather than when they believed themselves to be suffering from a specific disease or ailment. 'Ill' is understood here to mean not in full health, sick or unwell.

Although field research was only conducted in Freetown, respondents were asked to comment on HSB in other areas if they were originally from outside Freetown or they had particular knowledge of other districts. Nine out of fourteen interviewees were originally from the provinces[1] and many of the informed interviewees had worked in healthcare in the provinces for a number of years. Thus their opinions on health seeking outside Freetown can be considered informed rather than speculative.

[1] Provinces or 'up-country' refers to any district outside the capital, Freetown.

2.1 Survey

In order to gain a general perspective on where people seek treatment in Sierra Leone a survey of 50 people was conducted using short questionnaires. 25 men and 25 women aged between 18 and 72 were asked where, or if, they sought treatment the last time they felt ill, whether they had ever visited health clinics, traditional healers or faith healers and what ailments they thought were best treated by biomedical, traditional or faith healers.

The survey was conducted over a three-day period in two market places and outside a cinema in Freetown. Every tenth person was asked if they would participate until the quota of men and women had been reached. Two local researchers were employed to help collect data and translate questionnaires into Krio and Mende. These researchers were affiliated with Restless Development, a non-governmental organisation (NGO) that offers research training to young students. The purposes of the study and research methods were also explained before data collection was started.

Using local interpreters has many potential limitations. Questions translated into either Krio or Mende, could have resulted in mistranslation. Answers given verbally in either Krio or Mende could have been filtered or adapted by the research assistants. Despite these potential issues and the small sample size, the questionnaires offered a basic understanding of the proportion of people that were using various health facilities, which could then be investigated further in the in-depth interviews. Conducting the survey in Krio and Mende also gave access to the opinions of a different segment of the population to the interviews, which were conducted entirely in English.

2.2 Semi-structured interviews

14 semi-structured interviews were conducted with healthcare professionals, NGO employees, religious leaders, a traditional healer and members of the public. The use of semi-structured interviews allowed me to gain a more in-depth perspective of HSB

in Sierra Leone. Interviewees were asked where they or people they know go for treatment when they are ill and why they choose particular therapies. They were asked what problems they face in accessing health care, what they would like to see improved and whether they believed current public health strategy to be working well.

Interviewees were not selected at random; rather they were selected through snowball sampling and contacts from former colleagues. Some interviewees were selected based on the potential insights they might have on broader HSB in Sierra Leone; NGOs working in public health for example.

Whilst interviewees were forthcoming on most topics, the majority seemed reluctant to admit to visiting traditional healers and at times seemed hesitant to admit to being ill. This is likely due to the perception that being unhealthy is a sign of weakness and that, as educated Freetown residents, they should not be participating in 'backward' or 'up-country' practices such as traditional medicine. This was more problematic in the survey where building trust was more difficult. Additionally, due to my association with an NGO working in Freetown, some interviewees appeared to be tailoring some answers to include praise of the project they associated me with. Interviewees were assured that the research was completely separate to any projects I had previously been involved with but nevertheless this may have affected the results.

All interviews and questionnaires were conducted on a voluntary basis, all respondents were asked if they wished to remain anonymous and verbal consent was gained from each. LSE Research Ethics Policy and the ERCS Research Ethics Framework were consulted (ESRC 2010) and relevant LSE ethics reviews completed. For a full list of interviewees, in-depth interview guides and template questionnaires please see Appendices A and B.

3. Literature Review

This literature review aims to provide a conceptual basis for understanding HSB in Sierra Leone. It is undertaken with a view to hypothesising where and why people seek treatment for illness in Sierra Leone, a hypothesis that will be preliminarily tested in the following chapter. Due to the limited availability of research into HSB in Sierra Leone, it will draw on theoretical HSB models, as well as empirical investigations into HSB in SSA. The empirical investigations studied here have been narrowed to include only those from SSA due to the relative similarity between sub-Saharan African health systems and health systems in Sierra Leone (Good 1987: 2). Whilst HSB analysis from other developing and developed countries would provide interesting comparisons, the space restrictions of this paper necessitate the limitation of the field of study. This literature review begins with a critical review of the main HSB models, including how they aid the study of HSB and their limitations for analysis of developing countries. The second section analyses existing empirical studies on HSB from SSA. The final section suggests a HSB model that is appropriate for sub-Saharan African contexts, before literature informed hypotheses for HSB in Sierra Leone are drawn.

3.1 Health-seeking behaviour (HSB)

Helen Ward et al define HSB as 'any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy' (Ward el at 1997: 21)[2]. HSB is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a state of good health (WHO 1995: 4). Health behaviour also includes the sub-discipline of health belief modelling, which seeks to specify certain beliefs that can account for individual motivations that contribute towards health behaviour (Abraham and Sheeran 2000: 4). Understanding health behaviour in general is important in Sierra

[2] Health-seeking behaviour can also be referred to as 'illness behaviour' (Mechanic 1979) or as 'sick role behaviour' (Kasl and Cobb 1966).

Leone and SSA, particularly when embarking on preventive health measures such as mass vaccination programmes. However, the aim of this dissertation is to assess where and why people access health care when they believe they are ill and whether the MoHS's healthcare plan addresses such behaviours. Thus the focus here is on HSB specifically rather than health behaviour in general. It is, however, important to note that many aspects of health belief modelling inform HSB models.

HSB has attracted a lot of interest from policy makers across the globe and from the 1960s researchers began to develop models to aid in the description and prediction of HSB. MacKian, Bedri and Lovel suggest that there are two dominant approaches to HSB modelling; 'pathways' models, which describe the series of steps people take towards health care, and 'determinants' models, which outline the factors that influence that pathway (MacKian et al 2004: 137). This distinction will be used here to help clarify the discussion.

Edward Suchman wrote one of the first pathways models in 1965. He contended that each illness episode could be divided into five different phases; experiencing symptoms, assuming the sick role, contacting a doctor, being a patient and relinquishing the sick role (1965: 127). Suchman concluded that experiencing symptoms and assuming the sick role were particularly critical in the decision-making process, with level of pain from symptoms and discussion of symptoms with family or friends being highly significant. Suchman argued that once a person had decided to seek treatment the subsequent three stages were relatively easy. Whilst Suchman's five stages are useful for breaking down the process of an illness episode, subsequent studies have found that stages three and four of Suchman's model, contacting a doctor and being a patient, are not always as easy as Suchman assumed. Diana Dutton highlights that healthcare services can vary in quality and thus studies that do not take into account the potential for differing experiences in seeking a doctor and being a patient are unlikely to adequately explain different utilisation of health facilities (1978: 362). Stages three and four of the model are also particularly important in the developing world where contacting a doctor and being a patient are much more difficult than they are in the USA, where both Suchman and Dutton's research was conducted. For example, the ratio of biomedical doctors to the population in the United Kingdom is approximately 2.74 doctors per 1000 people. This is starkly

different to Sierra Leone where there are only 0.016 per 1000 people (WHO 2011). This huge disparity between the number of doctors available in developed and developing countries impacts upon the experiences people have when they try to seek treatment from a medical doctor. Additional pathway models have been created by Fabrega, who delineated nine stages in health-seeking and Igun, who produced eleven stages (Fabrega 1972; Igun 1979). Whist these studies are also useful for outlining the processes people might go through in their search for treatment they, along with Suchman's, do not help us understand why certain decisions are made and what factors influence them.

Models that seek to determine the factors that influence health care choices bring us closer to understanding why certain treatments are sought. A number of researchers have developed determinants models including Zola (1973) who argues that critical events in a person's personal or social life are what cause them to seek treatment and Kohn and White who contend that perceived need is the major prerequisite for accessing health care (1976: 395). Two of the most regularly cited HSB determinant models are those of David Mechanic (1968; 1972) and Ronald Andersen (1973; 1975; 1978). Mechanic's model is founded on HSB being a socially and culturally learned response and he stresses the importance of sociocultural and psychological determinants in explaining the utilisation of physicians (Tanner et al 1983: 361). This is a particularly valid model for thinking about HSB in SSA where decisions over health-seeking are directed by what John Janzen terms 'therapy managing groups', that might include family members and members of the local community (1978: 4). Additionally, understanding the psychological aspects of health-seeking is useful for investigations of SSA due to understandings of health that include analysing symptoms as spiritual as well as physiological afflictions (Rivers 1924: 7).

Andersen's initial model suggests that seeking health care is based on predisposing characteristics of the individual, enabling resources and need (outlined in Figure 3).

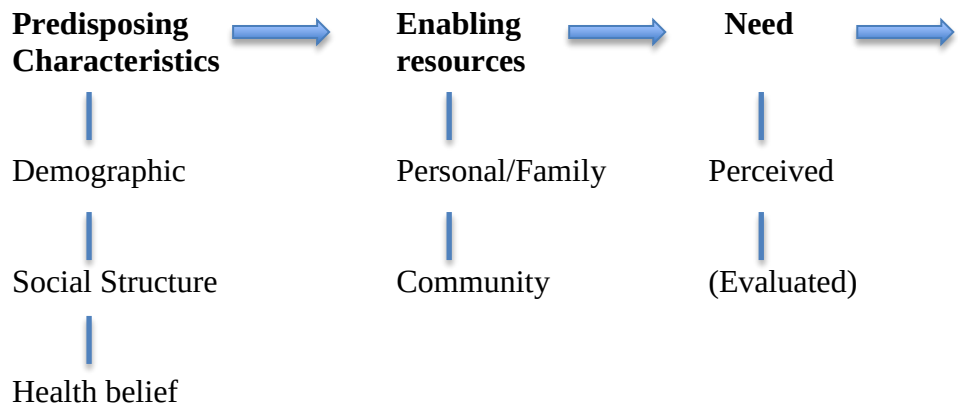


Figure 3: Andersen's Health-seeking Behaviour Model (Anderson 1995: 2)

Once again, this can be a useful model for understanding HSB in SSA. It includes vital aspects of enabling resources, which can be crucial in a developing world context where access to health care is more difficult, and predisposing characteristics, which attempts to take into account the sociocultural factors that may affect HSB.

Many aspects of the above models are useful for analysis of HSB in Sierra Leone. Suchman's delineation of the phases of health-seeking, Dutton's emphasis on the determinism of quality in health care experiences, Mechanic's concentration on the social and psychological context in which illness is occurring and Andersen's predisposing, enabling and need components all lay important foundations for the analysis of HSB. However, with only a few exceptions, these models were constructed with developed country contexts in mind and thus they often do not adequately account for situations in which there is a plurality in health care options. The majority of these conceptual models assume that people are seeking treatment from formal biomedical institutions. This is often not the case in SSA partly due to the limited availability of biomedical doctors alluded to above, and partly because the availability and use of alternative therapies[3] is often far greater both in comparison to developed countries and in comparison to biomedical therapies. Rajendra Kale estimates that there are approximately 200,000 traditional healers practicing in South Africa, whereas there are only 25,000 biomedical doctors (1995: 1182) and the World

[3] In this dissertation alternative therapy relates to both traditional and faith healing. For further clarification see Glossary of Terms.

Health Organisation estimates that 80% of the population of Africa use traditional medicine to help meet their health care needs (WHO 2002: 2). Faith healing is also increasing in popularity in SSA, no longer just being utilised by small independent churches but across a broad range of religious communities (Manglos and Trinitapoli 2011: 113). Particularly crucial within the sub-Saharan African context is the intertwining of these therapies at many levels of society. Janzen records many instances of patients and practitioners combining methods or treatments from different health systems in his study in Zaire (1978: 37) and Bledsoe and Goubaud found that biomedical pharmaceuticals were being interpreted and utilised based on their similarities to traditional remedies in Sierra Leone (1985: 279). Given the plurality in healthcare systems in SSA many of the HSB models outlined above fail to adequately describe or predict HSB in sub-Saharan African contexts. In order to gain a clearer picture of HSB in SSA it is necessary to examine some of the empirical studies that have been conducted in the region.

3. 2 Health-seeking behaviour in sub-Saharan Africa

A large number of empirical studies have been conducted on HSB in SSA and a small selection of them are discussed here in order to ascertain where people seek treatment and why they chose those treatment options. Thamar Klein's study of HSB in rural Benin, found that the most common form of treatment for illness was self-treatment (67%), of which 37% used biomedical pharmaceuticals from unlicensed drugs sellers and 30% gathered herbs from the bush or bought them from informal vendors. Village health centres and local indigenous practitioners were both visited in 11% of all incidences, with formal biomedical institution only being visited in 5% of recorded cases, of which the majority were private not government facilities (Klein 2007: 471). Klein argues that low utilisation of government health facilities is linked to the behaviour of staff, privacy, language skills and waiting times, rather than because people were rejecting biomedical health traditions, or because they were experiencing poor accessibility (2007: 477). Janzen attributes some aspects of HSB to belief, however, in his study of health-seeking in Zaire (now Democratic Republic of Congo). Janzen records a distinction made between natural illnesses that come from

God and unnatural illnesses that are caused by man (1978: 8). He outlines the belief that natural illnesses can be treated by biomedical interventions and sometimes by traditional healers, but that unnatural illnesses require treatment by traditional healers and cannot be treated with orthodox western medicine (1978: 9). He does emphasise however that therapy managers move back and forth between health systems, utilising biomedical therapies initially and then traditional therapies if no results are seen or vice versa (1978: 37). Cavender highlights similar patterns in Zimbabwe, where orthodox medical intervention is sought for illnesses considered 'normal' and traditional medicine sought for illnesses deemed 'abnormal' (1991: 363). Anita Spring found there to be a distinction between 'illness' and 'disease' in her study of northwest Zambia with diseases being treatable by both traditional and orthodox therapies but illnesses being best treated by traditional medicine. Illness in that context included barrenness, 'weak penis', 'rotten sperm' and 'madness' (Spring 1980: 132). Spring concludes that whilst expediency, financial resources and hopelessness do play a role in HSB, the primary factor that drives therapy choice is belief in the system and its pharmacopoeia. She argues that people accept biomedical services because they see good results but maintains that people would not forego ritual, herbal and proscriptive aspects of traditional medicine which are perceived to address underlying causality (1980: 137). In contrast, Taffa and Chepngeno record that lack of money was the most important factor in deciding not to attend biomedical health clinics in Nairobi (2005: 243), whilst Rose Ngugi found that people were willing to pay for treatment as long as the service was decent, thus they increasingly used private facilities that were more costly but that offered better quality of service (1999: 23). Frankenberg and Leeson, on the other hand, interviewed 28 traditional healers in Lusaka and found that 24 of them claimed the main reason people visited them was because 'others had failed' (1976: 253).

The picture assembled here can appear rather conflicting, with each study finding different determinants of HSB to be the most influential. However, this merely serves to highlight that each context is different and despite the utility for policy-makers of models that seek to offer universally applicable conclusions, it is necessary for each country, or even each region, to investigate HSB in their own locality. The literature outlined above, does however, allow us to build a picture of the potential factors that

could be influencing HSB in Sierra Leone, including quality of service provision, costs of care and belief in efficacy of therapies.

3.3 Towards a conceptual understanding of health-seeking behaviour in Sierra Leone

From the theoretical models outlined in section 2.1 and the empirical studies outlined in 2.2 it is possible to develop a conceptual basis for understanding HSB in Sierra Leone. Borrowing heavily from Axel Kroeger's HSB model (1983: 148) it is possible to incorporate the realities of pluralistic healthcare systems, which have multiple channels through which people can access health services. Kroeger's model itself utilises Andersen's predisposing, enabling and need characteristics but with the addition of different health care options as dependent variables. However, an important therapy that Kroeger does not account for is faith healing. As outlined above, faith healing is an important and increasing phenomenon in SSA and it should therefore be taken into account in any studies of Sierra Leone. Thus with faith healers added to the dependent variables the following conceptual model for analysing HSB in Sierra Leone can be put forward:

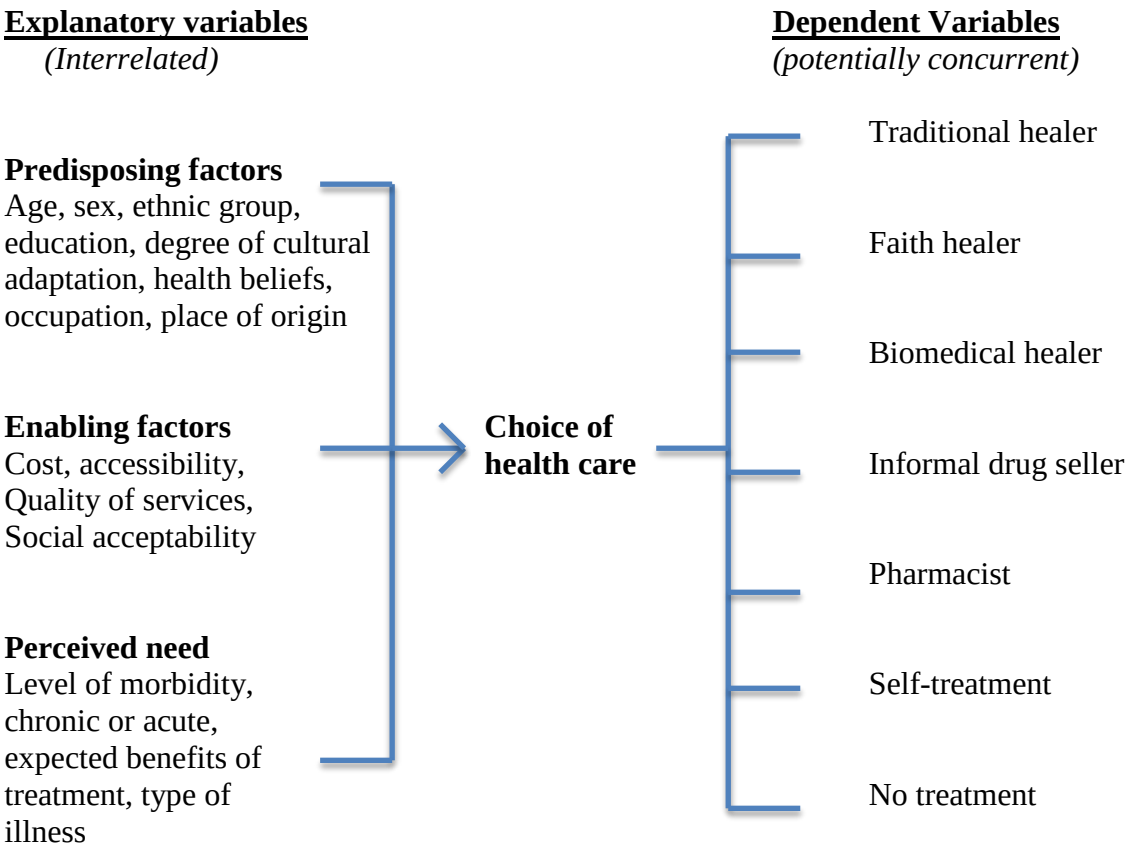


Figure 4: Health-seeking behaviour model adapted from Kroeger's and Anderson's models

Whilst this model is useful as an outline for potential empirical research it is important to remember that the explanatory variables are not mutually exclusive and that concurrent use of different healing systems is common. Kroeger calls this 'healer shopping', where a second healer is sought, without referral from the first, for a single episode of illness (1983: 147-153). Taking all the above information into account it is possible to establish the following hypotheses for research questions one and two:

1. What treatment do people seek when they feel ill?

i.) *Sierra Leoneans are likely to utilise a number of different therapy options for treatment of illness, including public and private biomedical treatments, traditional therapies including herbs and divination rituals, faith healing, self-treatment with biomedical and/or traditional*

remedies, no treatment at all or a combination of any of the above therapies.

2. What factors influence their decision?

ii.) *Their choice of health care is likely to be influenced by belief in and trust of the various systems and practitioners (predisposing factors), socioeconomic considerations and quality of the service provided (enabling factors), as well as by the type of problem they believe they have (need factors).*

The following chapter will use the above model and hypotheses as a basis for assessing HSB in Sierra Leone. Chapter 5 will then analyse the MoHS's strategic healthcare plan to determine whether HSBs have been taken into account.

4. Health-seeking behaviour in Sierra Leone

With the above two hypotheses established, this chapter outlines the results from preliminary investigations into the HSB in Sierra Leone. The first section gives a brief overview of the healthcare system, the second section uses survey data and semi-structured interviews to assess where people go for treatment. The third section draws on survey data and interviews to analyse why these treatments might have been selected and the final section draws some conclusions.

4.1 Background to health and health care in Sierra Leone

Sierra Leone has some of the poorest health indicators in the world. One in three children die before they reach the age of five and the maternal mortality rate is four times the global average (WHO 2012: 1). Malaria is the biggest killer, accounting for half of all outpatient consultations and almost 40% of under-five mortality (GoSL 2010: 8). Other common illnesses include diarrhoea, Acute Respiratory Illness (ARI), STIs and, increasingly HIV/AIDS, although prevalence rates are still well below the SSA average. Outbreaks of Cholera are reported frequently, with 4249 deaths recorded so far this year (Africa Review 2012). Biomedical healthcare utilisation in 2009 was only 0.5 visits per person per year (GoSL 2009: 3).

Health services in Sierra Leone are pluralistic with the government, private for profit and non-profit organisations, religious missions, traditional and faith healers all providing health services. Additionally there is wide availability of biomedical and traditional drugs, which can be purchased without prescription. Public health services comprise three levels; peripheral health units (PHUs), district hospitals and regional/national hospitals (GoSL 2009: 5). Health facilities are poorly distributed with rural areas suffering severe shortfalls. Of the 30 government hospitals in Sierra Leone, 12 are in Western Area, which includes the capital, Freetown[4] (GoSL 2009: 6). There are only 95 practicing midwives all of which are based in Western Area (GoSL 2009: 25).

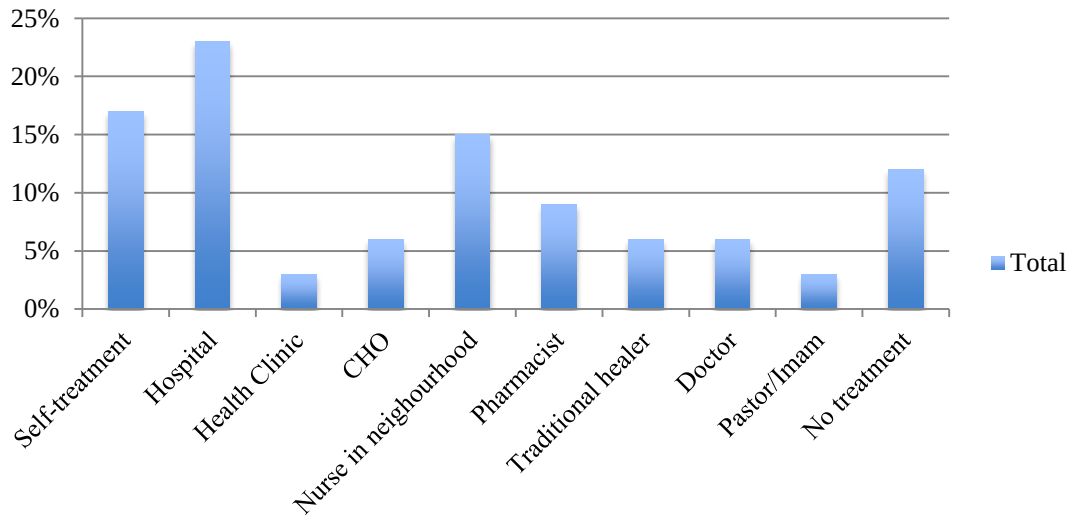
[4] Maps can be found on page 8.

Traditional healers include herbalists, spiritualists and traditional birth attendants (TBAs). TBAs are usually females resident in local communities or who are well known to their clients. Herbalists distribute herbal remedies and spiritualists use communication with the spirit world and divination to determine the causes and cures of illness. There is significant convergence between the two, with spiritualists using herbs and herbalists using rituals akin to those used by spiritualists (Vontress 1991: 243). Both are usually male and both are referred to as traditional healers in this paper. In Sierra Leone, faith healers are predominantly associated with Pentecostal churches.

4. 2 Where treatment is sought

From the sample of 50 people analysed in a Freetown suburb, 34 (21 women, 13 men) had been ill within the last year. Of these 34, the most common therapy option was treatment from a hospital, either public or private, at 23%. 17% had treated themselves at home, 15% had spoken to a nurse they knew in their local community, and 12% had sought no treatment at all (Figure 5).

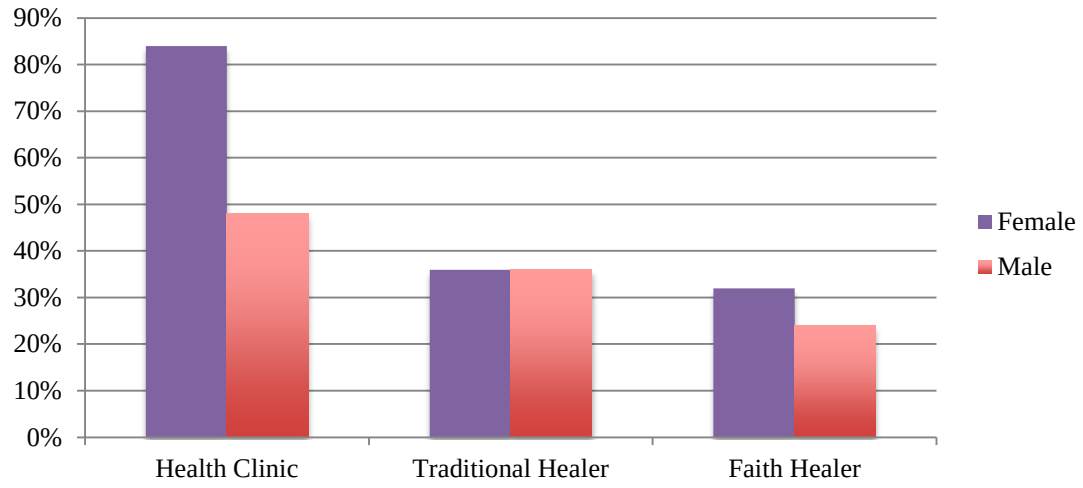
Figure 5: Therapy choices for illness in last year (total)
n: F = 21, M = 13



These figures show that a variety of therapies are sought, including biomedical options such as hospitals or pharmacists, and alternative therapies such as traditional and faith healing.

Similar patterns were found when respondents were asked whether they had ever visited certain health facilities. 36% of both males and females had visited a traditional healer at least once in their life and 28% of females and 24% of males had visited a faith healer. Particularly interesting within these findings is that only 48% of the males sampled had ever visited a government health facility, compared with 84% of women (Figure 6).

Figure 6: Percentage having ever visited health clinics, traditional healers and faith healers (gendered)
n: F = 25, M = 25



This sample size is very small and it is not possible to extrapolate these findings to the national, or even Freetown, level. However, the fact that people in Freetown, who in general have much better access to biomedical health facilities and who on the whole have higher levels of education, are using traditional and faith healing warrants further investigation into what factors are affecting their health care decision making. Moreover, that only 48% of males surveyed have ever visited a government health facility calls for further investigations into whether these findings are representative on a broader scale.

Findings from five in-depth interviews conducted with members of the public in Freetown also demonstrate that different people choose a number of different health care options. Treatment options amongst the five interviewees included self-treatment with biomedical drugs, self-treatment with *gbambaba* (a root which is boiled and drunk or inhaled for treatment of malaria), consultation with a private clinic and combinations of all three. Those who treated themselves with biomedical drugs said they bought drugs from a pharmacist without seeking their advice because they knew what to buy due to successful utilisation of the drugs previously. Two interviewees also stated that they used both biomedical drugs and took *gbambaba* at the same time. When interviewees were asked where family members who lived in the provinces sought treatment, all reported use of traditional medicine. Informed interviews with healthcare professionals and NGO workers also suggested that use of traditional medicine was much greater 'up country'.

From this limited data it is possible to assert that, at least for the sample population, *hypothesis (i)* is correct. A number of different therapies are utilised, including public and private, biomedical and traditional treatments. Despite the survey and interviews being conducted in Freetown, utilisation of non-biomedical health practices appears relatively common and is likely to be more common outside Freetown.

4.3 What factors influenced these decisions

Hypothesis (ii) suggests that HSB will be influenced by a plethora of factors, which intertwine and overlap. The following analysis seeks to highlight some of the factors that may be influencing HSB in Sierra Leone.

Cost

Nearly every interviewee highlighted cost as a major factor in people's health care decision-making. Reverend Francis Farma, a religious leader involved in HIV/AIDS awareness campaigns, argued that inability to find funds prevented people from seeking treatment at biomedical facilities, whether public or private (Transcript 2 2012: 3), whilst Tamba Pessima, a member of the public, suggested that if people

cannot afford biomedical drugs to treat malaria they will use *gbambaba* that they have foraged for themselves (Transcript 4 2012: 4). Additionally, eight interviewees mentioned that having to pay consultancy fees upfront deterred people from accessing hospitals and clinics. Morison Goba, a member of the public, provided a startling example of the extent to which payment before treatment can be taken when he described an incident in which his lip was severed by highway robbers:

> People cut my lip, I was lucky, I found it and hold it and when they took me to hospital and I was unconscious, they take it and join it but they make sure I pay this money before they start. But with traditional healer, there you can go, they solve the problem and after they ask you and then you talk and you can deposit. But the main doctors, medical doctors, the government doctors, you have to pay, you have to pay, this is what is happening, this is my experience and you know I was angry with this situation. I should have died if I had no money with me (Transcript 1 2012: 8).

Morison's account was reinforced by a number of other interviewees who suggested that traditional healers would be sought if payment upfront was difficult.

Access

Access was also mentioned continuously throughout the interviews, particularly in reference to those living outside Freetown. Sylvester Sharkh described how his mother, who was based in Moyamba District, lived 10 miles away from the nearest healthcare facility, for which she sometimes had to wait for two days for any form of public transport to take her there. He explained that if his mother required medical treatment he would drive the 100 miles from Freetown to Moyamba District to take his mother to a PHU or regional hospital (Transcript 11 2012: 6).

Service delivery

Service delivery was assessed in both interviews and the survey. When respondents in the survey were asked whether they believed they had received good treatment at various health facilities, 94% of those who had visited a traditional healer said that they felt they had received good treatment, whereas only 69% believed they had received good treatment at government health facilities. Interviewees almost

universally agreed that government health facilities were lacking when it came to waiting times, drug availability, confidentiality and time spent with patients. Mariam Koroma, a member of the public, detailed how she had gone to a government antenatal clinic when advised to by her private doctor. She explained that she spent a day and a half waiting for tests to be completed that she had already had done privately before being given 10 Panadol (paracetamol) tablets and sent away (Transcript 10 2012: 6). Limited drug availability was frequently brought up by interviewees who argued that even under FHC they either had to pay for drugs or were given minimal supplies of Panadol. Morison Goba argued that 'after the test (for malaria) what do they offer you? Panadol. I tell you it is not good' (Transcript 1 2012: 11).

Belief

In addition to cost, access and service delivery, all interviewees argued that belief in various health systems was crucial. Reverend Farma explained that 'there are people in here (Sierra Leone) who still believe in their herbs, no matter what access they have, they are still going on to their herbs' (Transcript 2 2012: 3). Sylvester Sharkh also suggested that 'even if it is free some people decide to use herbs…..people believe in herbs' (Transcript 11 2012: 11). Betty Sam, an experienced midwife and consultant to numerous NGOs operating in Sierra Leone, detailed a case in which a doctor informed a pregnant girl that she would require a caesarean section, to which her mother disagreed. Her family refused the caesarean and sent the girl to a faith healer, who confined her to the church until she delivered her baby. During delivery a number of complications arose and whilst both mother and child survived the child suffered serious brain damage and has never been able to sit, stand, walk or talk. Betty Sam argued that had the baby been delivered by caesarean in a hospital as advised, many of these complications could have been avoided, but the family's belief in prayer was so strong that they refused the advice (Transcript 8 2012: 2).

Perceived cause of and severity of illness

Closely related to belief is perceived cause of illness. Many interviewees suggested that 'unnatural' or 'spiritual' illness should not be treated with biomedical interventions, which were inappropriate if not detrimental in some circumstances. Four out of five members of the public interviewed suggested that traditional healers

were necessary for instances in which a person has been hit by a 'witch gun'[5]. Sylvester Sharkh explained that:

> The witch gun I'm talking about, the hospital cannot treat that one…..someone will die if you are not treated by a traditional healer.….if the hospital treats you, you will die in seven days because it is not for hospitals (Transcript 11 2012: 9).

Illnesses were suspected to be unnatural if they were seemingly incurable by biomedicine or if they persisted for a long time (Transcript 13 2012: 9). 18 out of 50 survey respondents also suggested that traditional healers were best at curing spiritual sickness, unnatural sickness, *allays*[6] or those hit by *witch guns*.

Severity of illness also appeared to be an influencing factor. Tamba Pessima explained that for his most recent bout of (suspected) malaria he just bought the drugs he had previously been prescribed (in this case Paludrine, an antimalarial drug), stating, 'well if it's really bad I would preferring seeing the doctor, but if it's just normal fevers and symptoms of malaria, we just get some drugs' (Transcript 4 2012: 3).

In addition to cost, access, service delivery and the type or severity of illness, survey data also suggests potential links between sex, age, place of origin and education.

Sex

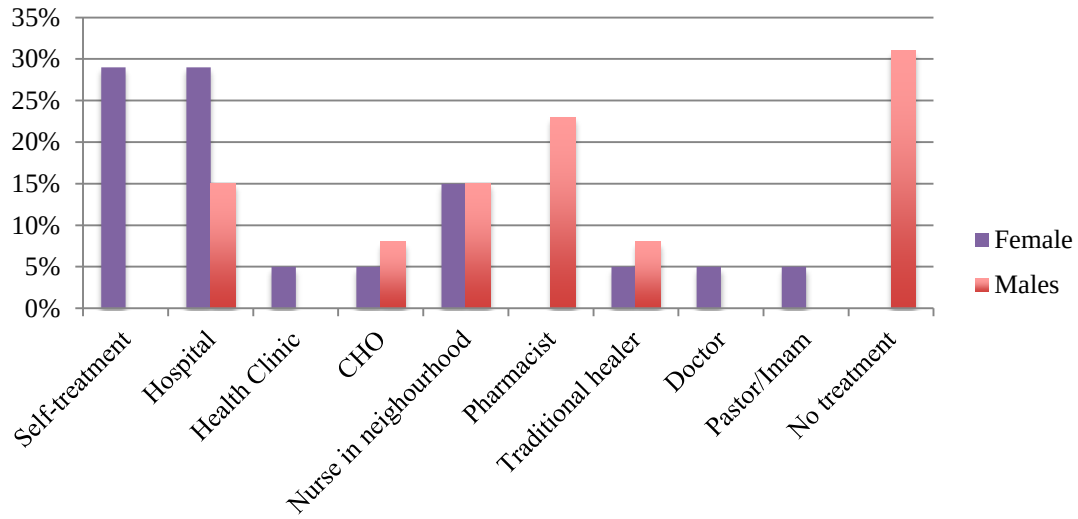
One of the starkest findings from the survey is the difference between male and female therapy choices. Figure 7 demonstrates that over 30% of the males surveyed said they opted for no treatment the last time they were ill, whereas no females took this course of action. Furthermore 23% of the males surveyed asked a pharmacist for advice (no females reported visiting a pharmacist) and 29% of the female respondents

[5] Witch guns were explained by interviewees to be invisible gun like objects, which were used by witches or traditional healers to kill people on behalf of someone else. Symptoms included fever, acute headache, vomiting and would result in death within seven days unless treated by a traditional healer.

[6] Allay is the Krio word used for spiritual or unnatural illnesses. For more detail see Glossary of Terms.

said they self-treated using biomedical drugs or herbal remedies (no males opted for this type of therapy).

Figure 7: Therapy choices for illness in last year (gendered)
n: F = 21, M =13



One possible explanation for these differences is the availability of Free Health Care to pregnant and lactating women. This could explain why 29% of the women asked said they had opted to visit a hospital when they were last ill whereas only 15% of the men surveyed took the same decision. If this were the case it would reinforce the information gained in interviews that suggests cost is a factor in determining behaviour.

Age

Analysis of the median ages for those who chose different health options presents a mixed picture, with female median ages remaining constant and male ages differing. The median age for women who have and have not been to a health clinic, traditional or faith healers, remain roughly the same at either 23 or 24 years old. However, for male respondents there appears to be a slight distinction between age and therapy choice. The median age for those who had seen a faith healer at least once was 30, whereas for those who had never seen a faith healer the median age was 25. Similarly the median age for those who had visited a traditional healer was 39 and for those who had not it was 22. Based solely on this sample, it appears that, for males at least,

younger age groups are more likely to seek biomedical attention and less likely to opt for traditional or faith healing.

Place of origin

The relationship between the origin of respondents and their health care choices suggests a potential difference between those born in Freetown and those born in the provinces. For both male and female respondents a higher proportion of people who had never been to a health clinic were not originally from Freetown. 23% of females who had visited a health clinic at least once in their life were born in Freetown, whereas none of those who had never been to a health clinic were from Freetown originally. Similarly for the male respondents, 42% of those who had attended a health clinic were born in Freetown, whereas only 23% of those who had never attended a health clinic were from Freetown (Table 2, Appendix C). Higher percentages of people born in Freetown were also found in those who have never sought treatment from a traditional healer, which suggests that those born in Freetown are less likely to use traditional healing than those born in the provinces. Evidence from interviews supports this finding; with numerous interviewees highlighting that utilisation of traditional healers was more prevalent in the provinces.

Education

Education levels of respondents also produced mixed findings. For female respondents education level does not appear to have had much impact. Percentages of those who have and have not attended high school are roughly the same for those who have and have not visited health clinics, traditional healers and faith healers. Interviewees also commented on female education having limited effect on women's use of TBAs. Reverend Farma explained that:

> If not 80 then 60 to 75% of women, even the educated ones, even the successful ladies, they prefer going to TBAs….most of them have a TBA even if some are going to a private clinic or government hospital but yet they still have their TBAs, because some prefer even with all the proper facilities they have, privileges they have, they prefer going to TBA than to the hospital (Transcript 2 2012: 6).

For male respondents however, education level does seem to have an impact on where they seek treatment. 78% of those who said they had visited a traditional healer at least once had not attended high school compared to only 19% of those who have never visited a traditional healer. Similarly, 54% of those who had never visited a health clinic had also never attended high school compared with only 23% of those who had visited a health clinic. Once again this suggests that there is a potential positive correlation between health-seeking and education levels, with greater levels of education leading to increased use of biomedical facilities amongst men.

From the survey sample it appears that age, education levels, place of origin and sex each have a complex relationship with HSB. Education and place of origin seem to impact where male respondents sought treatment, whereas these factors appear to have little bearing on female HSB.

4.4 Conclusions

Field research conducted for this dissertation suggests that HSB in Sierra Leone is similar to HSB recorded elsewhere in SSA. A number of different therapies are sought, sometimes concurrently, including formal and informal biomedical treatment, traditional and faith healing, as well as self-treatment or no treatment. Assessment of the factors that are influencing these HSBs suggests that cost, access, service delivery, belief, type of illness and severity of illness all influence where people go to seek treatment. Additionally, relationships were noted between HSB and place of origin for men and women and between HSB and age and education for male respondents. These findings uphold both the hypotheses and the conceptual model developed in the previous chapter, with predisposing, enabling and need factors all playing a vital role. Whilst much of the literature on HSB in SSA highlighted particular factors that were more influential than others, no one factor appeared to dominate in this study. Respondents reported different factors as the most important and there seemed to be a significant level of interaction between them. This suggests that different HSBs would be adopted in different settings. Further research with a larger sample size could, however, uncover a dominating factor. Having established some preliminary HSBs in

Sierra Leone, the next chapter will assess whether the GoSL and MoHS have taken these HSBs into account in their strategic healthcare planning.

5. Health-seeking behaviour and healthcare planning in Sierra Leone

The previous chapter established that cost, access, service delivery, belief and illness severity and type are all crucial factors that influence HSB in Sierra Leone. In addition, age, sex, education and place of origin appear to impact health care decision-making, although a much larger sample would be needed to determine whether these findings are representative of the wider population. Whilst there are many shortcomings in the data collected here, the findings appear to correspond to the HSB literature on SSA. This data can therefore be used to preliminarily establish whether the Ministry of Health and Sanitation's current National Health Sector Strategic Plan (NHSSP) has taken HSBs into account. Section one of this chapter demonstrates that the MoHS acknowledges that cost, access and service delivery are crucial to improving utilisation of healthcare facilities and the overall health status of Sierra Leoneans. Section two highlights that belief and perceived causes of illness appear to have been overlooked with far reaching implications. Section three outlines possible ways in which the issue of belief could be addressed and section four summarises these arguments.

5. 1 Cost, access and service delivery

In November 2009 the MoHS set out their National Health Sector Strategic Plan for 2010-2015 (NHSSP 2009). NHSSP's explicit aim was to provide a framework in which the Millennium Development Goals (MDGs) that related to health[7] could be achieved by 2015. Within this plan the MoHS acknowledged that cost, access and service delivery required improvement if service utilisation were to increase and the health status of the country to improve. Not only did the MoHS acknowledge that these factors needed to be addressed, they also took steps to improving them. Initial moves to address the cost of health care were taken in April 2010 with the

[7] MDG Goals 4 - reduce child mortality, 5 - improve maternal health and 6 - combat HIV/AIDS, malaria and other disease (UNDP 2000).

introduction of Free Health Care for pregnant and lactating women and children under five (MoHS 2011: 1). Improving access to health care was also tackled through a series of decentralisation measures that turned planning and management of district health services over to District Health Management Teams (DHMTs). Subsequently, the number of PHUs, which are the first line in health service and are located at village and town level, increased by 32% between 2005 and 2009 (Renner et al 2005: 2; NHSSP 2009: 5-6). Attempts to improve the procurement, supply and quality of drugs have also been made, including the establishment of a Pharmacy Board, which encourages the regulation of drugs and pharmacies (GoSL 2009: 33). Whilst the data obtained in this study highlights that there are still many problems with cost, access and service delivery, the efforts made to address them are commendable. Given Sierra Leone's low resource setting and the magnitude of its overall development challenge, the progress made so far deserves recognition. On the topics of cost, access and service delivery, therefore, the MoHS does appear to be taking into account factors that influence HSB in Sierra Leone.

5.2 Belief and perceived cause of illness

Despite the important attempts made to address some of the factors that are influencing HSB there has been a critical omission from government strategic healthcare planning. This study, whilst preliminary in nature, has shown that belief in and trust of various health care systems is an important influencing factor in HSB in Sierra Leone. Numerous interviewees detailed how even those who could afford and who had easy access to biomedical healthcare still used traditional medicine or faith healing because they believed it to be more effective than biomedical healthcare in certain circumstances. Indeed this study found that if the cause of illness was perceived to be 'unnatural' or 'spiritual', treatment by biomedical facilities was understood to be detrimental and best avoided. 64% of the population surveyed had visited a traditional or faith healer at least once in their lives and by the GoSL's own admission almost 90% of deliveries at the community level were attended by a TBA in 2009. Despite this evidence, however, the NHSSP makes no mention of faith healing and traditional medicine is only mentioned in passing as a source of medical

care (NHSSP 2009: 4). Additionally, since the introduction of Free Health Care, the GoSL has imposed a ban on TBAs delivering babies, fining those who do (Whitaker 2012). Omitting alternative sources of healing from strategic healthcare planning and restricting traditional practices suggests a failure on the government's behalf to understand the potential importance of belief in HSB. Whilst it is likely that in many cases TBAs are used due to the difficulties people face in accessing and paying for biomedical healthcare, there do appear to be those who utilise traditional medicine and TBAs regardless of those factors.

Failure to account for these instances could result in the wastage of valuable resources and ultimately slower progress towards improved public health. This has been suggested by Maryam Yahya, who outline how failure to account for local perceptions of health and belief about the causes of disease lead to the rejection of polio vaccines in northern Nigeria and the development of conspiracy theories about the government's objectives (2007). Wilbur Hoff also argues that failure to recognise the role of traditional healers leads to increased secrecy and unwillingness to refer patients on to biomedical facilities (1992: 184). Indeed, MoHS data on health facility utilisation has shown a marked decrease in consultations of under-fives since the initial spike immediately after the introduction of Free Health Care. Consultations peaked in May 2010 at almost 340,000 but dropped by 50% to 170,000 by March 2011 (MoHS 2011: 3). Whilst it is unlikely that this drop was due to belief in alternative medicine alone, it does show that addressing cost in isolation is unlikely to be efficacious.

5.3 Addressing belief in healthcare planning

Addressing issues of belief in healthcare planning is extremely difficult and opinions on the role that traditional healers and TBAs should play in health care delivery are diverse. Kelsey Harrison maintains that traditional healers are damaging for development of public health services in SSA and argues that rather than spending money on training TBAs, funding would be better utilised in public education, which he argues will bring down reliance on traditional medicine (2011: 1). There is,

however, a great deal of evidence to suggest that belief in traditional medicine and faith healing does not necessarily diminish with increased levels of education, globalisation and exposure to western culture and biomedical health practices. Shim et al argue that globalisation does not prevent medical diversity; rather it leads to co-development of biomedical and traditional medical institutions (2011: 781). World Health Organisation research on the use of traditional medicine also supports this conclusion by suggesting that utilisation of traditional healing in SSA is actually increasing rather than decreasing despite increased exposure to biomedicine and western culture (WHO 2002: 2). Furthermore, from the evidence collected in field research for this dissertation it appears that belief in alternative medical systems is prevalent, even among educated urban dwellers that are exposed to both biomedical and other western cultural practices.

Many policy makers and researchers argue for the inclusion of traditional healers in health care provision, including Itai Madamombe who pushes for the utilisation of traditional healers and suggests that they are essential in reaching those who are missed by modern medicine (2006: 10). The World Health Organisation also advocates for regulation of traditional medicine rather than out right exclusion (WHO 2010:28). Given the continued use of traditional and faith healing in Sierra Leone, combined with the potential problems that ignoring alternative medical practices could have on public health, it seems appropriate that some form of recognition of, or communication with, alternative medical practitioners is necessary for Sierra Leone's health objectives to be achieved.

NGOs and the MoHS have undertaken programmes with traditional healers and TBAs in Sierra Leone, offering training for TBAs as Maternal Health Promoters (MHPs) and workshops on HIV/AIDS for traditional healers. However, mixed messaging on the role TBAs and traditional healers should play demonstrates a lack of policy formation on this issue. Whilst TBAs are banned from delivering by the government, one interviewee who trains TBAs and counsels them not to conduct deliveries reported that when nurses in government health facilities are busy they ask TBAs to help them (Transcript 14 2012: 1). Furthermore, some traditional healers are given certification and, in at least one instance, an office in a government hospital. Dr Touray, a traditional healer based in a government hospital in Freetown, detailed how

the MoHS tasked him with accrediting traditional healers. Dr Touray explained that he judges traditional healers based on recommendations from community members rather than through testing their knowledge or practices himself (Transcript 9 2012). Some interviewees also reported hearing adverts on the radio for government accredited traditional healers who claimed they could cure HIV/AIDS (Transcript 8 2012: 8).

Irrespective of the debates surrounding the inclusion or exclusion of alternative medicine in public health, current policy towards TBAs in Sierra Leone is unlikely to produce the desired results due to the top down nature of the intervention. Banning TBAs from conducting deliveries and offering them small incentives to refer patients to health clinics is aimed to encourage women to deliver in hospitals (Transcript 14 2012: 1). Whilst the offer of incentives goes some way towards generating alternative incomes for TBAs, who earn a living from deliveries, preventing TBAs delivering is largely an attempt to address the outcome rather than the cause of TBA use. As mentioned above, many factors contribute to the use of TBAs, including cost, access and service quality, which the MoHS is trying to combat. However, without addressing fundamental beliefs or cultural preferences for TBAs, significant change is likely to be elusive. Studies of behavioural change in relation to HIV/AIDS have shown that bans imposed from the top down are unlikely to be effective in changing behaviour (Parker 2004). Thus, in instances where belief in traditional and faith healing is strong, bans imposed from the top down are unlikely to stop people seeking health care from these actors.

If the GoSL is committed to marginalising alternative medical practices then a behavioural change campaign that targets people's beliefs rather than targeting practitioners is arguably a better option. Improving access and addressing cost issues is more likely to be successful if attempted concurrently with behavioural change initiatives rather than outright bans. However, given the GoSL's limited resources and the apparent pervasiveness of belief in traditional medicine, accepting alternative practitioners as part of Sierra Leone's pluralistic health system, whilst making efforts to limit dangerous or harmful practices, is potentially more appropriate until biomedical health services have been improved. Some NGOs and faith-based organisations (FBOs) have organised for kits to be given out to traditional healers and

TBAs that help reduce dangerous practices such as reuse of unsterilised surgical equipment (Transcripts 7 and 14 2012), although the MoHS does not appear to have directly addressed such issues themselves.

5.4 Conclusions

The MoHS has recognised that cost, access and service delivery are crucial to improving utilisation of government health facilities and they have set out a number of different policies that seek to address these. Limited Free Health Care, additional PHUs and efforts to improve drug quality and supply are just some of the efforts made. Despite this, the MoHS does not seem to have accounted for belief as a factor that affects HSB in their strategic planning and their position on inclusion or exclusion of traditional healers and TBAs is not clear. Whilst there remains a great deal of debate about whether alternative medical practices should be included in public health services the MoHS arguably needs to at least develop a coherent policy towards them. Given that belief in alternative medicine remains prevalent in Sierra Leone and on the increase in SSA as a whole, communication with traditional healers and recognition of traditional medicine would likely be a better option than marginalisation. As Warren et al suggest, ‘separation of traditional medicine and biomedicine in policy does not correspond with the attitudes within society’ (1982: 1873).

6. Conclusion

This dissertation set out to examine where Sierra Leoneans seek treatment when they are ill, why they choose particular therapy options and what factors influence their decision making, as well as whether current healthcare planning considers these behaviours. Answers to these questions are important because there has been minimal research done into HSB in Sierra Leone and because the government's Free Health Care initiative appears to be faltering, with usage on the decline only two years after implementation. Getting health care right is also crucial for Sierra Leone's citizens who currently live in one of the toughest health environments in the world.

Using empirical literature and theoretical models on HSB a simple model was constructed that was more appropriate to developing country contexts that have plural healthcare systems. Preliminary investigations found that treatment was sought from a number of sources; formal and informal, biomedical and alternative. Cost, access, service delivery and belief were all reported to be crucial factors that influence where treatment is sought and additional relationships between sex, age, origin and education were recorded. These findings are similar to studies of HSB in other parts of SSA and they align with Anderson's predisposing, enabling and need factors, which were included in the model developed here. From the research conducted in this study it is not possible to assert that any one factor is more dominant than the others in determining HSB in all cases, rather the data suggests that predisposing, enabling and need factors interact with each other and thus produce different outcomes in different settings.

This HSB analysis was used to assess the Ministry of Health and Sanitation's National Health Sector Strategic Plan to determine whether HSB had been taken into account in healthcare planning. The investigation found that access, cost and service delivery were all acknowledged by the MoHS as important determinants of health-seeking and that efforts to addresses these factors were being developed with limited success. Belief in the efficacy of various health systems and in the causes of illness were not considered, however, and policies towards alternative medicine, including traditional and faith healing, were either absent or unclear.

Forming policies towards alternative medicine, and particularly traditional healers and traditional birth attendants, is challenging for any government but especially for those that do not have a well-functioning biomedical health system. Harmful practises and delayed referrals are just two of the problems associated with traditional and faith healing. Despite these difficulties, however, ignoring issues of belief in health-seeking will only serve to slow progress towards improved health and could result in significant wastage of funds. Whether the government opts for marginalisation of alternative medicine or inclusion, a clear strategy is needed that takes belief into account.

Data collected in this dissertation was preliminary in nature and further research of health-seeking behaviours is required in Sierra Leone. Further research would potentially benefit from looking at HSB in relation to specific illnesses or diseases with more concentration on data from rural areas.

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Appendices

Appendix A

Table 1: List of Interviewees

Interviewee Number	Interviewee Name	Interviewee Description
1	Morrison Goba	Public: Engineer/ organising secretary at Mosque
2	Rev Francis Farma	Professional: Reverend and part of Network of Christian Response to HIV/AIDS in Sierra Leone
3	Florence Bull	Former Reproductive and Child Health Manager at MoHS
4	Tamba Pessima	Public: Student
5	Lillian Lahai	Retired Midwife now manages health clinic
6	Pastor Allan Williams	Pastor – Divine Favour Chapel
7	Beatrice Gbanga	United Methodist Council (UMC)
8	Betty Sam	Midwife and public health consultant
9	Dr Alhaji Turay	Traditional Healer – Herbalist
10	Mariam Koroma	Public: Mother
11	Sylvester Sharkh	Public: Admin Assistant
12	UNS Jah	Former Minister for Social Welfare, 15 years with UNICEF
13	Victor Hindowa	Public: Student
14	Anonymous	Employee from an international NGO working in Health Care

All interviews were recorded with the exception of one due to a technical fault. Interview transcripts and recordings available on request.

Appendix B

Health Questionnaire

About you

Age: ……. Male/Female: …….

Occupation: ……. Level of Schooling: ……

Place of Origin: …… How long have you lived in Freetown: ……..

Health in Sierra Leone

How do you contract malaria: …….

How do you contract HIV/AIDS …….

What causes diarrhoea: ……..……

What causes Cholera: …….

What causes Typhoid: …….

How do you contract worms: …….

What disease causes the most illness in Sierra Leone:……..

Healthcare in Sierra Leone

	Yes	**No**	**Other**
Have you been ill in the last year:	☐	☐	……
If yes, did you seek treatment:	☐	☐	……
Who did you seek treatment from:	……..		
Have you ever visited a health clinic:	☐	☐	……
If yes, have you visited one in the last year:	☐	☐	……
Do you feel you received good treatment:	☐	☐	……

What could be improved:

……
……

	Yes	No	Other
Have you ever asked a faith leader for healing:	□	□	……
If yes, have you visited one in the last year:	□	□	……
Do you feel you received good treatment:	□	□	……

What could be improved:

……
……

Have you ever visited a traditional healer:	□	□	……
If yes, have you visited one in the last year:	□	□	……
Do you feel you received good treatment:	□	□	……

What could be improved:

……
……

Do you seek different advice or treatment depending :

on the type of illness you have:	□	□	……

For which illnesses would you most likely see a

Traditional healer: ……..……

For which illnesses would you most likely see a doctor: ……..……

Can traditional healers treat all illness:	□	□	……

What are they best at treating: ……

Do you think traditional healers should be regulated:	□	□	……

Do you think traditional healers are more cost effective

than health clinics:	□	□	……

Do you feel more comfortable visiting a traditional

healer than health clinics:	□	□	……

In-depth Interview Guide

Interviewee no:		Recording No:
Introduction Explanation of the study Aims of the interview and expected duration. Who is being interviewed What happens with the information collected Any questions Consent?		
Background If I could just start by asking you a few questions about yourself: Age: Education: Occupation: Place of Origin:		
Topic	**Question**	**Probe**
Health in Sierra Leone	What are the biggest health challenges in Sierra Leone?	Are malaria, typhoid, cholera, HIV/AIDS etc a problem?
Seeking treatment	Where do you or people you know seek treatment when they are ill? Why these treatment options	When you were last ill what treatment did you seek? Have you ever contacted a traditional or religious healer? Did cost, access, service affect your decision?
Healthcare systems	Do you feel the public health system works well? Does the traditional health system work well?	Do you have to wait a long time? Do you feel you are treated well? Are the drugs you are given effective? Are traditional medicines more effective?
Recommendations	What can be improved?	If you were MoH what would you improve? Better access, more drugs, cheaper care?
Close Is there anything else that you think I've forgotten or should know about health or healthcare in Sierra Leone? Any questions for me?		

Appendix C

Additional Tables and Figures

Table 2: Comparison between place of origin and therapy type

Place of origin % born in Freetown	**Female**		**Male**	
	Have visited	Have not visited	Have visited	Have not visited
Health Clinic	23%	0%	42%	23%
Faith Healer	38%	12%	17%	32%
Traditional Healer	22%	44%	11%	50%

Table 3: Comparison between education and therapy type

Education % not attended high school	**Female**		**Male**	
	Have visited	Have not visited	Have visited	Have not visited
Health Clinic	48%	50%	23%	54%
Faith Healer	51%	47%	66%	37%
Traditional Healer	56%	44%	78%	19%

Table 4: Comparison between median age and therapy type

Median Age	**Female**		**Male**	
	Have visited	Have not visited	Have visited	Have not visited
Health Clinic	23	24	27	29
Faith Healer	23	23	30	25
Traditional Healer	23	23	39	22

Figure 8. Percentage who felt they received good treatment (gendered)

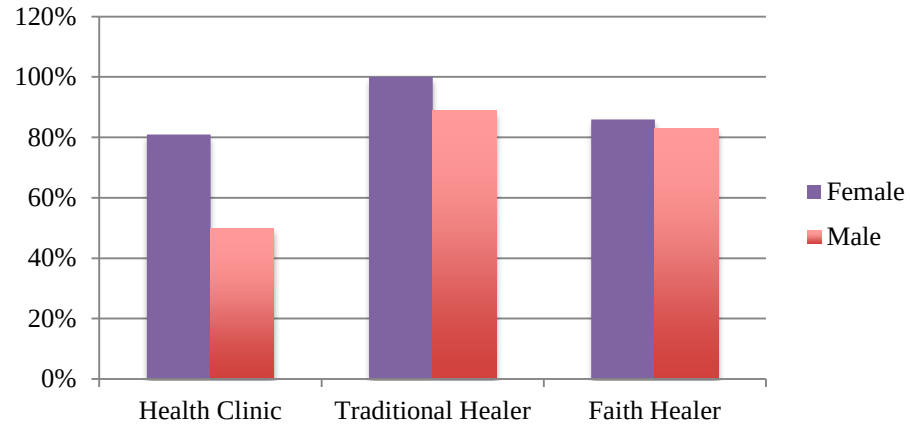

Figure 9. Percentage having visited health clinics, traditional healers and faith healers in the last year (gendered)
n: F = 25, M = 25