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"Where my pocket can afford is where I will take my child". The influence of structural factors on the health-seeking behaviour of the population in Gorama Mende and Wandor chiefdoms, Kenema district, Sierra Leone☆

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ABSTRACT

In Sierra Leone, maternal and under-five mortality rates are among the highest in the world. In 2010, the government adopted the Free Healthcare Initiative (FHCI) providing free healthcare for children aged under-five and pregnant and lactating women. However, the FHCI is seriously impeded by the limited availability of health staff, gaps in medication supply, and weak management. In this paper, we present experiences of the Gorama Mende and Wandor (GMW) chiefdom residents in Kenema district, Sierra Leone and how they navigate available options to seek care. We argue that the health-seeking behaviour (HSB) of the population is influenced by interrelated structural and social factors. This qualitative research was conducted in rural GMW chiefdoms in February 2020, using in-depth individual, paired, and group interviews. Contrary to the assumption that traditional healers influence HSB, data suggest that structural factors like proximity, affordability, previous experience, and reception at the health facility were the main determinants. Healthcare providers felt that people went to a traditional healer first; however, the population emphasised that their first choice was always the peripheral health unit (PHU) provided there were no barriers. These barriers include, living in hard-to-reach areas, transportation, unexpected payment for services, and fear of the health staff. The study reveals the complex reality people face in terms of access to healthcare and multiple factors that influence HSB. One community member noted that if people could not afford a PHU, they would turn to alternative forms of healthcare — *'Where my pocket can afford is where I will take my child'*.

1. Introduction

Maternal mortality in Sierra Leone is among the highest in the world, with 717 maternal deaths for every 100,000 live births in 2019 – and this is despite a reduction of almost 40% in the maternal mortality ratio from 1165 per 100,000 live births in 2013 (UNFPA, 2020; WHO, 2019). This reduction can be attributed to the Government of Sierra Leone prioritizing and receiving large donor investments on the availability and quality of essential obstetric and new-born care, as well as increased uptake of contraceptive care. Additionally, there is an improved referral system with a national ambulance service since 2019 (UNFPA, 2020). Under-five mortality in Sierra Leone is 122/1000 live births, with a neonatal mortality rate of 31 per 1000 live births and an infant mortality rate of 75 per 1000 live births (Statistics Sierra Leone - StatsSL & ICF, 2020). In 2013, the World Health Organisation reported that the causes of child mortality were acute respiratory infections (17%), malaria (14%), diarrhoea (13%), and measles (5%) (WHO, 2015). Coverage of preventive (full vaccination, bed nets) and curative (adequate treatment for diarrhoea, pneumonia, malaria) interventions is poor because of: lack of access to free, quality healthcare – in the sense of lack of trained healthcare staff, lack of quality medication, poor infrastructure to reach healthcare facilities, lack of knowledge and understanding around health

☆ Quote from a community member explaining that if people cannot afford a PHU, they turn to alternative forms of care such as self-treatment, local drug sellers, and traditional healers.

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and wellbeing and a lack of professional accountability (relating to quality of care) (UNICEF, 2020).

In 2010, the Government of Sierra Leone adopted the Free Healthcare Initiative (FHCI) with the aim of providing free healthcare to children under five years of age and pregnant and lactating women (UNICEF, 2009). However, the FHCI is seriously impeded by the limited availability of health staff, repeated gaps in medications and supplies, weak management, and entrenched corruption in the health sector. Health personnel often ask patients for money to line their pockets and to sustain services. This has resulted in a lack of trust and late health-seeking behaviour, leading to an increased need for secondary healthcare services (Edoka et al., 2016; J. W. T.; Elston et al., 2019). Studies have shown that the Ebola disease outbreak in 2014-15 worsened the situation for maternal and child health, with even fewer health workers now than before (Sharkey et al., 2017). In the meanwhile, many more health staff have been trained and employed to replace them. However, even if there are more staff, the quality of care remains poor with lack of supplies and medication.

Sierra Leone's pluralistic healthcare infrastructure in Gorama Mende Wandor (GMW) is composed of six entities. 1. The district hospital, located in the district capital Kenema, is used for referrals. 2. Ten Peripheral Health Units (PHUs) – government-run clinics providing primary healthcare. 3. Community health workers (CHWs), trained community volunteers provide home visits to promote preventive care; conduct defaulter tracing, diagnose and treat simple malaria, diarrhoea, and pneumonia; screen for malnutrition and carry out community surveillance. 4. Traditional birth attendants (TBAs) assist expectant mothers throughout pregnancy. TBAs have undergone trainings and sensitisation sessions to be able to refer women to the PHUs for delivery. 5. Traditional healers (TH), including herbalists, who treat illness using plants and animal products, and religious healers, who treat illness through spiritual means. 6. Drug shops and drug sellers/peddlers – either working in drug shops, called pharmacies, mostly located in bigger towns or drug peddlers moving from village to village, selling drugs and giving injections.

MSF (Médecins Sans Frontières) (International non-governmental organisation) started working in GMW in June 2017. Over the duration of this study, MSF's support to the Ministry of Health and Sanitation (MoHS) consisted of supporting the ten PHUs with providing essential drugs and commodities, capacity building of health staff, health promotion, rehabilitation of health facilities, facilitating referrals from primary to secondary healthcare, financial support to the MoHS volunteer staff working in the health facilities, and support to the implementation of integrated community case management (iCCM) of malaria and diarrhoea in 30 hard-to-reach villages. The iCCM was further expanded to 52 hard-to-reach villages in 2020. After almost three years of implementation, peripheral health units (PHUs) still reported seeing complicated cases with evidence of prior traditional treatment. It was presumed that people consulted traditional healers for treatment prior to seeking treatment from the formal healthcare sector. This assumption was based on the idea that people were not persuaded to favour treatment from a traditional healer but did so voluntarily. This paper explores perceptions of people navigating healthcare options and argues that the health-seeking behaviour of the population in GMW chiefdoms is influenced by interrelated structural and social factors.

2. Materials and methods

This anthropological study applied an exploratory qualitative research design (Skovdal & Flora, 2015) to gain multiple perspectives from community members, traditional healers, and MoHS and MSF staff on complex factors of health-seeking behaviour (Pope & Mays, 2006). The methods used for data collection were in-depth interviews either with one individual (IDIs), paired (two individuals), or focus group discussions (FGDs) with three to seven participants, and field notes to gain an inside perspective (Harris, 1976). Additionally, MSF project documents and internal reports were reviewed, and literature reviews were conducted before, during, and after data collection.

Table 1
Different characteristics of study population.

Characteristics	No.	Percentage
Age		
18-25 y	26	24%
26-35 y	32	29%
36-45 y	26	24%
46-55 y	17	15%
56-70 y	7	6%
>70y	2	2%
Education		
High	16	15%
Medium	3	3%
Low	39	35%
None	52	47%
Ethnic group		
Mende	103	93%
Limba	2	2%
Temne	2	2%
Mandingo	1	1%
Fula	1	1%
Sherbo	1	1%
Gender		
Female	66	60%
Male	44	40%
Religion		
Muslim	97	88%
Christian	13	12%
Total	110	100%

The study was conducted in an MSF project in Sierra Leone managed by the Operational Centre of the MSF in Brussels. The MSF GMW project is based in Baama town, Wandor chiefdom, Kenema district, Eastern province, Sierra Leone. Within Kenema district, the GMW chiefdoms are geographically the most isolated areas from the city of Kenema (capital of Kenema district); consequently, the population's accessibility to secondary healthcare in the region is one of the worst.

The study population comprised different groups of respondents (Table 1) with regard to age, education, religious background, and ethnic affiliation. The participants in the different study sites approached for data collection included women, men, traditional healers, drug sellers, healthcare professionals (MoHS, MSF, CHWs and TBAs/herbalists) (Table 2).

The study team, including the principal investigator and two study assistants, conducted 53 interviews in total (33 in-depth individual interviews, two paired interviews, and 18 group interviews) of which 16 were in English, 34 in Mende, and three in Krio. A total of 110 people were interviewed; any participant could only be either included for an IDI, for a paired interview or for a FGD. Healers and TBAs were individually interviewed (IDI) on their interaction with patients. For four additional participants, who had expressed the wish to be interviewed with a peer, paired interviews were conducted: for two health promotors and two MoHS staff members. FGDs were done with community members (women, men and leaders) on general questions regarding health-seeking behaviour and access to health care. Participant groups were not mixed among each other e.g., community members were not grouped with healthcare staff or traditional healers and TBAs.

2.1. Data collection

Before heading to different locations, the study team met to schedule visits to different places and to discuss about potential community members that could be interviewed. Once on-site, the study team

Table 2
Study participants.

Participants	No.	Percentage
General population male (incl. leaders)	31	28%
General population female	43	39%
CHW (all male)	7	6%
TBA/herbalists (all female)	7	6%
MSF staff	4	4%
MOHS staff	10	9%
Drug seller (all male)	3	3%
Traditional healers	5	5%

approached prospective participants with the help of community intermediaries.[1] On arriving in a village, the team requested for a meeting with the village chief or another representative for the location like town speaker, youth leader, or village head to whom the team presented the study aims and objectives and asked for their permission to interview diverse community members. MSF staff were directly asked to be interviewed. MoHS staff at the PHUs were identified with the support of MSF staff or directly asked to be interviewed. The sample size was not determined in advance as the team followed the information saturation principle (Green & Thorogood, 2018). Traditional birth attendants (TBAs) and traditional healers were identified with the help of village leaders, PHU staff, and the general population. Convenience sampling (stratified according to people's backgrounds) was applied for interviews with the general population who used MSF services and for the interviews with traditional healers. The mapping of traditional healers that was conducted initially at the project level supported the choice of healers that were visited. Snowball sampling was applied as and when further potential candidates like CHWs, TBAs or traditional healers were recommended to the researcher by the interviewees (Noy, 2008).

2.2. Data analysis

All interviews were conducted by the principal investigator (DB) either in English or in Mende or Krio with the help of a translator who identified as a male, and then audio-recorded and transcribed the interviews verbatim directly from Mende or Krio into English. Recorded discussions, transcriptions of IDIs, paired interviews, and FGDs, and notes taken during or after any encounters formed the basis for the analysis. An iterative and inductive approach was applied (Green & Thorogood, 2018) by reviewing notes and interview transcripts as they were transcribed in the field to draw preliminary observations related to the research questions. An initial set of conceptual codes was identified collaboratively by the principal investigator and the two research assistants. The principal investigator analysed and coded the notes manually and the interview transcripts manually and with NVivo 11, systematically applying codes to blocks of text (usually of three to five sentences in length). Methodological triangulation to ensure data validation was achieved by combining IDIs with FGDs and reviewing notes and documents (Green & Thorogood, 2018; Patton, 2002); emergent themes were tested by examining exceptions and counter examples.

2.3. Ethics

The study protocol was approved by the MSF Ethics Review Board (ID 1964) and by the Sierra Leone Ethics and Scientific Review Committee (ESRC).

Verbal or written informed consent was obtained from all respondents in the study. Participants' confidentiality was respected and the data obtained through IDIs and paired interviews was anonymised without inclusion of any personal identifiers (Richards & Schwartz, 2002).

3. Theory

In Sierra Leone, healthcare is free for children under five and for health needs that are from pregnancy for pregnant and lactating women since the introduction of FHCI in 2010. However, barriers remain in accessing respective healthcare facilities. There are still associated costs to seeking healthcare including fees for prescriptions or admission (Uenishi & Aruna, 2015). Additionally, women reported that nurses at the hospital like to 'receive a token to make them happy' (Sharkey et al., 2017). Another barrier is the insufficiently available infrastructure as transportation to health facilities is often difficult and expensive, especially from remote villages. Moreover, there are hidden costs and burdens to families when mothers are in the hospital such as needing someone to care for the other children, finding replacements for farming work, and paying for food while at the hospital (Dorwie & Pacquiao, 2014).

Sierra Leone has a plural health system consisting of state and non-state healthcare providers. These are district hospitals, PHUs, community health workers (CHW), traditional birth attendants (TBA), and traditional healers (Denney & Mallett, 2014). Traditional, complementary, and alternative medicine (TCAM) is defined as a broad range of treatments outside of conventional care and often based on indigenous traditions of healing (James, Wardle, et al., 2018). Drug peddlers (ambulant drug sellers) and secret societies[2] form another component of the healthcare environment. Traditional healing is part of the Sierra Leonean health landscape although both traditional healers and TBAs are not officially recognised by the Sierra Leonean government unless they are part of the Sierra Leone Indigenous Traditional Healers Union (SLITHU) (Medicines for Life, 2017). However, no legal prosecutions of any harmful traditional practices have been reported so far. These alternative healthcare providers are widely acknowledged, including by officials from the MoHS, and are often used as topics in health promotion activities such as drama plays in the communities. In this setting of globalisation and pluralisation, medical pluralism is used to analyse peoples' lived experiences as different healthcare practices exist side by side (Hörbst et al., 2017). This article examines one manifestation of medical pluralism investigating health seeking behaviour in GMW.

Health-seeking behaviour in a plural health system like Sierra Leone is influenced by several interrelated factors that form a complex net of determinants. These can be put into four categories: 1) illness perception and explanatory models; 2) decision making and social values; 3) access to care and resource seeking; 4) and medical pluralism (Hausmann--Muela et al., 2012). In addition to this model from Hausmann-Muela et al. we add; 5) perceived quality of services; 6) and previous experiences with different healthcare sectors influencing health-seeking behaviour (Denney & Mallett, 2014).

Studies on traditional healers and their influence on health-seeking behaviour regarding child and maternal health have shown that people often consult traditional healers first for various reasons as mentioned earlier (Bakshi et al., 2013; James et al., 2018a, 2018b, 2018c, 2019). Previous studies have examined the practices of traditional healers and their influence on health-seeking behaviour focussing on different districts and chiefdoms, but there are none with a specific focus on Kenema district or GMW chiefdoms (Burtscher, 2004; Scott et al., 2014; Sharkey et al., 2017). As health-seeking behaviour is always context specific and should be investigated in its locality, this study was conducted in GMW chiefdoms by analysing people's perceptions on available healthcare options. Operational research has looked at health-seeking behaviour in

[1] Community intermediaries could be TBAs, community health workers, or community health promoters; they were identified once on-site with the staff from the healthcare facility.

[2] Secret societies are sources of spiritual knowledge consisting of elders believed to possess knowledge of spiritual and herbal treatments. For the vast majority of people, joining secret societies is a normal process of transitioning to adulthood (Fanthorpe, 2007).

Tonkolili district (J. Elston et al., 2017) and Koinadugu district (Verschuere, 2016). With the same arguments mentioned in the literature and experiences from MSF's activities in the area an assumption was born that people seek first healthcare in the private sector with traditional healers. Elston et al. (2019) found that barriers such as problems in reaching a health facility and receiving adequate and appropriate healthcare were often critical to delays in deciding to seek healthcare (J. W. T. Elston et al., 2019). We have adapted a medical anthropological approach because all health-related issues are not just phenomena that can be explained in a biological sense but they are remarkably affected by social and cultural forces that lie at the core of medical anthropology (Singer et al., 2019) in that sense to gain an in-depth understanding of this health-seeking behaviour considering social, economic, and political factors.

4. Results

Three overall themes emerged in relation to people's health-seeking behaviour from the interviews: *1) 'accessibility and living in hard-to-reach areas', 2) 'affordability including unexpected payment of services, transportation and lost time', and 3) 'previous healthcare experience and reception at the health facility, comprising distrust, violent communication, and unmet needs'*.

4.1. Accessibility and living in hard-to-reach areas

When deciding where to go for treatment, people opt for treatment according to what is available and accessible. In that sense, proximity plays an important role. Due to poor road infrastructure, the distance that people must travel is a major obstacle to reaching a PHU. This barrier is mostly apparent in hard-to-reach areas and communities who live far away from a PHU. Travelling to the PHU often means hiring a motorcycle taxi or walking. With no phone signal, people are not able to call an ambulance in an emergency and must rely on options that are closer to them. Such challenges mean that most mothers travel to the PHU only when they think that their child's condition is very serious.

Some villages may be located closer to a PHU in a different chiefdom, but they are forced to travel to one that is in their own chiefdom although further away, or across a river, and therefore more difficult to access.

> 'When MSF wasn't in this area, G [PHU] was not within our chiefdom, GB [PHU] is in our chiefdom, but we have the river between us [and the GB PHU] and when the water level is high, people are afraid of the river [and GB PHU is not reachable]. Apart from that, there are diseases that affect you if you have a centre [PHU] closer to you, you go there. Therefore, when MSF wasn't here, when they go to G [PHU that is closer], they will shout at the lactating mothers and the pregnant women saying that that is not their centre [PHU].' Male CHW, 35 years

For pregnant women, it is often a big challenge to reach the PHU in time for their delivery; most communities are far away and lack adequate transportation. Although some women do stay at the awaiting house in Baama PHU, many others do not want to or are not able to stay there even if they wanted to. In the worst cases, women deliver by the side of the road on their way to the health facility.

> 'The other challenge is the river crossing. For instance, if a pregnant woman is in labour in the middle of the night, we will call the boat people from Baama, but they will not come. Because a house has been built in Baama [PHU] for pregnant women to stay there for delivery but in most cases, the pregnant women don't go. … Whether there is no food in the hospital, I do not understand.' Male CHW, 45 years

To resolve this lack of transportation, one village leader bought a hammock to carry pregnant women in labour to the health centre. Although the village has motorcycle taxis, it is not possible for a woman in labour to ride pillion on a motorcycle.

> 'When pregnant women are in labour, it is very difficult to carry them to the hospital as the distance from us to the hospital is very far. Because I am the chief [of the village], the people do come to complain some labour cases to me. … at times while sleeping, people come and complain labour pain of pregnant women that they need my help and advice as an authority. … That is why me as a chief, I have bought a hammock, to carry pregnant women in case of any emergency if we do not get a motorbike at night.' Male leader, 45 years

4.2. Affordability including unexpected payment of services, transportation and lost time

While the FHCI has abolished healthcare costs for pregnant women, lactating mothers, and children under five, associated costs that influence the affordability of healthcare remain, nevertheless. The costs associated with a visit to a PHU include: i) (un)expected payment of services, ii) travel costs, and iii) lost time.

4.2.1. (Un)expected payment of services

The introduction of the FHCI enjoyed a positive uptake initially and was perceived to be successful. Nonetheless, most of the PHUs still continue to charge payments before providing services or drugs.

> 'The challenges we get now in M [PHU], even with the children, the doctors and nurses are not treating us fairly, they are not working in the interest of people, so even now [with] the drugs at the hospital [PHU] still challenges are there. So, we know the drugs are free, even sometimes in M [PHU] if you go there and you don't have money you don't get [drugs]. The nurse will come; they will do correct work, but for now …; So really if you don't have money you don't go to the hospital [PHU]. Even the chiefs, they are aware of what is going on.' Man, 42 years

The sum of money, if charged, differed greatly from one PHU to another and from one person to another. In almost all interviews, communities consistently reported having to pay PHUs for healthcare services and medicines. However, some of these cases included services or medicines not covered by the FHCI, and communities were unaware that these services were meant to be paid for. In other cases, the PHU staff did appear to be charging for services or medicines that were meant to be free. Women explained that their husbands had to 'prepare' for their hospital visit with a minimum of 10,000 (US$1) to 50,000 (US$5) Leones.

> 'The nurses will treat us very nicely once we pay them money. … There are certain amounts of monies we need to have but it just depends on the condition of the illness. If our children get sick and the illness is worse, we can take 50,000 [5US$] along or 30,000 [3US$] Leones it just depends on the condition of the illness.' FGD women

When in the consultation room with the nurse, they ask the mother what she has brought with her — meaning how much money she is able to pay for treatment. Most interviewed women recounted instances wherein the nurses told them what to expect in return for free-of-charge treatment for their children — a 'free death'.

> 'When we say "something" [to bring to the PHU], we mean money, that means we should have money to go to the hospital [PHU] because every time we go there [the PHU] the nurses will ask us to pay some money. In fact, they [nurses] will tell us that if we take our children for "free treatment," our children will also "die for free"'. FGD women

In contrast, women said if they went with money, the nurses gave them drugs and treated them nicely. According to the interviewees, in the community, it is the husband's responsibility to pay for treatment; the

men in the community and male leaders also expressed their dissent by voicing their anger and dissatisfaction with the healthcare staff conduct but to no avail.

> 'Well, we are not happy when we pay because it should be free medical [care] in the country but if we don't pay the 'shake hands', our children won't be treated properly with a very good heart of the nurses, and we want to save the lives of our children. So that is really our main problem here because there should be free medical care and we have made so many complaints. But yet the payment for medical treatment for children, mothers and pregnant women cannot stop. We don't really know why.' FGD male leaders

Interview data also showed that the amount of payment required depended on the severity of the illness. It was also noted that nurses played with caretakers' fears; the caretakers were told that if they wanted their child to be cured, a certain amount of money was required, and 'free medicine' would not cure them. Sometimes the nurses held back people's clinic or vaccination cards until the person brought the money; this often resulted in them not going to the PHU anymore. On other occasions, mothers were sent home and asked to come back with money. In the case of one pregnant woman, nurses told her if she wanted her pregnancy to be safe, she had to come back to the PHU with 50,000 [US$5] Leones even though she had already paid 10,000 [US$1]. In another interview, women recounted that if a pregnant woman was asked for 70,000 [US$7] Leones, they could negotiate down to a minimum of 50,000 [US$5]. The research team was told that most PHUs expect 50,000 [US$5] Leones for deliveries. Charges also differ in terms of the sex of the child: if a boy is born, they charge 50,000 [US$5] whereas for a girl, they charge 40,000 [US$4] Leones.

The payment requests at the PHU often confused the mothers. MSF health promoters, who went to the villages for health promotion sessions, encouraged individuals within the FHCI target groups (mostly mothers) to go to the PHUs when needed to receive free care. When they arrived at the PHU though, they were asked to pay.

> 'They always tell us that if your child is sick; take it to the hospital [PHU]. When my husband wasn't here and I took the child to the hospital and he [the nurse in-charge] said because I had no money, he wouldn't treat the child, I became angry. People talked to him and he said he wouldn't even give a loan because whenever we go there my husband doesn't give money and so I should go back and bring money. Therefore, I left the clinic card there and haven't returned ever since.' FGD women

Some PHUs displayed posters with a toll-free hotline and ask anyone within the FHCI target groups to call if asked to pay for services. The staff's behaviour also changed when MSF outreach teams were present in the PHUs. However, this did not always happen. MSF teams were seen as a controlling body at times and were not always welcome in the PHU. If people complained about the nurses' behaviour, it had repercussions and even more money was charged sometimes.

> 'If you say that [complaints] they will yell at you, your husband will spend excessively. And if they realized [after complaining] that you applied traditional herbs, they will not attend to your child.' FGD women

The interviewed people emphasised that they always tried to bring money, and that they would even borrow the money or that their husband would take out a loan.

Of all the factors impacting health-seeking behaviour mentioned in interviews, (un)expected payments in the PHUs are tremendously important. It is one of the main reasons why people delay or forgo visiting a PHU and seek treatment from a traditional healer. Traditional healers and TBAs also charge fees for health services, but the fees were thought to be flexible as payments could be negotiated, paid over a period in kind or were only paid if the patient was cured. Several interviewees talked about these payments being reduced considerably following MSF's presence in the area. However, treatment costs continue to remain an important barrier to access, particularly in remote communities.

4.2.2. Travel costs

Although payments are needed for other healthcare providers, the location of the PHU beyond the community and the requirement of travel further make it less accessible and affordable. We conducted interviews in locations where there was a PHU and in villages without one — categorised as 'hard-to-reach' areas. The lack of transportation within the community and the considerable distance to the PHU necessitate either substantial walking or travel costs — a motorcycle taxi can take up to 30 min with costs ranging from 5000 [US$0.50] Leones to 30,000 [US$3] Leones. Some PHUs are either several kilometres away by motorcycle, not accessible by motorcycle, or located across the river. People know that payments are expected at the PHU, and if transport money is needed on top of that, families will evaluate their financial means and might turn to other, cheaper options as most households live on less than US$1 a day (Trading economics, 2021).

> 'Sometimes mothers will come and complain that the staff demand token [money] from them. And the other one is the distance. Because we can transfer pregnant women or even lactating mothers to the hospital [PHU] in Baama. But you know the distance from here to Baama [PHU] is far away from us so, some pregnant women and mothers will be afraid to cover this distance because they must pay motor bike fare to go. Therefore, the pregnant and lactating mothers will prefer to go anywhere to have their treatment. Because for example if people go and the staff ask for money, and that money is not paid, he or she will not give the people the full treatment. So that will discourage the mothers and therefore with their children they go elsewhere.' Female CHW, 48 years

One CHW explained that if people have 10,000 [US$1] Leones, they will rather use it to buy medication from the drug peddler or in the drug shop than for transport to reach a PHU where they must pay again.

> 'Imagine if a pregnant woman has to pay 20,000 [US$2] Leones to and from the hospital [PHU], she will then prefer to use that transport [money] to buy drugs around here even though sometimes to the wrong places or persons instead of going to the hospital.' Female CHW, 48 years

Additional costs occur if the family needs to stay overnight near a PHU in case they were not treated the same day on arrival or if they need to come back for another reason.

4.2.3. Lost time

Costs should also be thought of in terms of time and lost earnings. Most of the people do not have access to motorcycles and people often walk to PHUs which may take hours, especially for pregnant women. After leaving for the PHU early morning only to arrive by mid-morning, women often need to wait until the afternoon to be seen by the healthcare staff. Travelling to a PHU takes substantial time from other tasks such as farming, cooking, caring for children, or market trading.

> 'In the co-wife system, everybody is busy doing other things so who do you think is going to take care of the companion children; in my own case when I got married, we were just two in number at that time [wife and husband]. Let's say if it is two people in the house, then one person can take care of the children in the home but again how effective would that be because everybody will be busy doing works.' FGD women

PHU staff talked about lack of time when women who worked in clubs or in group farming visited for antenatal care or vaccination days only on a certain day.

'The [working] clubs are organised among themselves [women]; they have to schedule days from Monday to Thursday they have their work schedules. So if antenatal care days fall on Mondays, they will not come in majority; if under five is falling on Wednesdays, they will not come in majority except when sometimes it is Friday, then they will all come because Friday is not a working day and many of them are Muslims.' MoHS staff, 28 years

4.3. Previous healthcare experience and reception at the health facility comprising distrust, violent communication and unmet needs

Other factors that influenced people's health-seeking behaviour were previous healthcare experience and reception at the health facility. Nearly all community members who were interviewed reported poor treatment by the PHU staff — the staff was rude, shouted at them, were unhelpful, and sometimes denied water to the women after their long walk to the clinic. Such experiences deterred not only the women directly affected but also others within their community. Consequently, respondents spoke of avoiding the PHU and using alternatives. Conversely, although women were critical of a healer's medical treatment and its effectiveness at times, they always felt treated humanely and compassionately. Similarly, the interviewed women had a close and trusted relationship with TBAs.

'There are people if you shout and be harsh on them, they will prefer to use traditional herbs to treat their children; if they get well or not that is fine instead of shouting and being harsh on them.' Male CHW, 35 years

People talked about positive experiences in some PHUs and that they would be happy to go there. However, as these PHUs were not in the same chiefdom, undergoing treatment there was not possible. Yet again, they found themselves caught in structural barriers and were forced to go back to the PHUs where they were mistreated.

'I have three wives; I said, if that is the attitude of the health workers at G hospital [PHU], I will tell my wives not to go there anymore. They will be going to T [PHU in the other chiefdom] because that is where we used to go in those days.' FGD male leaders

Many CHWs spoke about challenges people faced when going to the PHU; among the three challenges mentioned, one is nurses' attitude towards welcoming people.

'One is the distance, two is the way the nurses welcome the people, three is the way the nurses treat the people. So, those are the challenges. I know the people will feel bad when they go to the hospital [PHU]. … if a pregnant woman or a lactating mother has visited the hospital [PHU], the nurses will just be busy talking other things. Example, the nurse will just say, 'give me this card!' shouting at the pregnant or lactating mother. If the woman wants to put the card somewhere, the nurses will shout at her like 'no no no don't put it there'. And if a mother goes with a [sick] child, then the nurses will ask the mother 'what did you bring' [asking for money]. So, you see all those things will discourage patients to go to the hospital [PHU].' Female CHW, 48 years

Male respondents also talked about discriminatory behaviour towards them from some of the staff at the PHU.

'The staff, you know, when someone is literate, he plays smart, but he discriminates against you when you are illiterate; whatever you tell him as long as it is the truth, he will downplay on your intelligence to make you believe that what he said is the truth.' FGD leaders

In one FGD with women, they candidly expressed their disappointment in the PHU staff's behaviour. They did not understand why they were treated discourteously. On some occasions, people recounted that the PHU staff did not attend to them at all and their child died.

'[Said together] Well we don't really know [why nurses behave in a certain manner] because when we go to them [nurses at PHU], we are happy, we talk to them nicely but they will avoid you and go away. We are suffering really.' FGD women

'The child's body got warm at night and we went to the hospital [PHU] early in the morning, we didn't go elsewhere. When we went, since we arrived in the night, they didn't touch the child – not knowing that the warm body would get severe. We spent the entire day at that hospital while they were happy playing and feeding an animal with milk and my child on my legs was in bad condition. We returned late that evening and the child died on the way back home.' FGD women

Healthcare providers said that they understood how important staff attitude is when motivating people to come to the PHU.

'It is what I am saying [that people do not come to the PHU], lack of drugs, no good approach from the health staff, so when they come, they don't welcome them, they shout at them, the treat them violently so this will discourage them to go to the centre.' Male MoHS staff, 54 years

An exceptionally positive experience was recounted by a TBA. She spoke about the welcome she experiences at the PHU when she accompanies a pregnant woman:

'Well, if I take a pregnant woman to the hospital, the nurses will talk to me very well, they will also treat the pregnant woman very well. If the pregnant woman is in serious labour pain, the nurses will give her and injection so that the woman can have quick delivery.' TBA, 75 years

Consequently, the attitude and the behaviour depend very much on the PHU and the individuals working there. When the staff is relocated and someone else is appointed in the same PHU such positive experiences can change again. Relocation of PHU staff, therefore, makes it difficult to know how one will be treated when arriving at the PHU.

'There is a mix of feelings because, some staff will treat people nicely and some will not. Because nurses and in-charges are transferred always from one place to another.' Female CHW, 48 years

'Normally in our own centre [PHU], we had a very good nurse called M who took very good care of patients and women in labour. But for the one we have now nurse P, she does not care. Like few days ago, I took a pregnant woman to the hospital and the nurse P was in town but did not come to attend the pregnant woman it was me and the TBA in the hospital that were looking after the woman. We were there for the rest of the night and it was only in the morning that P the nurse came.' FGD TBAs

5. Discussion

Resource constraints worsened by challenging geographical characteristics influence the health-seeking behaviour in remote and marginalised areas such as GMW chiefdoms. Healthcare seeking is dynamic and influenced by multiple factors that intertwine, overlap, and often vary within the same family during an ill-health episode. Given Sierra Leone's plural health system, this study looked at how families and households navigate the options available and what factors influence decisions on where to seek healthcare.

In GMW chiefdoms, volatile and hesitant utilisation of the formal healthcare sector is linked mainly to (un)expected payments of services, previous adverse healthcare experiences, and behaviours and attitudes of the healthcare staff. In addition, accessibility and affordability related barriers coupled with travel costs and lost time form a complex web of

factors that influence people's health-seeking behaviour. The PHU staff reported seeing complicated cases with evidence of traditional treatment. They noted that people consulted a traditional healer before turning to the formal healthcare sector. The perception that a traditional healer was consulted without any influence thus arose. However, data revealed structural barriers — people did not have another choice and these decisions were taken 'under duress'.

As is common throughout the world, people self-medicate at home before seeking further care (Arikpo et al., 2010; Chipwaza et al., 2014; L.; Treacy & Sagbakken, 2015). Depending on the perceived needs and characteristics of the ailment, and often on direction from 'important others' such as parents, relatives, or neighbours, help would be sought either at the village level with a CHW, a traditional healer, drug peddlers, or in the formal sector at a PHU (J. W. T. Elston et al., 2019). The associated anxiety and desperation increase if an illness persists after treatment. This may lead the patient or caregiver and 'important others' to try an alternative therapy. Consequently, biomedicine, traditional healing, and self-treatment often intertwine — serially or concurrently — during ill-health. However, data from this study reveals that for the great majority of people of the GMW chiefdoms, the PHU in the formal healthcare sector is the first choice as similarly outlined by Elston et al. (J. W. T. Elston et al., 2019) provided there are no barriers.

This study's findings suggest that health-seeking behaviour is influenced by a complex web of structural factors that hinder people's access to formal healthcare. One of the main barriers to access healthcare was proximity or inaccessibility. Most rural villages in this area fall under the hard-to-reach areas. People live in places with poor roads. This worsens in the rainy season — they can reach a health facility only by crossing a river, hiring a motorcycle, or by foot — it is not practical to reach a health facility when the river is flooded. Hard-to-reach areas are inaccessible for cars or ambulances. The distance to the health facilities and lack of accessible and affordable modes of transport form a significant barrier. This is further exacerbated by the second pivotal barrier: affordability of healthcare. Disease related costs hinder people from seeking prompt treatment with an additional negative effect on household resources (Hausmann-Muela et al., 2012; Russell, 2004). Reaching a health facility means overcoming the distance, finding transport means, and losing time that could be spent for income generation activities. This leads to the question: when people have found a way to travel, are they able to pay for it? Therefore, transport is needed to overcome the distance, but one needs to be able to pay for transport to bridge this distance. Finally, after having tackled these barriers, people face an additional obstacle when asked for unexpected payments at the health facility. In most cases, it can be explained by the PHU staff's work as volunteers, lack of pay, and/or expecting healthcare seekers to thank them with a token. These results are aligned with findings from other studies in Sierra Leone (Scott et al., 2014; Treacy et al., 2018). Therefore, transport is needed to overcome the distance, but one needs to be able to pay for transport to bridge this distance. However, even after all the other barriers are broken down, the main barriers are patient's and caretaker's previous healthcare experience and reception at the PHU suggestive of (dis)trust, fear, violent communication, and unmet needs.

An often underestimated factor is how healthcare providers welcome and treat users. Patients' experiences and perceptions of a previous visit to the PHU and their trust in healthcare providers and why they trust them must be considered when looking at health-seeking behaviour (J. W. T. Elston et al., 2019). These critical decisions on where to seek healthcare are influenced by both their and their community's previous experiences of treatment by provider. This contributes to patient satisfaction or dissatisfaction, generates expectations, and influences the perceived quality of care (Hausmann-Muela et al., 2012; Mackian et al., 2004). As mentioned earlier, when caretakers reached a health facility, they were often not attended to or treated in a rude and unfavourable manner. This explains why mothers delay their visits or do not go at all. The PHU staff's attitude pushes people to turn to traditional healers and other healthcare providers. At times, such behaviour reflects in not attending to a child with burns at the PHU because it was in the evening hours, thus forcing the caretaker to search for medication in a drug shop in vain, ending with treatment with a traditional healer. Such negative attitudes and its consequences align with other studies from different contexts (Haskins et al., 2016; Mannava et al., 2015). Ricketts and Goldsmith highlight the 'dynamic axis of learning and adaptation' that goes into care seeking (Ricketts & Goldsmith, 2005), suggesting that care seekers develop competencies to avoid interactions that negatively affect their self-worth, sense of trust, and sense of community (Scott et al., 2014). Such healthcare seeking is mirrored in a coping strategy — being confronted by an unchangeable situation and finding the best way to deal with it. In that sense, people in GMW do the best they can to deal with their ill-health conditions; however, when confronted with all the above-mentioned barriers, healthcare provision almost always becomes an unaffordable 'luxury'.

Several policy and practice recommendations can be drawn from this study. Firstly, the results of this study are intended to help improve the healthcare workers' overall attitude including treatment of patients and interaction with caretakers at a formal health structure. Since issues on reception and attitudes toward patients and caretakers have been identified as an access barrier, further studies need to be conducted to understand the reasons why PHU staff are hostile and ask for payment for free services. Additionally, discussions with the MoHS to resolve the request for additional money and finding the underlying cause. Secondly, these results are intended to inform MSF operations and MoHS policy makers to raise awareness on some extremely important and mostly preventable reasons that impede access to healthcare like better organisation of care at the PHUs. This could help make services available on certain days and times according to the needs of the community. Thirdly, the study highlights the importance of reinforcing community knowledge on what is included in the FHCI and access to relevant services. Emphasis on a humane reception at the health structures and on providing sustained support for treatment of common childhood morbidities at the community level by CHWs would reduce geographical barriers. Fourthly, the study is an important reminder that despite the initiation of the FHCI in Sierra Leone, uncomplicated access to primary healthcare is far from being achieved. A more humane and empathic reception and omission of compensation by health staff would encourage people to opt to seek care in the formal sector more easily. Finally, structural barriers to seeking health care such as distance, limited transport and requested additional payments should be addressed. Advocacy for the enforcement of the Free Healthcare Initiative should hold the government accountable for appropriate and timely salaries of health care workers, the implementation and control of standardized payment guidelines, as well as the improvement of road infrastructure or subsidized transport.

This study is, however, subject to some limitations. The interviewees clearly associated the study team with MSF which may have caused a response bias. This potential bias was minimised by careful explanation of the PI study team's role and their neutrality with strict assurance of anonymity and confidentiality. The team also ensured that impartial interest was shown to the different healing options available.

6. Conclusion

Contrary to MSF's assumption that the presence and use of traditional healers greatly influences the population's health-seeking behaviour, data from this study suggests that access to and usage of healthcare is particularly a question of accessibility, affordability, previous healthcare experience(s), and reception at the health facility. Satisfaction or dissatisfaction with the quality of services and healthcare providers' attitude towards care also influence behaviour.

Although healthcare providers felt that people went to traditional healers first, the population emphasised that their first choice would have always been the peripheral health units (PHU) — providing there were no barriers to access. These barriers were: living in hard-to-reach areas, transportation, payment for services, and fear of health staff.

The study reveals the complex reality people face in terms of access to healthcare and the diversity of factors that influence their health-seeking behaviour. It is not a question of beliefs or traditional methods that push people to turn to alternative healthcare providers, but a question of accessibility, affordability, communication, and humane treatment.

If money or compensation is continually demanded in PHUs where services must be free according to policies and healthcare practice is inconsistent and corrupt, a significant barrier to healthcare persists. This is counterproductive to the goal of promoting care at the PHUs. Welcoming women with the words 'Free treatment, free death' is rather demotivating than encouraging.

'Where my pocket can afford is where I will take my child', said one community member, explaining that if people cannot afford a PHU, they will turn to alternative forms of care such as self-treatment, local drug sellers, and traditional healers.

Ethical statement

The study protocol was approved by the MSF Ethics Review Board (ID 1964) and by the Sierra Leone Ethics and Scientific Review Committee (ESRC).

Verbal or written informed consent was obtained from all respondents in the study. Participants' confidentiality was respected and the data obtained through IDIs and paired interviews was anonymised without inclusion of any personal identifiers.

Declarations of interest

None. The principal investigator is an employee of Médecins Sans Frontières who commissioned the study.

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Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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