SIERRA LEONE

Community Epidemic and Pandemic Preparedness Programme (CP3)

Qualitative KAP Survey Results

Community Epidemic and Pandemic Preparedness (CP3) Qualitative Survey Results: Sierra Leone

Introduction

The Community Epidemic and Pandemic Preparedness Programme (CP3) strengthens the capacity of communities, Red Cross National Societies, and other partners to prevent, detect, and minimise the impact of epidemics. It is working with communities to provide basic information about the spread of diseases and how to prevent them, simple and effective systems to detect outbreaks, and communication mechanisms to ensure timely information sharing.

As part of the Monitoring and Evaluation (M&E) Framework, a mid-line Knowledge, Attitudes and Practices (KAP) survey was conducted in two districts in Sierra Leone to generate evidence, measure changes and identify gaps to communities' knowledge, attitudes and practices about epidemic diseases. The mid-line data collection process included household surveys, key informant interviews (KIIs) and focus group discussions (FGDs). The results of the quantitative household survey (both baseline and midline) can be found on the IFRC GO – Sierra Leone dashboard. This report summarizes the qualitative analysis of the KIIs and FGDs, making comparisons with key findings from the quantitative household survey.

Method

The KAP assessment was conducted in August 2023 in Sierra Leone applying a mixed methods (qualitative and quantitative) approach to gather data. The qualitative methods applied a questionnaire of open-ended questions with individuals through KIIs and small groups of stakeholders through FGDs. The same thirteen questions were applied to both KIIs and FGDs (see Annex 1). However, many of the questions had follow-up questions that were applied differently between the KIIs and FGDs. Data was analysed by sub-question, and as a result there are many responses that are categorized as "N/A" because there was no data for that specific question.

The questionnaire was carried out with 5 key informants and 3 focus groups (8 total interactions). The KIIs and FGDs were held across 7 villages within 3 target districts (see Table 1).

Table 1: Geographical distribution of key informant interviews and focus group discussions

District	Village	Number of KIIs	Number of FGDs
Kambia	Kassirie	1	1
	Madina	2	
	Mile 14	1	
	Rosinor	1	
Kailahun	Nambieso		1
	Senehun		1

The FGDs were held with mixed-gender and mixed-stakeholder groups, composed of a combination of local leaders (chairperson, chief), religious leaders and traditional healers, boda boda riders, teachers, and youth. Information on the role of key informants was not included in the dataset.

Data was analysed from the KIIs and FGDs using qualitative methods. Common themes were identified, and the responses were tagged accordingly. Descriptive statistics were used to show the frequency of occurrence of the themes. The FGDs were counted as one respondent/entry, even though there were multiple people in a group. Responses were calculated as a percent of total respondents (N = 8). Data was disaggregated mainly by the type of data source (KII or FGD) or by district, where relevant. The gender of the respondents was not included in the dataset and so disaggregation by gender was not possible. The results of the qualitative analysis were compared with the household survey results to triangulate data, identify any discrepancies, and provide more in-depth information to explain the findings.

Engagement with Red Cross

Participants were asked about their engagement with the Red Cross. The household surveys found that the majority of respondents from Kailahun (82 per cent) and Kambia (74 per cent) had contact with the Red Cross within the past 3 months.

The key informants and focus groups were asked the frequency and type of engagement with the Red Cross. The key informants mostly had a frequent engagement with Red Cross (see Table 2). This was through regular engagement meetings occurring usually once a month. One respondent said the engagement occurred every Friday and Wednesday.

Table 2: Frequency of engagement with the Red Cross

Frequency	Number of KIIs	Number of FGDs
Often	4	1
Occasional	0	2
Rarely	1	0

The focus groups more commonly mentioned an occasional engagement that 'did not happen on a regular basis.' They said that the engagement with Red Cross was through health information sessions, noting that the '*participation is excellent towards health education sensitization*.'

Immunization

Participants were asked several questions about immunization. In the household survey, there was a positive perception of vaccinations, with most agreeing that vaccinations are good for children's health (98 per cent), that they prevent serious diseases and save lives (93 per cent), and that they are safe (96 per cent). However, there was also a noteworthy segment of the population who believe vaccines are not permitted by God (22 per cent), that they are a way to make one sterile/infertile (12 per cent), or that they are a trick of the Government (21 per cent). This is reflected in the low uptake of vaccinations, where just over half of respondents in Kambia (54 per cent) and Kailahun (55 per cent) have an immunization card for his/her child and that between 25 to 30 per cent of these have missed vaccines. Vaccination uptake is lower among respondents in Kambia and Kailahun, where 23 and 24 per cent respectively have completed polio 3 vaccination, 24 and 32 per cent have tuberculosis vaccination, and only 18 and 6 per cent have hepatitis B vaccination.

The key informants and focus groups were asked about their opinion on immunization, with follow up questions on whether vaccines prevent serious diseases and whether vaccines are dangerous to one's health. The majority of respondents were positive about immunizations, believing that they prevent disease and save lives (see Table 3).

Table 3: Do vaccines prevent diseases and save lives?

Response	Number of KIIs	Number of FGDs
Yes	5	2
N/A	0	1

Only the key informants stated whether they believed vaccines were dangerous, all of whom responded 'no.' Within one of the FGD responses, there was indication of vaccine hesitancy specific to the COVID-19 vaccine. The hesitancy was overcome through the actions of the chairlady who led by example and got vaccinated, as well as through the health information provided by the Red Cross.

> "*People were afraid to take the COVID-19 vaccine but when people saw me take the vaccine, it motivated them to also go for the vaccine and as I am speaking majority of the community members are vaccinated.*" – Chairlady from the FGD in Kambia.

> "*Due to health education from some Red Cross volunteers toward the vaccine in the community, the majority of the community people have taken the COVID-19 vaccine and ever since have taken the booster vaccine also*." – FGD respondent in Kwania.

Participants were also asked about the obstacles to implementing immunization programmes. The main obstacle identified was a lack of awareness and health education (see Table 4). More than one third of respondents identified fear as a barrier, specifically the 'fear of reducing the population.' This reinforces the findings from the household survey that there is belief that vaccines cause infertility, as well as death.

Table 4: Barriers to implementing immunization programs

Barriers	Number of KIIs	Number of FGDs
Low awareness	4	0
Fear	1	2
Culture	1	0
N/A	1	0

COVID-19

Key informants were asked about the signs of epidemic diseases and specifically whether they can identify three signs of COVID-19. There was a wide range of symptoms listed, the most common of which was fever (see Table 5). Cough was only identified by one respondent. Other symptoms include cold, headache, sore throat, bleeding/bloody nose, red eyes, fatigue, body rash and runny nose.

Table 5: Symptoms of COVID-19 identified by respondents

Symptoms	Number of KIIs	Number of FGDs
Fever	3	0
Cold	2	0
Headache	2	0
Sore throat	2	0
Bleeding	2	0
Red eye	1	0
Cough	1	0
Fatigue	1	0
Body rash	1	0
Runny nose	1	0

N/A	0	3

The participants were asked how to protect themselves, their families and communities against COVID-19. Personal hygiene and handwashing were the most common protective measures mentioned, as well as health education and following health advice (see Table 6). Other measures identified include avoiding contact with infected people, wearing face masks, cleaning the environment, immunization and general infection prevention and control. One answer that stood out was to 'eat infected animals.' Although it may have been a misinterpretation of the question, the respondent also said, 'avoid contact' and 'personal hygiene,' demonstrating understanding of prevention.

Table 6: Measures to protect against COVID-19

Preventative measures	Number of KIIs	Number of FGDs
Hygiene	3	0
Health education	1	2
Avoid contact	2	0
Face masks	1	0
Clean environment	1	0
Immunization	1	0
Infection prevention and control	1	0
Eat infected animals	1	0
N/A	0	1

In addition to prevention, two of the focus group discussions brought up the issue that people were afraid of COVID-19, indicating there are misconceptions and misinformation about the disease.

> *"People were afraid about COVID-19. Because when their family member is taken to the treatment, he/she will not come back. That the biggest challenge to overcome at that time."* – FGD respondent in Kambia.

The household survey did not include questions about COVID-19.

Safe and Dignified Burial

Participants were asked about safe and dignified burials (SDB), who should be involved and who should lead. In the household survey, respondents identified religious leaders as the key decision-makers when it comes to SDB (59 per cent), followed by clan members (35 per cent), the wider family (26 per cent), the family (17 per cent). Few respondents identified authorities (14 per cent) and health workers (5 per cent).

The key informants and focus groups identified various people who should be involved in SDB, including a combination of youth, religious leaders, Red Cross, trained personnel, and community people. In terms of who should lead, there was not always a clear distinction of who should be the lead. In more than half of the responses, religious leaders (imam, pastors) were identified as the lead, either on their own or together with youth or the Red Cross (see Table 7). Very few respondents identified either trained personnel or the Red Cross as the lead.

Table 7: Who should lead safe and dignified burials

Lead	Number of KIIs	Number of FGDs
Religious leaders	2	3
Youth	2	2
Red Cross	1	1

Trained personnel	2	0
Community people	0	1

Participants were asked about the consequences of not following traditional burial practices. In the household surveys, the majority of respondents stated that negative reactions (95 per cent), sadness (93 per cent), and land-ownership issues (84 per cent) are major consequences to not following traditional practices. This was followed by anxiety and worry (70 per cent), spiritual concerns about the deceased's soul (68 per cent), and economic difficulties (65 per cent).

They key informants showed a greater recognition of the consequences of not following SDB, acknowledging that more people will get infected (see Figure 8). Others agreed that not following traditional burial practices would have negative reactions among the community, causing them to "feel offended" or "not be happy". One respondent noted that the consequence is that the youth committee and religious leaders will be less involved.

Table 8: Consequences of not following traditional burial practices

Consequences	Number of KIIs	Number of FGDs
Infection	2	0
Negative reaction	2	0
Low involvement	1	0
N/A	0	3

Response to an Outbreak

The respondents were asked where they would report health risks. The household survey found that respondents reported nearly equally to health workers (38 per cent), government staff (37 per cent), Red Cross volunteers (35 per cent), community health assistance (30 per cent), and community health workers (30 per cent). At the same time, nearly half (48 per cent) had never reported.

Key informants and focus groups were asked if they knew where to report a human epidemic disease alert and an animal epidemic alert. All of the key informants and two of the focus groups said they were aware of how to report suspected outbreaks.

The respondents identified where they would report a suspected outbreak. For human epidemic diseases, the key informants would report to the Chief Health Officer (identified as their supervisor) or the Red Cross (see Table 10). FGD respondents said they would report to the health facilities.

Table 10: Where to report human epidemic disease alerts

Report	Number of KIIs	Number of FGDs
Chief Health Officer	2	0
Health facility	0	2
Red cross	2	0
N/A	1	1

With regards to animal disease outbreaks, four of the five key informants said they would report to the Red Cross. There was no response recorded from focus groups.

Participants were asked about their level of confidence to report an outbreak. Key informants indicated they were very confident or moderately confident to report (see Table 9).

Table 9: Level of confidence to report a suspected outbreak

Level of confidence	Number of KIIs	Number of FGDs
Very confident	3	0
Moderately confident	2	0
N/A	0	3

Community Preparedness

Participants were asked to what degree they feel the community is prepared to overcome epidemic outbreaks. The household survey found that nearly half of the respondents (46 per cent) feel that the community is very prepared and a third feel somewhat prepared (33 per cent). Another 10 per cent say the community is not at all prepared and 8 per cent do not know. The main reasons for not feeling totally prepared was that it is not in their control to do anything (38 per cent), they don't have the financial resources (20 per cent), and there is nothing they can do (15 per cent).

The key informants and focus groups similarly felt that the community was 'very' or 'well' prepared (see Table 11). A small percent felt that the community was only slightly prepared or moderately prepared, noting that they were more prepared than before.

Table 11: Level of preparedness of the community to overcome epidemic outbreaks

Level of preparedness	Number of KIIs	Number of FGDs
Very prepared	4	2
Moderately prepared	0	1
Slightly Prepared	1	0
N/A	0	1

Few respondents gave reasons for their perception of preparedness. The few answers given gave credit to the greater knowledge, experience, and sensitization efforts of the Red Cross.

> "*From the past experience, people are knowledgeable now for any related outbreak*." – FGD respondent from Kwania.

Major Health Risks

Participants were asked about major risks affecting health in the community. In the household survey, the three most common health risks identified were malaria (30 per cent), diarrhoea (20 per cent), and fever illnesses (12 per cent). They also identified environmental risks of floods (10 per cent) and droughts (8 per cent). The main difficulty in making improvements to address health risks were the financial situation (82 per cent) and lack of resources (52 per cent).

The key informants and focus groups identified a range of risks. The most common health risks identified were the poor sanitation and lack of safe water source, which respondents noted is linked to cholera (see Figure 13).

> "*Lack of toilet and water facility, which normally leads to cholera outbreaks*" – FGD respondent from Kambia.

Table 13: Major risks affecting health in the community

Risks	Number of KIIs	Number of FGDs
Sanitation	1	2
Water source	1	2
Mosquitoes	1	1

N/A	2	0
Nutrition	1	0
Migration	1	0
Hygiene	0	1
Animals	0	1

Others noted the presence of mosquitoes that leads to malaria. Poor hygiene practices, poor nutrition and the presence of infected animals were other health risks identified. One key informant from Kambia identified the risk of population movement, specifically 'travellers coming into the community.'

They key informants and focus groups also listed the main serious epidemic diseases in in their area (see Figure 12). Cholera and malaria were each identified by more than a third of respondents. This was followed by Ebola, fever, cold, and finally measles. No animal diseases were identified.

Table 12: Major epidemic diseases identified by respondents

Disease	Number of KIIs	Number of FGDs
Malaria	2	1
Cholera	1	2
Fever	2	0
Cold	2	0
Ebola	2	0
Measles	1	0
N/A	1	0

The household survey inquired about the knowledge of modes of transmission of select diseases. There was high awareness of the modes of transmission of cholera (80 per cent). There was moderate understanding of the modes of transmission of measles (68 per cent), yellow fever (65 per cent), and Ebola (55 per cent). There was low awareness of the transmission of Lassa fever (8 per cent). There was also a high awareness of the ways to prevent malaria, such as mosquito nets (95 per cent), clean up activities (92 per cent) and covering water jars (90 per cent).

The household survey also corroborates the risk of poor sanitation. More than half of the respondents practice open defecation sometimes (55 per cent) or always (12 per cent). Nearly half say they practice open defecation due to the lack of latrines (48 per cent). Other reasons for open defecation were because people like it (23 per cent), latrines are smelly and hot (10 per cent), it is more convenient (9 per cent), they don't feel safe (4 per cent), they can get an infection from latrine (3 per cent), or they have never used a latrine (3 per cent).

Influential People

In the household survey, respondents were asked about the most trusted source of information about health concerns. Apart from radio (40 per cent), the most trusted people were health workers (16 per cent) and Red Cross volunteers (14 per cent). To a lesser extent, they also identified friends and family (4 per cent), community health workers (3 per cent), community leaders (2 per cent), and religious leaders (2 per cent).

The key informants and focus groups were asked to identify the most influential people in the community regarding human health and animal health. The majority of respondents identified health workers, such as doctors and nurses, as influential for human health (see Table14). This was followed by the Red Cross. A couple identified local leaders, specifically chiefs and chiefdom speakers. One respondent identified religious leaders (Imam).

Table 14: Most influential people in the community for human health

Influential person	Number of KIIs	Number of FGDs
Health workers	4	3
Red Cross	2	2
Local leader	2	0
Religious leader	1	0

Regarding animal health, the answers about influential people were varied (see Table 15). The majority of respondents identified Red Cross. This was followed by a mix of local leaders (chiefs), religious leaders (Imam), health personnel, staff members of the Ministry of Agriculture (Department of Livestock).

Table 15: Most influential people in the community for animal health

Influential person	Number of KIIs	Number of FGDs
Red Cross	3	3
Leader	2	0
MAP	0	2
Religious leader	1	0
Health personnel	1	0
AFP	0	1
Animal specialist	0	1

Communicating Key Messages

Participants were asked what are the main sources from which they receive health information. The household survey found that the main sources of information was the radio (56 per cent), followed by health workers (42 per cent), friends and family (26 per cent), and community health workers (25 per cent). Other sources mentioned were community leaders (15 per cent), posters (15 per cent), mobile SMS (12 per cent), community events (11 per cent), religious leaders (10 per cent) and home visits (7 per cent).

The key informants and focus groups were asked about the main source of health information. Key informants mostly identified Red Cross as an important source (see Table 16). Health workers and the Chief Health Worker were also important sources of information, as well as the radio. To a lesser extent, local leaders were identified as a source.

Table 16: Sources of health information

Source	Number of KIIs	Number of FGDs
Red Cross	5	0
Chief Health Officer	2	0
Health workers	4	0
Radio	2	0
Leader	0	1
N/A	0	2

Key informants and focus groups were also asked what are the most important messages to give community people to stop outbreak diseases and the most effective way to communicate the message. Two thirds of respondents said what message they would communicate. They all said to raise awareness about personal hygiene and environmental cleaning. One respondent also said proper infection prevention and control.

> "*Health sensitization about environmental cleaning and personal hygiene*." – KII respondent from Kambia.

A few also identified effective means of communicating the messages. There was emphasis on group meetings and focus group discussions, as well as communicating messages in the local dialects. The dialects identified were Lima, Krio, Limbo and Luo.

> "*Our local dialect is the most effective mean of communication*." – FGD respondent from Kambia.

Conclusions and Recommendations

The qualitative data validates and expands many of the findings of the quantitative household survey. Overall, the data show there is a moderate level of awareness of epidemic disease prevention among the target groups. Although the sample size of KIIs and FGDs was small, many of the findings were corroborated by the household survey.

There was a good level of engagement with the Red Cross. It seems that engagement meetings occur regularly. However, the health education sessions targeting community members seem to be less regular.

The perception of immunization was positive, with most believing vaccines prevent diseases. However, there is very low uptake of vaccinations and further probing found mistrust and misconceptions, such as causing sterility/infertility or not being permitted by God. There was particularly fear of the COVID-19 vaccine.

There was a varying level of awareness of the signs and symptoms of epidemic diseases. Respondents identified many symptoms of COVID-19 but did not show clear recognition of the most common symptoms. There was good awareness of cholera and the link to poor sanitation and contaminated water, as well as the transmission and prevention of malaria. There was lower awareness of yellow fever, Ebola and Lassa fever.

The results show that there is not a good understanding of the need for safe and dignified burials. There was a preference for religious leaders, family members or youth to lead or make decisions on SDB, rather than trained staff. There was some recognition, however, that diseases could spread if SDB were not done properly, but not following traditional burial practices would lead to sadness, anxiety, economic difficulties, and possibly land-ownership issues.

Respondents demonstrated good awareness and confidence to report human epidemic diseases. There seems to be less awareness of animal epidemic diseases, the sources of information for animal diseases, and to whom to report cases.

Respondents indicated there was a high level of preparedness among the community, yet there were many who felt that it was out of their control.

Based on the findings of the qualitative and quantitative survey results, key recommendations for the CP3 in Sierra Leone are:

1. Conduct health education and sensitization activities with community members on a more regular basis.
2. Continue to raise awareness of the symptoms and preventative measures of common diseases, particularly measles, yellow fever, Ebola, Lassa fever, COVID-19. Continue to reinforce knowledge on cholera and measles.
3. Raise awareness of the importance of vaccinations and work with local authorities to improve access to vaccines. Use targeted messaging to address misconceptions, fears and hesitancy

around immunization, such as vaccines causing infertility or not being allowed by God. Work with local leaders and chairpersons to lead by example and promote vaccination.
4. Increase awareness of zoonotic diseases, such as rabies, and how to report these.
5. Raise awareness and acceptance of safe and dignified burials to reduce the potential of further infection for hemorrhagic fevers.
6. Transmit key messages in local dialects through radio and small group discussions together with health workers.
7. Clarify the communication lines and protocols to report human and animal diseases.
8. Continue to promote the use of latrines and good hygiene practices, while working with stakeholders to install improved sanitation infrastructure.
9. Work with the community to identify strategies to better prepare for and overcome epidemics and other health emergencies.

Annex 1: Questionnaire for key informants and focus group discussions

1. **Participation in Red Cross activities**
- How often engagement meetings with partners and the Red Cross take place?
- How much contact do you have with the Red Cross?

2. **What is your opinion on immunization?**
- Are vaccines dangerous to our health?
- Do vaccines prevent serious diseases and save lives?
- What do you think is the greatest obstacle in implementing immunization programmes?

3. **Know the sign of Epidemic diseases**
- Can you please give me at least 3 signs of EBOLA?

4. **Perception of Ebola Treatment Centres.**
- Can the people discharged from Ebola isolation come back to the community safely? Why?

5. **Safe and Dignified Burial**
- If there is a need to do a safe burial because of an outbreak disease, who should be involved?
- Who is the best to lead SDB?
- What are the consequences if traditional burial practices are not followed?

6. **What would you do if you thought you saw the signs of a serious, possible outbreak disease?**
- Know where to report an alert i) human epidemic disease alert; ii) animal epidemic alert
- How confident are you about raising these alerts?

7. **Perceived current capacity of the community to raise alerts of potential human or animal disease outbreaks**
- How ready and able are you at the baseline?
- Or how vulnerable you are?

8. **To what degree do you feel that your community is well prepared and easily able to overcome epidemic diseases or emergencies?**
- If not prepared, why not?
- What changes / improvements are required?

9. **What do you feel are the most major risks that have most impact on the health of this community?**
- What are the main serious outbreaks or epidemic disease in your area?

10. **What makes it difficult for them to make improvements to address these risks?**

11. **Who is most influential on the people in this community, regarding their practices of**
- Human health
- Animal health

12. **What are the main sources from which you receive health information and updates?**

13. **What would be the most important messages to give community people here to inform them of how to stop outbreak diseases?**
- What would be the most effective ways to communicate those messages to them?