The practices of traditional healers and their influence on the health-seeking behaviour of the population in Gorama Mende and Wandor chiefdoms, Kenema district, Sierra Leone

ANTHROPOLOGY | Vienna Evaluation Unit

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# Free treatment, free death*

## Author's note

Coming back to Sierra Leone for the first time in 16 years to carry out this study on the practices of traditional healers and their influence on health-seeking behaviour was a special experience for me.

I would like to thank the research participants in Gorama Mende/Wandor (GMW) chiefdoms who contributed to this study, trusted me and my research assistants, and shared their personal experiences of the pluralistic healthcare system which led to the results, arguments and recommendations made in this report.

A researcher cannot make immediate impact, but I hope that the information I have gathered and the conclusions drawn, will enable MSF to strengthen our interventions, creating successful dialogue with the communities and healthcare providers to respond in an appropriate and feasible way.

My gratitude goes to the MSF teams in Baama and Freetown, as well as at the MSF headquarters in Brussels, for their valuable support. I particularly want to thank my Sierra Leonean and international colleagues working in Baama for their professional attitude, in-depth knowledge of the country and its people, and our enlightening discussions.

The health promotion team and the two translators/transcribers for the interviews were great, both professionally and personally, and they took good care of me. I especially want to thank them for their warmth and support and all the fruitful formal and informal discussions. Last but not least, I would like to thank our editor in the Vienna Evaluation Unit for the excellent editing of this report.

My experiences with MSF, my colleagues and the people of GMW, are precious to me; they all have my respect for their ability to cope with the difficult living conditions.

To all those who continue to work in the Goroma Mende/Wandor chiefdoms in Sierra Leone.



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Vienna/Brussels/Baama 2020

*Quote from several respondents explaining how they cannot access free medical care in the primary healthcare units or hospitals. The phrase is what health staff tell people when they don't bring enough money.

Cover picture: A bone healer treating a patient with neck pain
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# Abstract

## Background and aims

MSF has been present in Gorama Mende/Wandor (GMW) since 2017. The project primarily focuses on pregnant women and children aged under five, and provides essential drugs, therapeutic food, and medical materials when needed. Teams are also engaged in capacity building, health promotion activities, and integrated community case management (iCCM) of malaria and diarrhoea. After three years, a slight change in health-seeking behaviour was observed but the practices of traditional healers and people's attitudes towards them remain largely unknown. The GMW project therefore requested a qualitative study on the population's health-seeking behaviour.

## Methods

This exploratory qualitative research study was conducted in rural GMW chiefdoms in Sierra Leone in February 2020, using in-depth individual interviews (33), paired interviews (2), focus-group discussions (18) and observations. Purposive and convenience sampling was applied. Participants were selected with the help of community intermediaries. All interviews were audio recorded and transcribed verbatim. Transcripts were screened for relevant information, manually coded, and analysed using qualitative content analysis. Methodological triangulation enhanced the interpretation.

## Results

Contrary to the assumption that traditional healers greatly influence health-seeking behaviour, our data suggest that people are influenced primarily by proximity, affordability, and reception at the health facility. Whereas healthcare providers felt that people were going to a traditional healer first, the population emphasised that their first choice would always be the peripheral health units (PHU) providing there were no barriers. These barriers were seen as living in hard-to-reach areas, transportation, unexpected payment of services and fear of health staff because of distrust, violent communication and unmet needs.

## Conclusion

Our study indicates that the main factor influencing people's health-seeking behaviour is not the presence of traditional healers, but inaccessibility, unmet needs, and reception at PHUs.

"*Where my pocket can afford is where I will take my child*", said one community member when 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. If money or compensation continues to be demanded in PHUs, where the policy is that certain services should be free or where practices are inconsistent and corrupt, this also presents a significant barrier to healthcare and is counterproductive to the goal of promoting care at the PHUs. Welcoming women with the words "*Free treatment, free death*"[1] is then more demotivating than encouraging.



## Keywords

Traditional treatment, free healthcare, Sierra Leone, community health worker, collaboration with traditional healers, health-seeking behaviour




1 Quote from several respondents explaining how they cannot access free medical care in the primary healthcare units or hospitals. The phrase is what health staff tell people when they don't bring enough money.

## Abbreviations

| | |
|---|---|
| ANC | Antenatal care |
| BPEHS | Basic Package of Essential Health Services |
| CHC | Community health centre |
| CHO | Community health officer |
| CHP | Community health post |
| CHW | Community health worker |
| DHMT | District health management team |
| ERB | Ethics Review Board |
| ESRC | Ethics and Scientific Review Committee |
| FGD | Focus group discussion |
| FGC/M | Female genital cutting/mutilation |
| FHCI | Free healthcare initiative |
| GMW | Gorama Mende/Wandor |
| HDC | Health development committee |
| ICF | Informed consent form |
| iCCM | Integrated community case management |
| IDI | In-depth interview |
| KenGH | Kenema Government Hospital |
| MCHAid | Maternal and child health aid |
| MCHP | Maternal and child health post |
| MoHS | Ministry of Health and Sanitation |
| MSF | Médecins Sans Frontières |
| NEMS | National Emergency Medical Services |
| NGO | Non-governmental organisation |
| OCB | Operational Centre Brussels |
| PHU | Peripheral health unit |
| PI | Primary investigator |
| PNC | Postnatal care |
| SECHN | State-enrolled community health nurse |
| SLITHU | Sierra Leone Indigenous Traditional Healers Union |
| SRH | Sexual and reproductive health |
| TBA | Traditional birth attendant |
| TH | Traditional healer |
| WHO | World Health Organization |

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# Executive summary

## Background

MSF started working in Gorama Mende/Wandor in June 2017. The project was guided by an anthropological study carried out between July and August 2016 which assessed health-seeking behaviour in the area and found an underuse of peripheral health unit (PHUs); (Uenishi & Aruna, 2015). MSF is providing essential drugs, commodities, including therapeutic food and medical materials to gap-fill MoHS supplies; capacity building; health promotion; rehabilitation of health facilities; facilitating referrals to secondary healthcare, financial support to Ministry of Health and Sanitation (MoHS) volunteer staff working in the health facilities; and integrated community case management (iCCM) of malaria and diarrhoea in 30 hard-to-reach villages.

After almost three years of implementation, project improvements can be observed in terms of the population's health-seeking behaviour, knowledge and skills of healthcare staff, and the number of referrals. However, PHUs still reported seeing complicated cases with evidence of traditional treatments prior to coming to the PHU. It was assumed that people consult a traditional healer for treatment before turning to the formal healthcare sector.

Health-seeking behaviour in a plural health system such as Sierra Leone, is influenced by several interrelated factors forming a complex net of determinants. These can be put into the following categories: 1) illness perception and explanatory models; 2) decision making and social values; 3) access to care and resource seeking; 4) medical pluralism; 5) perceived quality of services; and 6) preceding experiences with different healthcare sectors influencing health-seeking behaviour.

## Methods



The study was based on qualitative research techniques. The study team conducted 53 interviews - 16 in English, 34 in Mende and three in Krio - 33 in-depth individual interviews, two paired interviews and 18 group discussions from 27 January to 28 February 2020. We spoke to a total of 110 people. The study team visited different villages in the catchment area of MSF-supported PHUs in the two chiefdoms, Gorama Mende/Wandor (GMW). All interviews were recorded and transcribed directly into English. Transcriptions were screened for relevant information, manually coded, and analysed using qualitative content analysis methods. An extended literature review prior and after the field visit, as well as discussions with the field team in Baama/GMW project, the coordination team in Freetown and key people in MSF's headquarters in Brussels, further helped to validate the findings and formulate recommendations.

The study protocol was submitted to the MSF Ethics Review Board (ID 1964) and to the Sierra Leone Ethics and Scientific Review Committee (ESRC). The ESRC approved the study on 31 October 2019. MSF ethical approval (ID 1964) was obtained on 21 January 2020.

## Overview of findings

This report provides an analysis of the practices of traditional healers and their influence on health-seeking behaviour related to maternal and child health, for the population in GMW. The overview of findings addresses the following questions: What alternative healthcare providers are available and how do they practice? When,

how and for what ill-health conditions are these different healthcare providers covering? How do people perceive the different healthcare options and which factors influence where to seek care?

## Sierra Leones pluralistic health system

All healthcare providers were referred to as options within the realm of healthcare provision. Within the different options, formal or public and informal or private, 'referrals' in both directions seemed to occur frequently as part of people's health-seeking behaviour.

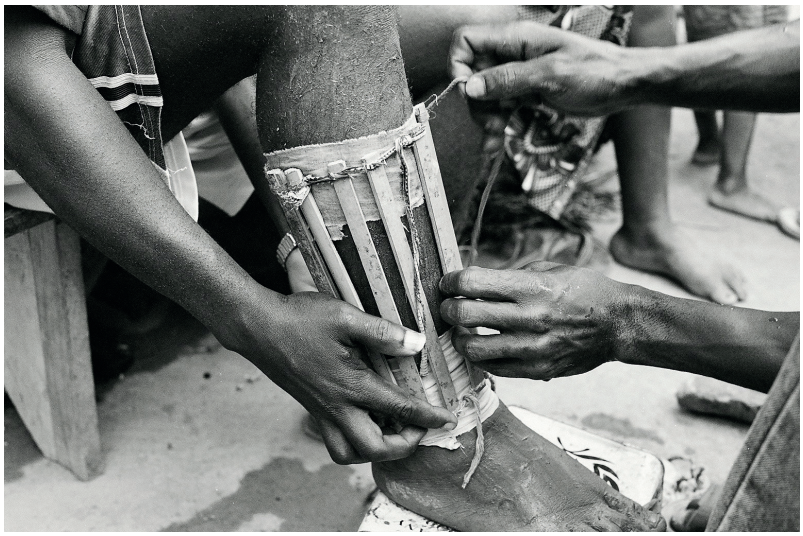
1. **District hospitals** – located in Kenema, the district capital, only mentioned for referrals.
2. **Peripheral Health Units (PHUs)** – government-run clinics providing everyday healthcare. In descending order of size, these include: Community Health Centres (CHCs); Community Health Posts (CHPs); and Maternal and Child Health Posts (MCHPs). Respondents did not differentiate between the PHUs and named all of them hospitals. MSF supports all 10 PHUs in Goroma Mende and Wandor chiefdoms.
3. **Community health workers (CHWs)** – community volunteers who are trained in community health education; provide home visits to promote preventive care; conduct defaulter tracing, diagnosis and treatment of simple malaria, diarrhoea, and pneumonia; screen for malnutrition and carry out community surveillance.
4. **Traditional birth attendants (TBAs)** – women in the community who assist expectant mothers throughout pregnancy; before home deliveries were outlawed by the government, TBAs assisted women in childbirth. 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 like Mondema, Ngiegboiya, and Baama; or drug peddlers moving from village to village, selling drugs and giving injections, also called 'peppeh docta'.



## Alternative healthcare providers

The different types of healers can be stratified by their specialisation, the treatments and services they provide, the methods they use to apply these treatments, and the skills they possess.

For this study we differentiate between traditional healers/herbalists and traditional healers/spiritualists. The latter uses the Quran and fortune-telling



Bone fixer applying the splint on a broken tibia

to find out the causes of disease and how to treat them. TBAs are also considered as herbalists for sexual reproductive health (SRH) purposes mainly.

The following list gives an impression of the different healers we spoke to during our research. Most of the healers were specialised in one or more areas of treatment. For example, a herbalist who uses the Quran to treat eye disease could also be treating illness believed to be caused by witchcraft.

- *Halemui* – healer, a person who deals with medicines and treats sick people, including peddlers
- *Mende halemui* – traditional healer
- *Tiffamui* – herbalist who uses herbal remedies to treat people
- *Karmoh* – diviner/spiritualist who acts as a fortune teller or uses the Quran; these healers also interact with spirits to treat people
- *Ndalamui* – healer who can fix or splint the bones for sprain or bone dislocations
- *Ngai-ngaimui* – splints the bones for fractures
- *Nga magba haimui* – eye healer
- *Tɔtɔgbemui* – fortune-teller, soothsayer
- *Mavulomui* – deliverer who assists women in childbirth; now referred to as TBA
- *Kemamui* – 'witch doctors'; they are believed to have superior power over witches, they can kill a witch, remove witchcraft, etc. They also use herbal remedies to treat people

## Traditional healer practices



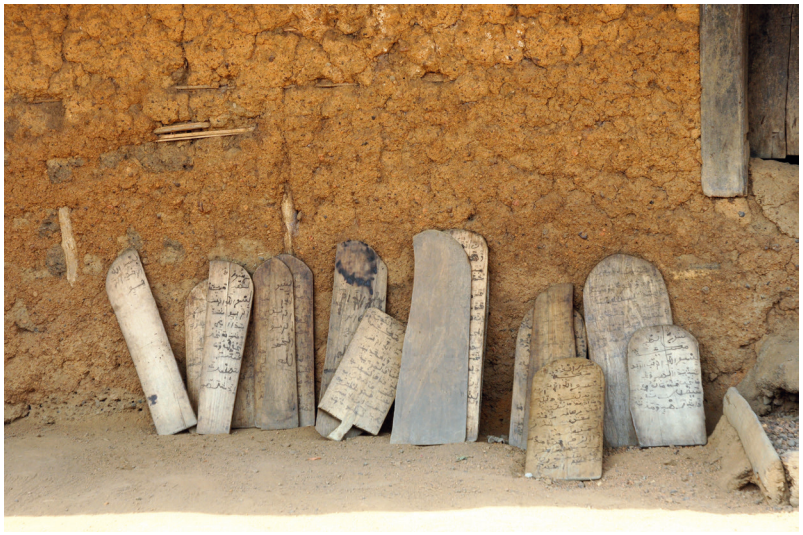
Traditional healer practices for herbal treatments include:

- External application of herbal remedies, which are rubbed on the respective body parts. The herbs are either used alone, mixed with other herbs or sometimes with the ashes of burnt plants or other substances, and some herbs are mixed with palm oil to create an ointment.
- Herbal powders or the ashes of burnt plants rubbed through incisions on the body.
- Herbal liquids dropped into the nose (to treat epilepsy) or the eyes.
- Oral administration of herbal mixtures, herbal drinks, concoctions and decoctions, mostly using leaves, bark or roots.
- Smoke and steam baths with herbs (to penetrate the body through the pores or orifices, like the nose etc.).
- Enemas: herbs inserted to the anus to treat the intestines.

Spiritual practices based on Quranic verses and incantations, which are mainly used for protective purposes to ask for good luck or success in life, are also used to treat illness, including:

- Specific Quranic verses written on paper, wrapped into a cloth or leather, and worn around the neck, arm or feet, or fabricated as a rope/belt and put around the waist or body.

- Quranic verses written on paper or on wooden tablets (Fig 3), then washed off and the water is drunk, or the person takes a bath in the water.
- Quranic verses prayed and spit over the person.
- Amulets and talisman to wear or hang at a certain place to protect the person, family or household
- Amulets prepared for children to protect them from certain diseases or conditions ('split head'/sunken fontanelle, convulsions etc.)



Student Quran tablets; particular tablets from spiritual leaders are used for treatment purposes



**Traditional healers' mobility**

Healers move from place to place for a number of reasons:

- To find more clients or patients;
- The treatment they offered has failed and they run away;
- They don't have clients anymore, people in the village have lost interest in them, e.g. a new healer arrives in the village;
- Some healers have a good reputation; they will stay in their village but sometimes bring another healer to work with them. Sometimes healers from other villages (Temne land[2]) will be recommended by people who travel around, and they might stay in a place for around one to two months; Sometimes healers are invited to work in villages by other healers.

**TBA practices**

The services provided by traditional birth attendants to pregnant and lactating women are greatly appreciated. Alongside their formal role as appointed TBAs, they also interact with pregnant women on a more informal basis regarding the development of their pregnancy. When it concerned more traditional methods like herbal treatments or behavioural rules and regulations, all appointed TBAs confirmed that they refrain from these practices. However, TBAs will still provide herbal remedies if pregnant women ask for it.

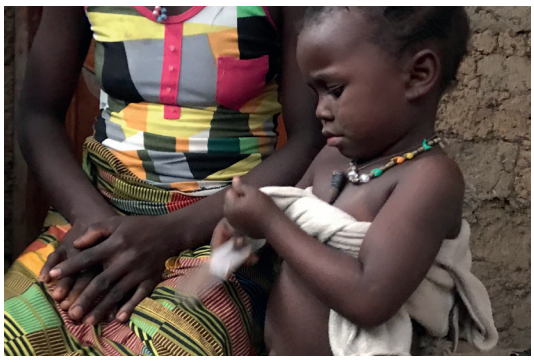
2 The Temne are the second largest ethnic group in Sierra Leone; they have the reputation that their healers are more skilled than the Mende healers.

### Ill-health conditions

After causality, diseases can be classified into two major groups: diseases from God or 'natural diseases'; and man-made diseases or diseases from bad forces (like spirits or witches) – 'non-natural diseases'. Apart from the belief that all diseases come from God, the Mende people differentiate between 'English medicine' that treats natural diseases, and 'Mende medicine' that cures non-natural diseases.

The most common Mende disease concepts are the following:

- Fever/cold/malaria – *dugbandi*
- Convulsions – *hiwei/swei-swei*
- Witch rope – *hɔnayeyei*
- Split head/sunken fontanelle – *ngublei*
- Witch gun – *huana-gbanday*
- Poisoned food – humboi and projected belly – *kohingbe*
- Diarrhoea/runny tummy/watery stool – *Kɔhuli*
- Stunted growth – *Kɔjei*
- Breaking a taboo – *Pudae*



Child with a little snail shell around the neck

Quranic verses wrapped into leather



## Health-seeking behaviour

Access and use of healthcare is first and foremost a question of money. Following financial barriers, illness perception and traditional linkage, distance to facilities, satisfaction with the quality of health services and providers' attitude towards patients also affect health-seeking behaviour. Before people are able to seek health services, logistical, social, financial and geographical obstacles may influence where they decide to seek care. The various obstacles do not always apply in the same way for the same families; sometimes the financial situation is better or worse, or a new healthcare provider is appointed in a specific PHU with a welcoming attitude towards patients, or a village is cut off from accessing PHUs during rainy season, etc. However, some standard patterns of health-seeking behaviour could be identified.

**Treatment at home**

Self-treatment or self-medication at home is mostly used as a first aid or emergency solution, and always mentioned in relation to lack of money.

**Community health worker (CHWs)**

CHWs are volunteers who have undergone specific training to provide first aid services to children aged under five and conduct malnutrition screening outside of fixed health facilities and delivered in the community. They also give health talks to their communities and teach people about hygiene and sanitation practises. They are trained to treat three diseases: pneumonia, diarrhoea and malaria. CHWs are an appreciated healthcare resource easily accessible for people: they reside in the same villages, are well-known by the local population and are part of the integrated community case management (iCCM) initiative. Most CHWs are well respected by their communities as they were chosen by them.

**Drug shop keepers, amulet drug sellers and quack doctors**

People often must rely on drug sellers when faced with drug shortages or stock-outs in the PHUs and are even sent by the PHU staff to buy drugs with the patent license bearer. People use drug shops to buy medication for mild conditions; when they do not have the money to go to formal health providers; when drugs are not available in the PHU; when the PHU is closed or are not attended by staff; out of convenience and former experience with drugs that worked well.

**Traditional healers and TBAs**

Healers are chosen by reputation and trust; word spreads about successful treatments and more people use their services. On the other hand, negative outcomes might harm a healer's reputation or even result in a healer leaving town, running away and trying their luck somewhere else.



A great many people in the two chiefdoms rely on traditional healers for various conditions they trace back to non-natural causes. All the staff from the PHUs we talked to, emphasised that people would still consult traditional healers before they came to the PHU because they trust them, although more people are coming directly to the PHU with the intensification of health promotion activities in the area.

**Formal healthcare providers**

Contrary to the assumption made in the GMW project document 2020, based on previous report assessments conducted in various districts in Sierra Leone, all the community members we spoke to said that their first choice would always be the 'hospital' – referring to a PHU. PHUs are trusted and seen as the place where people receive professional healthcare, supported by biomedical investigations and diagnostic findings using various tools like rapid tests, laboratory tests, blood pressure measurement and the use of stethoscope. The PHU is seen as 'guarantee medicine', meaning that these are the medicines of good quality and value.

The question now is why healthcare providers from the formal sector, MSF and the MoHS, have evidence that people still delay seeking treatment from a PHU. The main reason people gave was that if they want to go to the PHU, they need money first to pay for treatment costs at the PHU itself (like bribes for the staff and medication) and secondary costs for transport. One of the recurrent complaints made by caretakers and patients was that PHU staff prescribe medicines they must buy at the pharmacy, rather than items

covered by the basic package of essential health services (panadol, folic acid and iron). This adds to people's general disappointment over unmet needs and their expectations to receive certain treatments including supposed 'guaranteed' drugs.

**'Referrals' – navigating the different healthcare providers**

Different healthcare providers do work together and will refer patients between them. It was never explicit which facilities or providers people would use first or second, as various patterns could be observed. People always tried to do their very best with the options that were reachable. Many respondents described preferring care in the formal sector but found access often difficult due to various factors, and therefore use varies between the different providers. Reasons range from beliefs in non-natural disease causation, lack of money, distance, and emergency cases etc.

## Factors influencing health-seeking behaviour

Health-seeking behaviour is influenced by a plethora of factors which intervene, overlap, and often vary within the same family or during an episode of ill-health. Given Sierra Leone's plural and largely cooperative health system, how do households navigate the options available and what factors influence decisions?

We argue that volatile and hesitant utilisation of government health facilities is linked first and foremost to the perception of the health facility and the behaviour and attitude of the staff combined with a lack of the necessary financial and logistical resources, disease interpretation and explanatory models, distance and waiting time rather than because people were favouring treatment with a traditional healer or rejecting biomedical health traditions.

### 1. Financial and economic aspects – affordability and associated costs



The costs associated with a visit to a PHU include: expected payments to the PHU staff/user fees; travel costs and lost time.

**Expected payments to the PHU staff/user fees**

Despite the introduction of the free healthcare initiative for pregnant and lactating women and children aged under five, and its initial positive uptake and success, most of the PHUs continue to charge payments before providing treatment or drugs. These expected payments rank among the most important factors influencing health-seeking behaviour and were mentioned in all interviews. It is why people delay going to a PHU, or not going at all, and often refer back to a traditional healer.

- **Travel costs**

If the PHU is not located within the community and requires travel, it becomes much less affordable for local people.

- **Lost time**

Travelling to a PHU takes substantial time away from other tasks such as farming, cooking, caring for children, market trading, etc.

### 2. Illness perception and social and cultural traditions

Before deciding where to go and how to treat their condition, people tend to find out the cause first and then choose which healthcare provider they will use. This decision might change later if an expected cure is not achieved. Decisions about what therapies to seek usually involve or are even determined by relatives, neighbours, and other authoritative people acting on behalf of the patient, especially for more serious and threatening conditions.

### 3. Practical and environmental aspects

When deciding where to go for treatment, people opt for treatment according to what is available and affordable, and, in that sense, proximity plays an important role. Due to poor road infrastructure, the distance that people must travel is a major barrier to healthcare in a PHU. This is mostly apparent in hard-to-reach and isolated areas and for communities that live far away from the PHU.

### 4. Personal experience with different health providers

An often-underestimated feature is the way providers welcome and treat patients. We need to understand the patient's experience and perception of the PHU; what healthcare providers do people trust and why? Decisions about where to seek healthcare are influenced by previous experience of treatment from providers, including the experience of others. This contributes to satisfaction/dissatisfaction, and influences expectations and perceived quality-of-care.

### 5. Perceived quality and effectiveness of services

The perceived quality and effectiveness of health services is a key factor when deciding where to seek help. People will go back to the facilities where they or their children were successfully treated. Sometimes other constraints outweigh the perceived effectiveness of treatment, meaning people are forced to use services they do not deem to be the most effective but are more accessible in terms of transport etc. The majority of community members felt that the PHU offered better care than alternative providers. Male leaders and women generally said that PHU medicine worked more quickly than traditional medicine. In communities where access to PHUs was not a problem, or in communities relatively far away, households always opted to take sick children to the PHU first, if they could afford the logistical and financial constraints. However, in other cases they had to rely on the private sector; either a traditional healer or buying drugs from peddlers or at drug shops.



**Decision-making and household power structures**

The factors previously described are leveraged by power relations within the household, which are fundamental in the decision-making process towards health-seeking behaviour. In terms of children, decisions about which type of treatments to use were made primarily by the father, especially if there was an associated financial cost. In all interviews with community members, it was stated that it is either the child's father, the husband or the head of family who decides where to seek care. This was based on the fact that it is mostly the husband who has to provide the necessary financial resources for a visit to the PHU

**Traditional healers' influence on health-seeking behaviour**

Traditional healers directly influence a patient's treatment path only when patients have already actively started treatment with them. Before this stage, their impact on a patient's health-seeking behaviour

can be leveraged by providing the same services as formal healthcare structures: being accessible and most importantly welcoming, understanding and treating patients well.

Traditional healers' influence on health-seeking behaviour can be classified by four different levels:

- **Personal level – WELCOME the patient**

Where a person seeks treatment depends greatly on where they feel welcomed, trusted and well treated. Traditional healers usually take a holistic approach that includes not only the patient but also their socio-cultural environment. The way providers welcome and treat users characterises the 'proximity' between a patient and the healthcare provider. The way they communicate and engage with patients, the time they take to treat them, and the effort they put into the treatment provided, has significant power.

This study will look at what marks the healer/patient-relationship,and examine how these characteristics could be used to leverage and shape this relationship to motivate people to come to the PHU.

- **Socio-cultural level – UNDERSTAND the patient**

The socio-cultural level relates to the interpretation of the causes of a disease and where illness should be treated. It is a matter of speaking the same 'language' or sharing the same cultural background. Some diseases are thought to be treated by traditional healers and others at the PHU or hospital. In this area, health is believed to be a balanced relationship between man and man, man and nature and man and the supernatural world. A disturbance of any of these may manifest itself through physical or emotional symptoms causing disease or ill health.

- **Professional level – TREAT the patient WELL**

How do people assess what is a 'good treatment'? The traditional healer always prescribes medication or performs some healing acts. The length of a patient's stay with a healer, depends on the confidence they have in a healer's treatment. From the healers' side, it depends how convinced they are that their treatment will work and how many times they have provided this treatment successfully. On the other hand, the community might influence the length of stay depending on personal experiences and the level of trust and respect they have for the healer.



- **Structural level – be ACCESSIBLE for patients**

Traditional healers are accessible in terms of proximity and affordability. They mostly live relatively close to patients compared to many PHUs, and payments can be discussed and/or made in kind. In that sense, healers do not directly influence a patient's health-seeking behaviour, but the mere knowledge that prices are negotiable and accessible, makes people refer to them.

## Recommendations

**How to improve current healthcare provision**

The various groups of respondents had some proposals to improve the current healthcare system:

- MoHS and MSF staff pushed for the inclusion of traditional healers and better recognition of the TBAs in terms of incentives. Traditional healers could play a similar role to TBAs in referrals, and could support the treatment path, (considering who is good at treating certain ill-health conditions). Healers should

play an advisory role in a patient's treatment path, explaining when and for what they should go to the PHUs and which conditions healers can intervene. MSF should also consider providing incentives, as this could mean a loss of income as it does for TBAs. The idea of voluntarism is a Western concept and should be thought over.

- Communities' main concern was healthcare staff's attitude and how to get quality care in terms of medical and dignified treatment at the PHUs.
- Alternative healthcare providers (like traditional healers and TBAs) at the community level want to be recognised for their work.

**Increase integrated community case management (iCCM)**

Communities that are not satisfied with the quality of services provided in the formal healthcare structures, are forced to rely on community-based treatment with CHWs and other alternative providers.

**Value of CHWs**

As respected members of their communities, CHWs are often the first resource to be contacted. With this in mind, MSF should strengthen the role of the CHW by ensuring that they have the capacity to serve their communities. CHWs do not ask for money for services, so drug supply chain should be ensured with no gaps. We should support CHWs in their initial role as community-based drug distributors to avoid the misuse of medication bought from peddlers and in drug shops.

**Integrate traditional healers**

There is great potential at the community level to work with traditional healers, giving them an important role as advisors for patients' treatment paths. At policy level, MSF, currently collaborating and working with the MoHS, could potentially advocate for a more formal collaboration with traditional healers.



The collaboration with the TBAs is a success model, forming an important bridge between the community and the health system; alongside CHWs, traditional healers could be approached and invited to collaborate with MSF and the MoHS. The only weak point of this model is that TBAs have lost their income and generally are not compensated for their work. This matter should be discussed with the MoHS before integrating traditional healers into the current system.

**Quality of care provided at the PHU level**

PHU staff need to be supervised, monitored, motivated, and encouraged to work for the benefit of patients, showing empathy and compassion. This could be realised through a workshop evaluating their values and attitudes towards their work and patients, similar to the EVA (evaluate values and attitudes) workshops for safe abortion care, or a 'nonviolent communication' workshop (Marshall Rosenberg). Health workers are there to serve communities, evaluating their own practices will help them to modify their behaviour and help to foster good dialogue with patients.

**Influence health-seeking behaviour at the community level**

HSB is based on a patient's trust of the health provider and the services they offer. To minimise inappropriate 'healthcare shopping' at the community level, and maximise committed biomedical healthcare provision, the greatest challenges lie in correcting the structural deficiencies people are confronted with.

**Communication and health promotion**

The Baama health promotion (HP) team are doing a great job, are well respected and their presence appreciated. MSF should use this positive perception for future activities and mitigate misunderstandings and contradictory messages when promoting free healthcare at the PHU in the communities. We should focus on HP related to identifying danger signs and complications in child health, so people seek healthcare sooner. Include fathers/husbands, partners and mothers-in-law, as they make the decisions when a child is sick and where they should go for treatment. Health promotion messages should go beyond telling people to go straight to the PHU but encompass understanding illness and disease. Communities expressed that they want to seek care in formal sctor, but this is often ruled out and complicated in the face of the many practical constraints they face.

**Communication between healthcare providers and users creates trust**

At the PHU level, a welcoming atmosphere should be fostered that encourages people to come. PHU staff sometimes push people to turn to traditional healers and other healthcare providers, but then become angry again when patients come back to the PHU.

## Conclusion

Contrary to the 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 first and foremost a question of proximity, accessibility and affordability. Illness perception, use of traditional methods, satisfaction or dissatisfaction with the quality of services, and healthcare providers' attitude towards care also influence behaviour.



Whereas healthcare providers felt that people were going to traditional healers first, the population emphasised that their first choice would always be the peripheral health units (PHU) – providing there were no access barriers. These barriers were seen as: 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 health-seeking behaviour. Primarily, it is not a question of beliefs and traditional methods that push people to turn to alternative healthcare providers, but a question of accessibility, communication and human treatment.

If money or compensation continues to be demanded in PHUs, where the policy is that services should be free or practices are inconsistent and corrupt, this also presents a significant barrier to healthcare. This is also counterproductive to the goal of promoting care at the PHUs. Welcoming women with the words "*Free treatment, free death*"[3] is then more demotivating than encouraging.

"*Where my pocket can afford is where I will take my child*", said one community member thus 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.

3 Quote from several respondents explaining how they cannot access free medical care in the primary healthcare units or hospitals. The phrase is what health staff tell people when they don't bring enough money.

**The Vienna Evaluation Unit**

The Vienna Evaluation Unit was established in 2005 to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises and anthropological studies and organises training workshops for evaluators. More information as well as electronic versions of evaluation and anthropology reports are available at:
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