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'If they see you bleeding they will quarantine you': Women's help-seeking for violence during the Ebola and COVID-19 outbreaks in Sierra Leone

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ABSTRACT

There is increased awareness of the gendered impacts of outbreaks, including an exacerbation of violence against women and disruptions to essential health service delivery for women. However, there is limited understanding of women's own experiences of deciding to use the health system after experiencing violence in settings affected by major emergent outbreaks like Ebola and COVID-19. Drawing on data from 37 in-depth interviews and 4 focus group discussions conducted in Sierra Leone we described survivors' help-seeking pathways and interactions with the health system. Deciding to seek help and selecting a source of support was dependant on how 'unacceptable' the type of violence was, women's needs (be they for physical, psychological or social trauma) and the risk versus benefit anticipated in accessing support. Informal providers such as local mediators were often the first place that survivors sought help. Pre-existing challenges around access and poor-quality service provision were exacerbated by the outbreaks. Fear of infection, quarantine and widespread distrust of the Ebola response shaped women's help-seeking especially if symptoms like bleeding could resemble the virus. Our findings support the need to re-orientate towards survivor-defined interventions that are flexible in providing a wider range of support choices.

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Background

Violence against women (VAW) is a major global health problem, with recent data showing one in three women worldwide has been subjected to physical and/or sexual violence in their lifetime leading to a significant mental, physical and sexual and reproductive health burden (WHO, 2021a). Crises such as disease outbreaks, and their containment measures, often exacerbate VAW and yet during these periods essential services for women are often neglected or shut down (CARE, 2020; Fraser, 2020; Peterman et al., 2020; Smith, 2019; Wenham et al., 2020; WHO et al., 2020). Service delivery for VAW should include medical, psychosocial support and multi-sectoral referrals (García-Moreno et al., 2015). Despite recent normative work around gender-sensitive responses to outbreaks (Meinhart et al., 2021; Rosser et al., 2021; WHO, 2021b)

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there is very little primary research conducted with survivors to understand their experiences seeking help during outbreaks.

Our study was conducted in Sierra Leone which has a recent history of national-level action against VAW. Sierra Leone's experience with the largest global outbreak of Ebola from 2014 to 2015 also places it at the centre of international outbreak response agendas. Ebola resulted in almost 4000 deaths (WHO, 2016a) and during the outbreak period sexual violence was exacerbated, linked to survival sex amongst girls who had lost caregivers, closure of school which had served as protective spaces in the community, and sexual exploitation and abuse perpetrated by the civil–military responders (Minor, 2017; Onyango et al., 2019). Following the first recorded COVID-19 case in March 2020 the pandemic had a relatively limited direct impact, with stay-at-home orders lasting only days and under 7700 recorded cases reported at the time of this study in late 2022. However many factors known to exacerbate VAW and disrupt help-seeking were at play like inter-district movement bans, curfews, fuel shortages and economic stress, and securitisation (Lees et al., 2022).

Sierra Leone has a very high prevalence of VAW post-civil war and post-Ebola with 61% of women aged 15–49 having experienced physical violence by anyone since age 15, and 50% of ever married women experiencing physical, sexual or emotional violence by their current or most recent partner. Multiple forms of violence overlap and are severe with 30% of women having sustained injuries, and 40% seeking help (Statistics Sierra Leone, 2019). During the Ebola recovery period, the government in Sierra Leone launched a high-profile response after VAW was declared a 'national emergency', the First Lady's 'Hands off our Girls' campaign began, and by early 2019 reporting had improved with the number of cases reported to the police more than doubled (Martin & Koroma, 2020). However, overall the response primarily involved justice reforms with limited enforcement, which have not been matched by investment in health system responses (Graybill, 2021).

Despite renewed national attention following the civil war and Ebola, health service delivery in Sierra Leone for VAW is incredibly limited. The Rainbo Initiative is the only free provider of clinical and psychosocial support to survivors in Sierra Leone, and in 2020 its five centres assisted over 3500 people, with adolescents making up the majority of cases (Rainbo Initiative, 2020). One Stop Shops run by the Ministry of Social Welfare, Gender and Children's Affairs in district towns are the second main provider and were reported to reach a much smaller number of survivors (532 in 2020) (UNFPA, n.d.). As with other settings many survivors may also be seen at primary or secondary facilities presenting for treatment for sexual and reproductive health concerns, mental health or physical injuries. These facilities suffer from access and provision challenges, and a recent body of work has demonstrated the enormous impact of Ebola on delivery of these services (Bietsch et al., 2020; McKay et al., 2022).

In Sierra Leone, help-seeking for violence is predominantly from informal sources of support like family and neighbours, with formal health services seen as a last resort (Denney & Ibrahim, 2012; Horn et al., 2016; Statistics Sierra Leone, 2019). This is influenced by a range of factors including distrust of health and justice services, limited availability of those services and various costs implied in using them, and norms determining whether women acknowledge violence as a problem and seek help which are based on the broader economic and political context in which violence is embedded (Horn et al., 2016; Schneider, 2019). In Sierra Leone, reporting or seeking help for VAW remains highly socially embedded, constrained by the overlap between individual, community and state restrictions and norms (Mills et al., 2015; Schneider, 2019; Smythe, 2021).

Violence is often viewed as restorative rather than disruptive to relationships in Sierra Leone and similar settings in the region (Nnyombi et al., 2022), with certain types of violence normalised and seen to form part of functional relationships. Research shows participants in Sierra Leone espouse highly gendered notions of intimacy, affection, violence and agency, for example reporting that a violent husband indicates love or a wife's failure to be a good wife (Mills et al., 2015; Schneider, 2019).

Whilst there is some understanding of help-seeking for justice in the aftermath of Ebola, there is a paucity of literature on how survivors may use health services and the health system after experiences of violence. Given the landscape for VAW service provision is extremely limited in Sierra Leone, understanding what existing support is provided by the community and how survivors have interacted with services and sources of help is an important step towards intervention.

The aim of this paper is to describe women VAW survivors' experiences during the Ebola and COVID-19 epidemics in Sierra Leone examining their help-seeking pathways and interactions with the health system. We begin by assessing how Ebola and COVID-19 outbreaks impacted on women's experiences of violence. We then analyse women survivors' problem framing and decisions to seek help during outbreak periods, with a view to understanding women survivors' selection of a source of support during outbreak periods.

Theoretical framework

Liang et al. (2005) developed a framework (Figure 1) which focuses on help-seeking in the context of intimate partner violence (IPV). This framework sets out three stages of seeking help for a survivor: (i) defining the problem, (ii) deciding to seek help and (iii) selecting a source of support. A survivor's journey through these stages is not necessarily linear, and progression through different stages is characterised by a survivor's cost–benefit assessment of the situation and how she would benefit or suffer from seeking help. These stages are influenced by individual, interpersonal and socio-cultural factors.

This model resonates with other stage models whereby survivors move from more individual attempts to deal with abuse (e.g. resisting), to seeking help from informal sources (e.g. family and friends) as the violence worsens and finally help-seeking from formal services (e.g. the legal system) (Liang et al., 2005).

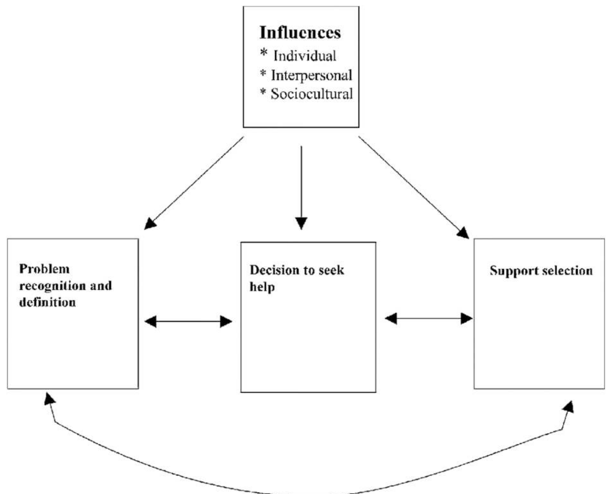

Figure 1. Liang et al. (2005) model of help-seeking and change in the IPV context.

Methods

Study setting

This study drew on qualitative data collected from in-depth interviews and focus group discussions in Freetown and Kambia and was part of a larger body of social science research on community

preparedness for outbreaks conducted alongside the EBOVAC3 Ebola vaccine trial (Enria et al., 2016; Lee et al., 2022; Mooney et al., 2018; Tengbeh et al., 2018). Two vaccine trials have been ongoing in Kambia district since the Ebola outbreak in 2015.

The two sites, which differ significantly in terms of access to health and other services for VAW, were selected as contrasting settings. Kambia is a small border town on the Sierra Leone-Guinea border. Kambia was not only disproportionately affected by the Ebola outbreak but it was the focus of 'Operation Northern Push' and the battle to end the outbreak (NERC, 2015). Kambia District had 286 confirmed Ebola cases from September 2014 to September 2015. Kambia district has approximately 350,000 residents (2015 census) with 69 public health facilities across the district including one hospital. VAW interventions being conducted in Kambia District are limited with some NGO programming around prevention, and with government and justice services delivered by the Kambia Family Support Unit (FSU). There were no health or medical interventions operating for survivors until 2022 when an NGO clinic was opened at the Kambia Government Hospital. Prior to this, referral protocols indicated a survivor should be offered basic care and referred to the Ministry of Gender 'One Stop Shop' in Port Loko (which involves travelling over 50 kilometres at significant cost) for medical services as well as the Kambia FSU for justice. In Sierra Leone, customary authority systems mean that chiefs (who are the top executive authority in local administrative units) and 'ababus' (community leaders who can act as mediators) manage a range of justice concerns including those around violence. Informal health providers such as unlicensed drug vendors and traditional healers also play a key role in managing health concerns.

The majority of national actors and headquarters of INGOs/NGOs focused on VAW programming and outbreak programming are based in the capital city, Freetown. At the Freetown study site, we recruited survivors from an NGO clinic. This site offers comprehensive, free, quality, age-appropriate medical care, psychosocial services and legal aid information to survivors of sexual and gender-based violence. During 2020 the site saw 1409 cases, the vast majority of whom were female survivors of sexual violence. This VAW health service delivery setting allowed us to examine survivors' help-seeking and use of the health system in a relatively well-resourced vertical health service delivery setting.

Sampling and recruitment

For the interviews, we recruited key informants such as outbreak actors and service providers, and women who had faced physical or sexual violence during Ebola or COVID-19 outbreaks. Community members living locally were recruited for the interviews and focus group discussions. Key informants and the community stakeholders sampled for both interviews and FGDs were approached using EBOVAC3 and the Rainbo Initiative networks, initially using purposive sampling and then snowball sampling to identify subsequent informants. We recruited a range of participants, including outbreak responders, providers of VAW clinical services, and traditional healers. A variety of community members were sampled for the focus group discussions, including those from semi-urban and remote-rural areas (Kambia) as well as informal settlements (Freetown) which were heavily affected by the outbreaks.

In Freetown, women who used services for violence during the height of the Ebola and COVID-19 outbreaks were recruited through NGO clinic staff accessing patient files from those dates, and then via telephone inviting women to be contacted by a research assistant. In Kambia, we purposively sampled women who experienced violence during these periods through community and EBOVAC3 networks. These women had not necessarily used health services following their experiences of violence, although most had sought help from someone. Compared to Freetown, these women had mostly faced IPV, for which women rarely present at clinics or hospitals. In Freetown, recruiting from a clinic setting meant that women recruited had mostly sought careafter being raped by someone who was not their partner.

Data collection

Thirty-seven in-depth interviews and four focus group discussions were conducted in Freetown and Kambia between September and December 2022 (Table 1). Topic guides for survivors and community members were designed to map women survivors' help-seeking pathways during outbreaks and included visual tools and a vignette, guides aimed to draw out information on how they framed the problem of violence, made decisions around help-seeking, chose a source of support, and what challenges or enablers they encountered in accessing these sources of support. Topic guides for service providers and outbreak key informants focused on their experiences delivering health services for women (formal and informal) during outbreaks, and consideration given to essential health services for women by the outbreak response. The Liang et al. (2005) help-seeking framework informed the development of the tools. Interviews lasted between 8 and 81 minutes in duration and focus groups between 88 and 101 minutes. Interviews and discussion groups were conducted in a private space convenient for participants to reach.

Table 1. Study participants.

Participant characteristics	Data collection method and location			
	Interviews		Focus group discussions	
Key informants	KIIs Freetown	KIIs Kambia	KI FGDs Freetown	KI FGDs Kambia
• Outbreak key informants	2	3	–	–
• VAW health service key informants	4	6	–	–
Community members	IDIs Freetown	IDIs Kambia	FGDs Freetown	FGDs Kambia
• Community members	3	3	2	2
Women survivors	IDIs Freetown	IDIs Kambia	FGDs Freetown	FGDs Kambia
• IPV (sexual/physical)	1	7	–	–
• Non-partner violence (sexual/physical)	7	1	–	–
• 18–29 years (at interview)	1	4	–	–
• ≥ 30 years (at interview)	7	4	–	–
Sub totals	17	20	2	2
Total	37		4	

Data were collected by two trained research assistants (in Krio and Temne) and the principal investigator (in English). The research assistant in Kambia was a native Kambian who had worked in community engagement during the Ebola outbreak. In Freetown the research assistant was seconded from a non-clinical role at the Rainbo Initiative and was familiar with the VAW service delivery landscape in Freetown. The principal investigator was based in London and had worked on social science research within the EBOVAC3 project in Kambia since 2019. The research team were all women.

Data management and analysis

Interviews and focus group discussions were audio recorded, translated into English and then transcribed. Interview and focus group discussion transcripts were coded jointly, aided by NVivo12, and analysed thematically according to Braun and Clarke's six-phase approach which reflects the researcher's interpretive analysis of the data (Braun & Clarke, 2006). Coding was initially deductive, structured according to different stages of the Liang et al. (2005) framework, starting from

the participant's initial decision, to their selection, access to and experiences with different sources of help. Emergent themes were then added inductively. Analytic memos were used to develop the themes into higher order concepts around help-seeking and to compare relations between codes. The coding framework was developed between the principal investigator, co-investigators and research assistants. During the interpretation of results consideration was given to the interpretation of categories that had local meanings attached.

Ethics

This study was approved by Sierra Leone Ethics and Scientific Review Committee (reference: 020/08/2022) and LSHTM ethics committee (reference: 28053). Local permission was granted from the Kambia District Medical Officer and from local traditional authorities. Study information was provided to all participants in their preferred language and they were given the opportunity to ask questions before they gave their consent. All identifiable information was removed during transcribing and drafting of field notes, and a script assisted staff and participants to answer questions about the study posed by uninvolved family and community members such that VAW was not communicated as the primary focus. International guidelines for conducting research on VAW were drawn upon throughout the study including the WHO and PATH guidelines (Ellsberg & Heise, 2005; WHO, 2016b), and a distress protocol was used, adapted from Drauker et al. (2009).

Findings

Our findings are structured according to three themes adapted from the Liang et al. (2005) help-seeking framework (see Figure 2). The first theme (top of Figure 2) outlines the ***context*** in which women lived, violence occurred, and survivors sought help. We found that patterns of violence in the home and communities changed during the outbreaks and were influenced by different

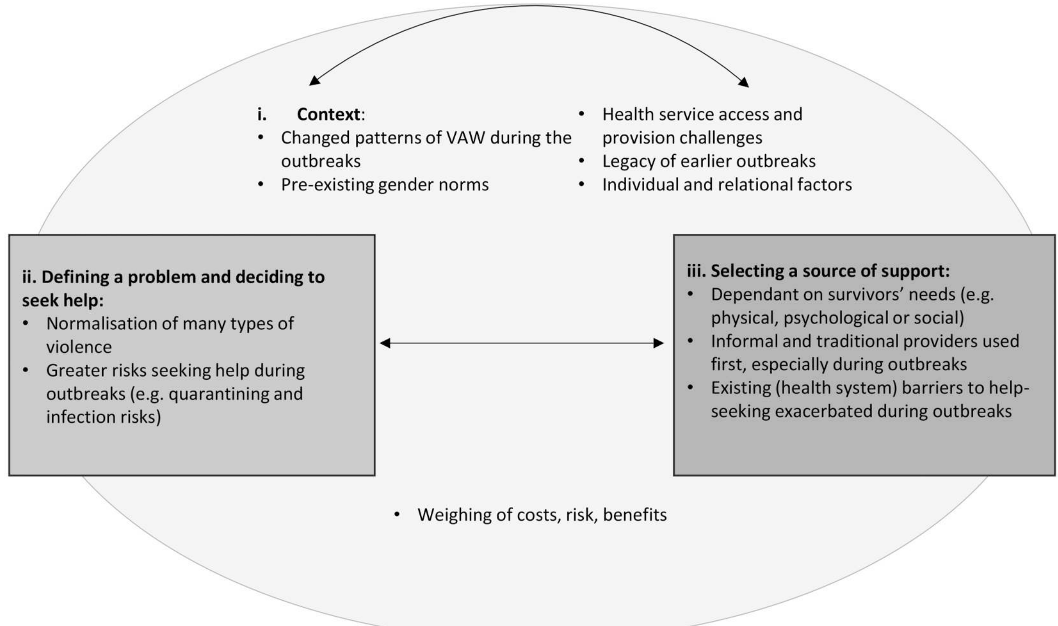

Figure 2. Summary of main findings on survivors' help-seeking during outbreaks presented as an adaptation of the Liang et al. (2005) framework.

factors including gender norms (which pre-dated the outbreaks) and social disruptions which shaped women's help-seeking pathways during the outbreaks. The second theme (left box in Figure 2) outlines women's ***problem framing of violence and decisions to seek help*** after experiencing violence. This was shaped by the normalisation of many types of violence, and during outbreaks there was an increased threshold for help-seeking. The third theme (right box in Figure 2) describes how women's ***selection of a source of support*** was dependant on their specific needs, with many known barriers to accessing services exacerbated during the outbreaks.

'Everyone was at home so there was a lot of fighting': Contextualising VAW during the Ebola and COVID-19 outbreaks

Participants described a broad range of male-perpetrated types of violence that affected their lives or that they witnessed within their communities, both within and outside of the outbreak periods. This included sexual violence, which many understood to mostly affect children and adolescents, and physical violence used by husbands within families. Others described structural violence '*the violence that is happening now here is poverty*' [male community member, Freetown] as well as relationship power inequality, infidelity, economic abuse and failure of fathers to provide money for their families. During outbreaks, many participants reported changed patterns of violence. Whilst some of the containment measures may have meant less time was spent in public spaces where violence perpetration by strangers occurs, participants overwhelmingly reported increases in IPV, often when husbands were out of work and economic and interpersonal stress within families intensified. The following participants describe both the increased tensions inside the home that triggered violence and the opportunity that an atmosphere of crisis gave perpetrators, given that authorities were focused elsewhere:

> Yes it was happening, because of the lockdown, closed schools and everyone was at home including the children and youth, so there was a lot of quarrelling and fighting going on, between family members [male key informant, Freetown]

> I learned that most us are having problems during hard times, people will use it to their advantage to do us bad like rape us, because the government's attention is all on the outbreak now … but we all have rights [woman survivor aged 30–39 years, Freetown]

Sexual and physical IPV were driven by gender roles within marriages whereby husbands were seen to provide financially and wives provide sexually. When this 'bargain' was fractured and wives did not want to have sex, sometimes in connection to husbands failing to bring home money for food during the outbreaks, husbands became violent. This was often described as 'fighting over mummy and daddy business'. As such economic precarity mediated through gender norms often triggered IPV. This violence also appeared to bolster a masculine identity that was under threat considering that many men had lost livelihood opportunities during the outbreaks. The following man explains this during an FGD:

> We are the ones that have the women and they also in turn have us as men, at times you will give her what to eat [money] at times it is not enough but she will add to it and so if you ask her for sex at night she will not agree thinking because you are giving her incomplete money, you have gotten someone else that you give more and that is where the fight will start. [male FGD participant, Kambia]

Experiences of violence during the outbreaks were contextualised within, and triggered by, the social disruption, family breakdowns and deaths that Ebola caused. The following survivor describes the precarity and stigma she faced after being quarantined and losing her parents to the virus. After relocating to her aunt's house she was raped by her uncle:

> When we were there (quarantine facility), that chlorine which they were spraying was too much, and they were spraying it too much, after my parent died, I was left all alone, and I too started getting sick … I was taken back to my house … I was crying day and night, and my aunt came and said I should not be staying home alone … so I agree because I have no one … and he (my uncle) had sex with me, after that, he said if I will tell anyone what happened, first his wife will not believe me because she trusted him, and he is the man of the house … and he will kill me. [woman survivor aged 30–39 years, Freetown]

'You just have to endure it': Increased threshold for framing violence as a problem and deciding to seek help

In the study communities, a survivor's decision to seek help was strongly influenced by whether the type of violence she experienced was defined as 'acceptable' or 'unacceptable' as per local norms around violence. If it was normalised and seen as part of a functioning relationship, such as sexual IPV, women were unlikely to define violence as a problem for which help needed to be sought. Violence needed to be considered transgressive for it to be 'unacceptable', such as violence causing injuries that required treatment and treatment expenses, rape of children, or in some cases violence from a husband who did not fulfil his obligations to provide money to the household (or was providing money to a girlfriend instead). These norms around rape were explained by the following study participant:

> For the women, they take it (sexual IPV) to be normal because, as long as you are married, when your husband needs you whether you are willing or not if he forces you they will not take it as serious even if you complain about it. So, it is just the children that they take it to be as rape. [woman survivor 20–29 years, Kambia]

In general, there was very little help-seeking for types of violence deemed 'acceptable'. This was reflected in differences between the sites. Survivors in Kambia were recruited from the community and most had faced IPV, which is generally more normalised compared to survivors in Freetown who were recruited from and had accessed a clinic setting usually after rape by a non-partner, which is perceived as more 'unacceptable'. As the following survivor describes, 'negative support' was often provided by family and community members who discouraged survivors from seeking help:

> I was told to forgive and let go of the case because he did not hit me hard nor hurt me too much or damage me, he was hitting my back, so I showed my family but when they looked they did not see any mark or damage. I wanted to go to the police station but I was advise not to do that [woman survivor aged 20–29 years, Kambia]

Women were not a homogenous group and normalisation of violence impacted on women differently, with some women finding it more difficult to decide to seek help than others. We found significant heterogeneity in terms of help-seeking within each site, for example remote areas of Kambia district were seen to be outside of the control of law enforcement, human rights and GBV prevention campaigns. Chiefs and customary justice actors played a greater role in survivors' help-seeking in these areas. Participants also felt these villages faced more pronounced patriarchal norms which reduced women's opportunities for help-seeking:

> If you are in your matrimonial home particularly in our own community – those in the bigger towns are a bit better than us here in our (rural) community-because here if you go to your husband`s house, you are now going to be the slave. [woman survivor aged 50–59 years, Kambia]

In addition, women over 30 or 40 years old seemed to face additional stigma which prevented them from defining violence as a problem. This was in part related to the misconception that sexual violence stemmed from a perpetrator's physical attraction to the survivor, leading community members to doubt the possibility of older women being subjected to rape. This was also reflected in national GBV reforms and campaigns which have specifically targeted rape against adolescent girls and girl children.

Normalisation of violence continued during the outbreaks, the main difference, especially during Ebola, was that the threshold for help-seeking was much higher. Injuries or symptoms needed to be more severe and the type of violence needed to be more transgressive or further down the spectrum of 'unacceptable' in order for survivors to seek help.

> … people could not move to report those cases [during Ebola], and nobody was getting any information from anyone on where to get help. Like my own case, you just have to endure it. [woman survivor aged 30–39 years, Freetown]

The increased threshold for help-seeking reflected women's assessment of the risk versus benefit of seeking help during these periods. And many participants experienced COVID-19 through the historical lens of the Ebola crisis where they faced the uncertainty of being quarantined or handled as a suspected case by health workers. After being beaten by her husband during the peak of COVID-19, one survivor described how she balanced this uncertainty with the urgency of treatment. She initially self-medicated using informal pharmacies, finally presenting at hospital as a last resort when her wounds were infected and she was in too much pain to work.

> Then I came back and said maybe if I go to the hospital they will go and hold me [quarantine] again because the sickness [COVID-19] was so rampant. So, I came back home and pepeh-doctor myself [self-medication] but I was not ok. [woman survivor aged 40–49 years, Freetown]

As such, women's problem framing and subsequent decisions to seek help were influenced by norms around 'acceptable' violence, as well as an evaluation of the risks of using health structures. These were greater during Ebola, and also initially during COVID-19, when participants in both sites feared the risk of infection and quarantining.

'If they see you bleeding they will quarantine you': Selecting a source of support

Informal and formal sources of support

For women survivors, support selection was not only shaped by how un/acceptable the violence they faced was, but also by the type of trauma (e.g. physical, psychological or social), and access barriers they faced or anticipated facing. During the outbreaks, and especially Ebola, there was very limited service provision for injuries, mental health and SRH concerns associated with violence in government settings, whilst the NGO clinical services in Freetown were reported to continue. Women described navigating access barriers familiar to 'normal' times in government settings such as corruption and transport costs which were then exacerbated by the outbreaks and their containment measures. This differed between sites with Freetown participants having accessed good quality treatment and care at an NGO setting which provided free services and covered transport costs.

During the outbreaks, informal providers such as 'sababus' (influential people acting as mediators) and chiefs, unlicensed drug vendors and traditional healers filled some of these service provision 'gaps' and became the first point of contact for survivors. If the violence was seen as very 'unacceptable' then formal providers may be used, however for many survivors basic commodities like paracetamol were the main intervention used, especially during the outbreaks. A survivor described this during the Ebola period:

> It was just medicines I went for when I said my head is aching and my body as well is aching me. Then they gave me medicines and came back, they gave me Paracetamol and Brufen (Ibuprofen). [woman survivor aged 30–39 years, Kambia]

Survivors' help-seeking pathways during both outbreaks usually involved multiple steps and referrals to different sources of help, with different community members supporting these referrals and providing the resources, like transport money, required to reach them. In navigating these different sources of help and multiple systems of care survivors often needed significant agency and resilience. This is illustrated in Figure 3 from an FGD mapping activity, Marie (top left), a hypothetical survivor, moved between different sources of help from her home, the chief, the police station and the hospital, facing different challenges at each place. As with the interviews, challenges mapped were similar in nature between the two outbreaks, but participants generally described the fear and access barriers as being more prohibitive during Ebola.

In our study sites, survivors' help-seeking was not always for physical or psychological trauma, but sometimes for 'social' trauma, or the rupture of family relationships, and this influenced their choice of support when seeking help. In the case of IPV for example, their goal was often to repair

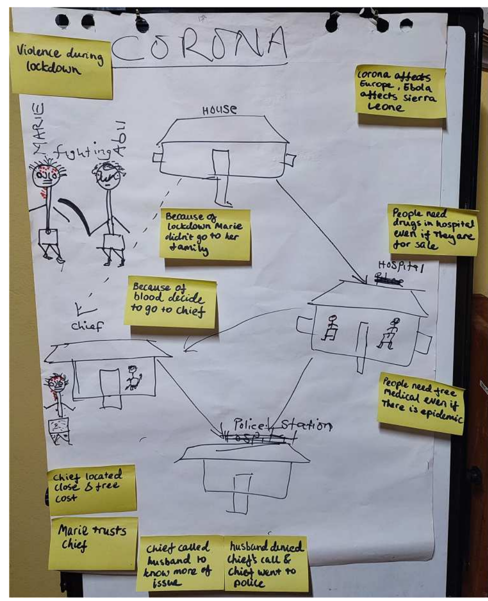

Figure 3. FGD mapping activity describing a survivor's help-seeking pathway during COVID-19 in Kambia.

the relationship with the perpetrator. Influential local actors, usually 'sababus' who play the role of a mediator to 'settle' cases or marriage disputes in the community, were overwhelmingly cited as first point of contact when violence happened despite the recent criminalisation of this practice. Participants trusted and knew 'sababus' personally, they had the authority to discipline husbands without ending marriages, for example through requiring perpetrators to pay fines. They were seen to maintain confidentiality and provide services at a lower cost than police or formal justice services. Mediation could also be provided by parents, parents-in-law and neighbours.

> Because you know that when you go to the hospital and if you have money you will be treated but there is no counselling. So, except that you go to your parents or to your 'sababu' 'Interviewer: "Ok, so when you go to the 'sababu' what he or she will do"?' E!, if you go and explain, you know that they are there to make peace, so they will invite the man and try to know the problem and from there they solve it and they will advise the two of you so that you will go back and stay in peace. [woman survivor aged 20–29 years, Kambia]

> You see, some men will beat you until they admit you at the hospital but you will not have a way of fighting him back even to take him to the law you will be afraid because the marriage will end, your marriage will end except in another way you take him to your 'sababu' so they will go and talk for you. [woman survivor aged 20–29 years, Kambia]

Especially in the absence of psycho-social care and justice provided through formal structures, survivors reported that they relied on 'sababus'.

Weighing the risks and benefits of seeking help

During both Ebola and COVID-19 outbreaks women's overwhelming fear when seeking help, especially from formal settings, was that they could be either infected with the virus or mistaken for being sick with the virus. This discouraged help-seeking. Sierra Leonians' distrust in the (heavily militarised) Ebola response had a legacy, with a large number of participants still reporting that outbreak responders had used chlorine to kill healthy people who were mistakenly contact traced, or that patients were injected with the virus if they attended hospitals:

> Because they said the nurses and the ambulances that were moving around are the ones that transmit Ebola and so if you go the hospital, they will inject you with the virus. [male FGD participant, Kambia]

This meant that individual experiences of violence were overlaid with experiences and rumours of violence perpetrated by health workers themselves. Such narratives of the epidemic remained 7 years later at the time of this study. Although participants universally described Ebola as a markedly worse epidemic, experiences with COVID-19 were situated within the legacy of Ebola and generated similar fears. What's more the two diseases were not necessarily understood as distinct, or as manifesting in different symptoms, for example bleeding was seen by many as a symptom of Ebola and also a symptom of COVID-19. The COVID-19 response was (especially initially) also assumed to involve similar levels of containment and militarisation as Ebola did.

The effect this legacy had on help-seeking manifested in different ways. For example, there was significant secrecy and stigma attached to symptoms that could be seen to resemble Ebola (which were several years later also associated with COVID-19). For example, bleeding after being beaten or raped, or having a high temperature which some participants thought could be caused by distress following violence. Many women hid these symptoms in public areas for fear that contact tracers would be called:

> The motorist was afraid to take (a survivor) because he saw the blood all over her … Because during the time of Ebola no one should ooze blood [male FGD participant, Kambia]

> If they beat you on the way during corona and then you begin to bleed then that again is a problem because if they see you bleeding, they will quarantine you, so the only thing you do is just to stay indoors. [female community member, Freetown]

In addition to this fear, containment measures exacerbated existing access barriers. Transport costs were inflated due to social distancing and increased fuel costs, and lockdowns – although relatively short in Sierra Leone during both outbreaks – prevented women from getting help from their family or parents in other districts:

> During Ebola my husband beat me but during that time it was a lockdown and I was not able to go to my parents except to my neighbour, he was the one that I met then he intervened and broker peace between us [woman survivor aged 20–29 years, Kambia]

There was also significant heterogeneity in terms of access experiences across Kambia district itself. Remote villages faced prohibitive transport costs especially during rainy seasons. Survivors may have needed to find money for increased travel costs to services outside their village during the outbreaks, causing significant delays. For example this resulted in survivors forfeiting access to time-sensitive (e.g. within 72 hours) treatment such as HIV post-exposure prophylaxis and emergency contraception, which are major clinical interventions offered after (usually non-partner) sexual violence:

> Well during Corona we had less cases, less fresh cases [within 72 hours]. Because most of them they must meet a family member to contribute for them to have transport before they can come to the hospital. [health service provider, Kambia]

Existing health (and justice) system challenges persisted and were exacerbated during the outbreaks. Many participants described corruption which usually presented as informal payments. This was a particular issue when presenting to the police, but also at government health centres (with NGO services reported as free of charge). Existing challenges were also made more complex by the fear and risk around seeking help especially from formal settings. Faced with escalated access barriers during outbreaks, many survivors endured on their own following experiences of violence. They either drew upon their own emotional resources, or in the case of the following vignette of a survivor, a significant toll was taken on their mental and physical health as they attempted to manage in isolation:

> So, at that time [of the COVID-19 outbreak] transportation cost increased and there was no way for her to travel to her parents. So, Marie will be considering all of these at home and then will not be able to go to the police station and report and the neighbours will just advise her bear up as it is a moment of corona

> no one is allowed to move freely, so all of that will stress up Marie at home and at times if you don't be careful that stress will lead her to sickness and that is the sickness that will shoot up her blood pressure and they later they will she has been infected with sickness [COVID-19] … After that Marie became helpless because she was not able to seek help. [female FGD participant, Kambia]

Discussion

Our findings detail women's experiences seeking help and accessing the health system following experiences of violence during both the Ebola and COVID-19 outbreaks in two settings in Sierra Leone. This paper adds to other literature highlighting the importance of place and context in understanding the impact of outbreaks on communities, their use of health systems during outbreak periods, and the memories of historical outbreaks in shaping peoples' health seeking (Bond et al., 2021; James et al., 2023). We adapt the Liang et al. (2005) help-seeking framework and show how women survivors' problem definition and decisions to seek help, as well as their selection of a source of support during outbreak periods, were defined by the exacerbation of 'normal' challenges faced trying to access the health system and other community support structures alongside more acute risks and fears of being infected or quarantined. With limited theoretical frameworks available to make sense of survivors' help-seeking, our study supports expanding this framework to analyse help seeking in LMIC settings and during crises like outbreaks. In our study, COVID-19 was not a distinct experience from Ebola. The fear and risks that survivors witnessed within the health system during Ebola, especially if patients had symptoms like bleeding, coloured both sites' experience with COVID-19.

Recent advocacy for improved responses to VAW during outbreaks have mostly been informed by the experience of COVID-19 lockdowns in high-income settings or have been guidance based, with limited primary data from LMIC settings or research spanning multiple outbreaks (Pearson et al., 2021; UNDP, 2020; Yaker & Erskine, 2020).

Our findings show communities experienced changed patterns of violence during both Ebola and COVID-19, with IPV in particular connected to the economic crises, lockdowns and movement restrictions. Violence and outbreaks have long presented as mutually reinforcing public health threats, with work on earlier epidemics revealing the embodiment of violence through epidemics (such as structural violence, racism, homophobia, etc.) as well as the ability of epidemics to magnify entrenched gender norms and inequities which drive VAW (Gilbert et al., 2015). A (re)emerging body of literature explains pathways connecting outbreaks and VAW including crisis-related instability and economic stress, movement restrictions which increase exposure to violence when survivors cannot escape abusive partners, stigma around infection and control of access to vaccines and hygiene items by perpetrators (Peterman et al., 2020; Roesch et al., 2020). Known as the 'shadow pandemic' increases in VAW during COVID-19 have been widely described across multiple settings (Sánchez et al., 2020; Stark et al., 2020). As other work on this has noted, a gender lens is not adequate to describe the interconnectedness of other systems of discrimination experienced during an outbreak (Lokot & Avakyan, 2020). In our study, a survivor's age and rural/urban status influenced the way she experienced norms impacting on help-seeking, access to services, and various additional challenges bought on by the outbreaks, indicating the importance of understanding access to services through an intersectional lens. In our study, social and gender norms around violence shaped women's problem framing and decisions to seek help. The importance of these norms resonated with other literature from Sierra Leone and sub-Saharan Africa which describes the invisibility of intimate partner sexual violence, the concept of a 'good beating' (Jakobsen, 2014), and longstanding community norms whereby the rape of a married woman or an unmarried woman who is not a virgin is not considered a crime (Beoku-Betts & M'Cormack-Hale, 2021; Nnyombi et al., 2022). Our findings also accord with feminist analyses underscoring the functioning role of male violence within relationships, especially the use of IPV by men to uphold and extend gender inequities within the family (Anderson, 2005; Jakobsen, 2014). Schneider's (2019)

ethnographic work in Sierra Leone shows that communities often only consider violence as unacceptable if it did not have the possibility of restoration, measured in physical or social capital terms, rather than psychological terms, such as killing, mutilating or impregnating a girl or woman. Our study links this work on the normalisation of certain types of violence to help-seeking theory, drawing attention to the importance of norms in contextualising survivors' problem definition and decisions to seek help.

A range of prevention work has focused on harnessing the influence of norms, or de-normalising VAW (Kyegombe et al., 2014; Lees et al., 2021; Nnyombi et al., 2022). Our findings indicate that interventions which seek to generate demand for VAW health services (whether during an outbreak or not) would benefit from this, specifically those targeting norms around IPV being non-harmful. This may be especially important during outbreaks when seeking help for IPV, and other forms of violence that may not sustain severe injuries, is especially difficult.

Following Ebola in West Africa, research emerged on the significant challenges encountered by women when accessing services and the collapse of sexual and reproductive health services (Brolin Ribacke et al., 2016; McKay et al., 2022). This is echoed in more recent literature on health service access, including for VAW, during COVID-19 in sub-Saharan African settings (John et al., 2023; Singh et al., 2023). We found familiar challenges such as limited service availability, high costs and corruption, and distance needed to travel for help. This differed between the two outbreaks, with Ebola unsurprisingly having a far worse impact on access for survivors. Our findings complement other work highlighting how to build effective health system responses to VAW in precarious and LMIC settings (Bacchus et al., 2023; Colombini et al., 2020) by providing insights on women's pathways into the health system. Our findings also counteract narratives around outbreaks as 'exceptional' times given that women experienced significant help-seeking challenges during so-called 'normal' periods. The Liang et al. framework examines help-seeking for IPV, our adaptation of the framework expands it to other types of VAW. Whilst we found help-seeking varied after experiencing different types of violence, access-related delays may be of particular concern for sexual violence and non-partner sexual violence where treatments such as post-exposure prophylaxis and emergency contraception are highly time sensitive (e.g. within 72 hours). With relatively few recorded COVID-19 cases, a major impact on health service access during the pandemic presented through memories of Ebola, including fears using clinics and (mis) understandings of symptomology. Memories of crises are known to change and evolve over time, and people affected by them adapt and contest crisis narratives and understandings of crisis periods (Lees et al., 2022). In making sense of our findings we tried to acknowledge the 'past-present' relationship of participants' narratives.

To improve access, interventions that target demand during outbreaks would benefit from understanding what women's needs are upon using services and what specific restrictions and challenges they face in seeking help during outbreak periods. There is a need for operational research to re-orientate services towards women-defined rather than provider-defined objectives. This would include greater flexibility in providing a wider range of support choices, including acknowledging the very widespread use of providers outside the formal health system (Liang et al., 2005). In our study, local actors ('sababus' were prominent) were often more trusted, known personally, seen to be able to discipline husbands without ending marriages, and provided help at a lower cost than police or other formal services.

While these community mechanisms for responding to VAW must not be ignored, it should be underscored that many customary justice and legal practices in African settings uphold practices that discriminate against women (Cohen et al., 2024; Horn et al., 2016) with traditional dispute forums (e.g. counsels of elders) often dominated by men and their decisions focused on protecting perpetrators or keeping a family together rather than upholding a survivor's needs (Cohen et al., 2024; Horn et al., 2016). However, there may be potential for these actors to provide linkage to the health system, triaging

of symptoms and to be engaged for norms change. In this paper, we point towards (missed) opportunities to leverage trusted informal providers, especially during outbreaks when their role is heightened.

Limitations

We acknoweledge only a small minority of survivors use the health system. In recruiting participants who had accessed NGO health services we are likely to have included the views of survivors who were less marginalised and encountered fewer hurdles.

Conclusions

There has been renewed attention on the disruptive impact outbreaks have on health service delivery for women and the role of outbreak containment policies in aggravating VAW. This paper outlines women's decision making and balancing of the risks and benefits in seeking help after experiencing violence during outbreak periods in Sierra Leone. There is a need for more operational research on how VAW health responses can be better adapted to the needs of populations affected by outbreaks. This includes targeting norms around non-harmful violence, alleviating concerns about infection risk, and differentiation between symptoms caused by the virus and other sexual and reproductive health symptoms. Women's preferences for informal providers (such as local mediators) reveal the need to better leverage these sources of support during outbreak and non-outbreak periods for VAW interventions.

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