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“THIS IS THE LIBERIAN WAY”: COPING AND HEALTH LITERACY IN
NARRATIVES OF SICKNESS FROM LIBERIA, WEST AFRICA.

by

Crystal Dawn Daugherty

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Doctorate of Philosophy

Communication

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Dedication

This is dedicated to my Mom, Dad, and Papaw. Mom and Dad thank you for the excellent example you've always set for me. I am forever grateful. Papaw, thank you for always listening with open ears when I came home from Liberia. I know that I got my sense of adventure from you. Thank you for looking out for me- I certainly miss sharing my stories with you!

Acknowledgment

First, I want to thank God who has always been faithful no matter how crazy this journey has been. Next, I would like to thank my parents. Mom and Dad, for years you have shown me what it means to be a hard worker. You have cheered for me as I have pursued my goals and I could not have picked better parents! Nathaniel and LaTasha thank you for being my first friends, the best siblings, and for bringing Lakayah and Damien into our crew! ZaKari, Chloe, and Charlie the three of you are my whole world; always remember that I love you. Next, I want to thank my wonderful committee. Joy and Sachiko there are no words to express the level of gratitude I have for the two of you. Thank you for being wonderful co-chairs, mentors, and friends. Tesfa, and Gray I cannot thank the two of you enough for walking with me through this project and for all of the wonderful insight you have provided to this work. Finally, this project would not have been possible with the generosity of the Liberian people. I am forever in awe of your resilience in the face of great adversity. I am humbled by your generosity and hospitality. Thank you for everything!

Abstract

Following two consecutive civil wars, Liberia's health infrastructure was left in shambles. As the country moved forward in restoring health facilities, a mysterious virus began to sweep through the country. Ebola traumatized Liberia and most of West Africa from 2014-2016. This qualitative study explores how people in rural Liberia, West Africa manage sickness. My work is situated in narrative theory and a culturally centered approach as well as literature on health narratives, approaches to medical treatment, and coping. Using semi-structured interviews, I collected health narratives from 30 individuals who identified as community members and 16 individuals who identified as healthcare providers. Additionally, I conducted two focus groups. The first focus group consisted of six healthcare provider participants, and the second focus group consisted of seven community member participants. All 46 participants were from rural Liberian villages. To interpret the data I used framework analysis, which consists of five steps: familiarizing the data; identifying a thematic framework; indexing; charting; and mapping and interpretation. Following the analysis, I identified three major themes: encountering my sickness; encouraging me to handle the sickness; helping me through sickness. The relationship between the major themes and subthemes provide insight into how Liberians experience illness, which is directly related to health literacy. Establishing a framework to better comprehend how Liberians experience and cope with sickness allows the researcher a richer understanding of health, culture, and coping in rural Liberia.

Key words: Liberia; health literacy; narrative theory; culture-centered approach; health narratives; coping; framework analysis.

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Chapter One Introduction

“Tomorrow morning I have been selected to kill the goat. Good grief, what have I gotten myself into?” (Personal journal entry, July 10, 2013). It is a vivid memory that I am certain will remain with me for life. Children, housemothers, my sister, and friends surround me as the Liberian heat pounds down from above. The young goat had already been untied from the tree and brought to the edge of the orphanage compound. Several of the older boys were sharpening the knife on a rock, ensuring me that this would be quick and painless. Afterward, Ma Rebecca stood beside me, half laughing, “Oh you killed the goat! Gboluparnu!” I have grown used to the frequent and sudden switch between Liberian English and the tribal language, Kpelle. “Ma, what does this word mean?” She picked up the quartered meat, headed toward the outdoor kitchen, and laughed again, “It means goat killer!”

The moment I stepped off the plane, I knew I would never be the same. During the summer of 2012, I traveled with eleven of my campus ministry friends to Liberia, West Africa (Figure 1). It could have been the humidity of the tropical climate or the vibrant colors of the women in their best lappa (brightly colored fabric); I may never know, but I fell in love. Our purpose on this trip was to serve a small orphanage located in Flehla Town, about four hours from the capital city of Monrovia (Figure 2). One of our hosts, John Travis, drove us through the Firestone Rubber Plantation as we exited the city. As we traveled on, John shared the rich history of his country. The stories and sights we were taking in moved me, and I later wrote in my journal, “As we began our 3-hour drive through the countryside, we came to a replacement village from the war. It is

devastating to know these people had fled and never returned to their homes” (personal journal entry, July 13, 2012). With each new story of civil war or individual success, my interest in Liberia grew. I was fascinated by America's first attempt at colonization. Liberia, with her vibrant culture, superstitions, and dense tropical rainforests had captured my attention.

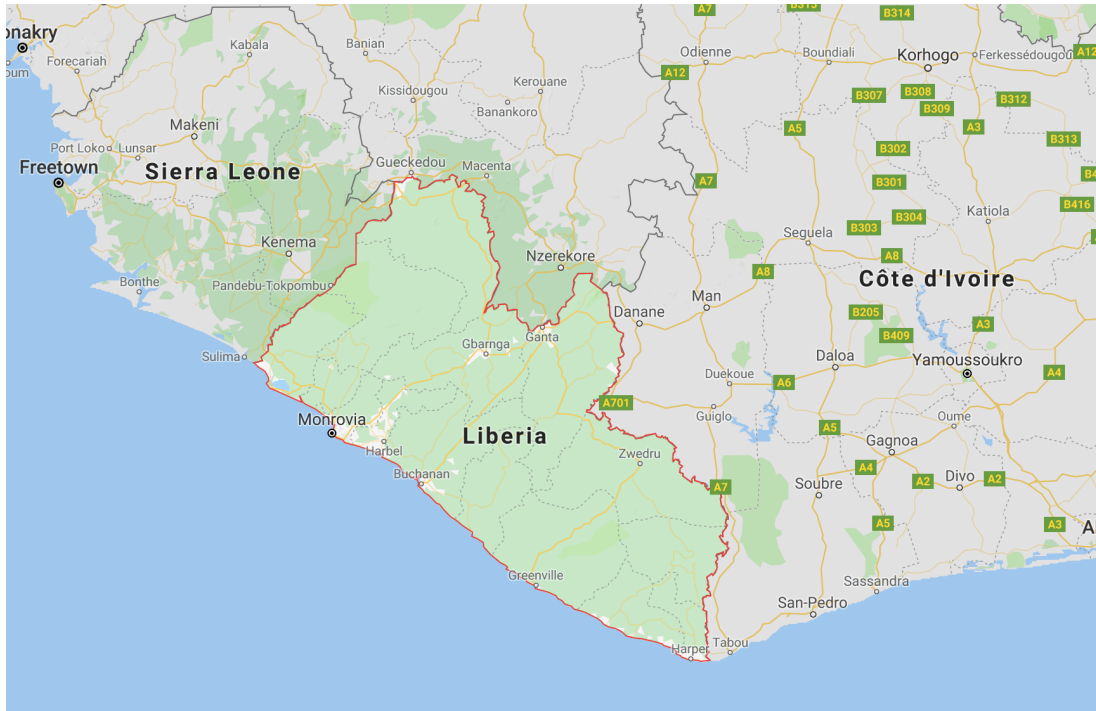


Figure 1 Map of Liberia, West Africa and surrounding countries. Map data: Google.



Figure 2 Map of Liberia. Flehla marked with a star. Map data: Google.

As the week progressed, we were introduced to people who wanted to share their stories with us. Many of the stories involved multiple civil wars or family trouble. However, no matter the focus of the story, illness was often mentioned. A few individuals would talk about how they fled through the bush from rebel armies, and how that journey was what caused malaria. Other individuals would discuss the need for health services in hopes that we would be able to assist them. Around the fifth day in Liberia, I was conflicted about what type of responsibility I had as a Christian to respond to the hurt and pain in Liberia. On July 17, 2012, I wrote out the following prayer, “Lord, help me to understand what is my role here? Romans 8:26. I am not sure what to pray for, but I know that Gods knows my heart...” (Personal journal entry, 2012). It was not until our group returned home that I knew I wanted to explore health and narrative in this beautiful country and village.

In 2013, I began my second mission trip to Liberia. During this trip, with approval from the University of Memphis Institutional Review Board, I conducted a small pilot study that explored spirituality's role in coping with illness. I interviewed four people who had been diagnosed with malaria. This study catalyzed my dissertation. There were several findings I found interesting and relevant to my dissertation. First, all study participants self-identified as spiritual. Second, participants discussed how their spiritual practices helped them cope with the numerous side effects of malaria. Third, participants mentioned using strategies other family members used. For example, if a participant's grandmother boiled an herbal tea, the participant would likely start with boiling an herbal tea rather than visit a healthcare provider. These examples are consistent with literature concerning familial health legacies, which are stories passed from one generation to another and “composed of corporeal, material, and symbolic resources, and illustrate the intergenerational webs of (dis) advantage and inheritance” (Manoogian, Harter, & Denham, 2010, p. 46,). Finally, four participants discussed their use of multiple coping strategies and healthcare options. For example, one participant said she would pray for strength while taking her prescribed western medicine and then follow up with a country herb doctor.

In April of 2014, I was ready to co-lead my third trip to Liberia. The plan was to take seven college students on a two-week mission trip. Our first Ebola warning came six weeks before our trip, in the form of an e-mail from a missionary connection in Monrovia. My co-leader had been exchanging e-mails with Dr. Kent Brantley, the first known American to contract the deadly disease. Dr. Brantley had cautioned us about taking college students to Flehla, especially given that Lofa County bordered Bong

County to the north. At that point, very little was known about the outbreak, and no US news sources were covering the situation in Liberia.

May of 2014 brought another warning from Dr. Brantley and several warnings from the CDC and WHO. Two weeks before our departure we canceled our trip over growing concerns about the Ebola outbreak. What unfolded in the following weeks and months was nothing short of catastrophic for Liberia. Stories began to trickle into mainstream US media; but, it was not until Dr. Brantley and nurse Nancy Writbhol contracted the deadly virus that the American news outlets began to cover the story in depth. From 2014 until my trip in 2016, Liberia faced a disastrous battle with Ebola. During this time, the country was devastated by the initial outbreak and struggled to contain the virus.

In the fall of 2015, the idea was being kicked around of returning to Liberia to visit and assist with Safe Home Children's Village in Flehla. However, the main concern was that the country had just experienced a resurgence of Ebola after being declared Ebola-free for a couple of months. It was not until early spring 2016 that I was asked to join a mission team headed back to Flehla. Finally, I was set to start collecting data for a process that had just been a crazy thought and journal question four years earlier.

Liberia had changed in the three years since my last visit. Our plane did not taxi close to the airport building. Instead it stopped several hundred yards from the terminal. As we deplaned, I realized there was a checkpoint station in the middle of the tarmac. Each passenger had their temperature taken and was made to wash their hands in a chlorine/bleach solution. This was the first sign of how Ebola had changed Liberia. As we began our trip to Flehla, I quickly realized that there were new billboards with

messages about Ebola, there were camps of plastic tents that had been used at Ebola trauma centers, and there were mandatory Ebola wash stations and checkpoints at each county line. I continued to be amazed at the impact Ebola had on Liberia and smaller villages like Flehla. While time and the Ebola crisis had drastically changed Liberia, one thing remained constant: the Liberian people had a story to share, and I was ready to listen.

History and Colonization of Liberia

A significant part of listening to Liberians share their story is having a broader view of how the modern nation of Liberia came to be and the many challenges they have faced. Around 1000 A.D., Mel-speakers and tribal communities were credited with being the first people group to inhabit and settle modern-day Liberia (Cassell, 1970; Clegg, 2004). From 1450 to 1650, another significant migration occurred bringing the Mande-speakers to Liberia. It is widely accepted that Mande speaking groups were long-time inhabitants of the region that was to become Liberia by the time the Americans arrived in Liberia (Konneh, 1996). Of the several tribal languages and groups present in modern-day Liberia, those who identify as Kpelle ethnicity are descendants of the Mande-speakers (Cassell, 1970; Sibley & Westermann, 1928). Of the sixteen ethnic groups, the Kpelle people are the largest ethnic tribe representing roughly 20% of Liberia's population. They are believed to have arrived in the Nyanforquelli, Jorquelli, and Zota chiefdom areas of present-day Bong County by 1600 (Konneh, 1996).

Liberia's current political, social, and healthcare status is closely linked to the colonization efforts of the United States of America. Fast-forward 216 years; across the Atlantic, there was a rising concern of what to do with slaves and freed people in the

United States. In 1816, the American Colonization Society (ACS) was established by Reverend Robert Finely and missionary Samuel Mills under the pretense of assisting freed people of color in their return to the African continent (Sibley & Westermann, 1928; Clegg, 2004; Whyte, 2016). By establishing a colony, the ACS believed that they had provided a viable solution for northerners who feared the growing number of freed Africans moved to the northern United States. For those who supported colonization, Liberia was a missionary venture for African- Americans to convert West Africans to Christianity. While the majority of ACS supporters were white, there were some within the African American community who viewed colonizing Liberia as a way for freed blacks to reclaim their homeland (Seeley, 2016). Those who opposed the creation of the Society were often nonwhite and accused supporters of “apologizing for slavery and slave-holders, increasing the value of slaves, thwarting the movement for immediate abolition, seeking the utter expulsion of the Negro, and deceiving and misleading the nation by encouraging and protecting the slave trade” (Garrison, 1831, p.1).

Guyatt (2009) reports that the majority of African-Americans during the 1820s, toward the beginning of the ACS, rejected the idea of colonization. Those who were in opposition to colonization highlighted the hypocrisy of the United States’ “separate but equal” mentality. William Watkins, a black man from Baltimore, “wondered aloud in 1828 how blacks who were ‘vicious’ and ‘contaminated’ in the United States might become ‘fit instruments to evangelize and civilize Africa’” (Guyatt, 2009, p.1005). It was evident from the onset that colonizing Africa was not a desire for many of the freed African-Americans in the United States. Peter Williams, a black minister from New York, offered an additional disapproval of the ACS efforts by stating, “the colonies

planted by white men on the shore of America, so far from benefitting the aborigines, corrupted their morals, and caused their ruin; and yet those who say we are the most vile people in the world, would send us to Africa to improve the character and condition of those natives” (Guyatt, 2009, p.1005). Individuals like Peter Williams and William Watkins made it clear that there was a collection of people willing to call out the ACS founders and the United States government for their efforts.

The initial push by the ACS was not the only opposition the new colony would face. The first ship sailed four years after creating the ACS. *The Elizabeth* left New York during February 1820 and landed north of modern-day Liberia. In 1821, a second ship, the *Nautilus*, sailed to Cape Mesuarado, north of modern-day Monrovia. After the landing, US Naval officer Robert Stockton, held King Peter of the Dei tribal group at gunpoint and acquired land in the Cape Mesuarado region. Even with opposition from native Africans, the ACS pushed forward in the pursuit of fulfilling a “post-revolutionary ideal of liberty” (Seeley, 2016, p.98).

In 1838, 17 years after Stockton’s acquisition of Cape Mesuarado, the new African settlements came together and formally established modern-day Liberia. During this time, the American Colonization Society encouraged the colony to declare their independence. This move shifted the United States’ focus from “planter and protector” to “helper and supporter” (Siefman, 1969, 2). Nine years later, in 1847, Liberia formally declared itself to be an independent republic (Whyte, 2016). Hilary Teage, an African-American emigrant to Liberia, published an editorial piece that suggested that Liberia was “the beginning of an Africa governed solely by people of African descent” (Mills, 2014, 79). However, the African-Americans in Liberia experienced a unique situation:

the United States did not consider them American because of their race and they were not considered Liberian because they were American in the eyes of the native Africans. While in the United States, African-Americans were only counted as 3/5th of a person, yet as Liberia's independence grew, those same individuals were handed a colony and encouraged to declare themselves a free and independent nation. The colonization supporters in the United States began to see value in letting the new Republic have independence and mimic the political system of the United States, despite the initial push to colonize and control the new colony. Two ways the new country tried to establish their legitimacy, as a self-governing nation, while still acknowledging their "mentor," was to create a flag that offered a nod to the United States and name their capital after President James Monroe (Mills, 2014).

During July of 1847, 12 delegates, including colonist and tribal leaders, produced and passed the Liberian constitution. The problem, however, was that those delegates only controlled a small portion of coastal land. From the beginning of Liberia's independence, there was friction between the colonizers and the native populations. The new Republic held a vote, after passing the constitution, and elected former ACS appointed a governor, Joseph Roberts, as the first president. While things were progressing well for ACS in Liberia, there were African-American abolitionists like Martine Delany, who were still criticizing the colonization of Liberia back in the United States. Delany once stated, "Liberia is not an Independent Republic: in fact, it is not an independent nation at all; but a poor miserable mockery-a burlesque on a government" (Mills, 2014, 104). Following Liberia's independence and the American Civil War, the American Colonization Society saw a decrease in funding and quickly declined. Even

with the rapid decline of the ACS, it was not until March 22, 1963, that the Society officially dissolved, marking the end of the organization that was responsible for establishing Africa's oldest republic and colonizing thousands of freed African-Americans (Seifman, 1969).

Post-independence, colonization continued to play a critical role in the development of Liberia. The most notable examples are Firestone and the continued control of the Americo-Liberian elite. In 1926, Harvey S. Firestone, an American businessman, purchased land and began to set up rubber plantations in Liberia. Firestone, with backing from the United States, signed an agreement with the Liberian government in 1928 making the country one of the largest producers of rubber in the world. Native Liberians were hired to work the plantations, which echoed the poor conditions of plantations in the southern United States. Liberians had little choice in their employment situation, and those who did not want to work for the American company were treated poorly by the Liberian government (Badru, 2010). American-Liberians were given preference for Firestone jobs leaving native Liberians fewer options for desirable work and dangerous jobs. Firestone's grip on Liberia was another reminder of the far-reaching effects of colonization among native populations. Firestone was a prime example of colonial power in a post-colonial country. As the republic grew, so did the control and power of the descendants of the American-Liberian settlers. Whyte (2016) states that "the American-Liberian elite implemented colonial systems of control over indigenous inhabitants of the area, established themselves as leaders of an expansionist civilizing mission, and continually sought to expand the capital's reach beyond Liberia's borders" (p.84).

From the early 1920s until the late 1970s, Liberia's political climate was stable. However, the trend of colonial tendencies continued until the rise of President Samuel Doe in 1980 (Gerdes, 2013). Doe brought an end to the Americo-Liberian oligarchy when he replaced President Tolbert, the last Americo-Liberian president and grandson of a freed slave from South Carolina (Meredith, 2011; Adebajo, 2002). Liberian elections and leadership are other examples of how the Americo-Liberians held power within the country almost 100 years after their independence from the United States. Many of the early Liberian presidents had ties to the United States. For example, President Tubman (1944-1971) served American business interests via Firestone; President Tolbert, though born in Liberia, had an American father. The shift from Americo-Liberian power happened when Samuel Doe became President (Badru, 2010). Once Doe became president, he ruled the country as a military dictatorship (Ali & Matthews, 1999; Adebajo, 2002; Meredith, 2011). Under Doe, Liberia began a downward spiral into despair and violent crime.

Charles Taylor's return in 1989 marked the beginning of Liberia's first civil war, which lasted from 1989 through 1997 and claimed approximately 200,000 lives (Adebajo, 2002). During this time, Taylor and various warlords fought to gain control of Liberia. From 1990 to 1997, Liberia was ruled by tribal factions and warlords who used child soldiers to execute their power and control. After the country held elections in 1997, Charles Taylor was elected as president. This official change of control marked the end of the first civil war (Adebajo, 2002; Meredith, 2011). Many Liberians hoped that with Taylor as president, the country would begin to recover from the devastating in-country fighting. However, from 1999-2003 neighboring rebel forces entered Liberia and joined

smaller tribal warlords to continue fighting (Meredith, 2011). Finally, after almost 14 years of continuous civil war, Charles Taylor stepped down from power on August 11, 2003 (Meredith, 2011). From 2003-2005, a transitional government led the Liberian people leading to the country's first election in 2005. Ellen Johnson Sirleaf's presidential win was historical but also rekindled colonial awareness. President Sirleaf was often believed to be a Congo (an individual whose descendants were freed American slaves). However, she is a direct descendant from two of Liberia's indigenous groups, the Gola and the Kru. Many of the misconceptions about Sirleaf's ancestry stemmed from her westernized education. Navigating the Congo/Country identity was crucial to her reception in Liberia. Her opponent was a famous footballer who was also of Congo descent, and he spent much of his campaign focusing on his lack of connection to Americo-Liberian ancestry. Sirleaf had to navigate her Congo/Country association carefully. If Sirleaf was too Congo, then voters might label her another Americo-Liberian trying to rule the indigenous groups of Liberia. If Sirleaf was too Country, she might lose her Western international support. Despite these identity politics, President Sirleaf took office in 2006 and was the first elected female head of state in Africa. Currently, Sirleaf has completed her term and George Weah is serving his first as president.

Following two civil wars, spanning 14 years, Liberia was in shambles. The country's infrastructure was destroyed, leaving those living outside Monrovia isolated with a lack of security, electricity, and healthcare. Since 2003, the country has been trying to reestablish essential infrastructure, including its health system (Svoronos, Macauley, & Kruk, 2014). During the civil war, roads, bridges, schools, and clinics were destroyed. Clinics, like the one in Flehla, have not been prioritized in the rebuilding

process. The government focuses on new roads throughout Liberia, leaving clinics to be rebuilt by communities or Non-governmental organizations. Liberia's history, especially rebuilding following the two civil wars, helps frame the country's healthcare situation.

Healthcare Pre-Civil War

In recent years, Liberia has faced various health problems. However, this has not always been the case. An article in *The Ladies' Repository* journal, a monthly religious periodical produced by and for the Methodist Episcopal Church, painted a much different picture of health during the early days of the Liberian colony (Johnson, 1842). W. Johnson's 1842 report offered a unique report of the health factors in Liberia. Johnson reports, "excellent water is everywhere abundant, and, in short, all the general causes affecting the health of people, are in the highest degree favorable." One of the common concerns for residents of Liberia, whether it is in bush villages or communities within Monrovia, is access to clean water; therefore, this report of "excellent" water is bizarre and suggests an early PR move for the ACS. Johnson goes on to report "some of the most fatal diseases of the East and West Indies, such as liver and bowel complaints, are almost unknown in the colony. A healthier people than the natives probably do not exist." This lack of disease was the health situation for those who were immigrating to Liberia.

Information about healthcare in the early days of the colony is scarce. However, there is evidence that in the early 1920s the Liberian government used public health policy as a way to resist colonization (Patton, 2005). During the early 1900s, British and French colonial governments surrounded Liberia. Patton's article explores the role of colonization during the public health and sanitation reform, which took place from 1912 to 1953. Colonialism had promoted urbanization, which influenced the environment by

creating new disease opportunities. Patton states, “By bringing African people together from different disease environments for the first time, colonial transportation systems allowed for the unprecedented diffusion of sickness, such as yellow fever, tuberculosis, influenza, syphilis, and other infections” (Patton, 2005, p. 40). During this time, other areas in West Africa were responding to the increasing spread of disease. Liberia, however, waited almost sixty years (1953) until “colonial take-over was no longer a threat” to start work on its first piped water system in Monrovia (Patton, 2005, p. 41).

While the Liberian government delayed public health reform, the Firestone Corporation launched the Harvard University Expedition to investigate the health efforts in the interior of Liberia. Health personnel from the expedition later reported, “there is among the Liberian people no health organization of any sort anywhere in the country, no public health laboratory of any description, and no adequately trained sanitarian or physician” (Patton, 2005, p. 42). Patton argues that Firestone was responsible for expanding medical infrastructure by building a hospital in 1933 and providing health care to hundreds of Liberians. From the 1930s until the start of the civil wars, healthcare in Liberia was somewhat stable. During this time there was a consistent rotation of doctors from the United States and other European nations; however, this changed once the civil wars began.

Healthcare Post-Civil War

Post-civil war, Liberia’s health system is fragmented. The struggle to understand, respect, and implement health care that honors traditional views is one that researchers, NGOs, and healthcare providers have to acknowledge and work toward improving. Post-conflict Liberia faces a dire health crisis, in addition to infrastructure deficits. The World

Health Organization and Child Mortality Estimate reports that the mortality rate for children under the age of five is 70 per 1000 live births, with the maternal mortality rate being 990 per 100,000 live births (WHO, 2016a). Comparatively, the WHO and CME report that in Cote d'Ivoire the mortality rate under age five is 91 per 1,000 live births while Liberia's other neighbor Sierra Leone averages 114 per 1,000 live births. The maternal mortality rate in Cote d'Ivoire is 645 per 100,000 live births and Sierra Leone 857 per 100,000. In contrast WHO reports that the United States the mortality rate for children under that age of five is 7 per 1,000 live births and the maternal mortality rate is 28 per 100,00 live births (WHO, 2016b). There is a prevalence of HIV (WHO, 2016a; Svoronos, et al. 2014), and malaria is a significant mortality factor (WHO, 2016a; Kruk, et al., 2010). Additionally, from 2013 to 2016, Liberia was ravaged with the Ebola Virus Disease (EVD).

Healthcare in modern-day Liberia differs from western practices in several ways. The first difference is in training. Liberians can obtain nursing and medical credentials with minimal formal education. Hart et al. (2016) used task analysis to study what knowledge, skills, and behaviors define the scope of health practices in Mozambique, Botswana, Lesotho, and Liberia. The research found that due to the civil war, Liberia's fragmented health system, compounded with their underprepared workforce, produced poor clinical outcomes (Hart et al., 2016). The end product of Hart's research was to suggest a curriculum reform that would be promoted by the government in the areas of "inter-professional education, with knowledge related to HIV, malaria, and postpartum family planning" (Hart et al., 2016, p. 260). In addition to curriculum reform, other researchers have suggested implementing accreditation programs for hospitals, clinics,

and health education in Liberia (Cleveland et al., 2011). Cleveland suggested that it would be feasible to have accreditation programs because 349 of the 437 active health facilities are government owned. In short, the government has the facilities they need to have consistency, but lack accreditation. Cleveland reported, “despite the widespread support from the NGO community the government-owned facilities of health services remained severely fragmented and inconsistent” (Cleveland et al., 2011, p. 273).

Implementing accreditation programs and reformed curriculum throughout all government-owned health facilities would help with the training of health providers.

The second way healthcare differs in Liberia is the healthcare approaches are ambiguous. Both traditional healthcare beliefs and westernized practices are used with few boundaries. While these practices also take place in the United States, they are not as widespread as in Liberia. Liberians often believe that illness is a result of witching or ancestral disapproval, rather than a biomedical issue. Trying to treat illness in these situations might produce additional problems. In 1968, Kenneth Orr, a medical anthropologist, studied this issue. Orr’s field notes offer two observations that have held up over time. First is the relationship between “kwi medicine,” what is known as a western approach to health, and “witching/traditional medicine.” Orr reports that native Liberians would not own up to using witching.

Additionally, individuals might seek a kwi or western doctor but would not disclose that the person had visited a Zóo (zō), or witch, because doing so would expose the Zóos’ or witches’ supernatural power. However, Orr reports that both native Liberians and Zóos would be open to working with the kwi doctor. The second observation was the kwi doctor’s lack of patience with individuals who hold traditional

beliefs when it comes to witching. Orr noted, “the biggest difficulty with some kwi doctors is their lack of patience” (Orr, 1968, 35). This frustration is still present among western health care providers and noticed by Liberians. Kruk et al. (2011), highlight the use of informal health care providers in their research, citing that Liberians self-reported visiting formal providers three times a year compared to visiting informal providers ten times (Kruk et al., 2011, p. 585).

Finally, the physical infrastructure of healthcare is lacking. The Liberian government is working to improve the infrastructure but still faces barriers such as limited or non-existent access, untrained practitioners, and a dearth of physical clinic locations. The civil wars destroyed homes, clinics, pharmacies, roads, and bridges that were critical to the healthcare system. Following the civil wars, larger cities received the majority of rebuilding efforts and funds. Smaller villages and towns did not rebuilt their clinics. During the war, non-profits who operated or supported clinics fled, only to return to bombed-out clinics and destroyed buildings. Rebuilding private and public clinics has been a slow process. Thirty percent of Liberians do not have access to clinics or hospitals due to poor infrastructure (Borba et al., 2017). By the end of Liberia’s civil war, 242 of nearly 300 health facilities were no longer functioning (Kruk et al., 2011). As of 2010, the Ministry of Health and Social Work (MOHSW) opened 378 health facilities, but many of them offered only basic services. In 2014 MOHSW released a report about Liberia’s health system. In this report, the only infrastructure update was about the Ebola Trauma Units. However, tracking the rebuilding of physical infrastructure has been a difficult and challenging process for Liberia.

Following the wars, the Liberian government has attempted to restructure healthcare. However, patients still do not have consistent experiences at government-sponsored hospitals. For example, one routine visit might be free; however, when patients return for the next visit, they might be charged an unexpected amount. Clinics and hospitals might not be adequately staffed or have enough supplies to handle more than a few patients.

Situating the Research Study

This research is situated in the interpretivist paradigm. Interpretivist scholars approach research through discovering “reality through participants’ views, their own background and experiences” (Thanh & Thanh, 2015, p. 24). The ontological beliefs of this paradigm are that there are multiple realities; those realities are constructed through lived experiences and can be explored through meaningful interactions. The nature of reality is that people make sense of their world through daily routines and conversations while interacting with others. The epistemological beliefs of this paradigm are that reality is known through the co-construction of talking, listening, reading, and writing. The methodological tools for interpretivism include interviewing, reflective sessions, and observation (Creswell, 2013). For this study, I utilize interviews, focus groups, and observations, which are consistent with the interpretivist paradigm. Finally, as a researcher situated in interpretivist paradigm, I made an effort “to understand the viewpoint of the subject being observed, rather than the viewpoint of the observer” (Kivunja & Kuyini, 2017, p. 33).

I approached this project mainly through the emic perspective. However, it is impossible not to acknowledge the impact of etic views. A central challenge in

approaching this research with an emic perspective was making sure that I maintained an awareness of my outsider view. It was important to always double check what I was hearing and understanding with the participants. On the other hand, there were advantages to being an outsider. The fact that I was an outsider meant participants were excited to share their life experiences with me and educate me about their culture. The other positive was that participants were patient with me as I asked clarifying questions. By asking clarifying questions about traditions and cultural approaches, I was able to listen to in-depth descriptions about health experiences in Liberia. The emic perspective brings richness to this research project because it allows subaltern voices to be heard. The etic perspective has allowed me to understand better cultural traditions that influence health practices and to better develop an understanding of the cultural context in which this research was conducted.

As I approached this study, I decided that narrative theory would be the best approach to exploring the lived experiences of the Liberian participants. Narrative theory gave me a platform to invite the health stories, experiences, and voices of the participants. Finally, I would be remiss if I did not address the process of recognizing my perspective throughout the research. As a white, western-oriented, American women studying lived experiences and culture, it was paramount that I pause to recognize and check my privilege as a western outsider.

Situating the research in communication

This study is situated in the communication discipline, specifically health communication, as it showcases how individuals communicate their lived health experiences. Communication and health communication scholarship, in particular, often

prioritizes the development and testing of interventions. However, what I have found is that despite the extensive research concerning narratives, coping, lived experiences, culture, and health literacy, there is a knowledge gap, which does not address the rural voices of Liberians. Additionally, current literature often focuses on other areas of West Africa, rather than on a particular country and culture.

Specifically, this study fills the gap of research in rural Liberia. Often throughout this process the scarce information I would find about Liberia would either be about Ebola, the civil wars, public health interventions, or highly populated cities such as Monrovia. While each of these is extremely important to better understanding the health needs in Liberia, it leaves room for communication scholars to step in and offer different perspectives of context and culture. By utilizing narrative and a culture-center approach, I am able to situate this study in the communication discipline because of the vital need to understand better how underserved populations communicate their lived health experiences. Finally, this research gives underserved and overlooked rural populations agency to share their culture, life, and stories.

Chapter Overview

Having presented an orientation to the historical, political, and societal complexities of Liberia and my experience and interest there, I have set the stage for an overview of this project. Chapter two explores the current literature that informs this study. In addition to narrative theory, I explore the role of a culture-centered approach to studying research while reviewing literature in health literacy, coping, spirituality, and health narratives. Chapter three describes in detail my methodological approach to data collection. In this chapter, I review the Institutional Review Board procedures and

highlight data collection details such as using semi-structured interviews for individuals and focus groups. Additionally, I provide a step-by-step guide to framework analysis, which I used in this research.

Chapter four presents findings from data analysis. In this chapter I outline the three major themes: encountering sickness, encouraging me to handle sickness, and helping me through sickness. Within each theme there are multiple parent and child codes. Throughout the chapter, I discuss the relationship between themes and detail a complex network of ideas and experiences that influence health literacy. Chapter five concludes my dissertation with a discussion of the major findings. In this chapter, I revisit the research questions and describe how the findings answer each question. Following the discussion portion, I conclude by detailing the limitations and future implications for this particular line of research.

Chapter Two Literature Review

Rosetta was across from me, sitting on a hand-made woven chair, looking out the window and watching villagers get water from the local well. She had just finished proclaiming, “I do not take the bush medicine. I am afraid of it. I only go to the clinic.” Later in the week, I would find myself talking with several Liberian women who would make similar statements. Many of the women offered reasons for not using bush medicine, and I noted what influenced their decisions. In this chapter, I present literature that details the theoretical frameworks and relevant scholarship informing this research project. The theoretical concepts of narrative, culture, health literacy, and coping are central to my literature review.

Theoretical Framework

For thousands of years, humans have used narratives to make sense of their experiences. Narratives allow us to process specific events in a manner that creates meaning to a particular event. This study is grounded in the narrative approach outlined in Creswell’s book and specifically focuses on individual narratives (Creswell, 2010). Rich descriptions of particular health events and how individuals, families, or communities make sense of those events are now recognized as illness narratives (Sharf & Vanderford, 2003). Because of the richness and complexity of health narratives, communication scholars have shown interest in how individuals create sense and meaning from their experiences. Consequently, Sharf and Vanderford’s understanding of illness narratives and Walter Fisher’s narrative theory provide a foundation for this study. Central to communication studies theory development, these two narrative approaches are fundamental to the conceptualization of this study.

Narrative research has many forms and can be both a phenomenon and method (Creswell, 2004; Chase, 2005; Pinnegar & Daynes, 2007). Scholars have also found that most studies that use narrative approach have a specific set of features. Narrative research collects stories, narrative stories tell of individual experiences, narrative stories can be gathered with different forms of data, narrative stories are often told chronologically (though not always), narratives can be analyzed in various ways, narratives often have turning points, and narratives take place in a specific context (Creswell, 2010). Many of the features listed are present in this research project. The first feature is that narrative researchers collect stories. Next, the narratives that are collected inform those who listen to them about the live experience of the storyteller. For example, Nolan et al. (2017) use narratives as a way to collect stories of adolescent and teenage mothers' uses of social networks as a means of support. Shields et al. (2015) use collected health narratives of patients with life-threatening illnesses to study how patients create their own health narratives. These are just two examples of how narrative researchers collect the stories and how narratives inform listeners about the lived experience of those creating the narrative.

In the same vein as the first feature, narrative research can be collected via different forms of data (interview and focus group methods in this study). Interviewing has been used in many health cases. By utilizing this data collection, method healthcare providers are able to obtain more detailed information than what might be revealed in a simple survey. For example, a group of breast cancer survivors was interviewed about their life from the time of diagnosis until they were in remission (Sadati et al., 2015). What Sadati et al. (2015) found was that narratives from breast cancer survivors

expressed ideas of hope and empowerment. Another way narratives can be collected are through focus groups. For example, in their study, Elliott et al. (2009) provide an example of how focus groups are used in gathering narratives. In this study, focus groups were used to gather health stories about caring for elderly family members with dementia (Elliott et al., 2009). The final criterion that I want to address is that narratives are created in specific places or situations. For the participants in this study, their narratives occur in rural Liberia two years after the world's deadliest Ebola virus epidemic.

As the popularity of narrative inquiry has risen, there also have emerged different types of narrative. Creswell (2010) highlights four of the most popular approaches as biographical, autoethnography, life history, and oral history. My research falls under the biographical approach because I am the one recording and re-telling another person's narrative. This differs from the other approaches because as the participants are not producing an autoethnography of their life or oral history of their community. Instead, participants are sharing biographical information from the times they have experienced illness. Additionally, the participant's narratives that I am sharing do not represent a *whole* life story instead they are focused on particular moments and experiences of illness. Next, I will introduce how narrative has been used in the broad context of health communication before focusing on illness narratives, pathographies, and health legacies.

Illness Narratives

Narrative research has played a critical role in health communication. Gray (2009) suggests that narratives are a communicative form that help patients bring their illness experiences into focus. Health communication scholars have used narrative inquiry to study and expand our understanding of how individuals facing various health episodes

share their experience. Patients can reflect and reconstruct their identities through narratives (O'Malley-Keighran, & Coleman, 2014; Gray, 2009; Sharf & Vanderford, 2003). A narrative paradigm has been used to explore patients' experiences as a source of meaning (Bute & Jensen, 2011; Vanderford, Jenks, & Sharf, 1997), understanding of illness and mortality (Sharf, 2009), and ability to communicate with their providers (Sharf, 1990). Harter and Bochner (2009) use narrative paradigm to understand healing. Researchers also highlight the use of the narrative paradigm in the larger healthcare context (Harter & Bochner, 2009; Hinyard & Kreuter, 2007; Gray, 2009), such as medical interventions and promotions (Shen, Sheer, & Li, 2015; Niederdeppe, Shapiro, Kim, Bartolo, & Porticella, 2014; Bute & Jensen, 2011; Larkey & Hecht, 2010). Of the uses of narrative paradigm, I believe that Sharf and Vanderford's work on illness narratives to be of essential importance to this study of Liberian narratives because of the focus on illness or as Liberians say "sickness."

For health communication scholars interested in how people share their experiences of poor health, illness is the phenomenon that we study (Sharf & Vanderford, 2003). Before Sharf and Vanderford's work on illness narratives, medical anthropologist Arthur Kleinman (1988) defined illness narratives as:

. . . a story the patient tells and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings . . . The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of

symptoms and suffering. (1988, p.49)

Sharf and Vanderford add to Kleinman's definition by drawing attention to the fact that "implicit in the way stories of sickness are told are underlying values, such as the desire for information, personal control, recognition of individuality, or enjoyable quality of life" (p. 15). Illness narratives then are positioned to offer an alternative to the biomedical and scientific understanding of illness, health, and disease for individuals and communities.

Sharf and Vanderford (2003) established five functions of illness narratives. The first function is narrative as *sense making*. Storytellers use their experience of health and illness to create a larger meaning of their experience. Sense making often involves placing blame and assigning responsibility as a way to process and make sense of the health event. Health events do not have to be catastrophic in order for sense making to take place. However, Sharf and Vanderford stress that sense making is an important function, "especially significant for patients whose lives have been altered by the suffering that results from severe chronic or acute disease or disability" (p.17).

The second function is narrative as *asserting control*. When an individual experiences an illness episode they are often at the mercy of whatever virus or medical condition they are facing. For Liberians, the issue of controlling how an illness impacts them is compounded with outside factors such as lack of resources and availability of treatment options and poor infrastructure. While individuals living in rural Liberia may not be able to control the availability of treatment, they are able to assert control in how they create and share their illness experience. Asserting control over the narrative allows individuals to "put the 'I' back into [their] understanding of his or her life" (Sharf &

Vanderford, 2003, p. 21). Asserting control ultimately lets individuals reshape their narrative so that they are at the center and not their illness episode.

The third function is narrative as *transforming identity*. The emergence of illness, especially chronic episodes or deadly epidemics, redefines those who experience them. Narrative then is a way for individuals to reclaim and define who they are. For example, Ebola survivors in Liberia were able to use narrative to transform their identity from Ebola patient to resilient survivor (Daugherty & Young, 2019). While surviving a deadly epidemic is dramatic and transformative, “the same can be true for people undergoing other forms of suffering, and the process of narrating an illness experience can reveal a person’s essential character through the struggles to adapt, persist, and thrive” (Sharf & Vanderford, 2003, p.24).

The fourth function is narrative as *warranting decisions*. Narratives reveal how and why storytellers made a decision concerning their illness experience. For participants in this research, many of their stories mentioned decision-making throughout their illness experience. Understanding that narratives reveal this information is useful to those of us who want to comprehend better the factors that inform decisions. Ultimately “narratives function to justify decisions already made and determine future decisions” (Sharf and Vanderford, 2003, p. 26, citing Vanderford & Smith, 1996).

The final function is narrative as *building community*. Building on Bormann’s (1985) concept of fantasy themes, Sharf and Vanderford assert “narratives serve a communal function in three ways” (2003, p. 27). The three ways narrative functions communally are providing support, raising awareness, and by serving for advocacy. Rural Liberians do not have reliable access to online support groups that are accessible for

individuals in more developed countries. However, the created and shared narratives of community members build community in other shared spaces such as the markets, churches, and mosques. Illness narratives serve an important function not just for the individuals who create them, but also for those of us who listen and hear them. Pathographies and health legacies are also illness narratives that should be discussed when examining narratives and health communication.

Sharf and Vanderford's work has been a launching ground for scholarship about narratives and health communication. Anderson and Martin (2003) explored how a married couple used narrative as a way to explain their changed identity as a cancer survivor and spouse of a cancer survivor. What they specifically found is that illness narratives can be used to gain control in situations where patients are sharing their experience of fighting cancer. Furthermore, Anderson and Martin suggest that health narratives are healing stories that highlight the complexities of illness. They conclude that illness narratives are a valuable way for individuals to heal and transform their identities (Anderson & Martin, 2003; Sharf & Vanderford, 2003).

Other researchers have used illness narratives to explore mental health in non-western cultures. For example, Tang and Bie (2016) used health narratives to explore culturally an understanding of mental health in younger generations throughout China. What they found was that their participants' narratives revealed insight into how Generation Y Chinese participants reflected traditional Chinese culture (which they did) and how the narratives dilated from traditional culture. Studies that use health narratives in culturally diverse, non-western contexts provide a rich contribution to health narrative research. Additionally, this study posits that narrative research needs to take a "situational

approach to mental health, which is distinct from the biomedical model prominent in the West” (Tang & Bie, 2016, p. 180). While the previous argument is made about mental health, it can be applied to various health concerns and certainly advocates for the use of narrative research in non-westernized situations. Other areas of health narrative research are pathographies and health legacies. Pathographies and health legacies, like illness narratives, are types of health narratives that advance how scholars understand the role of narrative during health events.

Pathographies.

Defined as “a form of autobiography or biography that describes personal experiences of illness, treatment, and sometimes death,” pathographies differ from other illness narratives in that pathographies focus more on the person in the experience and less about the medical issue (Hawkins, 1999a, p.1). Additionally, pathographies are unique in that they are typically written by heterogeneous groups of people and do not include those in poverty or minority racial groups (Hawkins, 1999b; McKay & Bonner, 1999).

Pathographies are not only for those who experience an illness. In their research, Slade et al. (2008) address how pathography was used to help nursing students become culturally competent. Nursing students were given a pathography that had been written by an individual from a non-western cultural background. The objective of the study was to measure how pathographies can increase cultural competence. What Slade et al. discovered was that using pathographies was effective in helping nursing students become more culturally competent. Pathographies are also used in medical schools as ways to train doctors. In their research Carlin (2015) argues that Theodor Geisel’s book

You're Only Old Once! should be viewed as a pathography and a resource for doctors. Carlin (2015) concludes that using pathographies as teaching tools could teach doctors about "restoring individual voice in the face of unfeeling institutions" (p.118).

Through her research, Hawkins' (1999b) has identified four types of pathographies. The first type is didactic pathographies, which are written with a desire to help others. The second type is written to express the inadequacies in care and is inspired by personal experience where a need was not met and is identified as angry pathographies. The third type is similar to angry pathographies, but is not necessarily angry. Alternative pathographies are generated to address dissatisfaction with medical treatments and are interested in finding alternative solutions to medical problems. The fourth, and final example, is ecopathographies. These stories serve as the link between personal experience and large contexts such as political climate, environmental concerns, and cultural issues (Hawkins, 1999b).

Health legacies.

Moving outside the creation of individual illness narratives, the narrative approach has been used to explore health legacies, which are subjective and abstract sources that are combined to illustrate the network of generational inheritance. Harter collaborated with Manoogian and Denham (2010) to address how health narrative moves beyond the individual and offers a "legacy" of understanding. Other scholars support the idea that health legacies play a significant role in familial communication (Yamasaki, & Hovick, 2015; McIntosh, & Stephens, 2012; Manoogian, Harter, & Denham, 2010). Legacies serve as a way to share concern and health history. Manoogian, Harter, and Denham suggest, "legacies emerge and shift through family storytelling processes that

create meaning, shape identities, and provide pathways to action" (2010, p.46).

Legacies do not have to be specifically about individual health. Legacies about proper healthcare roles are often passed down to siblings. As Halliwell et al. (2017) state caregiving responsibilities are often placed on sisters rather than brothers, an important factor in the assumption of a caregiver role is culture. Halliwell et al.'s article explores the narratives of siblings who shared caregiving responsibilities for elderly parents. What they found was that the sibling narratives served in a sense-making capacity. I include this with health legacies because families often pass down stories of what is considered as acceptable when it comes to providing healthcare for elderly members of a family.

Participants who receive a message from previous generations may then feel the need to pass the health legacies on to others. If this holds true in Liberia, the implications are significant for understanding how individuals cope with illness. Healthcare practitioners need to understand the importance health legacies play in assisting families in shaping and understanding their health, health narratives, and coping. Manoogian et al. (2010) conclude that scholars and health practitioners should attempt to "listen to stories, understand the culture of the patients, and help co-create new stories that shape current knowledge into empowering family legacies" (p. 54). The use of narrative research, as described above, is extensive and helpful in the communication discipline.

Fisher's Narrative Paradigm

Framing humans as *homo narrans* is the critical foundation upon which Fisher (1984) builds his narrative paradigm. The narrative approach addresses questions of human nature and human social interactions. "Narrative paradigm is a philosophical statement that is meant to offer an approach to interpretation and assessment of human

communication and assumes that all forms of human communication can be viewed as stories that are shaped by culture, history, and character (Fisher, 1989; Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008). Based on this framework, narrative paradigm is positioned to address issues of human nature, especially how we tell our stories and to gain practical knowledge. Fisher argues that the creation of practical knowledge can be created through stories of lived experiences. Fisher's narrative paradigm deviates from the rational world paradigm and he outlines the five main tenets of narrative paradigm.

The presuppositions of structure narrative paradigm are (1) humans are essentially storytellers; (2) the paradigmatic mode of human decision-making and communication are "good reasons" which vary in form among communication situations, genres, and media; (3) the prediction and practice of good reasons is ruled by matters of history, biography, culture, and character...; (4) rationality is determined by the nature of persons as narrative beings, their inherent awareness of narrative probability, what constitutes a coherent story, and their constant habit of testing narrative fidelity, whether the stories they experience ring true with the stories they know to be true in their lives...; and (5) the world is a set of stories which must be chosen among to live the good life in a process of continual recreations (Fisher, 1984, p. 7-8).

Fisher later elaborated how narrative rationality is established. In his own words, Fisher clarifies "narrative probability refers to formal features of a story conceived as a discrete sequence of thought and/or action in life or literature (any recorded or written form of discourse; i.e., it concerns the question of whether or not a story coheres or hangs together, whether or not the story is free of contradictions" (Fisher, 1985, p. 349). Fisher

also clarified narrative fidelity as “the ‘truth qualities’ of the story, the degree to which it accords with the logic of good reasons: the soundness of its reasoning and the value of its values” (Fisher, 1985, p. 349-350). In short, for narratives to be rational they must be coherent and must be true with other stories that listeners have experienced. Narratives that have both probability and fidelity then have the ability to enhance reason and rationality (Fisher, 1984).

An excellent example of how a narrative can gain probability and fidelity is the 2014 Ebola outbreak. Early in the epidemic, rural Liberia community members began to share stories of how the Liberian government was killing individuals who were presenting malaria symptoms. The narrative was consistent in that people who had malaria symptoms (similar to Ebola symptoms) were placed into government ambulances and then the outside of the ambulance was sprayed. Those individuals were then taken to hospitals where they died. The story also held truth as other villages began to witness the same thing.

In order to address this narrative, health workers and government officials had to create a new, stronger narrative for the country: the individuals who were taken to the hospital were not killed. The spray that went on the back of the ambulances was disinfectant and the malaria symptoms were not malaria. It took multiple survivors returning to their villages before the government’s narrative gained any truth. For those of us who are outside of this story, this may seem like a trivial example. However, what this demonstrates is the power of narrative in shaping and influencing our world.

The complexity of Fisher’s definition can be intimidating. However, it offers researchers a new distinctive avenue to understanding how participants recognize their

own experiences. Ragan et al. (2008) stated, “Fisher’s ideas mark a clear break with rational positivism by naming all people as creators of knowledge that guides action.” To compare, Fisher (1984) outline the difference in the tenets of each paradigm. Table 1 offers a simplified visual for how narrative paradigm contrasted the rational world paradigm (Fisher, 1984; Rowland, 1988).

Table 1
Comparison of Narrative and Rational World Paradigm

Narrative Paradigm	Rational World Paradigm
Humans are storytellers.	Humans are rational.
Decision-making is based on “good reasons”.	Decision-making is based on arguments.
Good reasons are determined by history, culture, and character.	Arguments have specific criteria for logic.
Rationality is based on people’s awareness of consistency and lived experience.	Rationality is based on quality evidence & reasoning.
The world is full of stories and we must choose among them.	The world is understood through logical relationships discovered by sound reasoning.

Scholars have used Fisher’s narrative theory across many disciplines. However, for this research, I am interested in how others have used narrative paradigm in health communication scholarship. Balint and Bilandzic (2017) conducted a study that explored how narrative research has been used in health communication. Through their research Balint and Bilandzic (2017) studied ten research articles that employed narrative theory. The ten studies consisted of articles from various continents and were representative of current research. In response to their exploration, Balint and Bilandzic (2017) assert that the ten articles provided “synthesis of knowledge and direction” in the field (p. 4863).

What this research demonstrates is that there is current and active research using narrative theory and that there is further need for new research in health communication.

In addition to the research conducted by Balint and Bilandzic, other scholars have examined how narrative is used in health communication and health promotion. Larkey and Hecht (2010) assert that narratives can be used to produce culturally-centered health promotions and interventions. They argue that those who are interested in various areas of health communication should turn to narratives as a tool and theory for studies concerning cultural health messages.

Lee et al. (2016) also proposed that narrative theory “can be a guide to develop culturally grounded narrative interventions that can connect with hard-to-reach populations” (p. 60). They also posit that current health communication has not addressed the growing need to effectively communicate health information to those in underserved and diverse populations. Murphy et al. (2013) studied how the use of narrative influences health messages and can help reduce health disparities. In their research, they studied how culturally diverse women in America received narrative and non-narrative messages about cervical cancer. In their findings, they highlight that women who received narrative based health messages had an increase in knowledge about cervical cancer.

What all of these studies have in common is they establish that there is a valuable connection between narrative theory and health communication. Additionally, they demonstrate the need to continue to expand the use of narrative research. A noticeable gap was present in the reports from these studies and the general searches I conducted. There are a limited number of narrative and health communication studies conducted in non-western context. One reason for the scarcity of research could be “lack of rigorous

evidence that narrative could be a superior conduit” (Francis Collins, quoted by Murphy et al., 2013, p.118).

There are several qualities of Fisher’s paradigm that make it a desirable theoretical framework for this research. First, the inclusion of all people as a creator of knowledge is important (Ragan et al., 2008). Later in this chapter, I discuss Dutta’s culture-centered approach, which argues that researchers should focus on subaltern voices as ways to shift power to those that are often overlooked. Acknowledging that all people create knowledge is conducive with Dutta’s research. The next reason that narrative is a useful approach is the fact that decisions are not made through arguments with a set of logical rules. For this study, the narratives that were created and shared demonstrated how culture, history, and social context influenced decisions. Finally, the fifth tenet, that the world is full of stories is valuable because, for Liberians multiple stories are shared. In a country that consists of 17 different tribes that each have their own stories, it is useful to understand that there is not one way that *all* Liberians understand their world. Of course, this also holds true for how individuals experience various health episodes.

To conclude in Fisher’s own words, narrative paradigm:

. . .celebrates human beings, and it does this by reaffirming their nature as storytellers. Regardless of genre, discourse will always tell a story and insofar as it invites an audience to believe it or to act on it, the narrative paradigm and its attendant logic, narrative rationality, are available for interpretation and assessment. (Fisher, 1989, p. 56)

This paradigm is situated in a way that helps researchers better understand various health

communication issues. Ragan et al. (2008) suggest “the inclusion of narratives in an exploration of health communication is one approach that challenges the assumptions of scientific knowledge, thus enabling us to highlight and focus on the communicative domain of care” (p.19). Using narrative paradigm is a beneficial foundation because researchers are able to further develop and understand the mechanics of human communication. This has proven especially helpful in the study of illness narratives. If narratives are created in relationship to culture, context and time (history), then it can be argued that there is a strong bond between narrative and illness, which also exists in relationship to culture, context, and time. It is important to examine how culture influences health communication. In the following section, I will be discussing cultural sensitivity and culture-centered approaches.

Cultural Approaches

It has been crucial to this project to acknowledge how my own culture influences my life and my research. Exploring the influence of culture allows us to understand specific life events better. My research is no different. Cultural communication scholars Ting-Toomey and Dorjee (2018) define culture as “a complex frame of reference that consists of patterns of traditions, beliefs, values, norms, symbols, and meanings that are shared to varying degree by interacting members of an identity community” (p. 14). Ting-Toomey and Dorjee (2018) end with a description of the interdependent relationship of culture and communication asserting, “culture affects communication, and communication affects culture” (p. 19). Acknowledging the interdependence of culture and communication leads me to outline two cultural approaches to health: cultural sensitivity and culture-centered approach.

Cultural sensitivity.

For this dissertation, I approached this study through the lens of Mohan Dutta's culture-centered approach. Before moving to discuss culture-centered approach, I need to highlight the closely related cultural sensitivity approach. "Cultural sensitivity is one of the most widely accepted principles among health behavior researchers and practitioners" (Ahmad, Harrison, & Davies, 2008). The cultural sensitivity approach attempts to include cultural characteristics and norms to produce health interventions for the targeted culture (Resnicow et al., 1999). Cultural sensitivity approaches do not necessarily advocate for the voices of the underserved. Cultural sensitivity approaches, according to Dutta, are theorized as "health communication theories becom[ing] culturally sensitive by extracting and incorporating certain aspects of culture into the dominant theories and applications of health communication" (2007, p.308).

Resnicow, Briathwaite, Ahluwalis, and Baranowski (1999) posit that there are two primary dimensions of cultural sensitivity: surface structure and deep structure. The surface dimension "is identified as matching intervention material and message to observable social and behavioral characteristics of the target community" (Ahmad, 2008, p. 2). Surface structure can include people, religion, media outlets, and schools in the areas where the targeted culture is active. It is at this level that interventions are able to enter into culture. Deep structure then references the less visible structures in a culture such as social factors. Deep structure "reflects how cultural, social, psychological, environmental, and historical factors influence health behavior" (Ahmad, 2008, citing Resnicow et al., p.17).

Cultural sensitivity approach defines culture the same way as Ting-Toomey and

Dorjee (2018). Through the cultural sensitivity lens, health communicators are interested in how the values, beliefs, and practices of a culture can be conceptualized and included in health messages (Dutta, 2007). As Dutta (2007) outlines the main difference between cultural sensitivity and culture-centered approach, then is that sensitivity approach allows all decision about objectives, relevant cultural characteristics and the crafting and evaluation of health messages to remain controlled by dominant and external forces. In my personal experience and from conversations with many Liberians, I am able to see the pitfalls of this approach. Native voices and their cultural values have been overlooked for the sake of prioritizing western health knowledge and messages.

The key argument for cultural sensitivity is that “it is generally believed that by understanding the cultural characteristics of a given group, public health and health communication programs and services can be customized to better meet the needs of its members” (Kreuter & McClure, 2004, p.439). While this is an excellent approach, I would agree with Dutta that this concept can be expanded. Expanding cultural sensitivity to the point where members of the specific culture are actively involved in the process of constructing health messages. Because of my experience in Liberia and the rich voices of rural community members, I decided to use culture-centered approach rather than trying to mask my western voice with thinly veiled reference to Liberian culture.

Culture-centered Approach

In the culture-centered approach, culture is viewed as a complex network of parts that is constantly evolving and changing (Dutta, 2007). According to Dutta, “the culture-centered approach to health communication is concerned with the voices of subaltern gross in discussion of health” (Dutta, 2007, p. 310). For Dutta, the “subaltern voices” are

the voices of individuals, communities, and culture that are often over looked or completely left out of important conversations. Dutta asserts, “the culture-centered approach uses culture as a theoretical lens to interrogate the dominant paradigm for its absences and silences” (Dutta, 2007, p. 311). The individuals who participated in this research would fall within this group. Rural Liberians are often left out of conversations about the health condition of their country solidifying the use of this lens throughout my dissertation.

A culture-centered approach is beneficial to this study because as Pawlowski (2011) states, “Dutta argues that much of our health models in the past have had a focus on the biomedical approach to health communication...” and suggests that culture-centered approach offers, “an alternative to traditional ways of looking at health issues in that it is value-centered and built on the notion that the ways of understanding and negotiation the meanings of health are embedded within cultural contexts and values deeply connected with them” (p.1). This study offers, to the best of my ability as a western researcher, an alternative to exploring coping and health literacy for rural Liberians.

First, culture-centered approach (CCA from this point forward) is situated in grassroots participation. Unlike cultural sensitivity, where decisions and interpretations of cultural value are made by outside forces (e.g. NGOs, researcher, western voices), CCA shifts power to those who are closer to the ground. Grassroots involvement means “participation is grounded in local cultural understandings of human life and well-being, is situated in resistance to the dominant narrative of development and to mainstream development practices” (Dutta, 2015, p. 132). For countries like Liberia, who rely on

assistance from more developed nations, this is a way to de-center their power. In the previous chapter, I provided a detailed historical background on Liberia. The modern nation was born out of colonization efforts that ultimately set a trajectory that would go on to influence the country's political and social structure. Dominant in the narrative of Liberia are voices of colonization. CCA and grassroots participation is positioned to shift power from those voices and toward the voices and stories of Liberians. Part of this shift in power and grassroots campaign is listening.

Second, Dutta (2015) asserts that listening to subaltern voices is valued and seen as resistance. Listening is important to CCA because it “turns the critical lens on the taken-for-granted principles of communication, and simultaneously foregrounds subaltern articulations of materiality that challenge mainstream development” (Dutta, 2015, p. 135). Liberia's early colonial history is riddled with examples of how members of the ACS (discussed in chapter one) came in and did not listen but took control over what is now known as modern-day Liberia. Therefore, listening to stories created and shared by Liberians is critical to breaking the cycle of western culture's domination. Listening to subaltern voices brings a new perspective to the table. This is especially beneficial to health communication scholars as we try to better understand how to communicate health information. This idea is similar to the work of Walter Mignolo and his concept of de-linking from colonial thought. Mignolo (2009) states that one way to disengage colonial power and thought, which has dominated Liberia since the ACS, is through a de-colonial option. A de-colonial option acknowledges that “regions and people around the world have been classified as underdeveloped economically and mentally” (Mignolo, 2009, p. 3). I would add to Mignolo's statement that particular regions and people groups have

often been categorized as underdeveloped in terms of health. Mignolo and Dutta's work confronts and resists colonial power and thought that often impact countries such as Liberia.

In addition to listening as resistance, Dutta (2014) emphasizes that listening allows researchers to explore meaning in what participants are not saying. As an American researcher who is not part of Liberian culture, this tenet of listening and CCA is very important to me. As I conducted research, it was imperative that I not only listen to what participants said but also listen to what was *not* being shared. The lack of response to a question or a vague answer could be a signal that I was crossing boundaries. Listening as a form of resistance is no doubt important but it is often listening for the unspoken narratives that begin to change how we approach narratives.

Finally, CCA asserts that participants obtain agency through the sharing of their lived experiences (Dutta, 2014). One of the many factors that drew my attention toward CCA was the assertion that participants take an active role in obtaining agency through the shift of power and even the rebuilding of political, social, and economic structure. CCA defines agency as "the capacity of cultural members to enact their choices and to participate actively in negotiating the structure that constrain their access to resources...both in everyday forms of meaning making that negotiate the structures and configure creative strategies of addressing the structural barriers that are experienced by the community" (Dutta, 2014, p. 72). Liberians have numerous structural barriers to resources. In terms of health and healthcare, there are infrastructure, political, social, and financial barriers that prevent subaltern voices from being heard. However, CCA argues and supports the claim that if grassroots participants use their voices and stories, then

structural power will be shifted in a way that allows them to participate in the creation of culture-centered messages and narratives.

Dutta's culture-centered approach has been used in many cultural research projects. However, it is beneficial to examine a few examples of how culture-centered approach has been applied in the health communication context. Yehya and Dutta (2010) explored health, religion, meaning, and biomedical model among Druze women. They found that there is space for religion and biomedicine to work together, stating that while the "Druze worldview challenged the universal constructions of health under biomedicine, they also found space of collaboration and complementarity as biomedicine was taken up by participants" (Yehya & Dutta, 2010, p. 854). Thinking about this approach in Liberia is encouraging. Liberians are spiritual people who hold their spiritual and traditional practices near to the heart. Yehya and Dutta offer that in many cases there is a way for local approaches to religion to intersect and collaborate with biomedical approaches to health.

Along the same lines, Dillard et al. (2014) also looked at religious practices while also using culture-centered approach to explore "the intersection of culture an structure as an alternative entry point to understanding the linkages between spirituality and health...decentralizing the field's primary focus on biomedicine" (p. 148). This study is important to this research because it explores how non-western philosophies interact with biomedical health systems. Much like this article, Liberian culture is pluralistic and has experienced some difficulty with Liberian cultural practices (non-western philosophies) and biomedical approaches. These intersections of two different views are a point of entry for those of us who study health communication. Or in the words of Dillard et al.,

“creating entry points for alternative rationalities for healing and curing offers opportunities for expanding the scope of health services delivery beyond the narrowly defined principals of biomedicine as constituted within the mainstream framework” (2014, p. 155).

Culture-centered approach has also been used to address health disparities concerning food insecurity (Tan, Kaur-Gill, Dutta, & Venkataraman, 2017). One of the key features of culture-centered approach is the emphasis on bringing subaltern voices to the center of the conversations. In their research, Tan et al. (2017) share that by listening to underrepresented voices, they were able to identify areas that could improve, such as the structural support for those facing hunger in Singapore. Finally, Newman et al. (2014) use culture-centered approach to advocate for culturally sensitive health messages concerning diabetes. In their study, they found that Zuni Indians who were diagnosed with diabetes received information from several different sources, resulting in very different information. Newman et al. (2014) suggest that a point of intervention and growth would be to have culturally centered health messages for the Zuni tribe as a way to promote diabetic health. These studies are important to explore as they are a few examples of how culture-centered approach is used in health communication and health promotions.

Acknowledging that there are many underserved voices, like those in Liberia, would benefit from further use of this approach in health communication. During the early stages of this research, I grappled with which lens I would use. The cultural sensitivity proved to be the most comfortable and utilized approach, but the aspects of the culture-centered approach listed above are the reason I decided to use CCA. Ultimately,

this research serves as a way to create agency for subaltern voices of the participants in this study. Moving forward, I will address coping, resilience, knowledge, biomedical vs. biopsychosocial, spirituality, and health literacy. These are the key concepts for examining illness narratives along health crises.

Coping

There are many ways of coping with a health episode. Throughout the data analysis, it became clear that coping was a key feature of the narratives I had collected. In this section, I will be focusing on the following factors that influence coping: coping and communication, health literacy, knowledge, treatment of illness, spirituality, and resilience. Each factor not only influences how individuals cope, but also impacts health literacy and individual decision making.

Communication and coping share a relationship: better coping leads to more communication and more communication leads to better coping. Viewing coping and coping strategies as communication allows communication scholars to explore how these strategies work in the daily lives of the participants. Coping involves the cognitions and behaviors individuals use to manage both the internal and external demands of situations that are appraised as stressful (Yi-Frazier, Smith, Vitaliano, Yi, Mai, Hillman, & Weinger, 2010; Folkman & Moskowitz, 2004). Coping, health, and communication have a long history. Many scholars have explored the role of coping with various health issues involving both patients and healthcare providers. Individuals have expressed that communication plays a critical role in their ability to reduce and cope with stress (Schneider, 1997). Others studies have expressed that humorous communication between

healthcare providers and patients is perceived as a positive coping strategy (Wanzer et al., 2006).

In terms of coping with illness through a cultural view, scholars have looked at different ways culture impacts coping. Rana et al. (2015) explore the impact of culture on how participants in Germany and Pakistan cope with having a stroke. What they found was that religion and social support were two major factors in how participants coped with their illness and that each culture placed different values on each coping strategy (Rana et al., 2015). DeVaus et al. (2018) examined the different approaches, eastern vs. western, in how individuals coped with negative emotions. What they found was that an individual's culture worldview affected how they processed their mental health. Most scholars would agree that there needs to be additional research conducted to further our understanding of how culture impacts coping. Additionally, we need to examine how culture and coping are communicated through health interventions and messages that are delivered to diverse groups.

In Liberia, individuals who experience a health problem have different internal and external demands regarding the management of their illness and how they cope. For example, a person in the United States with malaria could cope with the illness by using paid sick days to take off work. Liberians do not have the luxury of sick days. Coping with illness is critical to the study of health communication because it expands our understanding of how individuals communicate various experiences and it has the potential to be an entry point for health communication interventions.

Resilience

Resilience is the “dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 543). Resilience, much like other concepts discussed in this chapter, has been defined in various ways depending on the discipline of the researcher (Richardson, 2002). However, for this research, resilience is defined with coping in mind. While the two concepts are similar resilience can be viewed as an outcome of coping positively in the face of adversity.

Most resilience research focuses on how children are resilient in the face of adversity; there is also a line of research addressing the intersection of culture and resilience. Ungar (2008) reports that culture impacts several aspects of resilience in children. It is in the same study that he proposes a revised definition of resilience that better acknowledges culture: “in the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways” (Ungar, 2008, p. 225).

In thinking of Ungar’s definition of resilience, I am drawn back to Sharf and Vanderford’s classification of illness narrative as transforming identity. Demonstrating resilience is one way to transform identity in the face of adversity. In my previous research, this is demonstrated in the health narrative of an Ebola survivor (Daugherty & Young, 2019). Akoi uses his illness narrative to transform his identity from Ebola victim to Ebola survivor and in doing so demonstrates resilience.

“At its core, resilience embodies a vision of healthy individuals and thriving communities, and a resilience-centered framework provides concrete actions people, organizations, and institution can take to promote the sustainable and long-term well-being of communities in the face of adversity and disaster” (Wulff, Donato, & Lurie, 2015, p. 363). Resilience is included in this discussion because of how participants identified their ability to positively cope in the face of adversity such as chronic malaria. Liberians are some of the most resilient people that I’ve had the opportunity to meet. Civil wars, Ebola epidemics, and everyday health concerns like malaria, typhoid, and HIV are adversaries Liberians who participated in this study have had to face. In spite of numerous setbacks and crises the individuals represented in this research demonstrate resilience through their narratives and their daily lives.

Knowledge

Epistemology refers to the branch of philosophy the deals with how knowledge is created. The creation of knowledge and knowing is complicated. Merriam-Webster offers that knowledge is “a condition of knowing something with familiarity gained through experience; or acquaintance with or understanding of a science, art, or technique” (2019). Knowing as defined by Merriam- Webster (2019) is defined as “having or reflecting knowledge, information, or intelligence.” As researchers, we know that there are infinite factors that impact our ways of knowing. This is no difference when it comes to knowing about health and more specifically how to treat a sickness.

Stange adapted previous research on knowing to suggest that knowing, through the lens of health and medicine, has 2 dimensions: inner/outer and individual/collective (Stange, 2010). Table 2 demonstrates the different ways of knowing.

Table 2
Different Ways of Knowing (Stange, 2010).

	Inner	Outer
Individual	I	It
Collective	We	Its

Within inner knowledge, there is individual knowledge that is based on personal lived experience (I) or there is shared experiences labeled as collective “we” knowledge. Outer knowledge, on the other hand, is objective and can be quantified and observed from the outside (Stange, 2010). “It” knowledge then is created by how systems in the natural world work while “its” knowledge is how various systems work together. Stange goes on to assert that “much of the problem of translating research into practice comes from focusing only on a single way of knowing and ignoring other ways that are important for the application of knowledge” (p. 4-5).

Along the same lines, Hughner and Kline (2004) offer that lay individual’s creation of knowledge are “complex interweaving of information drawn from different sources including lay knowledge, folk beliefs, experiences, religious and spiritual practices, and philosophy” (Hughner & Kline, 2004, p. 3). Finally, in one of his early works, Dutta highlights how interpersonal relationships are often the channel which information, in this case health knowledge, is exchanged (Dutta-Bergman, 2004). This approach to knowledge is connected with a concept I’ll discuss later: relational health literacy. Stange (2010), Dutta (2004), and Goldsmith and Terui (2018) all agree that there is a communal aspect to the creation of knowledge and health literacy. For this research, this is important because of how the participant’s health narratives described both

knowledge and health literacy. Approaching knowledge this way deviates from the idea that knowledge created by outsiders (e.g., western approaches to illness) is superior to inner knowledge and advances the scholarship toward an inclusive understanding of how knowledge is created.

Biomedical vs. biopsychosocial.

Often, when individuals fall ill they have multiple options. The two main approaches are biomedical and biopsychosocial. The biomedical approach “focuses more on the treatment of a certain physical disease while only seeing the biological factors” (Khan & Qureshi, 2018). The main criticism of this approach is that it does not value non-biological factors. In response to the biomedical model, George Engle offered up an alternative approach to health: the biopsychosocial model. This approach argued that health practitioners should focus on more than the biological illness; instead, practitioners should address biological concerns along with psychological and social concerns of illness (Engel, 1977). Engle’s model “offered a holistic alternative to the prevailing biomedical model that had dominated industrialized societies since the mid-20th century” (Borrell-Carrió, Suchman, & Epstein, 2004). The biopsychosocial model’s holistic approach allows healthcare providers to address other areas that may have been overlooked in the past, such as how culture influences how individuals approach illness.

In Liberia, the main medical options can be categorized as biomedical treatments and traditional treatments. Having a pluralistic culture can cause confusion and tension in a community when trying to navigate healthcare; Liberia is no different. According to the World Health Organization (2015), “Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences

indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.” Traditional medicine is a major source of care for many people across the globe and counts for a large portion of health care in Africa (Ndulo, Faxelid, & Krantz, 2001). Ae-Ngibise et al. (2010) explored the role and impact of traditional healers in West Africa. What they found was that the decision to use traditional healers was influenced by a complex intersection of infrastructure, social, and cultural factors. Despite the complexity of various factors and preconceived beliefs that the two approaches may be at odds with each other, research shows that traditional healers and biomedical healers are open to collaborating toward providing healthcare for individuals (Kaboru et al., 2008; Kaboru et al., 2006).

On the other hand, we have biomedical approaches to health. According to Wade (2004), the “dominant 20th century biomedical models originate from Virchow’s conclusion that all disease results from cellular abnormalities” (p. 1398). Healthcare providers who use this model have successfully treated and healed patients from various disease. However, even though there are some who view the biomedical model as the superior approach, there are areas of concern and criticism. One of the main criticisms is that physicians and practitioners who use this model marginalize the feelings of the patient (Basu & Dutta, 2008). The biomedical model often situates the patient as a passive participant. Using this approach means the biomedical models often overlook and shy away from culture-centered approaches. Culture-center approaches would shift power from the expert position (doctor) and allow for an even plain for patients (Basu & Dutta, 2008).

Even though Liberia is considered a developing country, the biomedical model has an impressive presence in the country. In Monrovia, there are numerous “western” style hospitals that focus on treating symptoms and diagnosing health problems. My experience with these organizations is limited. However, from conversations with community members, an individual has to be extremely sick before they go to one of the major hospitals. Common illness that cannot be treated at home result in a trip to the nearest clinic, which raises the concern of access to treatment.

Access to healthcare in Liberia greatly decreased following two back-to-back civil wars (1989-1996 and 1999-2003). As previously mentioned, Flehla does not have a health clinic due to bombing during the last civil war. Stories such as these are prevalent throughout the smaller “bush villages: across Liberia. Dutta and Yehya (2010) do a wonderful job of summing up this issue with this statement: “Many of their medical choices therefore were limited by the immediate context of poverty and not having structural resources...” (p. 853). Having access to resources is a basic component of achieving a healthy life and one that many Liberians are denied. Peters et al. states “people in poor counties tend to have less access to health services than those in better-off countries, and within countries the poor have less access to health services” (2008). There are numerous studies that address access to healthcare resources in developing countries. Ahmed, Creanga, Gillespie, and Tsui (2010) address issues such as economic status and the implications for maternal health in developing countries. WHO acknowledges that one of the major factors to location barriers is having road transport (Jacobs et al., 2011). Victora et al. (2017) state that access inequalities such as

geographical location of facilities, cost, cultural barriers, and transportation are more prevalent in low-income populations.

Spirituality

Scholars offer various definitions of spirituality (Hodge, 2001; Parsian & Dunning, 2009; McSherry & Cash, 2004; Northcut, 2000). Davis et al. (2012) define spirituality as: "a private and personal experience...[that] can be understood as a search for the sacred, and a process through which people seek to discover, hold onto, and when necessary, transform whatever they hold sacred in their lives" (p. 121). Simply put, spirituality is a process through which individuals seek to connect with the sacred. Spirituality is about relationships and experiences one encounters in the journey towards a sacred connection. While scholars may differ on the definition, one thing remains clear: spirituality and its practices are relevant in people's lives and serve as mediators when illness strikes (Bouso, Serafim, & Misko, 2010).

Probably one of the most notable scholars in the field of spirituality and health is Dr. Puchalski. Her work focuses on the importance of healthcare providers including spirituality in patient treatment especially during end of life care (2007). However, her most notable work is the FICA Spirituality Tool (Puchalski & Romer, 2000). This tool is a way for healthcare providers to acquire information about a patient's spirituality beliefs and how they would like to incorporate them into their care. Procuring patient's health and spiritual narratives offer healthcare providers non-medical ways to approach patient care.

Several studies link spirituality to health narratives and coping; examples include breast cancer survivor narratives (Gallia & Pines, 2009), birth narratives (Callister &

Khalaf, 2010), the role of spirituality in coping (Gall et al., 2005) and spiritual identity in health testimonies (Kline, 2011). Gallia and Pines (2009) assert that there are three major themes when studying the relationship of identity and spirituality: agency, communication, and images. “Agency” reflected how participants felt the need to continue to carry out the will of God. This sense of agency could mean that they continue their current roles or find new roles. “Communication” reflected relationships and responsibilities within the family and the individual’s church. Individuals also mentioned communication with pastors and church mentors as a means of coping. Finally, individuals used the theme of “Images” to explain how their image as a grandmother or mother was changed and reflected through the previous themes. Gallia and Pines’ assertion that spirituality is important in preserving ones identify, as well as providing direction during and after recovery tie directly into Sharf and Vanderford’s (2003) research on narrative as transforming identity. Studies such as these validate the need for healthcare providers to understand the role of patients’ spirituality and reinforce it. This is important for this research because participants would identify how their spiritual beliefs either influenced or were incorporated into their illness experiences.

Spirituality in Liberia.

Examining Liberia’s spiritual climate is crucial to understanding the role of spirituality in coping and offers insight into the fluidity of an individual's healthcare practices. The United Nation’s National Population and Housing Census (2008) reported the population to be 85.6 % Christian, 12.2 % Muslim, 1.5 % claiming no religion, 0.6% indigenous religious groups and less than 1% other religious groups (i.e., Hindu, Buddhism). In contrast, Douglass-Chine reports that “traditional indigenous religions are

still practiced by about 70 percent of the population, while about 20 percent are Muslim and 10 percent Christian” (Douglass- Chine, 2010, p. 215-216). There is no clear reason for the drastic differences in the United Nations’ Census and Douglass-Chine’s report.

Conflicting reports, such as these, make it difficult to paint an accurate image of Liberians spiritual practices. I believe the picture of spiritual practice to be somewhere between the UN and Douglass-Chine’s claims. My field observations from my trip suggest that in addition to a major religion (i.e., Christianity or Islam) people often adhere to indigenous religious practices in conjunction with their major religious preference. People identify with different spiritual practices at different times, which may account for the difficulty when identifying the spiritual practices of Liberia. Additionally, secret societies heavily influence the Liberian culture, especially in rural "bush" areas. The secret societies serve as power groups and integrate youth into the local culture. Poro and Sande societies (similar to the Masons in the United States) train males and females, respectively, how to live concerning their community and in the traditional beliefs and practices that uphold their society (Konneh, 1996), including how illness is treated. Power sources, such as the Poro and Sande, have the potential to influence medical decisions because many of the highly esteemed members of both Poro and Sande are bush doctors or medicine men and women.

Health Literacy

Due to an increase in the attention that has been directed at health and factors that influence health, over the past decade scholars have continued to research and explore the impact of health literacy on health outcomes (Yom-Tov et al., 2016). The U.S. Department of Health and Human Services defines health literacy as “the degree to which

individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions” (Healthy People 2020, 2019). Included in this definition is not only the ability to read, but to comprehend additional health materials such as prescriptions and appointment systems. Health People 2020 goes on to list that there are several factors that can influence health literacy, such as: poverty, education, age, and disability (Healthy People 2020, 2019).

While this definition encompasses critical elements of health literacy it is beneficial to examine how international organizations define the concept. The World Health Organization states that health literacy

implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living condition. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people’s access to health information, and their capacity to use it effectively, health literacy is crucial to empowerment (Health Promotion Glossary 1998 version, WHO, 2019).

Additionally, WHO asserts that empowering citizens to play an active role in their own health management is critical to increasing health literacy. It should be noted that these are only two of many definitions of health literacy and both of them are from the western perspective. A brief search for a definition of health literacy produced several definitions, all of them slightly different (Parnell, 2015).

There are limitations to the definitions provided above. Several researchers have addressed the weight and responsibility of being health literate on the individual (Goldsmith & Terui, 2018; Parnell, 2015). Additionally, the definitions are generated

from western world views. This is problematic for studying health literacy in non-western contexts. Approaching health literacy through the lens of CCA would be beneficial in changing how health literacy is conceptualized. Goldsmith & Terui (2018) put forth a conceptual model that uniquely looks at “the role of communication in serving as a barrier or pathway to improved and co-created health literacy” (p. 3). There are five domains that are represented in the model: patients, caregivers, providers, communities, and systems; however, my research examines the narratives of patients who I call community members, caregivers (to the extent that patients identified as this role), and providers. In the Relational Health Literacy model, the five areas are equally informing and co-creating health literacy, which offers a new approach to previous definitions that place the burden on the individual.

Additionally, the previous definitions of health literacy did not articulate space for the voices and experiences of the subaltern. However, the Relational Health Literacy model holds space for the cultural voices of community members (patients/caregivers) and their experience of health. While there are several factors that influence health literacy, it is important to also address overall literacy in Liberia, especially since literacy is foundational to health literacy and health outcomes (Nielsen-Bohlman, Panzer, & Kindig, 2004).

Literacy in Liberia.

Literacy is generally understood to be an individual’s ability to read, write, solve problems, and use technology (UNESCO, 2006). In Liberia, the adult literacy rate is 59.1%, which is lower than other countries in the sub-sub-Saharan region (61.0%) (LISGIS, 2013). However, it should be noted that rural areas experience even lower

levels of health literacy. In Bong County, where the majority of my research took place, literacy rates are even lower than the country average. Table 3 compares the literacy level for men and women in Bong county (LISGIS, 2013).

Table 3
Literacy Percentages for Female and Male Residents in Bong county.

Measure	Female (age 15-49)	Male (age 15-49)
Literacy Rate	20%	53.4%
Secondary school or higher	13.2%	38.1%
Can read a whole sentence	2.1%	4.8%
Can read part of a sentence	4.7%	10.5%
Cannot read at all	80%	46.6%

To expand how we research health communication in Liberia, and specifically rural Liberia, there is a need to understand the complexities of health literacy better. Examining the ways individuals discover pathways for health management will shed light on how narratives are used to make sense of health events. Participants discussed how they understand illness by describing various access points of knowledge. The narratives shared discussed how individuals not only obtained treatment, but also described how they came to those decisions. Each of these and additional factors of health literacy are discussed in detail in chapter four. What makes this unique is that by exploring health literacy in Liberia, I am adding to the current research on health literacy.

Illness narratives, coping, and health literacy is critical to the study of health communication. Interest in the intersection of narratives, coping, and health literacy has

increased over the last several years; however, there remains a gap in exploring how these areas of research influence those who do not live in developed countries. Therefore, using narrative theory and culture-centered approach, I am proposing a study of coping and health literacy in health narratives of sickness in Liberia. My proposed research questions are:

RQ1: What do narratives of sickness from Liberian community members and healthcare providers reveal about coping?

RQ 2: What do narratives of sickness from Liberian community members and healthcare providers reveal about health knowledge?

RQ 3: What do narratives of sickness from Liberian community members and healthcare providers reveal about concepts of illness and culture?

It was early in the morning, so early, that the kids from the orphanage were not awake and had not run down to the house where I was staying with the other Americans to yell greetings in my window. I walked into the makeshift living area of the house and I found Rosetta wrapping her lappa around her waist so she could go draw water. “Good morning, Crystal,” she smiled. I greeted her and asked if I could help. Of course she said no and pointed to a thermos of boiling water. I made a cup of instant coffee and thought about our conversation the day before. “I do not take the bush medicine,” was what Rosetta had shared and I wondered to myself, under what circumstances would she take the bush medicine?

I share this reflection because Rosetta is one example of many women and men in Liberia who do not live in close proximity to a clinic. She is a young woman whose early life is marked with memories of civil war. Rosetta is a reminder to me that Liberia

is a country with a rich history, a dynamic culture, and a hopeful future. And her life sparks questions of healthcare, interventions, culture, and stories. The complexity of the health situation, outside of the Ebola epidemic, has not resulted in many research studies. Additionally, research studies focusing on rural Liberians are especially hard to find. There is so little known about rural Liberian health that this study creates a space for those voices to be heard. In the following chapter, I outline the methodological approaches I used to collect data and analysis the health narratives of rural Liberians.

Chapter Three Methodology

In this chapter I discuss the methodological processes I use in this study. My research questions led me to find ways to understand what narratives of sickness from Liberians can tell us about coping, health knowledge, illness, and culture. First, I detail the methods I selected are interviews and focus groups. Next, I outline the study design and provide descriptions about the data collection process and participant recruitment. I include the process I used to understand the narrative paradigm at work in the data and application of the framework analysis on the data collected. To make the analysis clearer for the reader, I include a step-wise description of how framework analysis unfolds. Finally, I conclude the Methods chapter with descriptions of how I established validity and reliability throughout the data collection and analysis.

Interviews and Focus Groups

For this study I am using methods of semi-structured interviews and focus groups. Interviewing is the most popular way to collect data for qualitative researchers (Jamshed, 2014). Gall, Gall, and Borg (2003) suggest that there are three ways to design interviews: informal conversational, general interview guide, and standardized open-ended interview. Informal conversational interviews are open and guided by the conversation with the interviewee rather than a set of questions (Turner, 2010). These interviews are considered unstructured. General interview approach is more structured than conversational approach and has pre-determined questions but maintain the flexibility of being able to ask follow up questions of participants. Semi-structured interviews are most often associated with the third design, standard open-ended questions, consisting of highly structured questions. Unlike the other designs, standard open-ended interviews offer the

least amount of flexibility in how to conduct interviews.

In her article, Rabionet (2011) outlines six stages she used in learning to conduct semi-structured interviews. I adopt her six stages as a way to guide my approach. Stage one includes selecting the type of interview. For this study, I selected semi-structured interviews because of their flexibility. I knew that I wanted my interviews to be structured, but I also wanted the flexibility of asking follow up questions and to investigate answers more deeply if needed. The second stage is establishing ethical guidelines. Prior to conducting interviews, I obtained IRB approval from the University of Memphis. I used informed consent and upheld the confidentiality of all participants.

Stage three is crafting the interview protocol. During this stage I adapted the McGill Illness Narrative Interview protocol. I used this tool and adapted its prompts to reflect my research question. Stage four consists of conducting and recording the interview. I conducted interviews in several locations, which is detailed later in this chapter. While I was in Liberia, I used a hand-recorder to capture interviews. Stage five is comprised of the analysis of the interviews. After transcribing all interviews, I began to use framework analysis, which I detail in the last portion of this chapter. Finally, stage six is all about reporting the findings. The findings from framework analysis are interpreted in Chapter 4.

Semi-structured interviews were appropriate for this study because they allowed me to ask open-ended questions and give participants the chance to share their narratives in various ways. This provided the flexibility to go off script and ask follow up questions based on participant direction. Another benefit is that semi-structured interviews foster a

conversation flow that provides a thick description. Thick description involves rich and detail-laden context concerning interview questions (Kvale & Brinkmann, 2009).

In addition to interviews, I also used focus groups. Focus groups are well-established and credible tools to examine health narratives. This method can range from group sessions, to brainstorming, to group interviews in the field (Lindlof & Taylor, 2002). Focus groups are “perceived as a methodology which can generate complex information at low cost and with the minimum amount of time. It can also but used with a wide range of people and groups in different settings” (Liamputtong, 2011, p. 2).

Morgan (2002) posits that there are two types of focus groups. The first type is structured and is often associated with market research. The second type is less structured and used in social science research. For this research, I used the less structured approach for focus groups. I chose focus group because as Liamputtong (2011) states it “is useful in exploring and examining what people think, how they think, and why they think the way they do about the issues of importance to them without pressuring them into making decision or reaching a consensus” (p.5).

For this study, I conducted focus group interviews in the field during the same time period in which I collected individual interviews. Focus groups bring out different ideas and experiences through the chaining effect of group conversation. Focus groups used in other research settings also advocate for this method because of chaining effect. Hundley and Shles (2010) interviewed teenagers using focus groups in order to better understand how teenagers think and use digital devices. In healthcare settings, focus groups have been used to explore workplace stressors for medical residents (Minai & Ali, 2013). The chaining effect that often takes place in focus groups provides a rich

description of the phenomenon being studied that might not have been shared had participants not been in a focus group setting (Lindolf & Taylor, 2002).

In selecting interviews and focus groups as a data collection method I knew that there were advantages and disadvantages for each method. However, for this research the advantages outweighed the disadvantages. The advantages of using interviewing in this research study are: the amount of information I was able to receive about individuals; the quality of the information shared; and the ability for individuals to express themselves freely. The interviews that I collected were rich in both quantity and quality of information. Participants were very open to share their experiences and providing additional details when I asked follow up questions. This is the major advantage of conducting interviews in order to illicit in depth stories of lived experiences. Another advantage of the interview is the ability for participants to express themselves in an intimate manner with the interviewer.

Because my time was limited, I elected to triangulate methods in order to cull as much data and conversation as possible within my constraints. The focus groups in the methods were important because they promoted group conversation around health. In the focus groups I was able to gain group generated conversation about how participants experienced and conceptualized health experiences. Additionally, because there were multiple views in the focus group, I was able to receive a broader range of information at once.

On the other hand, there are disadvantages to both of these methods. The main disadvantage of interviewing is that they are time consuming. I had a very short two-week window to collect data. This meant that I had to manage my time very carefully

when conducting interviews. There were many days that I was interviewing for five to six hours non-stop. Additional disadvantages of focus groups are that participants may be hesitant to share (e.g. in the event they have an unpopular opinion) and participants could begin to experience groupthink (Cyr, 2016). Irving Janis coined the term groupthink, which is a phenomenon that happens when a group makes poor decisions because of group pressures (Janis, 1971). If a member of the focus group believed that their opinions or experience would negatively influence their acceptance into the group they may withhold their opinions and agree with the group instead. In the community member focus group I had to really encourage participants that there were no right/wrong answers because at first some community members were not sharing or speaking up. However, as the group became more comfortable with each other, all participants would speak up and share their experience. Going into the focus groups, I was vigilant about watching for signs of groupthink. During the healthcare provider focus group, I had to ask several follow up questions and probe for explanations because I was afraid that the participants were just agreeing with others in order to not cause any trouble. However, like the community member focus group, the longer we were in the focus group the more comfortable and open the healthcare providers seemed. Using both interviews and focus groups was how I triangulated the data in order to establish reliability and validity of the data collected. Combined with field observation and notes, the interviews and focus groups were able to mitigate the disadvantages that arose with each method. In the following section I go into detail about how I collected the data and the specific protocol I created for both interviews and focus groups.

Study Design

I selected narrative paradigm for this study because this approach privileges the telling of a story through the lived experience of individuals. Approaching this research through the lens of the narrative paradigm gives individual participants a platform to share their health experiences and offers researchers the ability to study how illnesses get narrativized (Sharf & Vanderford, 2003). Because the individuals who participated in this research are often underserved and overlooked, a narrative study was the best choice to explore and share culturally rich experiences and understandings.

Semi-structured interview protocol

The interview script I used for community members was adapted from the McGill Illness Narrative Interview (MINI) and I independently developed the healthcare provider interview. The MINI is designed to “elicit illness narratives in health research” (Groleau, Young, & Kirmayer, 2006, p.671). I used the MINI because it “guides a conversation that produces narratives that can be used to study individual illness meaning, modes of reasoning, historical sequences, and the sociocultural context of illness experiences” (Groleau, Young, & Kirmayer, 2006, p.678). I also picked the MINI because the flexibility was conducive to the specific questions I asked about illness, knowledge, and coping. I asked participants ten questions that prompted them to describe the following: any health problems they had experienced; types of treatment they sought; whether family or others in the community had experienced similar health problems; what has helped them through their health problem; and how spirituality, faith, or religious beliefs helped them through their health problem.

I asked the healthcare providers asked eight questions about how they approach patient needs in the context of treatment care. I asked them to describe how they have approached coping and whether or not they have addressed patient spirituality or faith. I also asked questions about how they incorporated their own spiritual or religious beliefs into their care for patients. Both interview scripts for community members and healthcare providers can be found in Appendix A & B.

Recruiting.

I recruited participants with the help of John Travis, a man I had met on my previous trip to Liberia who was prepared to help with the study. Participants knew John through local schools, community involvements, and his previous connections as a photographer. Prior to my arrival in Liberia, I spoke with three individuals about helping recruit study participants. John Travis, Brittany Eagleman, and Jeremy Eagleman are members of the Flehla community and have access to local clinics, hospitals, and community members. John Travis, also the Director of Safe Home Orphanage, was the main recruiter. I sent John recruiting scripts for both patients and healthcare providers. John used the scripts as he went around the community asking people if they were interested in helping with my study. I had informed John that I would like both men and women of various ages to participate. By the time I had arrived in Liberia, many of the participants were already selected. Once I was able to meet participants, I explained the purpose of my study. I also explained the interviewing process and asked if they knew anyone else who might be interested in participating in my research. Participants often showed up in groups of five or six. There were a few community members who were included in this study because of this snowball effect. However, many of the participants

were there because of John's recruitment efforts. I would explain the interviewing process and study to the group. I explained that interviews could take up to an hour and they were free to wait or come back in an hour; all participants decided to wait. Next, I would hand out the consent forms and wait for participants to return them. Recruiting individual participants was not hard. Many community members were very excited and interested in the research project. Several community members would stop and ask if I needed anyone else to interview.

Healthcare providers were recruited in the same manner. John knows several hospital workers and arranged interviews prior to my arrival. During my interviews at the private clinic, I was allowed to ask other clinic workers if they would like to participate. The recruiting and interviewing process was easier at the private clinic. I developed a fast friendship with the doctor who ran the practice and I was given permission to approach both patients and healthcare workers. While John knew several of the workers at the hospital, recruiting was not as open. John had previously approached the director of the hospital in order to explain my research. Once I arrived on campus, John and I went to meet and talk with the director. After meeting with the director, I was given a list of people who were willing to participate. Much like the patients, when I first met the healthcare providers I explained my study and the interview process. Each provider was given time to read and sign the consent forms prior to beginning our interviews. Throughout the process, only one community member and two healthcare providers declined to participate.

Community Member Interviews

Interviews with patients were collected in three places: Safe Home Christian School, Hope Christian School, and a private health clinic. Safe Home sits on a small hill on the outskirts of the village of Flehla, while Hope is between Flehla and Totota, about ten miles away. Construction of the Hope school is ongoing and it currently has three completed rooms. Safe Home School, on the other hand, is completed and has eleven furnished schoolrooms. John Travis was able to gain access to the schools because he knows the principals. Prior to my arrival, John asked for permission to use the schools because of their central locations. Many of the community members that participated in my study did not have any connection to the school. However, there were a few who said that they taught at the schools. After patients agreed to participate and signed the consent forms, I asked them to complete a short survey with demographic information (Table 4). Survey questions included items such as: age, gender, education level, family size, role in the family, and illness history. Individual interviews ranged in length from 10 to 45 minutes and were recorded on either my iPhone or with a hand-held recorder.

Table 4
Community Member Demographics

Characteristic	Number	Percentage
Age		
20-30	10	33.3
31-40	6	20
41-50	6	20
51-60	5	16.6
61-70	0	0
71-80	3	10
Gender		
Female	10	33.3
Male	20	66.6
Education Level		
None	5	16.6
High School	10	33.3
Professional certificate	15	50
Family size		
0-5	8	26.6
6-10	17	56.6
11-15	4	13.3
16+	1	3.33
Religious Affiliation		
Christian	27	90
Muslim	2	6.6
Other	1	3

Healthcare provider interviews.

I conducted healthcare provider interviews in three different locations. The first location was at a private healthcare clinic. The clinic courtyard was enclosed and offered privacy from the town. At this location, I interviewed seven healthcare workers and four patients. Figure 3 is a picture of the courtyard of the private clinic. The second set of interviews was collected at Renee Hospital, a small bush hospital outside the village of

Kakata. The complex consists of several one-story, white brick buildings that house specialty wards. Renee Hospital also has a large courtyard that boasts a covered pavilion for staff, which is where I conducted interviews. To maintain privacy, employees were asked by hospital administration not to use the pavilion while I was collecting interviews. The final location of my healthcare provider interviews was in the Safe Home Christian School. This location was used to interview two traditional healers who self identified as *Zóos* and who the community members call by the following names: *bush doctor*, *country doctor*, and *herbalist*. The two traditional healers had never received any medical training. The demographic information for healthcare providers is demonstrated in Table 5.



Figure 3 Private Health Clinic.

Table 5
Healthcare Provider Demographic Information

Characteristic	Number	Percent
Age		
20-30	5	31.25
31-40	3	18.75
41-50	5	31.25
51-60	2	33.3
61-70	1	6.25
Gender		
Female	11	68.75
Male	5	31.25
Education Level		
Cultural	2	12.5
Training School	13	81.25
Medical Degree	1	6.25
Religious Affiliation		
Christian	14	87.5
Muslim	0	0
No Answer	2	12.5

Focus Group Protocol

I developed five questions for the community member focus group(s). I developed questions based on the individual interview content for gaining deeper understanding on the narratives. Community members were asked to describe common health problems in their communities and how the community and patients address the problems. I asked participants to explain the different healthcare options available. Other questions focused on how the community copes with widespread illness such as malaria, HIV, and Ebola. Finally, the focus group was also asked about the role of spirituality in how the community copes with illness.

I developed eight questions for healthcare providers during their focus group. Questions asked were similar to the questions asked in the individual healthcare interviews. The questions I asked providers in individual interviews were about how they address patient health. I inquired about how providers incorporated spirituality into their patient care. Additionally, I asked questions about how they address coping processing with their patients. Finally, I asked providers to share how patients discuss and share concepts of spirituality, illness, and coping when they come to receive care. In asking these questions, I hope to gain a better understanding of how healthcare providers approach their care practices and gain a better understanding of coping, spirituality, and health literacy in their experiences. Both focus group scripts are in Appendix D & E.

Recruiting.

Prior to their individual interviews, as I was going over the consent form and why participants had to sign it, I made sure to point out that there was an option to participate in additional group discussions. Individual participants, community members, and healthcare providers had already been recruited to participate in the interviews when I informed them of the opportunity to participate in focus groups. I explained that if individuals wanted to, they were welcome to participate in a focus group interview. All interview participants checked the box on the consent form saying they wanted to join the focus group. However, I also asked John Travis to reiterate that focus groups would take place at the end of the day. At the end of my first day interviewing at the clinic I did not have any participants, community members or healthcare providers, who remained for the focus groups. So on the second day at the clinic I went through the same script but I

asked both the doctor at the clinic and John Travis to speak to those who were waiting to be interviewed.

Once I realized that recruiting for the focus group would be more challenging than expected, I changed my approach as I started strictly interviewing community members. For community members I also went over the consent form and identified the opportunity to participate in a focus group. However, I had John tell community members that I needed some of them to come back a few hours after their individual interviews. Giving participants a specific timeframe worked better for the recruiting participants for the community member focus group.

Focus group protocols

My first focus group consisted of six healthcare providers from the private clinic and lasted 35 minutes. After the clinic was closed, we met in the intake room for the session. Once everyone was gathered, I explained that I would be recording our discussion and that I would like for each person to chime in when they had something to add. Once I asked the question, there was usually a short pause before someone spoke. Throughout the focus group, participants would wait until their colleagues had finished before they would add their thoughts.

Later in the week, at Hope Christian School, I conducted a second focus group with seven community members, which lasted for 30 minutes. I conducted this focus group in the same manner as my first group. After explaining the protocol, I began recording and asking questions. This group of patients was much more open with information than the healthcare provider group. I conducted one focus group for healthcare providers and one for community members because of time and availability of

participants. My time in Liberia was limited. The challenge of assembling a group for the focus group collections was most difficult, and so achieving one group that was representative of both primary stakeholder groups was significant.

Protection of Participants

The University of Memphis Institutional Review Board approved this study. Research for this study was conducted in accordance with the University's ethical research standards for human participants. Each participant was presented with consent forms to read and sign. As noted in the literature review, many individuals in Liberia do not read. To ensure that these individuals fully understand the consent documents before signing them, I reviewed the consent form with all participants in detail before leaving the room. I also asked John to help them read to allow them to ask any questions to John or myself. Participants signed the form only after they finished asking all the questions they might have and fully understood the documents. With the trusting relationship between John and the Liberian people there, I could ensure that all people who signed the consent form wanted to join the project. Participants who were not able to sign were allowed to place their mark as consent. In Liberia, individuals who are not proficient in writing often know their initials and are able to sign legal documents that way or will place their inked thumb on the signature line.

Confidentiality.

Individual privacy was protected throughout the interview process. Interviews took place in private rooms of a schoolhouse, private rooms of clinics, and in an open courtyard. Individuals who gave consent for the study were taken to a room and the door was shut to provide privacy when answering questions. All interviews were recorded

with no markers that would identify the participant. In writing about the study, I will refer to participants with a pseudonym, with no other identifying marker. In Flehla, all materials were kept in a locked trunk in my room. All study materials, such as the demographics sheets and the interview transcripts, were marked with the participant's study ID number.

Once I returned to Memphis, I transferred all data to an electronic file. Following the transferring process, all the files and the computer have password protection. I am the only person using the computer and will be the only person with the password. In the event a participant did not want to complete the study, the documentation regarding that participant was destroyed immediately following the session. Once the consent forms were signed, there were no participants who asked to end the interviews. Only one individual declined to participate in the study, which took place prior to the signing of consent.

Exclusion and inclusion criteria.

All participants in this both interview and focus groups live in rural Liberia. Participants are over the age of eighteen. The first group includes men and women of various religious or faith practices. There were two restrictions: patients had to 1) be able to speak English (Most residents of Flehla do speak English), and 2) have had experienced a health problem. The second group of participants was male and female healthcare providers in Liberia, both in Flehla and the surrounding towns and villages. I needed to go beyond the confines of Flehla to recruit enough participants, as many towns and villages have few providers, and some have no providers.

I was able to interview a total of 46 participants. Sixteen healthcare providers participated in individual interviews; of those sixteen, six elected to join a focus group. Thirty community members participated in individual interviews. Of those thirty community members, six volunteered for the focus groups.

Framework Data Analysis

I used framework analysis to analyze my data. Framework analysis has been used in various capacities to manage and analyze qualitative data since the 1980's (Gale, Heath, Cameron, Rashid, & Redwood, 2013). This approach allows the voices of participants to establish the framework, rather than have a westernized theory dictate the coding framework. For this study, I used the framework analysis developed by Ritchie and Spencer (1994) as a practical approach for their social policy work (Ward, Furber, Tierney, & Swallow, 2013). Gale et al. state that framework analysis is frequently used for analyzing semi-structured interviews (2013). Framework analysis has several benefits that will be helpful during my research process. First, framework analysis is both systematic, meaning that there are specific steps to be followed to analyze the data. Second, because of its systematic nature, framework analysis shows how the analysis progresses from one stage to the next (Smith & Firth, 2011). Third, there is growing support for the use of this method in healthcare studies (Thorarinsdottir & Kristjansson, 2014; Smith & Firth, 2011; Ward, Furber, Tierney, & Swallow, 2013). Finally, framework analysis does not focus on finding a new theory; rather, it centers on ideas and themes from the data set (Ritchie & Spencer, 2002; Ward, Furber, Tierney, & Swallow, 2013).

When using framework analysis, specific steps are necessary: familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation

(Ward, Furber, Tierney, & Swallow, 2013; Ritchie & Spencer, 2002). Smith and Firth developed Figure 4 to represent the stages of framework analysis and how they are on a continuum throughout each stage (Smith & Firth, 2011, p.60; Ritchie & Spencer, 2003)

Processes	Stages		
	Data management	Descriptive accounts	Explanatory accounts
	<ul style="list-style-type: none"> • Becoming familiar with the data (reading and re-reading) • Identifying initial themes/ categories • Developing a coding index • Assigning data to the themes and categories in the coding index 	<ul style="list-style-type: none"> • Summarising and synthesising the range and diversity of coded data by refining initial themes and categories • Identify association between the themes until the 'whole picture' emerges • Developing more abstract concepts 	<ul style="list-style-type: none"> • Developing associations/ patterns within concepts and themes • Reflecting back on the original data and analytical stages in order to ensure participant accounts are accurately presented thereby reducing the possibility of misinterpretation • Interpreting and explaining the concepts and themes • Seeking wider application of concepts and themes
<div> <div></div> <div>Continuum</div> <div></div> </div>			

Figure 4 Stages of framework analysis (Smith & Firth, 2011, p.60).

Step 1: Familiarizing oneself with the data.

This step involves transcribing the recordings and reading and rereading the transcripts. Once I returned from Liberia, I transcribed all interviews word-for-word and did not correct any grammar issues. During the transcription process, I made note of conversation markers such as laughter, long pauses, and voice inflection. Throughout the transcription, I would make notes in the margins to come back and re-evaluate once the interviews were transcribed. For example, if I thought the individual had misused a word or was using words interchangeably I made a note to come back and investigate what

those individuals were trying to say. Interviews were transcribed in a Word document that was then uploaded to NVivo.

Once I transcribed the interviews, I went back and consulted with my field notes. Any notes or observations were added to the end of the relevant transcripts. Next, I began to read each transcript starting with the healthcare providers. As I read, I took notes of emerging patterns, ideas, and questions. At first, the notes were handwritten on each transcript. As the notes grew, I began to identify themes that emerged from the transcripts, which can be noted on software such as NVivo, a platform for quantitative, qualitative, and mixed-methods research. Re-listening to the original audio is also important during this stage. Each process listed was repeated numerous times until I was deeply familiar with the data.

Step 2: Identifying a thematic framework.

Developing a theoretical framework is a continuation of familiarization. As familiarization continues, it becomes necessary to identify any issues or themes that appear to be important to the individuals I interviewed. After interviews have been reviewed, I went through my notes to identify emerging themes. Throughout this stage I was looking for themes, issues, or experiences that emerge in multiple interviews, and concepts that I believed are critical to better understand the data (Ritchie & Spencer, 2002). This initial framework was not the final coding scheme. Taking a small sampling of five transcripts, I refined the categories of my initial framework into major subject headings and subcategories. As Ritchie and Spencer (2002) point out, this stage also involves making sure the framework reflects the original research questions.

Step 3: Indexing.

Indexing involves assigning codes and sub-codes to segments of texts; whether this is with pen and paper or by using software like NVivo. To begin this process, I uploaded all the transcripts into NVivo and applied the codes. My unit of analysis was a single idea unit within conversational turns. Indexing requires me to make judgments about the meaning and importance of each idea unit within each conversational turn, which may result in multiple indexes assigned to a single idea unit. Indexing allowed me to explore the frequency, relationships, and patterns of major themes within a single interview. Figure 5 shows my indexing of one small portion of a transcript.

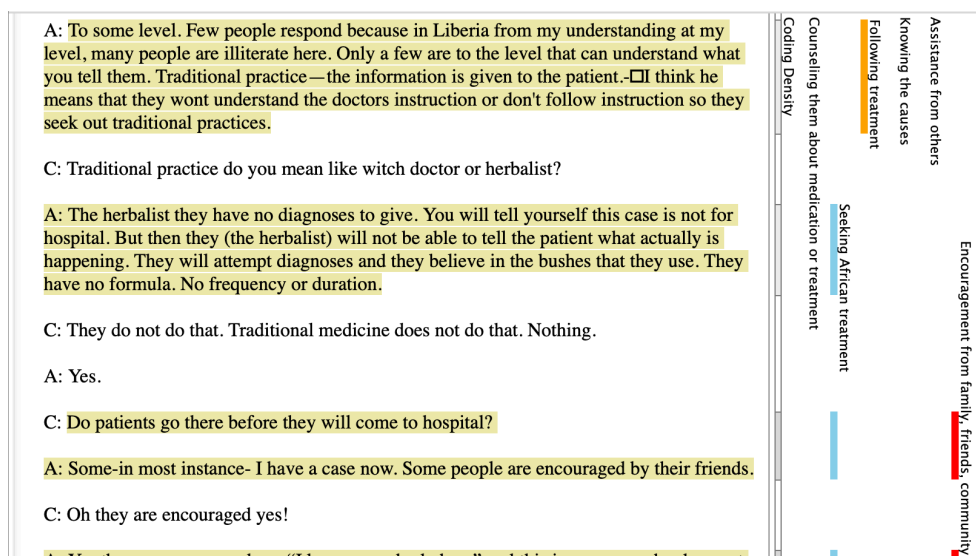


Figure 5 Indexing sample.

Step 4: Charting.

Once all my transcripts were indexed, I developed a clear representation of my data as a whole. Charting involves taking the data out of the original context and rearranging it by theme. According to Ritchie and Spencer (2002), charts are created with heading and subheadings taken from the framework. Charts can be created by theme or by case. I created theme charts for each major theme, and indexed all individual

interviews under the correlating subject. Case charts differ in that they explore each case across all themes. Cases often are identified because they share a similarity (e.g., participants are all female, or participants have a shared experience). In NVivo, this involves assigning a code to appropriate text units. Figure 6 and Figure 7 illustrate two ways to achieve charting in NVivo.

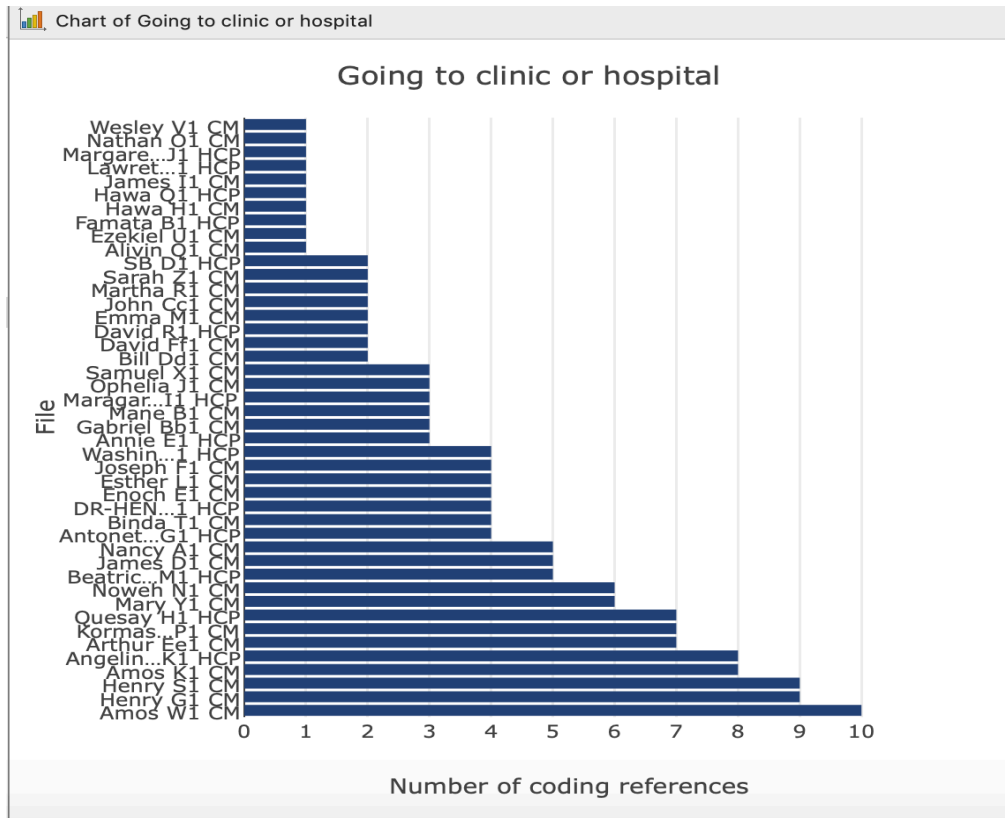


Figure 6 Charting for subtheme by number of reference codes.

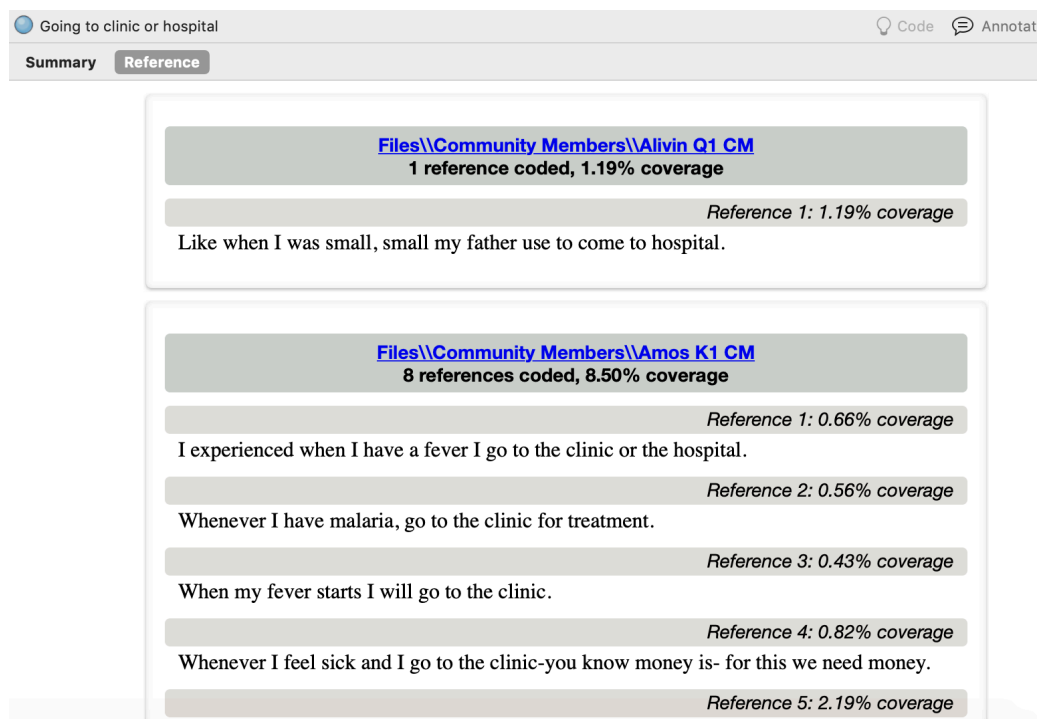


Figure 7 Charting for subtheme by participant case.

Step 5: Mapping and interpretation.

Finally, once all the data has been indexed and charted according to the framework, I began to pull out the main features of my data. This final step began the mapping and interpreting of the relationships present throughout the data. During this stage, I was guided by my original research questions. This final stage includes “defining concepts, mapping the nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies” (Ritchie & Spencer, 2002, p. 321). In NVivo, creating charts and graphs of the co-occurrence of codes, which allowed me to gather text units from across the data set into specific categories. Figure 8 shows the co-occurrence of themes across all the transcripts. Once I had mapped the data, I began the process of interpreting. During the interpreting process, I pulled together key characteristics, reviewed the indexes, reread research notes, and searched for patterns

(Thorarinsdottir & Kristjansson, 2014). Interpreting the data also included defining concepts and finding associations within the data (Ritchie & Spencer, 2002; Gale, Heath, Cameron, Rashid, & Redwood, 2013). Ritchie and Spencer describe this process as the most difficult part of the analysis process. One of the reasons this process is difficult to describe is because it sounds mechanical, when, in reality, it requires the researcher to be intuitive (Ritchie & Spencer, 2002).

	A : Encouraging me to handle the sickness	B : Access to resources	C : Access to treatment or medication	D : Having \$	E : knowing how to pick herbs	F : Location barriers	G : Not having \$	H : Deciding what will cary you through	I : Not seeking treatment	J : Picking the most comfortable option	K
3 : Couns...	0	0	3	0	0	2	0	0	0	1	
4 : Knowin...	0	0	1	0	0	0	0	0	0	0	
5 : Impact...	0	0	0	0	0	0	0	0	0	0	
6 : Daily life	0	0	0	0	0	0	0	0	0	0	
7 : Financial	0	0	0	0	0	0	0	0	0	0	
8 : Home l...	0	0	0	0	0	0	0	0	0	0	
9 : Social l...	0	0	0	0	0	0	0	0	0	0	
10 : Work	0	0	0	0	0	0	0	0	0	0	
11 : Knowi...	0	0	0	0	0	0	0	0	0	0	
12 : Knowi...	0	0	0	0	0	0	0	0	0	0	
13 : Knowi...	0	0	2	0	0	1	0	0	0	0	
14 : Knowi...	0	0	0	0	3	0	0	0	0	0	
15 : Not k...	0	0	0	0	0	0	0	0	0	0	
16 : Knowi...	0	0	0	0	0	0	0	0	0	0	
17 : Identif...	0	0	1	0	1	0	1	0	0	0	
18 : Knowi...	0	0	2	0	0	0	2	0	0	0	
19 : Knowi...	0	0	2	0	4	1	1	0	0	0	
20 : Not k...	0	0	0	0	0	1	0	0	0	0	

Figure 8 Co-occurrence of themes across all transcripts.

Validity and Reliability

Rich and abundant data is a sure mark of qualitative research. In my attempt to uphold the rigor of my study, I address two key issues, validity and reliability. Johnson states that when “qualitative researchers speak of research validity, they are usually referring to qualitative research that is plausible, credible, trustworthy, and therefore, defensive” (Johnson, 1997, p.282). Creswell summarizes validity as “an attempt to assess the ‘accuracy’ of the findings, as best described by the researcher and the participants” (Creswell, 2013, p. 249-250). Riege (2003) states that reliability involves the researcher’s

ability demonstrate the steps of the research process and the ability of other scholars to replicate the process with similar findings.

Validity.

There are five ways that I have established validity throughout my study. First, I have already begun “prolonged engagement and persistent observation” by traveling to Liberia three times (Creswell, 2013). While on these trips I created personal journals with observations about cultural and political history of Liberia. In addition to traveling to Liberia I have read significant academic and non-academic literature about Liberian culture and life. The second way I established validity was through triangulation. As mentioned earlier, I examined multiple sources and methods to corroborate my findings. Primarily, data collection took the form of both individual interviews and focus groups; but my own observations provided a third confirmatory line of data to validate my results.

The third approach to obtaining validity I used was through peer debriefing. This often took place when I was describing the findings to my advisors and colleagues. My advisors often asked clarifying questions that forced me to be clear in how I represented the voices of the participants in this study. The fourth approach to validity that I used was clarifying researcher bias. Often this took place simultaneously with peer debriefing. Throughout the research process, but especially during the analysis, I actively checked the western bias I hold. This was important when participants described non-western medical treatments. It was my responsibility to check that my bias did not encroach on the actual content within the data.

Finally, the last way I established validity was by member checking. Throughout the research and analysis process, I contacted John Travis to clarify any questions I had about themes that were emerging. I continued this process by checking in with John Travis to make sure that I did not misrepresent Flehla and Liberian culture.

Reliability.

As outlined by Creswell, there are multiple ways to establish reliability in qualitative research (2013). There are three ways that I established reliability throughout this process. First, I used my detailed field notes as a way to check if I was interpreting information the way participants were reporting their narratives. Second, I used a quality voice recorder for all interviews. During the transcription process, I would listen to the audio files multiple times to study and re-listen to content and affect (e.g., differences in tones and any noticeable pauses). This allowed me to produce a word for word careful transcript of each interview. Finally, using framework analysis meant following a set of steps. Following the five steps of framework analysis left a trail of research operations. In conducting a framework analysis, I demonstrated the analysis process, which is supported by Riege's concept of reliability (2003).

Chapter Four Findings

This research uses the narrative paradigm as a theoretical guide. Narrative theory supports that all humans are storytellers. As storytellers, we use narratives to create meaning from our lived experience. In the context of health communication, the storytellers create health narratives that offer a rich description of how factors such as coping, social support, treatment, and health literacy impact their experience. Narrative theory provides a theoretical framework conducive to collecting rich health stories.

I used framework analysis to analyze participants' health narratives. Framework analysis allows participant's narratives and voices to determine the framework. There are five stages involved in the analysis process. The five stages are (1) familiarizing oneself with the data; (2) identifying a thematic framework; (3) indexing; (4) charting; and (5) mapping and interpretation. In this chapter, I strive to address the following research questions using this analytical approach:

RQ1: What do narratives of sickness from Liberian community members and healthcare providers reveal about coping?

RQ 2: What do narratives of sickness from Liberian community members and healthcare providers reveal about health knowledge?

RQ 3: What do narratives of sickness from Liberian community members and healthcare providers reveal about concepts of illness and culture?

To begin, I will go into detail about the parent codes and offer exemplars for each child code that is included in the concept. As I move through the themes and codes, it is important to note that Liberians use the terms illness and sickness interchangeably. In health scholarship the majority of researchers use the term illness. However, I have

approached this research through the lens of culture-centered communication and believe it is important to use the terminology that participants use when possible. Therefore, when participants use the term sickness, it can also be understood as illness. Throughout this analysis there are other terms that have a different meanings between western culture and Liberian culture.

Concepts, Parent and Child Codes

To better understand the findings in this section, it is important to explain the terminology I use as I define the framework. Child codes are the lowest level that I have coded. Table 6 demonstrates that the first child code is “daily life.” The next level above this is a parent code. This level is a broad concept that encompasses multiple related child codes. In Table 6 the first parent code is “impact of the sickness.” Finally, the last level and most encompassing layer is the theme. Themes are less concrete and incorporate both parent and child codes. For example, the first major theme is “experiencing my sickness.”

Interacting With Sickness

Interacting with sickness is one of the three overarching concepts that emerged from the data. This concept explores how participants interact, experience, discuss, and describe their sickness experience. Within the concept, three parent codes emerged: impact of sickness, treating the sickness, and recognizing the sickness. Table 6 demonstrates the frequency at which child codes were assigned throughout the data, resulting in a total of 407 utterances about encountering sickness.

Table 6
Frequencies of Parent and Child Codes For Interacting Theme

Code (Frequency)	
Child Code	Exemplar
Impact of the Sickness (32)	
Daily life (13)	Yes they will tell you how it really hurt them and how it influences their daily life.
Financial life (9)	For my department my patients talk about financial problem. Yeah they talk about financial problem.
Social life (5)	Some of them-most of them talk about their social life.
Work life (5)	My aunt own the farm- sometimes they will be sick and they won't be able to farm.
Knowing how to treat the sickness (119)	
Knowing from culture, dreams, visions (9)	You cant just go and pick it. If you don't know it you cant pick the medicine. It will be powerless. Somebody, the one that should pick the leaf and you saw it in a dream
Knowing from education (82)	One or two times a week we will go out in the community. We like to check on people and we also give a health talk. The health talk reminds them about their illness.
Knowing from family (18)	They practice (individual's parents)- they learn it from you know people that told them too. Yeah so you know the generation that can be teaching you, yeah.
Not knowing (10)	People did not know. People did not know the management-the preventive measure. People did not know.
Recognizing the sickness (256)	
Identifying the symptoms (76)	Whenever I have malaria I feel like I start feeling pain from my head. My eyeballs are getting red and my nose starts sneeze fast, fast which I know I have malaria. I get a cold and I know that is when malaria is coming around me. I start sweating. I sweating hot! Start sweating two or more mornings and malaria starts."

Frequencies of Parent and Child Codes For Interacting Theme (continued)

Child codes	Exemplar
Identifying the causes (39)	Like mosquito bite can give you malaria. One day when you are working like especially if there is too much dirt around the area it can always give you malaria- when they fly from there sit on the food you eat and give you malaria. People who live around people who do not know how to take care of themselves that is when they can always get malaria from them.
Identify prevention measures (15)	At the same time advise to use mosquito net. To avoid mosquito bites because mosquito bite develops and will cause the malaria symptoms.
Identifying/not identifying the sickness (126)	Actually most of time I battle from typhoid fever and sometimes malaria. That is the sickness that can really keep me down- most often.

Impact of the Sickness

There is substantial scholarship that outlines how illness impacts various facets of an individual's life. This parent code consisted of four sub-categories: daily life, financial life, social life, and work life. **Daily life** codes are participants' expression of home life such as tasks related specifically to the physical location of their homes. This code includes tasks such as parenting, preparing food, and cleaning. When I asked about how sickness can influence individuals, Beatrice, a healthcare provider at the government hospital, said,

Ok for instance if the person is a single parent and she is pregnant the man disown the pregnancy. That is a big problem for her-she is just alone, she is not working, she is thinking on how to take care of that unborn baby. How she is going to eat. You know all of those things can depress her. So we probe into all case to see how well we can help her.

Beatrice continued to address how many women who are abandoned by their partners often face compounded issues because of the increased pressure to care for a home and

support a family during a sickness episode. Margie, a healthcare provider who worked in the government clinic, shared an excellent example. When asked about how her patients talk about the impact of sickness, Margie revealed, *And some times they come with a problem that will affect their daily life. Let me see- sometimes a patient comes and tells you 'I'm having sleepless nights- I don't sleep at all at night. My body is screaming and I am just confused and not feeling fine.'*

Finally, a community member, Noweh describes, *Oh yes it influences my daily life! If I get malaria then I will be home for a month. You cannot do anything.* Other community members like Abram echoed similar statements; *Your day will not be normal if you are sick. You cannot do the things you usually do because you will be too tired or too weak. It really messes things up.*

Financial life is a child code that describes the impact of sickness on financial well-being. This code is different from other codes that address money as a barrier to care as the majority of the exemplars are from healthcare providers. When asked how patients talked about the impact of sickness, healthcare providers were quick to identify the financial impact. Fanta stated, *Oh yes they will talk about their financial problems.* Abu, another clinic emergency room worker, echoed the same remarks; *For my department the first impact they say is financial. Yeah they talk about what it means.* When asked to elaborate Abu was hesitant. *It is just the first thing they will talk about. They usually ask how much it will cost.*

Social life child codes addressed how sickness impacted the real life aspects of participants' lives. Two major areas of social life in Liberia are visiting with friends and going to the weekly market. This code was particularly interesting considering that

Liberians were still gripped with the fear of Ebola. I expected there to be more fear-based comments about sickness and social life. However, there were a few comments about the impact of Ebola. Noweh, shared how her social life was impacted by illness in a post Ebola society, *When you are sick, even if it is malaria, some people are still afraid of Ebola. So no friends will come around. You have to wait until you are better. Then socially things are better.* When I asked healthcare providers about how their patients discussed the impact of an illness on their lives, the replies were often short and to the point. A young nurse, Ante, replied with, *Yes some of them will mention their social life. And so we will look to see if this is a social problem.* Another healthcare provider from a different clinic, Johnson, mentioned social life in terms of questions you might ask patients to better understand their condition. Johnson stated, *You look at several social aspects as the patient's general conditions. That is one way to find out what is wrong.*

Work life codes include descriptions in which participants mentioned how work life was influenced or impacted when an illness occurs. Many of the participants mentioned that they simply did not go to work when they were sick. I asked Joseph, a young man who works in the community, if his malaria influences his ability to work. Joseph replied, *I don't do no work.* Other community members offered that they simply rest and then return to work if they are experiencing less threatening sickness episodes. Martha, an elderly woman in the community, laughed when I asked if she skipped work. She replied with hearty no and continued, *I will lay down to rest and then come back to work.* Along the same lines, a healthcare provider suggested that due to the type of labor that is available in the rural villages, that many of the sickness episodes are caused by work. Annie, a healthcare worker in a government clinic explained it this way:

Yes- like maybe occupation- that could be one factor that would cause medical problems. So you have to look at a person occupation and relate it to the medical problem. Those working in hard labor area like mine area. Most of them will come down with backache. Some of them having or coming down with hernia because of the strenuous work.

The impact of sickness on participants is disruptive to many aspects of their lives. This parent code demonstrates how participant's daily, financial, social, and work lives are impacted by sickness

Knowing how to treat the sickness

The parent code, knowing how to treat the sickness, developed in a way that was consistent with the existing scholarship. Participants identified four ways of knowing. The first code, **knowing from culture**, includes mention or acknowledgement of culture in knowing how to treat a particular sickness. This code emerged mainly through responses of healthcare providers. One particular participant was an elderly man in his sixties who served as a traditional healer in the area. Traditional healers, or Zóos, are highly respected members of Kpelle culture and society. In our discussion, Tarnue shared that some of his knowledge about sickness came from cultural views. He shared that there is a snake society in Liberia that is highly respected in Kpelle culture. When I expressed that I did not understand what he meant he shared,

It is a society that you join it to know the medicine. So they [the ancestors] can't just show it to you outside, openly. You gotta go to the head Zóo or the herbalist for the snake, then you join, you got to pay with chicken. A small price. Also cola nut. All the old members will eat that food. When they eat it they will call you in and show you the medicine, show you the leaf. They will show you all the- the different, different type of leaf that can help to cure somebody when they have snake bite. When I got that- we are plenty- even the old man there (points out window) he has been there for snake medicine. You know the snake when it bite the person- you put the medicine there- the person can vomit with the medicine. When the snake bites somebody the teeth, can break- a piece of it can remain in the person. You got the medicine- scrap the place clean, clean the place, cut a hole and put the medicine there it will bring that piece of teeth, the teeth, it will

come out. Then we will rub a certain medicine, that we beat it with chalk, and rub it around it. The person will want to vomit. The poison cannot be in the person. But only certain people in our tradition can join.

The second child code, **knowing from education**, demonstrates how participants came to know about treating their sickness. Education in this code can mean formal school education, informal education of health talks. One community member, Kofi, described that he knew about malaria. When I asked him how he knew, Kofi replied, *I know from the USAID. I worked with Save the Children and was trained in this way.*

One of the ways participants knew about treating their sickness was by healthcare providers and “health talks.” Health talks explain treatment options and medication that are specific for different sickness. One healthcare provider, a young woman named Hattie, shared how she helped her patients by educating them about medications and treatments. Hattie stated,

Yes- some of them will come to the hospital and they don't have any knowledge on how to cope and manage their condition. Some of them when they are diagnosed they don't know whether that condition can be managed even though it cannot be cured. It can be managed so we take a longer time to discuss with patients. So you go in with extra time to explain to them-this sickness is a sickness that don't have cure for it but it can be managed. So once you take your drugs and you go to hospital regularly for your treatment you can live a long, long time. So you will have that time and from there the person will feel relieved and know that there is some hope...So with the extra education that you give patients it will help them to manage and cope with their condition.

Another example is from a community member, Nathan, who revealed that he always takes the advice that might help him avoid unknown illnesses and educates the people in his community. He shared,

I live- based on my experience and I was even educated that it is not good to always buy tablet. It is not good. Meaning that it is not good, you have to go to the hospital to go for treatment because if you go there the doctor will diagnose what is happening to you. And those who live around me, they listen to advice, and when they go there they will say 'Oh yes, what you say is true'. I always

advice 'You don't even know the sickness you are treating' maybe it could be a sickness that is developing and you going to take malaria tablet (laughing). It will not work. So that is how it is.

Another community member, Amos, explained that he learned from his healthcare provider. Amos stated, *I went for malaria. They gave me tablet and told me how to take the tablet and get better.* Healthcare provider Margie's response to how she learned how to treat various sickness highlighted the importance of training for healthcare providers. *I was trained by Dr. Kollie and I've received a certificate. When my patients come in I tell them the things I know about treating their disease.*

The third code, **knowing from family** includes instances of knowledge attribution in relation to families or communities. Many of the community members credited their family or neighbors with sharing information about treating illness. The common response was community members being told by older members of the village about which herbs to pick in order to treat symptoms of various illnesses. Noweh, a young woman from the community, shared how the older women in the community informed her about the herb. Noweh said, *Some of them would fix herb and I would take it in. Then they showed me. Yeah because they got some tree in the bush when you sick they can beat it and boil and then you drink the water. Then sometimes they say if you go on it will clean the system. That is what they told me.*

Even in my interview with Tarnue, a Zóo, he shared how his family also helped him know how to treat sickness. When I asked Tarnue how he knew which herbs to pick in order to treat the various sicknesses, he offered, *I saw some in my dream. My late father use to be an herbalist.* Tarnue continued to explain how he came to know about treatments,

There is certain words you have to use to pick that leaf. When you pick it, you will pick it and that word- you were trained to use- that my late father use. He use to go pick the leaf and say certain words before you pick the medicine. You cant just go and pick it. If you don't know it you cant pick the medicine. It will be powerless. Somebody, the one that should pick the leaf and you saw it in a dream. I will talk to that leaf before I touch it, I got to call down my late father. He is the one that show me, you, that you should use it to heal people. But you can't just go and pick the leaf. You have to call their names [late ancestors] so they can place the leaf for you. Once they show you the leaf and they are part of you and the past- you will go into the bush to find the leaf- you gotta call upon their names and let their spirits follow you into the bush. So you can pick that leaf.

Other participants explained that they learned about different ways of treatments from their families. When I asked one community member, Wesley, to explain how he knew about treatments he said he knew because he followed his family. He shared, *For malaria also I do that. We have- my grandfather, my mom, my dad told me that whenever you contact malaria go in the bush there are certain medicine called go-jeer-abo. Take it and boil it and drink it.* Other participants highlighted that their families did not teach them about the traditional herb but rather advocated for clinic visits. Amos K. shared that he liked to encourage his friends because of how his family taught him about treating illness. Amos replied, *I encourage my friends in the country that when they get sick go to the hospital don't go to the country side. Tell them go to the hospital. That is what we do in my family.*

Finally, **not knowing** represents the times when participants did not know how to treat the sickness. This code was mainly present in community members and the traditional healers that I interviewed. One of the Zóos, Sah, a middle-aged woman was frank in her ability to treat complex and mysterious illnesses. When I asked what she told her patients, she replied, *Anybody can have that problem. If you come to me with your problem. If I don't know the medicine for it, the problem. I will tell you I don't know.* Dr.

Kollie answered that sometimes people do not know because of lack of support and education. Dr. Kollie described,

then go home but then they relatives are not educated- they don't know what to do they are just there to give support which may not be adequate and so we have lost a lot of patients for negligence. They don't know how to treat the sickness in the way we tell them.

Knowing how to treat a sickness is valuable to the participants of this study. In knowing how to treat sickness participants demonstrated the ways in which they came to possess the knowledge of treating sickness. Exploring where participants learn about illness is valuable to better understanding how they interact with sickness.

Recognizing sickness

Recognizing sickness parent codes are ways in which participants demonstrated specific knowledge about the symptoms, causes, prevention measures, and identification of their sickness. This code differs from the previous code of knowing how to *treat* the sickness because for this parent code participants demonstrated their knowledge of the sickness. On the other hand, the parent code knowing how to treat the sickness describes how they came to have knowledge about their specific sickness. When discussing sickness, participants' responses were coded into four child-codes.

The first child code, **identifying the symptoms**, is statements that participant's made in reference to the symptoms they experienced and were able to identify while experiencing a specific sickness. Participants were able to identify many illnesses that are present in their communities. However, without exception, both community members and healthcare providers were most familiar with malaria. Arthur, a community member, was quick to respond when I asked if he could describe to me what it was like to experience a sickness in Liberia. Arthur shared,

Oh malaria! The first time for me, it can start for me when there is too much pain in the body. Joint pain, alright, in a few days it will be followed by fever. From there then the malaria will come in and the skin will be hurt so much. And if it is not immediately treated you can leave it alone and die. Sometime my own malaria when I get it- it starts with very heavy joint pain from then it will start with fever, fever and there will be a runny stomach, for me that is the symptoms I get for the malaria.

Joint pain, fever, and runny stomach (diarrhea) are the most identified symptoms of malaria and typhoid fever. Mary, a middle-aged woman, shared Arthur's symptoms adding weakness. When I asked about the symptoms, Mary shared that *Even at this moment I have malaria. My whole body hurts in the joints. I feel so weak and it can be hard to move.*

Healthcare providers offered a different perspective. Many shared that when patients show up to the clinic or hospital, providers have to dig for answers. Hawa, worked in Dr. Kollie's clinic and expressed how a patient's report of symptoms can be misleading. Hawa laughed as I asked her to explain what she meant.

Oh a patient will come and say 'I have a running stomach and I need malaria tablet.' You have to investigate that sometimes. You can tell maybe this patient is hiding something. So you ask if maybe it is an African problem. That means maybe they have taken some herb or potion to make their stomach run. But sometimes the patient will bring the truth. 'I ate food from the street' and you will know that the symptom is not malaria.

The second child code, **identifying causes**, are statements in which participants were able to identify the cause of their sickness. Most the participants were able to give detail about knowing what caused their sickness. One community member, Amos W., was matter of fact in his response to my follow up question of "what causes the malaria to be high?" Amos highlighted mosquitos and environmental factors when he stated,

Like mosquito bite can give you malaria. One day when you are working like especially if there is too much dirt around the area it can always give you malaria- when they fly from there sit on the food you eat and give you malaria.

People who live around people who do not know how to take care of themselves that is when they can always get malaria from them.

Binda, a female community member, shared similar sentiments and expressed with urgency,

But when it comes to malaria I don't lie to you. Malaria is so much in Africa because after the rain. That is when we get it, the malaria too much. Because the mosquitos that gives us these things. When the mosquito bites you it puts things in you. And when the nurse says when you start experiencing malaria. So in my community in other communities we face malaria a lot.

The major exception to knowing the causes was when participants would discuss Ebola.

Quesay, a community member, recounted that knowing the causes of Ebola was still mysterious. She reported, *We did not understand why they were dead. Many people thought they had been witched. But we did not really know what caused the Ebola to come here.* Quesay's experience was similar to many others I had overheard in casual conversation.

The third child code is **identifying prevention measures**. This includes statements that identify various prevention measures promoted by healthcare providers and adapted by community members. Kormash, a young community member, shared how she prevents malaria. She laughed when I asked her about preventing illness, Kormash said, *Oh it is easy. You have to use the mosquito net. It is simple.* Other community members shared that they too use a mosquito net. A community member demonstrated prevention measures by explaining the importance of mosquito nets when asked about the most common illness in the village. John proudly told me, *To avoid mosquito bite. Because mosquito bite develops and will cause the malaria symptoms. According to where I am, I have my own mosquito net.* Antoinette, a clinic worker, shared how she taught prevention measures to her patients. She laughed when she shared,

You have to tell them something. Maybe something to scare them. That will work on some. But most often I share with them the illness and give them the prevention ways. If it sugar related I tell them the things they can and cannot eat. If it is malaria I tell them about using their nets and keeping the area clean. I tell them to do these things as way to prevent the sickness.

Identifying prevention methods is closely related to health talks (mentioned previously under knowing from education). Identifying prevention methods is different because it focuses on the ability of participants to identify various ways they are able to prevent illness. Often participants *know* about the prevention measures from health talks but that is not the meaning of this code. However, many of the exemplars demonstrate the strong association between the two codes.

The final code, **identifying the sickness**, is statements when participants are able to name the sickness while describing their experience. Enoch, a community member, offered the best example when he shared with me the various sicknesses he had experienced in addition to the numerous sicknesses that were present in his community. Enoch reported,

Oh yes I've experienced malaria. We all have. The other sickness I have experienced is with my sinuses. I do not know the true name used by the doctor but he said it was a sickness with my sinuses. It gives me a hard time in the rainy season...But in the community there is typhoid, malaria, and diarrhea. These are the things we suffer.

Other participants demonstrated that they are able to identify the sickness by sharing the following statements, *In Africa malaria is the main problem*, or *Oh yea you get it when the malaria is bad. Here in Liberia we call it yella john-a*. Even though I did not know what “yella john-a” meant during my interview times, many of the participants brought it up when talking about chronic malaria and have since been able to understand the phrase refers to when malaria has gone untreated for an extended time.

Included in this code are the times when participants were not able to identify the sickness they were experiencing. An elderly community member, James, was not able to identify his hernia (I was able to confirm this health concern with one of the local doctors). James shared, *I saw it when I breathe. It would shoot out. So now when I poke myself then I notice that there was something in my stomach showing to me. But as the time went I didn't know. Later on it started affecting me with bad pain- severe pain.* Sometimes participants could not even name the sickness after visiting a healthcare provider. For example, Alvin, a young community member, stated, *I go to the lab and they will be able to diagnose you. So I know what is really happening to me. But I cannot understand the problem and I do not know.*

Code associations for interacting with sickness.

Included in step five of framework analysis is making associations within concepts. Using Nvivo I ran a matrix coding within each concept and was able to determine where codes overlapped. Finding areas where codes overlapped will help in answering the research questions posed in chapter two. Within the concept of experiencing my sickness there were three examples of where child codes overlapped or were associated. The first was an overlap of knowing from education and identifying prevention. As I addressed earlier this was not shocking revelation. Often community members learn about prevention methods during health talks or visits to the clinic of hospital. The selected examples also demonstrate how healthcare providers discuss prevention strategies.

Bea, a healthcare provider shared how she promotes prevention strategy with pregnant women. She shared that she tells them ways to prevent labor pains, complications, and how to maintain a healthy pregnancy. Bea shared,

We have to continue to pursuing them. Because the labor risk in our country is high. But when you are educated you will know and understand well. You can read in-between lines and you know where dangers lies. So the only thing we can continue to do is continuing to tell and talk to them and motivate them. And just their awareness to continue carry on their wellness so they can really understand what we are saying so that they can benefit from what we are saying. That is all. Yes.

Another example is from a healthcare provider Dr. Kollie. She shared how she tries to teach her patients proper diet as a preventive measure for complications with diabetes. Dr. Kollie shared,

An examples for diabetic patient. Most of them, they don't want to be on the diet and diabetic patient need to be on diet. When you take your diet correctly your treatment, you will be fine. But some of them will, leave here and forget about the treatment and then they diet. Oh now they go into shock. Diabetic coma and it will be a problem too.

Finally, a community member, Amos shared how he learned about using the mosquito net. *Yes I learned it from the clinic a long time ago. It can be hot under the net sometimes but it is better to sleep under it than to get malaria. So yes because of the clinic nurse I use a net.* Through the association between knowing from healthcare providers and knowing identifying prevention measures participants demonstrated the importance being educated about all aspects of illness.

Along the same lines the second association was between identifying symptoms and identifying the sickness. In this association participants were able to both recognize and name the symptoms and the specific illness. For example, Arthur shared about his memory of getting malaria for the first time.

Oh malaria- the first time for me, it can start for me when there is too much pain in the body. Joint pain, alright, in a few days it will be followed by fever. From there then the malaria will come in and the skin will be hurt so much. And if it is not immediately treated you can leave one and they will die.

Like Arthur, Noweh was able to identify typhoid and name the symptoms *Then from there the typhoid was ready for me. My whole body inside gets hot and when it gets hot if I not take treatment again it can be easy for me.* Participants often mentioned both the symptoms and sickness by name when they were describing various ailments they had experienced.

Finally, the third connection was between identifying the causes and identifying the sickness. Participants in the study were able to not only identify the illness, as established previously, but also were able to identify what caused it. For example, Binda, shared about malaria,

But when it comes to malaria I don't lie to you. Malaria is so much in Africa because after the rain. That is when we get it, the malaria too much. Because the mosquitos that gives us these things. When the mosquito bites you it puts things in you. And when the nurse say when you start experiencing malaria. So in my community in other communities we face malaria a lot.

Ophelia, another community member, shared that it was more than just the rain that cause malaria. She highlighted that mosquitos love water and there is an abundance of standing water in Liberia. Ophelia shared,

Oh yes the rain will cause it. But so will the storage water. They use the barrel water to bath, cook, to do the things. The water is still and the mosiquitio will land on it. And the children play in dirty water around the community around the house it bring the mosquito in the house. And the mosquito sit on you, bite you, give you malaria.

Participants demonstrated a wealth of information when I asked them questions about how they experience sickness. It is evident that participants have a strong

understanding of various health problems. The connections within the concept give a deeper understanding about what Liberians know about illness.

The codes presented here are different from knowing how to treat the sickness. Knowing how to treat the sickness describes how participants came to know about sickness. Recognizing the sickness codes are the demonstration of knowledge. These codes are important when exploring what particular groups of individuals know about sickness.

Encouraging Me to Handle my Sickness

This concept encompasses various points of decision making that take place throughout participants' experience with sickness. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Throughout the analysis this concept has changed. Initially there were four parent codes, but as I began to code, I realized that I needed to combine codes. Part of this process included combining "cultural and traditional influences" into the "family influence." By combining the two codes I relabeled "family influence" as "influencing factors." The final three parent codes are: access to resources, deciding what will carry you through, and influencing factors. Table 7 demonstrates the breakdown of parent and child codes present throughout the data and the frequency of each child code. The encouraging concept was present a total of 257 times throughout the data.

Table 7
Frequencies of Parent and Child Codes for Encouraging Theme

Code (frequency)	
Child Code	Exemplar
Access to resources (133)	
Access to treatment and medication (42)	I experience many things. That are related to malaria sicknesses. I experience is that no qualified doctor or nurse. Another reason is more people get sick...something we can do is these leaves from the bush that are boiled, drink it. There is no nurse or qualified doctor to help.
Money (44)	I go to the clinic if I have money to go.
Ability to pick the herbs (20)	I go into the bush and look for medicine. Country medicine in the bush. I boil it and they drink it and they will get well.
Location barriers (27)	Yeah in the hospital-we don't have hospital here we have to go to Phoebe or JFK.
Deciding what will carry me through (52)	
Picking the most comfortable/familiar approach (18)	Uh on the part of the healthcare providers so the patients prefer to go to the lesser evil where they don't have their legs put into something that is tight or something that is depending on where they went.
Trusting biomedical approaches (15)	Because sometime the country medicine cant be cure- I cant be cured by the country medicine. So I go to the clinic I will be healed faster than the country herb.
Trusting traditional approaches (19)	Because of the traditional belief. They believe it is the best way. Sometimes a person will have just pressure and you will see one of the limbs rotting away. They will say that the person step on medicine. Instead of going to the hospital or clinic to find out. The first thing they will do is go and try the traditional.

Frequencies of Parent and Child Codes for Encouraging Theme (continued)

Child codes	Exemplar
Influencing factors (72)	
Community or cultural influence (17)	The elderly uh they've been doing it all along- its just something that you either try to discourage or its just a way of life for them now. So it's the young people we target to let them come back to the traditional (biomedical) healthcare methods.
Family history (55)	My mother go to the clinic. Yeah. My mother when she only tell me to take the country medicine because treat the disease and will always be there, the medicine. They do not believe too much in pills. The country medicine they take it in to clean their system and say yes. It can help you. It will help get it from the system.

Access to resources

Access to resources describes how participants in this study identified the accessibility of medical and financial resources. In the initial framework, there were six codes. However, as the framework developed I decided to combine access to biomedical and traditional treatments into a single code, *access to treatment*. I also decided to combine *having money* and *not having money* into a single code labeled *money*. All other codes remained the same. The first code, **access to treatment**, focuses on how participants discussed their access to treatments and medication. This code includes both biomedical and traditional approaches. One participant, a middle-aged man named Amos, explained the lack of resources at the local clinic during the Ebola outbreak. His description of visiting the clinic demonstrates the lack of biomedical resources available. Amos describes the scene when he walked into the clinic to be screened for Ebola, *When we got there they said there was no vacancy. No empty, no mattress, no bed*. Another

community member offered commentary on access to treatment during the time following the Ebola crisis. Emma described her experience of having to wait for treatment due to the over extension of hospital staff. Emma shared,

The process is kinda slow. It is like you must have patience with you before you can meet the doctor on time. In some area you will go there and sit for the longest- before you can even see the doctor. Unfortunately if you cant you have to go and come back the next day because the patients are many. And probably you have 1 or 2 physicians within the clinic to care from this point to that point. So it takes a long time so if you don't have the patient you will walk back home until the next day.

While both of these examples particularly address the lack of access to biomedical treatment, there were participants who also addressed access to traditional approaches. One participant, Ezekiel, described how he used traditional approaches because of the lack of access to biomedical approaches. He shared,

I experience many things. That are related to malaria sicknesses. I experience is that no qualified doctor or nurse. Another reason is more people get sick....something we can do is these leaves from the bush that are boiled, drink it. There is no nurse or qualified doctor to help.

The second code, **money**, represents the times participants referenced not having or having money to pay for treatment or medication. For many participants, money was the major factor in terms of access to treatment. For some, it determined whether they went the biomedical or African/traditional approach to treatment. For example, a young man from the community described how his family's ability to help him financially determined his treatment. Wesley shared,

Sometime if they have money they help me. When they have the money I ask them "I'm ill" they have the money, they give it to me, they say go to the near by clinic or the drug store and get some drugs. I usually do well. When there is no money go in the bush and get the herbs. But the herbs are free.

Another community member described the importance of having money in receiving

‘proper treatment’. Noweh said,

Yeah. You have to pay money to report to proper clinic. If a small, small clinic then you go but if it a proper clinic when you go there you have to pay money before you get treatment. And when you not get treatment and when not take your medicine for the sickness that is on you- no way nothing else you can do now either the person die or different thing happen.

Not having access to money often appeared during the healthcare provider interviews.

Many of the providers mentioned that lack of money for the medical visit and for the treatment plan prescribed. One of the Zóos described that she often does not receive payment from community members. Hawa expressed her dissatisfaction with the financial situation of her patients. She stated, *I do the work and they cannot pay me so I forget about it. They cannot pay me. When I give them plenty herbs they say they cannot pay. What am I to do?* Community member, Henry, shared his experience of not having money to buy the treatment. *After the clinic sometimes you will go buy drugs but you don't have the money to buy the drugs. But then you cant be cured and be strong. But you don't have the money for the drugs.*

The third code, **ability to pick herbs**, is the times participants signaled that they had special access to knowledge of traditional approaches and treatment. Mary shared that while she did not personally have the knowledge her family was able to go pick and prepare the country herb. Mary shared,

Oh the country herb. My mother went into the bush- she wanted to carry me to the hospital several time but there is no way- she went into the bush to get some herbs, some medicine. So they find it, dry it and pound it. They cook the food and put it inside for me to eat. I will try small, small up to now at least I am ok little bit.

Faith, a young community member, shared that when she began to feel malaria coming on, she could retrieve the herbs herself. With pride Faith shared, *I go into the bush and look for medicine. Country medicine in the bush. I boil it and drink it and will get well.*

Finally, **location barrier** codes related to access to transportation and the geographical location of healthcare facilities. Amos K. shared a sentiment that many of the participants mentioned: too often those who live in rural bush areas are not able to make their way to a clinic or hospital. When prompted about the biggest barrier to treatment, Amos K. shared,

Yeah you know one thing I don't mention in some areas I travel, you go to some area in Liberia that is not clean and then the distances from one village to another will take you 4-6 hours. Then the question come to my mind but what if someone get sick. How do they get to hospital and when do they get to hospital? Because looking at transportation can be hard.

One healthcare provider echoed Amos' concern stating, *Those living in the rural areas how do they care for themselves? If they live in the bush how can they make it to the road? Will they be able to get a car?* Access to resources is one of the main factors that influence how an individual will be encouraged to handle a sickness. Understanding the importance of access helps us to better understand why individuals respond to different treatments.

Deciding what will carry me through

Decision-making is a critical component of health. Individuals who experience a sickness episode will be faced with numerous decisions concerning how they will approach their sickness. The code deciding what will carry me through, describes the times when participants identified their reasoning behind following a specific approach to their healthcare decisions rather than the influences that impact their decision making.

The phrase “carry me through” is used by Liberians; and John Travis suggested that I use the phrase when asking participants about sickness. For this particular theme participants identified three ways they decide to seek treatment.

First was **picking the most familiar**, which was also identified as being the most comfortable choice. Fanta offered a unique perspective as a healthcare provider. I asked her if she had any insight on why patients pick one approach over another. Fanta said, *some people will not go to the hospital but will go the smaller places, smaller clinics for treatment and once that patient is treated they feel that they have gotten the best treatment. So they come back.* When I probed her about her own decisions she shared, *That is the individual differences. People believe in different things. My patients may not come here to the clinic. But that is not me-this is normal for me.* Community member Noweh, shared that she felt more comfortable because the country medicine was not consistent. Noweh said,

The preference is to go to clinic. Yes that is the most important one. It is advisable that if you take country medicine don't be only thing you do, you have to go to clinic, because country people do not investigate how you choose that and whether you are warm and all this. They get treated because they say it's a worm medicine but at the clinic they will tell you are suffering from so-so. They will tell you, you are suffering from worm and this is the kind of worm and this is the kind of medicine for it. They don't do that in the country.

Angeline, a clinic worker, suggested the same thing in her answer and added that for many they've had bad experiences at the clinics. She shared,

Because of the traditional belief. They believe it is the best way. Sometimes a person will have just pressure and you will see one of the limbs rotting away. They will say that the person step on medicine. Instead of going to the hospital or clinic to find out. The first thing they will do is go and try the traditional because the belief is very strong in it. But sometimes it is because they have no good experience with hospitals. Maybe it because they don't buy medicine and follow the plan to get better. So they think the hospital not work for them. So they go to what they know.

The second and third codes are **trusting biomedical approaches** and **trusting traditional approaches**. Participants offered different reasoning behind why they would trust one approach over the other. For Nathan, a community member, he expressed his trust of biomedical approaches because they worked for him in the past. When I asked him why he thought biomedical approaches would carry him through his sickness he replied,

At the time I last had malaria, let say, a tablet. It is called armadarquene. We buy it because we are educated about the usage. But when you buy the armadarquene, you are going to take it along with juice. So I will follow that and take it in. Also parasitomon, we take it in. Those are mostly used for that and it works to make you better... That is why I take them because I know that they will carry me through this sickness to health.

Dr. Kollie's experience of treating patients echoed Nathan's remarks. When asked why patients come to her clinic rather than a bush doctor, she replied, *Maybe at one time they have lost faith in the medical. But when they come here and see that it works they will say "oh this do work" and will continue to return.*

However, there were participants who did not trust the biomedical approaches and made the decision to use African, or traditional, approaches for their sickness. Esther, a young community member, offered her perspective on why her neighbors and friends decide to use traditional approaches. Esther stated, *Because they know that better. They have the experience like in the past that it work for them. That is why I pick the herb. It works for me.* Deciding what will carry me through codes are important to understand because they represent the ways participants make decisions about their health. This is important to know because it provided insight into why participants decision to follow a particular path for how they handle sickness.

Influencing factors

There are many factors that influence an individual's ability to make decisions about their health behaviors. When it came to influencing factors of how individuals handled their sickness, participants mainly focused on cultural and family influences. The first code, **cultural and community influence**, represents when participants credit their culture and/or community with influencing their decision making process.

One participant, a well-connected young man in the community named Konah, shared how the community can influence decision-making. He shared how his friends convinced him to use biomedical treatments. *So most of the time they call and me, 'my friend the hospital is where to go' so that when I go there they can get the drip and injection to help me feel restored. So my friends can share with me that I should go.* Konah, however, was one of the participants who openly expressed his use of both biomedical and traditional approaches to his sickness. He shared that other community members, mainly elderly village women, also influenced him to use the country herb. Konah smiled when he shared that the old women were persuasive in their use of country herbs. He shared that the elderly women would mix up the country herbs and strongly suggest that the younger community members take it prior to harvesting new rice,

Then the old mothers will cook certain medicine for all of the ugly, ugly things we have been eating during the rainy season. Because some of these children will go all around finding pieces of cassava, plantain, cracking all that wanting to eat it. So when the new rice is about to come the old mothers will tell us cook that leaf and divide the water. Some will have stomach run but they will fill better for using the country medicine. It will prepare our bodies to receive the good rice.

However, most participants credited their decision-making influences to their **family history**. One younger community member, Alvin Q., shared that his family does not use biomedical approaches because of allergic reactions. Alvin Q. shared, *I am afraid*

of injections and pills. When I asked further questions about why Alvin was afraid, he revealed his family's history,

In my family we are allergic to the injections. Everyone that has the injection gets more sick. So I am afraid to try them. If every family member gets sick then why would I not also get sick. The clinic says maybe our bodies cannot take this medication. So I stay away from that one tablet and injection.

Other participants shared that a family history of using a specific approach was the reason they continued. Binda shared that her family had been using bush medicine for many generations and so she continued to do the same thing. For her it was a comical evolution process,

But I have an aunt and my grandma who use it. But it is the same thing- They use the country herb. Because those are the things that we are brought up with. Medicine was not available. We were not able to get to that level- so country herbs will be used. We were forced to take it in as kids. They will have you lay down and they will stop your nose and open your mouth for the herbs. [Binda laughs] But now I take it on my own when I am not feeling well.

Enoch, on the other hand, offered a different experience of family influence. For his family there were strict rules for treatment options. He shared, *Some families go to the bush or use herbs. Not my family. It is forbidden to use the herbs. For all things we go to the clinic or pharmacy. It is not ok in our family to use the herbs.* In order to fully understand how Liberians are encouraged to handle their sickness, there needs to be discussion of influencing factors. The two main influencing factors that demonstrate the driving forces that impact participants' decisions were culture and family. Exploring influencing factors provides a deeper understanding to how decisions are made concerning illness.

Code associations for encouraging me to handle the sickness

Within the concept of encouraging me to handle the sickness there is one case

where codes overlapped. The first example is access to treatment and medication and location barriers. Participants like Noweh often expressed that the largest barrier to access of treatment and medication is location. Noweh shared, *I would have to go a distance, very far off to go and meet the doctor. And that is in the city so I cannot do it. It is too far.* Another community member Truth discussed how her location impacts her access to treatment. Truth does not live in the village she lives in the bush and therefore access is compounded by the fact that she does not live in an established town. Truth shared, *it will have to be bad for me to go to the hospital or clinic. You cannot get there from this side. So I stay here unless it is very serious. But sometimes they will bring a community car here that has drugs for us in the bush. But it is just for things like headaches.* Understanding that location is a barrier to health access is an important reminder that there people who live outside the large cities (e.g. Monrovia and Firestone farms) that have limited access to healthcare.

Helping Me Through The sickness

Helping me through sickness is the third major concept present in the data and appears more frequently compared to other major themes. The helping concept addresses how participants approach, cope, and experience their healthcare. Helping me through the sickness is very closely related to the parent theme of deciding what will carry me through. Deciding what will carry me through represents the influences that impact how individuals make decisions about health. Helping me through the sickness represents the coping strategies that individuals use to get through a sickness. This concept has four parent codes: psychosocial approach, spiritual practices, using biomedical approaches,

and using traditional African approaches. Table 8 demonstrates the parent and child codes that emerged throughout the data.

Table 8
Frequencies of Parent and Child Codes for Helping Theme

Code (Frequency)	
Child code	Exemplar
Psychosocial approaches (175)	
Assistance from others (58)	They help my family to take care of me which is wash clothes, to provide food, these are some of the things my friends done for me when I am sick.
Describing emotions (22)	For me I will try to associate myself with that I am not really sick. I can't let it over come me.
Encouragements from friends and family (62)	They encourage me say "My man get on your feet come to church service on Sunday, God will make you get healed from that sickness.
Isolation from others (18)	Um I cant really be around people. I keep in my own place until I get well, before I get around people-when I experience malaria.
Physically moving (15)	I cannot keep lying there the whole day, I can be moving around. Take some exercise and when I sit down for long time I stretch my legs to also help me-for the malaria to leave.
Spiritual practices (121)	
Faith (15)	I have faith that even if your doctor is treating you, God will not permit my hurt. So I will have faith that God will not hurt me. I have the faith and confidence.
Fasting (5)	They Pentecost you know they go on the daily basis, praying, fasting, keeping themselves with hunger. And most of the time they come down with ulcer-abdominal ulcer because you know you keep yourself with hunger for long you know what can happen there.

Frequencies of Parent and Child Codes for Helping Theme (continued)

Child code	Exemplar
General claims of spiritual practices (9)	You see patients that are Jehovah witnesses they believe that they are not allowed to take blood. So you will see a patient that really need blood immediately and if you don't transfuse that patient will die. They will say I will not take blood. The level of faith that patient has-will prefer to die than to take the blood. Than to be transfused.
Going to Church or Mosque (30)	They go first to the church and then after it starts to decay then they come back and sometimes at that point it is too late.
Praying (62)	My spiritual life help me by prayer. When I sick, when I come to bed, I will pray to put myself in the hand of God. Pray to him or call the doctor for God to heal me and if I in church, church members that know I am ill say-they come around to pray. The pastor will pray on me. Everybody will come to pray along with me.
Using biomedical approaches (267)	
Buying tablets from pharmacy (21)	They use their own prescription. Most people believe to buy the treatment, that is the medicine and tablets from the ones who sell around. They buy it and just treat their selves.
Following treatment plan (62)	What helps me through to get better is as I said- I must take treatment. If I don't take treatment I will not get well.
Going to clinic (164)	Whenever I have malaria, go to the clinic for treatment.
Not using biomedical approaches (20)	But from the time I know myself, as a man, I have not go to a big hospital to check to see if I am sick.
Using African/traditional approaches (160)	
Finding your own herbs (25)	I will find the medicine. Most of the time I use the leaf that she boil for me. Yeah I drink the leaf 2, 3 days and I'm ok.
Not using traditional approaches (13)	No I don't use the country medicine.
Seeking African/traditional approaches (122)	Sometimes maybe there is too much complaining and you try something and you go to the country side because some country medicine you will take. Then mostly when there is too much complain I will go to the country medicine, the traditional.

Psychosocial approaches

Participants identified several psychosocial approaches that helped them through a sickness. First is **describing emotions**, which references times where participants are expressing emotions as related to how they deal with their sickness. One of the questions I asked participants after they told me about the illnesses they had experienced would be how it made them feel. As previously stated they would often share symptoms of the specific illness. However, there were times when they would share various emotions they experienced during their sickness episode. For Aker, an older community member, he reported, *you become lonesome*. Emma, a community member, shared a similar feeling about her experience with malaria, *sometimes when this happens I am down hearted*. And finally James shared how when he had malaria, worry was the main emotion he experienced. He shared, *Yes it was bad for me. I was to be worrying about that. Worry about work. I found small job so I don't have to be worrying about that. Worry about the sickness*.

Second is **assistance from others**, which references the ways participants' family, friends, and community offer assistance during sickness. A young man from the community shared the importance of his community during his time of need. Henry shared, *You alone cannot really take care of yourself in life. You need a help, a system of others around you. So how do they help me. I do not keep my sickness to myself. Any problem I have I tell them. Then somebody will be able to have an idea to help. Yeah*. Binda shared her experience about how she benefited from family and community assistance. She specifically shared how family and community assistance changed during the deadly Ebola outbreak,

Oh when it comes to my family they are so concerned. They want to know- because if I don't get on my feet the family will have problem. So they are concerned. They will say let's help him get on his feet- to see what we need to do. So if someone prescribe medicine or need to go to nearby clinic for check up- and I cannot move they will come and check me to see what the problem is with me. Like one time I came about and I started feeling misery. I told my boss that I had to get home. So I entered my room and started vomiting and you know what was the blessing for me? It was in the Ebola time- if I were to vomit in the street they would take me to the camp. So when I got home and started vomiting my wife started to help me. She helped me a lot and she really helped me and I was able to get on my feet. But if I were to do that in the street at the time when Ebola was in this country Oh My God they would not have allowed me to go to my house. They would arrest me and send me to Ebola camp. And when-if I go to Ebola camp I wouldn't survive. It was not Ebola it was ordinary malaria fitting me. But you get it then and the whole thing people may say "Oh the man has Ebola- you cant come around." They would've left my family.

Third is **encouragement**. These codes are references to the ways social support networks offer encouragement to participants. Many of the participants mentioned how the encouragement helped them during their sickness episode. Enoch shared how social encouragement helped him to refocus while he was sick,

It also help me really. It helps me- it help me to- to not be thinking of the sickness all the time. All the time I associate myself with my friends and I interact with and gradually I begin to- to forgo the sickness. It being malaria I take the treatment and I feel important with my friends.

Gabriel shared how his friends would come and encourage him while he was sick. He stated, *My friends that are able to relate will help me. Coming and say 'oh you sick sorry' or 'don't get sick sorry'. They will pity my condition. They will sit with me and encourage me to do better and get better.* For other participants, the encouragement came from their family. Hawa K. shared how her family encouraged her with advice, *Yeah my family and friends they help me when I am sick. First they visit me- when they visit me they encourage me to not worry. They give me some advice.*

Fourth is **isolation**, which is examples of reasons and ways participants isolate

themselves from the larger community or their family. For many of the participants isolation served as a way to recoup during an illness. Esther shared, *Um I cant really be around people. I keep in my own place until I get well, before I get around people-when I experience malaria.*

Amos, on the other hand, expressed isolation as result of the Ebola outbreak and the fear associated with the virus. For many Liberians, isolation is the only way to protect their families. Amos shared,

... during Ebola people were very, very, very afraid. Myself I sustain some losses in the family several persons died in the family, in my family, family members died. So when it happened you will not be able to go [to funeral] because they said the virus is risky. So there is no way you can get there. So after this it brought some limitation for family members and other people. If it happen to them you don't go there, they will think you to be their worst enemies. And for now nobody want to die. Yeah. Friends will not come visit you. In fact the government went over air and the moment you are sick in the Ebola time your family have to leave you. Your family have to leave you.

Another community member, James, shared his belief that isolation was important because often in Africa the sickness can be unknown. For James, isolation was precaution that was worth it. James said,

well at times people feel the need to be isolated because for some illness we-you don't know because this is Africa and at times some sickness you don't need to go close so others will encounter it. So for us we find it reasonable that whenever you are sick at least- in find a sitting area to be that it may not be spread around. Because we may not know how it spread around. Isolation is safe.

Finally, there is **physical movement**, which describes the instances where participants shared how physical movement or lack of physical movement was a way to handle their illness. Participants either believed that physical movement was not an adequate way to handle an illness or they believed it helped them. For example, James, like many people in his community, believed rest was the best option. He shared his approach to malaria, *I give myself bed rest because sometime the system needs to be in*

the resting system. So I leave the job and because I do some hard work- and I rest a little bit from farm work. I usually come back and give myself enough rest. So I can bring back my health.

Other participants reported that physical movement was one of the ways they handled illness. George, a young man in his mid twenties shared his approach to malaria, which seemed to be driven by the fear of letting the illness overcome him,

I cannot keep lying there the whole day, I can be moving around. Take some exercise and when I sit down for long time I stretch my legs to also help me-for the malaria to leave. To be outside, to play football, to say I am going around my friends in my yard. I will also play with myself take a jog around the house or yard. Just to see them. You cant take part in what they are doing. You are just stretching your legs from the malaria. You will overcome it. The more you lay down you wont over come it.

There are many ways Liberians express how they are able to carry through a sickness. This parent code shows how participants use psychosocial approaches to coping with a sickness. Assistance from others, describing emotions, encouragement, isolation, and movement are all ways that participants described how they use psychosocial approaches to carry through a sickness.

Spiritual practices

Participants reported four specific spiritual practices and several other practices that were labeled as general claims of spiritual practice. First was **general claims of spiritual practices**, which are ways individuals mentioned spiritual practices that are not specific to their coping or that did not fit into the existing codes. Take for example, Esther, when asked to describe or explain if her spiritual life influenced how she handled her sickness, she simply replied, *my spiritual life it help me a lot. Yes it is helpful.* Other responses like those from clinic worker

Antoinette focused on how spiritual practices might influence health. Antoinette shared,

Uh yeah you see patients that are Jehovah witnesses they believe that they are not allowed to take blood. So you will see a patient that really need blood immediately and if you don't transfuse that patient will die. They will say I will not take blood. The level of spiritual that patient has means they would rather die. Than to be transfused. Yes.

When I asked her how she responds to patients who hold this belief she said she tries to understand,

Yeah you have to do so because sometimes giving them advice will it conflict be with their religious practices. So you have to take into consideration so if you are doing anything to them, you have to ask them "Can you do this? Or will you be able to do this?" They say "Oh no! For my religion practice I cant do this." Then find something else to give them try to find another way.

Second, **faith** codes were used to identify the times participants mentioned their "faith" in a higher power, church service, or healing. Joseph, a community member was very passionate in his response to my question about if spirituality helped him cope with his various illnesses. He said,

I have faith, yes. I have faith this is why I humbly choose to serve God. I have faith that even if your doctor is treating you, God will not permit my hurt. So I will have faith that God will not hurt me. I have the faith and confidence.

Dr. Kollie shared how her organization, a faith based clinic, addressed faith. It offers devotionals and encourage patients to explore the role of faith in healing. Dr. Kollie shared,

In our organization we are a faith based. And so every morning, you just missed it, we have devotion and so when we lead amongst the staff all of our patients heard you will be here tomorrow. They will be sitting under the tree and so they get their dose of faith. How thankful we should be for what we have and so they will raise a song and they will sing and they are very religious when it comes to faith. And so we try to tell them about faith and how important it is but also the wisdom that God gave to us to use the proper medical ways to deal with issues and then add that to our medical convictions. Faith. So we talk about that.

The third code, **Fasting**, references times when participants would fast because their religious beliefs dictated that fasting would solve their health problems. There were some participants like Mary who did not go into detail about why they fasted. However, Mary simply shared, *Sometimes I will fast 2-3 days and it will help me feel better*. James, a clinic worker shared how his patients fasted because of their faith. He also highlighted that sometimes they would visit the clinic because of the fasting! James shared,

There is health problem associated with why Christianity. It is because of fasting. Somebody fast for so whole long where they keep theirself hungry and they say is there really a practice here? So when you just want to discuss the problem you don't just discuss the source of it. Sometimes you go to the man in the religion and you tell him "My man you have to leave the fast away" we know everybody can pray to God we agree- so you have to be a bit social, a bit religion before you can be medical. But if you get to discuss the medical part of the issue yeah you give the drugs but they don't know how to curtail it-how to prevent it. So to discuss the prevention of certain condition you have to cannot be solved by fasting. It only make it worse.

Fourth is **going to church or mosque** and referenced the times that participants go to church either to socialize, receive prayers, or to be anointed with Holy oil. For Henry, going to the church allowed him to commune with God. He shared, *Sometimes I go to the church and I do something- I commune with God for a period. Because he is the only man who can heal, even if I take all the drug and it doesn't work he is the next person I go to for healing*. For George, going to church was pleasing to God and therefore helped him to be healed. George shared,

During that time I was going to church, really going to church, doing the things of God. So one time I lie down and I was having a dream. I don't know if it was an angel or Jesus came in front of me. I call the name Jesus and that person went away. God healed me and I took no medicine. Yes so this is how in the spiritual way God help me in the church

And for Gabriel, church was a place to lift his spirits and socialize. He stated, *When I feel fine I will go to the church. When I am sick they will send people to see me. When you are sick and in the church they will always send people to visit you.*

Finally, **praying** represented the times participants addressed a higher power, times when churches would come to pray for them, and general utterance of personal prayer for healing. Amos shared how he prayed and would have church members praying and encouraging him while he was not feeling well. He shared,

My spiritual life help me by prayer. When I sick, when I come to bed, I will pray to put myself in the hand of God. Pray to him or call the doctor for God to heal me and if I in church, church members that know I am ill say-they come around to pray. The pastor will pray on me. Everybody will come to pray along with me. They encourage me say "My man get on your feet come to church service on Sunday, God will make you get healed from that sickness.

Community members were not the only participants who mentioned prayer. Several healthcare providers mentioned the use of prayer in their care of patients. Dr. Kollie shared that often her patients were willing to be prayed over. She described that while patients are waiting to be checked into the clinic, either her or her clinic staff would take prayer requests. She shared the experience, *I ask should we pray for you or what? 100% of the time uh people are willing to prayed for, uh in those situations. When they are there to seek help.* S.B. a clinic worker for Dr. Kollie shared how he approached prayer. He highlighted that sometimes patients were not Christian but were still appreciative of having a healthcare provider care and pray in that way. He shared an example,

Of course I pray for them [patients] and sometime when we go into the community before I handle a health talk or before I pass it over to the people what I do is I tell them for us to pray before we start. Yeah. So from that if we have person from the Islamic background, you ask them to pray in their Muslim way of doing things. Then we all will accept and pray normally as a Christian. Any Muslim among us we say, 'we are sorry for that'.

Spiritual practices have long been identified as a way to cope with illness. Liberians demonstrate several ways that they incorporate spiritual practices as coping strategy. Exploring the spiritual practices code offers a holistic approach to coping with an illness. Faith, fasting, general spiritualism, going to places of worship, and praying are the major ways Liberians incorporate their spiritual beliefs with coping.

Using biomedical approaches

Participants identified four ways they approach biomedical treatment. First **buy medicine and tablets** from black baggers or a pharmacy. I quickly learned that black baggers were people who sold various tablets for illnesses but had no certification as a pharmacist. Binda was the first community member to inform me about the black baggers. She shared that people in the community will bypass the pharmacy and go to black baggers. Binda shared,

But in Africa sometimes we take some risk with something, but it can be helpful for us. There are some guys who are black baggers. They have the bags and they sale tablets. Even though the nursing will sale you. When they [black baggers] come to you and ask you what you want, what tablet do you want. They will give it to you and not want to check you. Or how is this sickness treating you. So we will go around because I know that I need malaria tablet. And you can buy it from them.

James K. shared that often community members would rather skip the clinic and go straight to the pharmacy to buy tablets to treat themselves. James said, *Sometimes you get money and you will buy tablet from pharmacy to cure yourself. Yeah. So this is what it has been in the health area around here.*

The second way they used biomedical approaches were **visiting a clinic or a hospital**. The majority of participants identified that at some point they went to the

hospital or clinic for their health concerns. Arthur shared that if the malaria tablets do not work, he goes to the clinic. He shared,

Uh I can go to the clinic but mainly sometimes uh I-we can buy the tablets. But if the tablet doesn't work so we go to the clinic and probably I would like to go to a nice clinic because to deal with the type of malaria I have probably some can be plus malaria and if you don't know the type of malaria you have you get to be where it doesn't work that well. So I will go and do the test, go to the lab, after that when the lab result comes they will know the type of treatment to take care of me.

Emma shared that she, too, goes to the clinic as a way to be tested for various illnesses, *one of the best things is first of all you go to the hospital and do your test. And then every doctor will diagnose then they will prescribe you a treatment to give you. Then to prevent it or to help you.* Then there were participants like Henry K. who picked the clinic over all other approaches. Henry said, *When I am sick, as I told you, when I am sick sometimes I will go to the clinic. When I go to the clinic they give me medicine. Yeah to the clinic, not to the hospital, not to spirit man.*

The third code is when participants **follow a treatment plan** from the clinic or hospital. Amos shared his experience of following a plan,

The doctor or other people will prescribe the medicine you will take, send you to the other doctor and will sign it and give you pills to take. Tests-they will test your blood to see which one-the malaria is in your blood getting harder and getting the pills. If you do as they say you will maybe get better.

Lawerter, a nurse at the government hospital shared her experience of patients who do not follow the treatment plan outlined by providers, *Yeah. Most of often you see several patient will always, re-collapse, always come down with that same ol sickness, then come back to the hospital because they are not taking the medication properly. They are not taking it on time.*

The fourth and final code was about individuals making the active decision **not to follow a biomedical approach**. Participants offered little explanation about why someone wouldn't seek biomedical approaches. Hawa, a healthcare provider, suggested that maybe it was because some of the illnesses were common. She shared, *Eh but when they encounter the malaria most of them do not come really soon. Only if it is really bad.* However, after talking with Henry, I would guess that the Ebola outbreak and many stories from clinics may have something to do with people not deciding to use biomedical approaches. Henry shared,

When I get sick, really after the Ebola, yeah. I not go to clinic. When Ebola came I lost some people. My father, mother, sisters. Then my uncle went to the Ebola center and he got cure. But not so for me I would not go. I saw people go into the center and then from there no come back. So I took some of my family to the medicine people. Yeah so from there when I came back, even after Ebola, I was aching in my body. But from the time I know myself, as a man, I have not go to a big hospital to check to see if I am sick or to experience really serious sickness- where I would go to the hospital and they would tell me "You are sick with so so so thing" and then they give me treatment- no I have not done that. When you do that with Ebola you will die.

Biomedical approaches are examples of when participants sought treatment from non-traditional approaches. Biomedical codes include going to the clinic, purchasing medication, and following a treatment plan. Participants demonstrated that using biomedical approaches was one of the main approaches that helps them carry through their sickness.

Using African/traditional approaches

On the other hand, participants addressed three ways they use the approach of traditional African methods of healing. First, **they find their own herbs** rather than going to visit the bush doctor. This is the actual act of following through with the decision and influences. This code is different than having access and knowledge of the

herbal medicine. Rather, this code represents the follow through of retrieving herbs.

Moses shared how his mother assisted him with retrieving the herbs,

My mother knows my medicine. It is a certain leaf in the bush, yeah and if I drink sometimes 2 days, 3 days I am up. Yeah. They have certain leaf that my mom will provide for me to drink. When you boil it, it sometimes is yellow like something, then you measure it and drink it. As I say- when I start complaining about feeling cold and my head aching. I will inform my mind. I will find the medicine. Most of the time I use the leaf that she boil for me. Yeah I drink the leaf 2, 3 days and I'm ok.

Sarah shared a similar story detailing how she would gather herbs for her family. When I asked what traditional practices she used, she answered,

Then I will go for country herb. I will pick the country herb so now I can be johnna and then there you be there for a week- so now you will weak in the body. So you can feel the country herb is helpful. Sometime headache, sometime stomach, sometime if we know them we will pick the country herb. Yes for the stomach because the stomach sore will beat him. So feed them the country herb, we boil it and give it to them. It can help them.

Second, they **seek traditional approaches**, which can be difficult to define because there is not a consensus about what traditional approaches are called. There were some individuals who mentioned herbalists, witch doctors, bush doctors, spiritual men, and different but equally interchangeable concepts. Samson, a younger community member, shared his earliest experience of using traditional approaches. He became sick with an unknown illness and his family responded by seeking traditional approaches. Samson shared, *And when I came back after the turn of the medicine my uncle took me to the sick bush to be cured.* Others, like Amos, shared that he sought traditional treatments when biomedical approaches did not work. His experience was common and so he shared an example,

Ok. You see there are some sickness that catch someone like example: if a man happen to get a severe headache, that headache is sometime the person can be witched. Ok and then the doctor at the hospital cannot have any diagnose for that,

you see. Because if the doctor check he will not see malaria symptoms, will not see anything that any other sicknesses in the person body. But when the person leaves the hospital the sickness comes back to them. Then it leads to traditional healer and the traditional healer deal with the spirit aspect and that is how you get to know.

Then there are others like Henry who know that only an African or traditional approach can be a cure for an African sickness. Henry shared why he and other participants might seek traditional approaches,

Sometimes I go to the country doctor to sometimes find what is really happen to me. But if they check they will say “what happen to you? Is it a sickness that is in your body’s blood?” Sometimes, we the African will go find out what happen. Sometime some people want to do medicine to take your life. They will witch you. So it is most of time- we go there to find that someone has taken something from us or tried to do something to us.

Finally, **not seeking traditional approaches** was identified as times participants would purposefully not seek traditional means to healing. Much like not seeking biomedical approaches, participants would report, with no explanation, that they did not seek traditional approaches. Ophelia shared, *Oh I never use the country herb*. For Abram he simply stated that, *don’t really believe in the traditional thing*. Then there were people like Amos K. who would not seek traditional treatment if he was already using biomedical approaches. He shared, *If I taking the hospital medicine I don’t use the country medicine. They do not mix*. And finally there were some participants like Sah who identified that traditional treatments do not work. She shared, *For example that country doctor give you medicine and it will not solve it. Sometimes it will increase the problem. So yes, it can increase the problem. So I was afraid of that!*

Code associations for helping me through the sickness

There were three associations within the concept of helping me through the sickness. The overlap of these concepts demonstrates the complexity of coping strategies

and how Liberians approach coping with illness. The first association is between going to church or mosque and praying. This association did not come as a shock because prayer often takes place in houses of worship. Enoch, a community member shared his experience of going to church and praying as a way to help him through his sickness. Enoch shared,

At times when I am sick I pray. I pray at times and it really helps me because I came up in an environment where I see everybody going to church and praying you know. Believing in God so- I think even the time I say there is no medical attention- I don't have access to hospital so I go to the church and I pray. And through Jesus Christ I can over come at times. So I go to the church and pray.

A healthcare provider shared that her patients will go to churches and pray for healing if they are not satisfied with the treatment they are receiving. Mary laughed when she started,

Ha! Oh yes we will have patient that is not patient. Oh you will give them medicine and if they are not better the next day they are angry. So they will go to the healing churches. At those churches they will be prayed over by the pastor and elders and anointed with oil.

The second association also included praying. Praying and Encouragements from family and friends demonstrates how friends would come and offer both encouragement and prayers for those who were suffering from an ailment. For example, when she was answering what helped carry her through Sarah shared,

Ah to sit with me they sometimes offer prayer. My friends in church will come and encourage me in this way. Because we believe in prayer. Because the ministry I am from we believe in prayer. If whatever we say-the first person will go to God and ask him for strength and so now he helps us. God is the healer for every disease.

Another community member, Hawa Q. shared a similar story about her friends coming to sit and pray with her when she was experiencing sickness. Hawa shared about her friends,

Sometimes they will come around and sit. So sometimes they will have some prayers with me and recite something's. Again there are many, many ways of praying. They can worship with me and lay hands. If believe then it can happen that I will be well.

The third association that was found under helping me through the sickness was between going to the clinic/hospital and seeking traditional treatment. This association was particularly interesting because it demonstrates how Liberians use both biomedical and traditional approaches to treating their sickness. For example, Moses, a community member, shared about how some ailments can only be treated by traditional healers.

Moses shared,

The Liberian way they have a country doctor. Yeah in Liberia we have a country doctor. Country doctor sometimes. If you sick sometimes they taking you to the hospital, clinic for so many time. Sometimes you cant get better. Sometimes the doctor will say "We cant find no sickness in your body" then you move to the country side. Sometimes it can be some traditional way they want to throw medicine on you for you to die or for it to be damaged.

Angeline, a healthcare provider, also shared her experience of patients using both biomedical and traditional approaches to sickness. She shared,

...But some of them the traditional practice is very strong. When they come to the hospital and it take time for the person to recover because they were far into the illness- so they don't have patience to wait! They don't have patience so they will stay a week or more then they say, "I told you that this is not a hospital sickness. It is a traditional sickness." Some of them will take the patient and carry them back to the bush doctor. That is the way.

Another way that participants described what they do to carry through is using African or traditional approaches. Using African approaches are the times when participants sought out traditional approaches to carrying through their sickness. African or traditional approaches include finding your own herbs and going to visit a country doctor, bush, or witch doctor. This code provides a better understanding of how Liberians use traditional approaches to carry them through sickness.

Conclusion

Throughout the analysis process, there were three main themes that developed from the data. The three main themes, parent codes, and child codes offer substantial information pertaining to the research questions about coping, illness, and culture. In the following chapter, I will discuss how the analysis of the data answered the research questions of this study.

Chapter Five Discussion

Arriving in Liberia for the first time was a shock to all of my senses. I arrived with a group of college friends ready to spend ten days in the rural village of Flehla. We stepped off the plane and were assaulted with the hot and humid climate that engulfs the country of Liberia in July. This would also be my experience the second and third time I arrived in Liberia. During my second trip to Liberia, I began to develop this research study. I had planned to return for a third consecutive year and collect the data for my dissertation: however, a month before our departure, we canceled our trip because of a virus that was making headlines—Ebola had arrived in Liberia.

Once I was able to return to Liberia for a third visit, things had changed. There were hand-washing stations on the tarmac and at checkpoints throughout the country. Liberians were hesitant to greet you with a hug or handshake. Ebola had come and gone, like the civil wars, leaving Liberia forever changed. During this time I was able to collect health narratives for this dissertation. Using semi-structured interviews I collected 46 interviews from community members and healthcare providers. After the interviews were transcribed, I used framework analysis to analyze the data. Three main concepts emerged from the analysis. The concepts were experiencing sickness, encouraging me to handle my sickness, and helping me through the sickness. However, more substantial than the three concepts are the narrative interpretations born of all 46 interviews. Building on Sharf and Vanderford's (2003) work on illness narratives and Fisher's (1984) narrative theory, I will discuss how the findings and individual narratives support and create meaning that is driven by the community and its relationship to illness.

Study Relevance and Findings

This research study expands current health communication literature on coping, health literacy, culture, and community health narratives. Additionally, this study uniquely privileges the health narratives of community members (patients and their families) *and* providers (formally trained and traditional healers) in rural Liberia, West Africa. In addition to giving Liberians agency to share their health narratives, the work offered in this study deepens our understanding of health and illness in a part of the world that is commonly seen as poorly resourced, ill-equipped, and compromised in health literacy. Informed by the framework analysis, I was able to identify three major concepts, ten parent codes, and thirty-nine child codes from the data.

The first major concept, **experiencing sickness**, includes participant interactions, discussions, and descriptions their experience of illness. Housed within this concept are parent codes that address the *impact of sickness*, *knowing how to treat the sickness*, and *recognizing the sickness*. These parent codes ultimately identify ideas and factors that inform what participants understand about health literacy. The concept of experiencing sickness highlights factors that influence the health literacy of participants.

The second major concept, **encouraging me to handle my sickness**, addresses various stages of decision making for participants. Parent codes for this concept are *access to resources*, *deciding what will carry me through*, and *influencing factors* and they illuminate the many filters through which individuals factor decisions about their health. Child codes demonstrate individual filters through which decisions are made. For example, family history is a filter through which an individual might use to make their decisions.

The third and final concept is **helping me through the sickness** and encompasses coping with an illness experience. Parent codes for this concept are *psychosocial approaches*, *spiritual practices*, *using biomedical approaches*, and *African/traditional approaches*. Parent codes represent specific pathways in coping with an illness, while the child codes detail particular coping strategies. For example, going to a Church or a Mosque is a particular spiritual practice of coping with an illness. Coping approaches are the most significant for individuals in rural Liberia, as demonstrated by code frequencies in the analysis. Coping strategies, the concept of **helping me through the sickness**, occurred 723 times compared to the concepts of **encouraging me to handle the sickness** (257 times) and **experiencing sickness** (407 times). Furthermore, the narrative concepts, parent codes, and child codes ultimately led me to an understanding that highlights the richness and strength of community.

What I found as I began the interpretative stage of framework analysis is that the individual narratives I collected for this study, when viewed as a body of data, demonstrate the complexity of community narrative. In studying the community narrative, I identified three interpretive themes present in the data: health literacy, coping strategies, and a fluid relationship between biomedical and psychosocial approaches to coping. In the following sections, I will begin to unpack the interpretive themes.

Community Narrative of Health Literacy

Living in a part of the world that is so different from Flehla, a common assessment of this place from the outside is one that focuses on its high level of poverty, low level of education and functional literacy, and limited access to healthcare. For a part of the world that is often overlooked, those on the outside assume that Flehla and similar

places have low levels of health literacy. However, participants in this study demonstrated great facility with health literacy, which I define as the transactional process of demonstrating, obtaining, understanding, processing and responding to health information through community, whether that is a cultural, social, or medical community. Narratives demonstrated facility with this idea in the following ways 1) demonstrating existing knowledge about illnesses; 2) obtaining health information from healthcare providers, family, culture, and community; and 3) processing health information with the influence of culture/community and family history.

Community members (CM will be used when referencing excerpts from community members) revealed their level of health literacy by demonstrating their *existing knowledge about illnesses* that is common in Liberia. For example, Amos (CM) stated that when he gets malaria, he knows that it is caused by the mosquito bite. He continues by explaining that he also knows that it can be prevented if he would sleep under a mosquito net. The majority of participants' stories and focus group interviews reinforced Amos' narrative. What this exhibits is that community members in Flehla know the causes of malaria and how to prevent it. Additionally, participants know and are able to identify symptoms of common illnesses. When asked what she knows about common illnesses, Angeline (CM) began describing the symptoms of malaria and typhoid fever. This pattern repeated itself with one participant after another demonstrating a strong knowledge base when it comes to illnesses that are common in Liberia, such as malaria and typhoid.

Another way participants verified functional health literacy was in sharing how they *obtained health information*. Health talks, hosted by healthcare providers (HCP

when references participants in the study who provide health services), take place in clinics and public meeting places, like the market or center of town, and are excellent resources for community members to gain health information. Moses (HCP) explained that once a week he and a team of nurses will go into the community with the specific purpose of hosting a health talk. The talks vary each week but provide community members with information about (un)common illnesses, prevention methods, and causes of various illnesses. Moses (HCP) stated that the purpose of these talks is to help disseminate information to more people because they may not come to the clinic; instead, the HCP take the information into public places. Beatrice (CM) credited health talks to her learning about diabetes and how it could impact her aging mother.

Participants also credited family members as sources of health knowledge. When I asked Topka (CM) how he came to know about treating malaria, he quickly answered that his mother and grandmother had shared with all of the children how they can prevent malaria. William (HCP) reported that many of his patients would share that they know about specific prevention methods because of their parents. In addition to knowing from health talks and family, some participants mentioned that health knowledge was obtained through cultural aspects of community. For example, obtaining information about what country herb to use was often shared through cultural knowledge. John (CM) expressed that when girls and boys join their respective societies, some learn how to treat basic ailments with the available natural resources.

Based on the examples above, participants of this research exemplified primary pathways to co-create and obtain health knowledge (Goldsmith & Terui, 2018). Additionally, Sharf and Vanderford's (2003) research on narrative function states that

narratives function as building community. This idea of building a community through a shared health experience is not a new one for Liberians. In western occurrences of illness, encounters with healthcare providers are initially centered on individual autonomy (Zahedi, 2011). However, once an individual is diagnosed with a chronic or acute illness, they often decide to seek community.

Frank (1995) describes the moment in his life when he had to decide to share his health story. In his book, he describes that by telling his illness narrative, he was widening his circle to include other storytellers who experienced the same thing or something similar (Frank, 1995). Illness narratives allow individuals to reclaim their identity and shift illness experiences from passive events to active ones (Frank, 1991; Frank, 1994). Illness narratives serve as a way for an individual to empower and be empowered and as a means of taking care of oneself (Frank, 1998). However, this approach focuses on how narratives function for individuals and not how they function for communities.

Autonomy may be the default in western contexts; however, this is not the approach to community or illness in Liberia. Community, for Liberians, is first established through tribal connections. To understand how community works in Flehla, there needs to be an understanding of social norms that govern Kpelle society. Most villagers living in Flehla identify as members of the Kpelle tribal group, the largest tribe in Liberia. Within Kpelle society, there is great importance placed on conformity to social rules (Bledsoe, 1980). Children who are born into the Kpelle tribe are often inducted into tribal secret societies, Poro (males) and Sande (females). These societies function as the political, social, and educational institutions for the Kpelle community

(Murphy, 1980). In joining the Poro and Sande, young children are not encouraged to be individuals; however, they are taught what it means to be part of a community. In Liberia, individuals are not isolated when they experience an illness event; rather, they experience illness in relation to the community they have been brought up in which includes the physical community and the tribal society (e.g., Poro and Sande) and based on evidence from the data, these communities demonstrate high levels of health literacy.

Narratives also demonstrated health literacy in how participants processed health information with the *influence of culture/community and family*. Once participants have obtained health information, they begin to decide how they might handle their illness. The narratives and coding frequencies revealed that these decisions are influenced the most by family history and then by culture/community. Noweh's (CM) narrative demonstrates that her family and family history are major influencing factors in how she processes information. She shared that during a visit to the clinic, the nurse gave her a new type of pill to treat malaria. Noweh brought the new medication to her family but decided not to take it because her parents were not familiar with the name of the pill. Later, Noweh reported that she had returned to the clinic to learn that the medicine was the same but the name on the packaging had changed. Hawa (HCP) shared that some of her maternity patients would not take her advice because of their mothers and grandmothers. She shared that if the patient is still living at home, it can be challenging to get them to follow newer treatments because a patient's family may not be familiar or up to date on the new approaches. Hawa also described the role of culture in community that influences patients. She explained that if a patient believes a course of treatment would not be acceptable, the patient would smile and agree with the provider but never follow

through with the treatment because of cultural influences. An example of this would be when women are given birth control for family planning but do not use it because there is a cultural taboo surrounding the use of contraceptives.

Health literacy narratives and Fisher.

The influence from culture/community and family is directly related to decision-making and is supported by Fisher's (1984) idea of good reason and narrative rationality. The stories that are shared by family members and shared through cultural beliefs have a major impact on how individuals process information. It is here that the narratives of health literacy are tested for coherence and fidelity and participants are presented with good reasons. The community narrative in Flehla serves as a coherent and credible decision making narrative of health needs, enforcing tenets from Fisher's work (1987). Narrative theory consists of five main axioms: 1) humans are storytellers; 2) decision making is based on good reasons; 3) good reasons are determined by history and culture; 4) rationality is based on people's awareness of consistency and lived experience; and 5) the world is full of stories and we must choose among them (Fisher, 1984). Participants in this research are all storytellers. They actively created and shared stories of their health experiences, which articulate both a representation of individual and collective community experiences. In the sharing of illness stories, participants explained and expanded "good reasons." Good reasons are "the elements that provide warrants for accepting or adhering to the advice fostered by any form of communication that can be considered rhetorical" (Fisher, 1987, p. 107). It is here that the community health literacy narrative increases in its complexity. For Liberians in this study, there are multiple ways

to address health concerns: biomedically, traditionally, spiritually, and psychosocially (I discuss these in detail in a later section).

When it comes time for a community member to make a health decision, they not only look for good reasons, but they filter those good reasons through a lens of family and culture. Participants in this study resonate with Fisher's work by describing how they decide to handle their sickness. Participants' narratives provided examples of good reasons. For example, when someone becomes ill, participants identified that one way they experience the sickness is by being able to identify the ailment and the causes, which represents health literacy. When an individual can identify the causes they filter their experience through family or cultural influences as a way to find a good reason. Other filters used to determine good reasons are represented in codes *trusting biomedical approaches* or *picking what is the most comfortable* which family and culture influence. Individuals in this study represented the system of values, beliefs, and good reasons primarily through the major concept of *encouraging me to handle my sickness*, which appears 257 times throughout the data.

Narrative theory posits that the rationality of the story depends on the coherence and fidelity of the story. Narrative coherence is the degree to which the story being shared makes sense, is consistent, and presents a unified story (Fisher, 1984). Individuals in this research presented a recognizable and familiar story about their health experiences. Coherence for this research was established through consistent explanations of how participants demonstrated, obtained, and processed health information. Community members shared narratives privately with me, which makes the coherence

and congruence of their combined narratives more forceful. The narrative rationality was present in the individual interviews but also held true for focus group content.

Additionally, narrative fidelity is the degree to which the stories being told ring true for the listeners and their experiences (Fisher, 1987). In establishing the coherence of a narrative, listeners must decide if the narrative is true based on their experience. It should be noted that coherence and fidelity work together to determine whether or not a narrative is rational. In this study the test of individual and community narrative coherence and fidelity are complex. There is not a single good reason or approach to health that is proven to be superior over the others. However, for individuals in Flehla there are multiple good reasons (e.g., family, culture, etc.) and there are multiple rational narratives of coping strategies, which I discuss later in this chapter.

The interpretive theme of community narratives of health literacy advances the field because health literacy is situated as a transactional and co-created process that involves numerous community stakeholders. The exemplars and community narratives also challenge the notion that individuals and communities can demonstrate high levels of health literacy even though they do have high levels of education, unlimited access, and high levels of general literacy.

Community Narrative of Coping

Within the definition of health literacy that I presented in the previous section, the last factor was “responding to health information.” During the interviews I quickly realized that coping was not a word used often by Liberians, but the phrases that expressed sentiments and strategies of coping typically included language describing elements that “carry me through illness.” In chapter four, helping me through a sickness

was the largest concept, based on the frequencies of coding, accounting for 723 codes or 52% of the combined data.

After participants have obtained and processed health information, they are then faced with the decision of what to do next. For Liberians, “carrying through” a sickness is never the end point, especially for an illness like malaria that often reoccurs. For example, Yatah (CM) explained that when she starts showing symptoms of malaria she would immediately go to the clinic and receive the treatment. However, she knows that it is only a matter of time before she will have to go to the clinic again for more malaria pills. For Aaron (CM) shared that when he begins to show symptoms of malaria he goes to his grandmother’s and she will determine if he needs to visit the clinic or try the country herb. After she advises him about the best thing to carry him through he will follow through with that approach. Yatah and Aaron’s narratives demonstrate that coping is part of the transactional process of health literacy.

The more I studied how coping was portrayed in Flehla narrative, I realized that for Liberians coping meant using multiple strategies. Both individual and focus group interviews revealed that participants use multiple methods to cope with their ailments. This idea of a fluid relationship between coping approaches is supported by research conducted in Ghana, West Africa (Smith-Cavros et al., 2017). It was reported that village elders in Ghana coped with illness by using multiple methods that included biomedical treatments, herbal treatment, and faith-based practices, effectively affirming the interpretive themes identified here.

Community Narrative and Biomedical vs. Psychosocial Approaches

Liberians identify four ways that they are helped or carried through an illness episode: biomedical approaches, psychosocial approaches, spiritual practices, and using African or traditional approaches. At first, I believed these to be four individual ways Liberians cope or carry through an illness. However, as I began to interpret the data I realized that three of the approaches could be collapsed into one leaving me with two ways Liberians integrate and practice “carrying through”: psychosocial and biomedical approaches.

The biomedical model of health implies that “health [is] created or challenged by classes of pathogens and events, ordered into clear categories or strata...” (de Leeuw, 2017, p. 330). Stated previously in chapter two the biomedical model of health is only focused on the biological factors of illness (Khan & Qureshi, 2018). However, biomedical approaches are identified in this work as any healthcare technique that is associated with professional medical care. For Liberians biomedical methods consist of all healthcare approaches that exists outside of the non-medical approaches such as prayer, going to the bush doctor, and taking herbs. Liberians identify biomedical approaches as going to the clinic or the hospital, following through with a treatment plan, and buying tablets from a pharmacy or black baggers. Psychosocial approaches to health acknowledge and address the social environment and the psychological factors in which a patient exists (Woodward, 2015 & Martikainen, et al., 2002). For this research psychosocial approaches are spiritual/religious practices, social support, emotional support, and African or traditional approaches.

To better understand the complex relationship between the approaches it is necessary to grasp each approach. Participants referenced biomedical approaches 267 times in their narratives. *Biomedical approaches*, when looking at the codes in chapter four, represent the largest representation of how Liberians cope. Famata (CM) described using biomedical approaches to cope with her illness. When I asked her what helped her through an illness, she replied that she would go to the clinic so that she would know for certain what her illness was. Following her visit to the clinic, she would go to the pharmacy and retrieve whatever prescriptions the clinic had provided. Others reported a different biomedical approach. Akah (CM) shared that he would skip going to the clinic and make his way to the pharmacy. For Akah, the clinic was an unnecessary step since he was “an old man who has this experience [malaria] a lot.”

On the other hand, there were the community members who were identifying and talking about psychosocial approaches. Participants identified *social support* as a psychosocial approach they used. For many of the community members, this meant one of two things: receiving assistance from others (financial or help with a daily task) or receiving emotional encouragement from family, friends, and community. When asked about what helped her through, Martha (CM) beamed and shared that her friends helped her through the sickness. She went on to elaborate that when she was not feeling well, her friends would come to her house, bring water, and help her by making sure she had food prepared for the day. Martha continued that help from her friends carried her through because it reminded her that she was cared for in the community.

Others talked about using *spiritual/religious practices* to help them through a sickness. For Mohamed (CM), when he experienced illness he would make a plea to his

Mosque and they would send another member to come pray with him. Mary (CM) expressed that going to her Church for prayer and anointing oil is what helped her through. Additionally, there were community members like James (CM) who shared that he would go to his Church, to pray and fast, hoping that his dedication to fast would prove to be enough to carry him through.

The final way narratives demonstrated psychosocial approaches were through *African or traditional approaches*. Participants identified two traditional forms of carrying through an illness: 1) finding your own herbs, and 2) seeking the help of an African or traditional healer. Samson (CM) expressed that when he experienced an illness episode, his first choice was to head “to see the bush man,” meaning the one of the Zóos located along the outskirts of the village. For other community members like Abram, picking their herb was the best way to help them through. Abram shared that he preferred to pick his own herbs because it took less time than walking into the bush to find the bush doctor. Other participants like Famata (CM) echoed Abram’s claims that picking your own herbs was not only faster but it also meant you could save money. Antoinette (CM) shared that if she is ill and does not want to walk to the bush doctor or does not have money to pay the bush doctor, she will pick the herbs that her mother taught her about as a child.

Even more interesting than how participants described psychosocial and biomedical approaches independently, was their combined use of psychosocial and biomedical care. Mind-body dualism, or the common belief that the body and mind are two separate entities, is predominately accepted by western cultures (Burgmer et al., 2018; Forstmann et al., 2012). The Western concept of a person is “composed of a body

and a mind that co-exist, but are often regarded as separate (Cartesian dualism). Concepts of the mind are often associated with concepts like morality, will, virtue, and weakness; while understandings of the body are often grounded in a biological understanding” (WHO, 2017, p. 26). However, Liberians believe that a person is both a physical body and spirit (mind) and that both parts are interdependent (WHO, 2017). For Liberians, “the separation of the spirit and the body occurs at death, but it can also occur during life as a result of tampering with powerful spiritual forces during life through witchcraft or sorcery” (WHO, 2017, p. 26).

Participants who described the use of multiple approaches to healthcare, such as going to the clinic, prayer, and encouragement or support from family and friends, demonstrated how Liberians believe in the interdependence of the mind and the body. For most participants, the coping or carrying me through process did not consist of just one approach. Remember back to Famata (CM) who was sharing about her use of biomedical approaches; as I continued to interview her, she revealed that she also uses psychosocial care. When I asked her to elaborate, she said that depending on how severe her symptoms were, she might try to treat herself by either picking herbs or buying a tablet at the pharmacy. However, if those approaches did not work in a few days, she would go to the clinic.

Healthcare Providers shared similar stories about their patients. Washington (HCP) seemed agitated when he started sharing about his patients who do not follow their treatment plan. He stated that he had several patients that would abandon their treatment plans because they were not seeing visible results within mere hours. Those patients, Washington said, are the ones that will then go off to the bush doctor and it is there under

the bush doctor's care that patients may start to see the effects of the tablets Washington had given them; but, it never fails the patients always believe it is the healing of the bush doctor. In these examples, the fluidity of the relationship is heavily predicated on time.

Other participants navigate the fluidity based on the cause of the illness. James T. (CM) shared that if he believes that someone has cast bad medicine (spell or witchcraft) on him, he will first go the traditional healers because they will understand what needs to be done. However, James T. also said that there had been times, just to be safe, he has stopped by the clinic to pick up a tablet. This way, if his illness is caused by "infection," he will be covered. Others shared similar stories of using multiple approaches just in case one of them fails.

For Liberians, coping is not the end game of health literacy; there is no linear progression from obtaining knowledge to coping with an illness to fully recovering. The narratives presented by individuals in this research demonstrated a larger community narrative. The Flehla community narrative is complex and sometimes fluid. Often, the Flehla community narrative defies western ideas (i.e., dualism) and approaches to healthcare, instead focusing on methods that hold true to their traditional and cultural values. This is important because it changes how we see understand health literacy as a process that is transactional and co-created, not a set of western standards that can be imposed on an individual or community. Transactional and co-created health literacy allows for the decolonization of health in marginalized communities. This research advances our understanding of how Liberians define coping. Finally, this research advances the scholarship as it demonstrates that psychosocial and biomedical approaches

to health do not operate in silos independent of each other; instead, they are complex concepts central to health and its treatment in rural Liberia.

Implications and Future Research

In the previous sections, I have made a case for the importance of community illness narratives. Participants in this research study shared individual narratives with me, and through analysis, several important ideas emerged. However, when the narratives are examined together, they create a community narrative for individuals living in Flehla and the surrounding villages. This study advances health communication in a few ways. First, this study fulfills a gap in health communication that is vacant of subaltern voices in communication and narrative research. Second, this study challenges preconceived notions about developing countries. Many people hold the beliefs that because developing countries are often poor, they must be lacking in all areas including health knowledge. However, this research demonstrates how a developing country, and more specifically a rural area, can demonstrate high levels of functional health literacy. Third, this research is a reminder that cross-cultural health communication research can expand our understanding of health in Western culture, rather than serving only as a springboard for intervention in places that are not well resourced. Finally, this research provides additional narratives that add to the rich, culturally diverse, non-western stories growing in our discipline as researchers reach beyond their immediate surroundings to extend knowledge about health information, illness, and patient care. Culture-centered approaches to health advocates for the ready inclusion of subaltern voices in the examination of health needs and communication about it (Dutta, 2008). This research follows the culture-centered approach in that the voices of rural Liberians and their

communities are no longer ignored or overlooked. Rather, the community narrative serves as a tool to bring central attention to the lived experiences of rural Liberians.

In light of the implications of this study, there are several ways this work can inform and inspire future research. First, there is room for culturally centered health literacy interventions for illnesses. Participants in this study demonstrated a great deal of knowledge about malaria and typhoid fever. However, other illnesses would benefit from health literacy interventions. For example, HIV/AIDS is still considered to be culturally taboo. Developing material that provides information and support with the culture at the center would serve as a way to promote health literacy concerning HIV/AIDS.

There were other concerns expressed by the healthcare providers, specifically about diabetes, which community members did not fully understand. Other health concerns, such as family planning, sexual health, and mental health, would all benefit from culturally driven and informed health interventions. Ultimately, developing culture-centered programs would empower communities to handle illnesses other than malaria and typhoid.

Second, there needs to be continued research in rural Liberia. Almost all of the research conducted in Liberia takes place in Monrovia. While that research is important, so are the voices and experiences of those who do not live in heavily populated areas. Continuing to research in rural areas and share the stories of residents will promote subaltern voices and expose the world to different understandings of health in tribal communities in Liberia. Finally, understanding how communities use narratives as persuasive forms of discourse informs researchers who are developing and sharing health messages. When health messages or interventions lack an understanding of discursive

practices, the messages and interventions often fail. Through a deeper understanding of community and individual narratives, these failures could be avoided. This is especially important during times of health crisis like the Ebola epidemic.

Limitations

For this study, I identified three limitations: culture differences, power differences, and generalizations of my data. As I recruited participants and conducted my interviews, the cultural differences between the participants and myself became increasingly apparent. After several individuals declined to participate due to lack of monetary payment, I began to wonder if this would be a continuous hurdle throughout the data collection process. However, my host informed me within the last 10-15 years, many Liberians expect monetary payment for any service, maybe even something as small as holding a door open for someone as they carry in their luggage. Because I am American, the assumption was that I had disposable income and should freely dispense it.

In addition to my concerns about money and culture, I am concerned that some of the figures of speech or examples participants used will be lost or be poorly represented in the research due to a breakdown of cultural knowledge. To combat this issue, I asked additional questions to clarify any confusion or misunderstanding on my part. I was also able to be in contact with John Travis throughout the analysis process to help clarify questions.

Throughout the research process, I was highly aware of the power difference between the participants and myself. Many participants mentioned my education and expertise, highlighting the ways I was different from the vast majority of my research participants. Within the research context, there is the perception of power and authority

placed with the lead researcher. These perceptions are compounded when adding a different culture, race, and gender. To address these issues and potential power differences, I always attempted to place myself physically lower than my participant. Liberian culture places a great deal of significance on physical power placement and posture. I wanted my research participants to understand that they were the honored guests despite any perceived power difference between us. Both cultural and power differences could have prevented participants from being more transparent and forthcoming with details about how they handle illness. This assumption could be especially prevalent when individuals were asked about their use of traditional or bush medicine. I made several attempts to assure participants that I was interested in their experience and learning about their health stories. Finally, another limitation is that this study did not result in generalizable data, due to its qualitative nature and the collections of the data that was unique to me and my relationships in this community.

Liberia is a country that has been riddled with a traumatic history. However, Liberians have remained resilient throughout multiple hardships. This research is critical because it is a way to give agency to the rural Liberians who are rarely included in health communication research. In giving rural Liberians agency to share their stories of illness and resilience, this research is adding to the existing literature in communication, culture, coping, narrative, and health.

Conclusion

I began this research project by posing the following research questions: 1) What do narratives of sickness from Liberian community members and healthcare providers reveal about coping; 2) What do narratives of sickness from Liberian community

members and healthcare providers reveal about health knowledge; and 3) What do narratives of sickness from Liberian community members and healthcare providers reveal about concepts of illness and culture? These questions provided me the opportunity to explore larger themes outside of those presented in the framework analysis; therefore, leading me to explore how community and individual narratives of sickness describe coping as a complex process.

When an individual encounters an illness, there are multiple filters used before making a decision on how to cope. For example, the experience is filtered through knowledge, or lack thereof, to determine if the individual or community knows the specific illness they are dealing with. Once the illness is identified, the factors such as causes (e.g., spiritual or biological), cultural norms, access to resources, family history, and familiarity of treatment options are imposed on the illness experience. There are hundreds of decisions and factors that must be considered before an individual makes a decision about how they will cope with an illness. The complexity of coping can then be compounded by factors such as power structures and poor healthcare infrastructure. It is during these chaotic times that community narrative assumes the role of a persuasive communication tool. Individuals who operate within the community are able to use the community narrative as a way to determine what might be the best approach for their illness situation.

Community narratives revealed that participants have a broad understanding of health knowledge. Liberians in this study demonstrated functional health literacy and confirmed that participants know the causes, symptoms, treatments, and prevention methods for common illness such as malaria and typhoid. Narratives also revealed that

community members are able to process and act on the health knowledge in order to make health decisions that work for them.

Finally, narratives revealed that rural Liberians in Flehla conceptualize the concept of illness uniquely. Throughout narratives, the term *illness* was often used interchangeably with the term *sickness*. For Liberians, illness/sickness is both an internal (e.g., what is happening within your body) and external (e.g., it impacts their lives in a public way) experience. Narratives also validated that culture plays a vital role in how individuals experience a health event. Culture is the foundation for how individuals and communities not only craft their narratives but also how they make decisions. Ultimately, the narratives shared in this research study invite scholars into a deeper understanding of cultural community narratives.

Personal journal entry on July 23, 2012, the conclusion of my first trip to Liberia. “Leaving Flehla was horrible. The children cried. We cried. It is a strange experience to receive such hospitality from a community of people who have limited resources. I think it is their hospitality that has moved me the most. Liberians are eager to share their home, food, and even personal life stories. It’s really amazing if you think about. If I have learned anything, it is that the people of Liberia are strong. They are fighters and have endured so much considering the back-to-back wars.”

Personal journal entry on July 14, 2013. “Leaving this time was much easier. We concluded our trip by helping unload supplies for a fence. Each time I arrive in Liberia, I leave with a newfound respect of the culture and people. This trip was different for me because I was able to spend some time interviewing people. Their stories... wow. They are in fact a strong community. We are already planning our return trip next year. The

team is excited and so am I. Our plan is to arrive around mid-May. Until next time, so long Mama Liberia.”

Personal journal entry on May 30, 2016. “We are finally in Monrovia. Our day was spent driving from Flehla to the airport, and by some miracle we are here early. Just a few observations about Liberia... 3 years later and so much has changed. The extra checkpoints, hand washing, and fever checking stations at the crossing of each county line are the big change. The Ebola epidemic is over but you can still sense the fear and concern. I’m still impressed with the overcoming attitude of the Liberia people, first the civil wars and then Ebola. It’s crazy. But one thing that hasn’t changed is the chaos inside the airport. Once I made it through check-in and customs, I grabbed a seat over near a dark tinted window. Even though it is hard to see out, I know there is a shuttle waiting to drive us to the plane. I know we will feel a slight breeze mixed with tropical humidity. After two weeks, I am somewhat used to the heat.”

Liberians and expats who have spent time in the country refer to Liberia as Mama Liberia. I smile when I think of this woman, Mama Liberia. I can instantly visualize a broad-shouldered woman in her mid-thirties, toned arms, sweat dripping down her forehead. She has a bundle on her head, using one arm to steady it when needed and around her waist is a bright lappa wrap. This woman has borne many generations of children and they have survived the unthinkable. She demonstrates resilience in a way that catches you by surprise. As you pass her, she offers a smile and says “yah-twa-yay” or hello in Kpelle. She is the epitome of Liberia.

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Appendix A

Interview Questions (Individuals)

Adapted from: Groleau, D., Young, A., & Kirmayer, L. (2006). An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry*, 43, 671-691.

1. Could you tell me about health problems (HP) you have experienced?
2. Could you tell me when you realized you had this HP?
3. If you went to see a healer of any kind, could you tell us about your visit and what happened afterwards?
4. If you went to see a doctor or other healthcare provider, could you tell us about your visit and what happened afterwards?
5. Did a person in your family ever experience a HP similar to yours?
 - a. In what ways do you consider your HP to be similar to or different from your family members?
6. Did a person in your social environment (friends, co-workers, village) experience a HP similar to yours?
 - a. In what ways do you consider your HP to be similar to or different from this person's HP?
7. Did your healer, doctor, healthcare provider give you any treatment, medicine or recommendation to follow for your HP?
 - a. How are you dealing with these recommendations?
8. What has helped you through this period in your life?
9. How have your family or friends helped you through this difficult period of your life?
10. How has your spiritual life, faith or religious practice helped you go through this difficult period of your life?
 - a. Does your healer, doctor or healthcare provider know about your spiritual life, faith or religious practice?

Appendix B

Interview Questions (Healthcare Providers)

1. Could you tell me about how you address a patient's health problem (HP)? (i.e. strictly from medical view or from a holistic life impact?)
2. Could you tell me about how patients present HP?
 - a. Do they talk about physical aspects or the social aspect? Spiritual?
 - b. Which do they most emphasize?
 - c. Can you give me some examples?
3. Do you sometimes suggest ways for patients to cope with their health problems? If so, could you give me some examples?
4. Do you incorporate spirituality, faith or religious practices/beliefs in your care?
5. If so, could you tell me how you incorporate spiritual, faith, or religious practices/beliefs in your care?
6. How do you see patients incorporating spirituality, faith or religious practice in their care?
7. How do you see patients incorporating spirituality, faith or religious practice in their coping process?
8. Do you suggest ways patients can incorporate spiritual life, faith or religious practice into their healing process?

Appendix C- Recruiting script

For individuals with illness:

We have an American visitor in Flehla this month who is doing some research on how our villagers cope when they are sick. She is interested in interviewing 35 people and I would like to know whether or not you would consider meeting her to find out more about the study. You won't get paid to participate but you might enjoy talking with her and telling her your stories. Participating in the project might also help us in the future to better support people when they are sick.

The visitor's name is Crystal Daugherty. She will be here during the weeks of May 12th- May 30th. Anyone who lives here and is over 18 can participate as long as they can speak English and have been seriously sick at some time in their adult lives.

You do not have to decide now whether or not you want to do the interview. The first step is to meet Crystal and then you can decide to do the interview if you want to. If you are interested, please let me know.

For healthcare providers:

The recruiters will briefly describe the study, using the script above, and ask if they can introduce Crystal to them to further explain.

Appendix D

Focus Group Questions (Individuals)

Go around and allow participants to introduce themselves. Remind them that they have signed the informed consent. Ask them to keep this conversation private. Spend a few minutes reviewing informed consent, audio recording and privacy measures I will be taking.

1. Could you share what health problems (HP) are most common in this area?
 - a. How do individuals address these health problems?
 - b. How does the community address these health problems?
2. Could you explain different healthcare options available in this area? (Traditional healers, western doctors, etc).
 - a. Could you explain how an individual decides which option to take?
3. Could you share how illness influences local families?
4. How does the community cope with widespread illness (malaria, yellow fever, HIV/AIDS, ebola)?
5. How has the spiritual life, faith or religious practice helped the community cope with illness?

Appendix E

Focus Group Questions (Healthcare Providers)

Go around and allow participants to introduce themselves. Remind them that they have signed the informed consent. Spend a few minutes reviewing informed consent, audio recording and privacy measures I will be taking. Ask them to keep the group's conversation private.

1. Could you share what health problems (HP) are most common in this area?
 - a. How have your patients addressed these health problems?
 - b. How does the community address these health problems?
2. Could you explain the difference healthcare options available in this area? (Traditional healers, western doctors, etc).
 - a. Could you explain how your patients select their healthcare providers?
3. How do you see the community incorporating spiritual life, faith or religious practice into their healing process?
 - a. Could you answer the same question for individuals?
4. How do you see the community incorporating spiritual life, faith or religious practice into their coping process?
 - a. Could you answer the same question for individuals?
5. How do patients respond to healthcare instructions? (i.e. compliance?)
6. How often do patients consult both holistic healthcare and biomedical healthcare measures?

Appendix F

IRB Approval

Date: 4-8-2019

IRB #: 4144

Title: Health legacies, spirituality and coping: A study of health narratives in Liberia

Creation Date: 9-7-2016

End Date: 9-14-2019

Status: **Approved**

Principal Investigator: Crystal Daugherty

Review Board: University of Memphis Full Board

Sponsor:

Study History

Submission Type	Legacy	Review Type	Unassigned	Decision
Submission Type	Renewal	Review Type	Expedited	Decision Approved
Submission Type	Renewal	Review Type	Expedited	Decision Approved
Submission Type	Renewal	Review Type	Expedited	Decision Approved

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