Risk Communication In The Healthcare Sector: A Case Study Of Risk Communication Among The Doctors, Nurses, And Patients In Kenema Government Hospital In Sierra Leone

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Abstract: This study investigated the various forms of risk communication among doctors, nurses and patients in the healthcare delivery at the Kenema Government Hospital (KGH). The main objectives of this research were to identify the forms of risk communication among doctors, nurses and patients; assess the level of awareness of, and involvement in the various forms of risk communication; identify the channels of risk communication and the impact of risk communication on the healthcare delivery in the study area. In order to collect relevant data and information from the various sources, a number of data collection and analysis tools and techniques were employed. These included the use of survey tools such as questionnaires and focus group discussions that targeted target groups of respondents that included medical doctors, nurses, healthcare givers and patients. Data were analysed and presented using tables and graphs. Research findings indicated that the healthcare services at the Kenema Government Hospital were characterised by deceptive diagnosis of test results, inattentive application of intravenous injections, misreading of prescriptions, rampant self-treatments by patients without prior knowledge of healthcare providers. Shortage of human resource, poverty and the fact that Sierra Leoneans were considered non-nationalistic were found to be major causes of risk communication in healthcare delivery. Also, errors were seen as the main reasons for deformation and untimely deaths at the Kenema Government Hospital. To improve on the current forms of risk communication at the Kenema Government Hospital, Government of Sierra Leone should endeavour to minimize absolute poverty, and close the gap of income inequalities among Sierra Leoneans. Additionally, the Government of Sierra Leone (GoSL) should expand educational opportunities in terms of human resource development, recruit staff with the right knowledge, skills, and aptitudes. On their part, Sierra Leoneans should inculcate the spirit of nationalism and love towards their fellow Sierra Leonean especially when they are sick and in need of help.

Key words: Risk Communication, Healthcare, Doctors, Nurses, Patients, Hospital,

1. Introduction

The healthcare system in Sierra Leone is provided by a mixture of government, private and Non-Governmental Organizations (NGOs). All medical care is generally paid for in Sierra Leone. Before now there was over one hundred (100) Non-Governmental Organizations (NGOs) operating in the healthcare sector. The Ministry of Health and Sanitation (MOHS) is responsible for organizing healthcare and after the end of the civil war, the ministry changed to a decentralized structure of health provision to increase its coverage. Even though there had been lack of healthcare facilities in the country as a result of the civil war, these have been gradually reconstructed since the war ended. The government has divided the country into thirteen (13) health districts based on the administrative districts of Sierra Leone. The health districts correspond to the districts of Sierra Leone except for the Western Area Rural and Western Area Urban districts which are combined into the Western Area Health District. Each district has a health management team and an average of fifty (50) Peripheral Health Units (PHU) and over one hundred (100) technical staff. The management team is responsible for planning, organizing and monitoring health provision, training personnel, working with communities and supplying equipment and drugs. The Peripheral Health Units (PHUs) are designed to be the delivery point for primary healthcare in the country and there are three (3) main types. The Community Health Centres (CHCs) carry out health preventing measures, cures and health promotion activities and is in charge of overseeing the other Peripheral Health Units (PHUs) in the area. It is planned that every chieftown which is the unit of local government in Sierra Leone below the level of district should have at least one community health centre. Community Health Posts (CHPs) perform a similar function to community health centres but have fewer facilities and are used to refer patients to the health centre or the district hospital. Maternal and Child Health Posts are the first level of contact on the ground and are located in smaller towns with populations between five hundred and two thousand. Much of the healthcare infrastructure was decimated during the civil war and the health service is still in the process of being organized with hospitals and Peripheral Health Units (PHU) being rebuilt or created and staff being trained (The Primary Healthcare Hand Book Policing, 2007). Public Health in Sierra Leone is generally poor and in 2007, the country had the highest level of child mortality in the world.
1.1 Risk Communication

Risk communication, in the context of environmental health, is the art of communicating about the potential health risks associated with environmental exposures. Communication refers to the reciprocal exchange of information, ideas, beliefs, feelings and attitudes between two persons or among a group of persons. It is a dynamic process requiring continual adaptations by those involved (Taylor, 1986). Risk communication is an interactive process of exchange of information and opinion on risk among risk assessors, risk managers, and other interested parties. Risk communication is an integral and ongoing part of the risk analysis exercise, and ideally all stakeholders should be involved from the start. Risk communication makes stakeholders aware of the process at each stage of the risk assessment. This helps to ensure that the logic, outcomes, significance, and limitations of the risk assessment are clearly understood by all the stakeholders (FAO/WHO, 1998). Risk communication is essential in decision-making processes as it enables people to participate in deciding how risks should be managed and relaying mandatory regulations and risk management processes in place and ways to guard against health risks. Decisions on risk communication, including what, who and how, should be part of an overall risk communication strategy. Risk communication is a continuous process that involves assessment of the probable risk, gathering relevant information, communicating it to the stakeholders and making appropriate decisions (Max and Tim, 1940). Some of the benefits of good risk communication include improved decision-making, both individually and collectively, and the development of productive working relationships among diverse interest groups (National Research Council, 1989). Effective risk and crisis communication relies on strategies, or best practices, that at first glance appear to be common-sense recommendations. Actually, these best practices can sometimes be said to be counter-intuitive. When pressure to present accurate, timely information is high, the tendencies to guard information, reassure the public and deny responsibility often increase. When spokespersons rely on their institution for constructing and delivering messages, they are bound to make the same type of mistakes (Venette, 2006). In the context of the health sector, one of the hardest tasks of doctors and nurses is that of delivering bad news to patients. It is usually the doctor who tells the patient that he/she is not going to recover. It is important for the nurse and doctor to talk and agree on how and when to tell the patient. Sometimes the complete truth is too much for the patient. Sometimes it may be best to tell the person a little at a time about what to expect in the future (Watters et al, 2004). Effective communication of such news is therefore important if the patients or their caregivers are not to be traumatised.

2. Objectives of the Study

The objectives of this study include the following:

(i) identify the forms of risk communication among doctors, nurses and patients;
(ii) assess the level of awareness of, and involvement in the various forms of risk communication;
(iii) identify the channels of risk communication and the impact of risk communication on the healthcare delivery in the study area.

3. Methodology

3.1 Description of Study Area

The study area is located in the eastern part of the Sierra Leone, which is Kenema the administrative headquarters of the Eastern Region that comprises Kenema, Kono and Kailahun Districts. There are sixteen (16) chiefdoms in this district, sharing boundaries with Kailahun district in the East, Kono District in North East, Pujehun district in the South, Bo district in the West and Tonkolili in the North. Kenema Government Hospital (KGH) is located on the main Combema Road, a feeder road leading to Kailahun through Segbwema. Kenema Government Hospital was built with funds provided under the colonial development and welfare Act in the 1950s and serves as the regional and referral hospital for the entire Eastern region. The premises originally had acreage of 24.2 acres, but this has been gradually pilfered, leaving behind only 22 acres. Presently, the constructed area occupies only about 48 percent of the land. The selection of Kenema Government Hospital as the area of research was based on the fact that the hospital Administration was willing to accord the necessary support to the researchers as well as the perceived development that the hospital had seen over the years. Additionally, there was interest from the Administrators to have understanding of the major risks that the institution was facing and how these were being communicated within the institution. Moreover, the fact that the researchers were very familiar with the Eastern Province meant that they could easily communicate with the staff of the hospital in providing needed data. Kenema Government Hospital consists of the following departments/units; the Dental Clinic donated by the Israeli
Government to the people of Sierra Leone in April 27, 1961, an X-ray Unit also donated by the same Israel Government in 1961, the Main Operating Theatre, the Annex Ward donated by the Lebanese community in 1985. Wards 1 and 2 are components of the original structures built in 1958 while Wards 3 and the maternity Unit, constructed with funds from the Italian Committee for UNICEF in 2004 dedicated now and forever to the women and children of Sierra Leone. Additionally, the Eye Department supported by Sight Savers International (SSI), the Department of Ophthalmology was established with help from Connaught Hospital and the paediatric ward supported by MERLIN (Medical Emergency Relief International) sponsored by ECHO/Humanitarian Aid offices (Status Report – Government Hospital – Kenema (2011). The hospital also has an Under Five Maternal/Child Health Centre and Antenatal Clinic constructed with funds made available by Oxfam and the Government of Sierra Leone; Ward 6 donated by the International Committee of the Red Cross (ICRC) in 2001 and the Rainbow Centre funded by DFID through International Rescue Committee (IRC) Kenema branch. This unit handles rape cases with complete support and guaranteed privacy. There is a Lassa Laboratory / Lassa ward supported by World Health Organization (WHO) and Tulane University USA and a Tuberculosis Ward; There is also the Kenema Government Hospital Laboratory, with Blood Bank supported by Global Fund and WHO and a Dispensary. There are a number of Out-patient department (OPD)/ consulting rooms and one minor theatre for examination of outpatient wound dressing /sutting and observation of patients. (Status Report 2011).

Kenema Government Hospital is an institution that seeks to meet its goals and objectives which should be derived from a strategic plan. Usually these pertain to the institution’s survival, growth, levels of service or production of human resources management plans, develops and administers policies and programmes to make expeditious use of an institution’s human resources (Armstrong, 2007). The human resources base of the Government Hospital charged with the above responsibilities include:

**Medical Doctors**
One surgeon specialist supervising Eastern region Medical Superintendent; one dental surgeon – retired; one Physician specialist on contract retired; one medical officer in-charge of paediatric; one medical officer in-charge of Lassa Unit and one medical officer in-charge of the maternity unit.

**Nursing Staff**
One (1) Matron; two (2) midwives; two (2) Anaesthetics; four (4) staff Nurses; fifty nine (59) State Enrolled Community Health Nurse (SECHN); ninety (90) Nurse Aides; five (5) Maternal Child Health’s (MCH Aid) and thirty five (35) on study leave. Technicians Six (6) Community Health Officers (CHO’s); four (4) Pharmacy Technicians; sixty one (61) Laboratory staff; two (2) x-ray attendants
1) Auxiliary Staff
2) One (1) Administrator; eight (8) finance Clerks; three
3) Securities; Six (6) Drivers; Ten (10) Kitchen staff; twenty two (22) porters; fifteen (15) maternity cleaners.

3.2 Design of the Study

B. The design of this study is a case study. It is an intensive study geared towards a thorough understanding of risk communication that exists among Doctors, Nurses and Patients at the Kenema Government Hospital in the Eastern region of Sierra Leone. Descriptive statistics were provided for reporting the quantitative findings. The dominant features of qualitative findings through focus group discussions were also included in the analysis.

3.3 Population of the Study

The researchers explored the views and representations of influential stakeholders. Independent from their level of expertise, influential stakeholders were defined as the key voices that have a direct influence on the formulation and communication of policy decisions. Doctors, nurses were included in the selection as there was perceived risk communication among them and patients resulting to severe illnesses, disabilities and death. Medical Doctors were selected for discussion, while nurses were selected to respond to a structured questionnaire including the selected patients. The key selection criteria were the direct relationship among the medical doctors, nurses and the patients within the healthcare system. Secondly, since doctors and nurses are the undisputed dispensers of drugs and handle all medical instruments, it was critical that their views be identified, understood and integrated in the research findings.

3.4 Population and Sampling Procedure

Population in this research was classified as either target or accessible. The target population were all the members of a specified group to which the investigation related, while the accessible population was defined in terms of those elements in the group within the reach of the researchers (Bryman and Bell, 2007; Creswell, 2007). Six (6) Medical Doctors at Kenema Government Hospital were selected using quota sampling. Quota sampling entails selecting those elements having particular characteristics of interest to the researcher that are accessible (Smith, 1988; Punch, 2009). The six (6) doctors were selected because they were specialists in and headed the various departments as; Surgeon specialist; Dental surgeon; Physician specialist; Paediatric; Medical officer in-charge of Lassa unit and Medical officer in-charge of the maternity unit. This group was accessed by the researchers for group discussion on risk communication in the healthcare sector that has seen a number of unprecedented deaths among doctors, nurses and patients within the Kenema Government Hospital. The second target population of one hundred (100) nurses and patients working or admitted in the various wards were also considered with a sample size of eighty (80) respondents. A purposive sample size of eighty (80) respondents was defined by the use of some criteria stated below:
1. Determine the registered and payroll nurses who must have served the Kenema government hospital (KGH) for over five years;
2. Patients who had been admitted under Doctor’s supervision and must have in one way evidenced/experienced risk communication in their attempt to seek for cure. The rationale for targeting this population was considered to be the group from whom the correct information about risk communication will be revealed. First of all, nurses in the various wards were registered by the researchers and patients using the above criteria. Registration numbers of these respondents were folded given a total of one hundred
(100). The folded papers were put into black plastic bags. A child of six (6) years was instructed to draw out one at a time. The folded papers were repeatedly drawn till the required sample size of eighty (80) was achieved. After every draw, the bag was shaken to give equal chance of being selected.

3.5 Instrumentation
The research instruments used for this study varied according to the respondents involved in the study. The main research instrument used in this study was a structured questionnaire which was administered to the respondents. In addition, interviews were conducted using a checklist. The procedure used in data collection is further explained below:

Focus Group Discussion
A discussion programme mainly for the six doctors in the various departments was organised. In a group discussion, a small number of individuals were brought together as a discussion or resource group. This technique enabled the researchers to interact with the medical doctors in consensus formation. It was believed that such a group discussion would collectively probe deeper into risk communication within the healthcare sector generally and Kenema Government Hospital in particular through debates in which disagreements could be used to lift the veils covering risk communication in the healthcare provision. Observation - The researchers used observation as an instrument for this study. Observation involved watching people, events, situation or phenomena and obtaining first-hand information (Marschan-Piekkari and Welch, 2004) relating to the research title “risk communication in the healthcare sector”. The researchers were non-participants; they observed the behaviour of workers and patients in the study area in their day to day activities and working relationships. The researchers selected observation techniques as it helped to watch and describe behaviour, the way it occurs in the natural setting (Merian, 2009). This enhanced first-hand information to be obtained from such situations. Through observation, things were seen the way they were conducted in reality. Such information could not be obtained through any other procedure since generally, healthcare provision is guided by confidentiality, empathy and sharing humour. Moreover, collecting data on human behaviour demanded an observational approach. Therefore the researchers prepared a list of relevant aspects of the situation in the form of checklist to be observed at the study area. The checklist enabled the researchers to indicate those attributes that were present or absent at Kenema Government Hospital.

Questionnaire - The use of a survey research questionnaire was also used as an instrument of data collection. Questionnaires were used to obtain information on issues based on the objectives. A structured questionnaire was used and was divided into four (4) sections. Section A sought data and information on the socio-economic characteristics of the respondents such as gender, age and education levels. The data provided were believed to be essential since it was believed that it could help in the understanding of the communication of risk at Kenema Government Hospital. Section B identified the forms of risks communication among the respondents while section C assessed the level of awareness of, and involvement of the respondents, and section D identified the factors usually associated with risks communication in the healthcare provision. On its part, section E assessed the impact of risks communication on the healthcare provision by medical practitioners and the patients in the study area. Apart from the research objectives, information was collected from a number of issues such as the socio-economic status of healthcare providers at the Kenema Government Hospital. The draft instrument was pre-tested and later piloted in two private hospitals in Kenema Township; Ahmadiyya Muslim Private Hospital, Hangha Road and Ralph Hospital situated at Nyandeyama section in Kenema. This was undertaken to modify the schedule to make sure that relevant information was not omitted in the field. The information observed to have been left out was added and final corrections made to the questions. Pre-testing was necessary because it ensured that the questions were understandable and that they were presented in a suitable way. It also ensured that the length of interview was appropriate (Roche 1999).

3.6 Data Collection
Before starting this process, an official letter was obtained from the hospital Secretary, which was used as an attestation of identity and also explained the nature and purpose of the study. Thus, this document was very useful as it served as a means of allowing the researchers to have unrestricted access to information where the researchers went and presented it. Additional information for this study was collected from Libraries, the internet and other research centres. However, the primary data were collected from the field from late June to mid July 2016. All members of the sample were interviewed. Before the commencement of the interview, the permission of the units and departments directly involved in this research was sought. Interviews were conducted in the morning and late in the evening. In order to reduce mistakes in recording information, the questionnaires were explained to the interviewees although most of the nurses were literate. This was also done because some could not have had the patience to answer the questionnaires adequately if such explanations were not clearly made. Responses were recorded in English against corresponding questions. Two (2) days was spent to administer the questionnaires in the various units. At the end of every day’s exercise each interviewee’s work was reviewed and mistakes appropriately ratified (this made them recall where the respondents were not available during the first visit). One week was spent to cross-check and make all necessary corrections. The entire exercise was a success as it was carried out in a friendly and peaceful atmosphere. Besides, numbers selected for the exercise were given a high degree of freedom in terms of answering the various questions including questionnaires and their privacy was regarded.

3.7 Data Analysis
Coding and Data Summary
With the completion of the data collected, frequency tables of the various responses provided in the questionnaires were made. This was used to determine the weight of responses influencing the coding. Statistical tables and graphs were later derived from the coded information on the questionnaires. From the data summarized, adding totals and making frequency distribution, the researchers calculated the mean scores using descriptive statistics. Most of the results were presented in simple percentages.
4. Results and Discussion

4.1 Characteristics of respondents

Designation
Analysis indicates that 46.2% of the respondents were nurses, 45.0% were patients while 5.0% were laboratory technicians and 3.8% medical doctors (Figure 1). These findings indicate that the majority of the respondents were nurses which were in line with the expectations of the research since nurses are seen as a more targeted group with regard to risk communication due to their interaction with the patients compared to doctors and technicians. Even though the number of doctors in the respondents’ list was high (45.0%), this could be attributed to the fact that there was need to have all the departments represented by a senior person that happened to be the doctors. At 5.0% the representation of laboratory technicians can be seen as realistic since these rarely deal with patients directly even though they form a critical role in the communication of risk at their workplace.

![Figure 1: Designation of healthcare delivery in Kenema Government Hospital](image)

3.7.1 Education levels
Educational status of individuals in any organization / institution influences the competency and efficiency on quality of what the institution produces. The researchers assessed the educational levels of the respondents was assessed as represented in figure 2. According to Figure 2, 45.0% of the respondents said that they attended the Nursing School where they were trained and qualified as nurses. However, 26.3% of the respondents claimed not to have attended any formal school system but have been practicing under trained and qualified practitioners in the study area, while 13.8% had primary education. However, 6.2% went through the secondary school education while 5.0% of the respondents had their education in tertiary institutions (university/polytechnic) and 3.7% had gone to medical school. This percentage represented the medical doctors. The research further revealed that 20.0% of the total respondents had low level of education while 26.3% were completely illiterate (Figure 2). The researchers concluded from this data that there was need to improve the educational levels of the human resources at Kenema Government Hospital if risk communication strategies were to be understood and put into effective practice.

![Figure 2: Educational Status of Healthcare workers](image)

Forms of Risk Communication
Respondents to the questionnaire were asked to identify the forms of risk communication in the healthcare delivery process in the Kenema Government Hospital. According to the statistics, 97.5% of the respondents accepted that deceptive diagnosis of test results and blood group was a major form of risk communication existing at the Kenema Government Hospital. Another 95.0% of the respondents indicated doubt in medical tests being positive or negative, while 92.5% responded that there is lack of attention by health workers in the application of intra-venous injections (IVs) as major forms of risk communication that had caused hazards and death among patients and healthcare practitioners in the study area. Additionally, the wrong dosage of drugs administered by most practitioners was seen as a serious problem that had caused serious problems years at Kenema Government Hospital. Some of these mistakes have led to the loss of lives of some patients.

![Figure 3: Forms of Risk Communication among Doctors, Nurses and Patients](image)

Data further showed that 85.0% of the respondents accepted that patient’s use of drugs without the prior knowledge of healthcare providers had resulted in serious health consequences. The implications of these attitudes of patients have most often resulted to death of the patients. Additionally, 72.5% of the respondents agreed that prescription forms were being misread by patients and even in Pharmacies where drugs were being bought. Patients have had their illnesses more serious rather than the illness initially reported. Furthermore, 67.5% of the respondents claimed that most of the healthcare providers paid little or no attention to the bed record sheets of patients, a record that actually shows the history of the sickness reported. There was also a high per cent of respondents (53.7%) who...
accepted the fact that there was misreporting during “handoff” in the shift system. The transfer of essential information and the responsibility for care of the patient from one healthcare provider to another is an integral component of communication in healthcare. This critical transfer point is known as a handoff. An effective handoff supports the transition of critical information and continuity of care and treatment (Solet et al, 2005). However, 27.5% of the respondents revealed that poor handling of medical tools/instruments have from time to time resulted into medical errors. For example, there was an incident of a Medical Doctor piercing his hand with injection needle immediately after administering treatment to a deadly diseases (Lassa Fever) patient. That was a fatal error that eventually cost him his life in 2005. Moreover, 2.5% of the respondents said that there had been an incident where there was an exchange of treatment for identical names. A doctor in their discussion with the researchers confirmed this but hurried to add that such mistakes were indeed not common at Kenema Government Hospital.

Channels of Risk Communication in the Healthcare Delivery
According to the results of the data analysed, 57.5% of the respondents acknowledged face-to-face communication in the healthcare delivery as the main and most effective channel of communication, while 31.3% of the respondents cited written prescriptions as the main channels of relaying risk to the various stakeholders (Figure 4). However, 8.7% of the respondents claimed that healthcare providers communicated better and more effectively with patients through written records. Only 2.5% of the respondents said that communication of risk through the channel of cell phone was a better means.

**Figure 4: Channels of risk communication at Kenema Government Hospital**

Identification of Specific Factors Associated with Risk Communication in the Healthcare Delivery
Results as presented in Figure 5 below revealed that 96.2% of the respondents agreed that poverty was a factor of risk communication in the study area. While 93.7% of the respondents agreed that medical practitioners in their delivery of healthcare were sometimes too impatient with patients; while 90.0% acknowledged negligence of responsibility quite prominent in the healthcare delivery. The attitudes of most healthcare providers as reported by respondents have from time to time contributed to the worsening of some of the illness/sicknesses sometimes resulting into death of patients. As poverty prevails in the country, endemic corruption is being drawn into the healthcare sector with 87.7% respondents thinking so. Moreover, where there is corruption, competency and efficiency is lost because of quest for money. Statistics further showed that 83.7% of the respondents admitted to low level of education for most of the healthcare providers and patients who seek for good health. However, 78.7% of the respondents indicated that there was inadequate research in the general healthcare sector in Sierra Leone. This situation was crucial in redefining healthcare delivery in Sierra Leone at large. Furthermore, 70.0% of the respondents stated that the poor incentive in terms of salaries and wages for healthcare workers was a contributing factor to risk communication in the healthcare delivery. Instances where healthcare workers received meagre remuneration seemed not to be motivated to work diligently. This was echoed by 67.5% of the respondents who said that there is shortage of expertise. Human resources development must be a priority area for healthcare delivery.

Moreover, 65.0% of the respondents said that many people in the healthcare sector including some of the patients were ignorant of their needs as well as expectations from the healthcare system. Somebody does wrong because he/she is ignorant, therefore ignorance must be replaced with education which according to this study is lacking. In another development, 58.7% of the respondents indicated that management ineptitude is more conspicuous among the authorities in the study institution. For example, government vehicles meant to render emergency services in the hospital were instead found to be used in homes for private errands. However, little or no effort had been made by Government to correct the absurdity in the system. Also, ethnicity was found to play a major role in risk communication as findings revealed that 95.0% of the respondents proved that ethnic differences were a factor associated with risk communication in the healthcare provision. Instances where Krios and Temnes who do not speak or comprehend languages spoken in the Eastern Region (Mende, Kono, Kissi) led to constrained service delivery as most of the populace preferred to use their mother tongues. Moreover, even in situations when there were interpreters, communication tended to be difficult especially where confidentiality is the pre-requisite in the healthcare delivery.

**Figure 5: Specific factors associated with risk communication at Kenema Government Hospital**
Impact of Risk Communication among Doctors, Nurses and Patients

Data contained in Figure 6 shows that 97.5% of the respondents said that there was inaccurate diagnosis of medical investigation. This was followed by 95.0% of respondents who cited deceptive diagnosis of blood groups as having serious impact. Additionally, 86.3% of the respondents highlighted the issue of the patients’ use of drugs without prior knowledge of healthcare providers as a major impact while 57.5% conceded on the negligence of healthcare providers in intra-venous injection (IVs). 65.3% looked at misreading of prescriptions as affecting healthcare delivery at the Kenema Government Hospital (Figure 6). Moreover, misreporting among nurses during handoff rated 53.8% while 45.0% of the respondents indicated poor handling of medical tools/instrument leading to risk and 41.3% expressed neglect of bed record sheets by healthcare providers to a moderate extent to have impact on risk communication. However, 78.8% of the respondents contradicted the exchange of treatment for identical names of patient to a low extent as an impact on risk communication in healthcare delivery at Kenema Government Hospital (Figure 6).

**Figure 6: Impact of risk communication**

![Impact of risk communication](image)

**Focus Group Discussion**

A discussion forum for Medical Doctors in bid to tap their views on risk communication in the healthcare delivery was organised. Whereas six doctors were targeted for discussion only half of these were able to take part in the discussions. Other participants included two physician specialists, one paediatrician in charge of the children’s ward and the Hospital Secretary, the custodian of all documents dealing with day to day running of the institution. With all protocol observed, the researchers craved on the indulgence of the respondents that the discussion was on risk communication among healthcare practitioners and patients on a note that data collected would only be used for academic purposes and will be treated with the utmost confidentiality it deserves. Doctors admitted that they were aware of risk communication either voluntarily or involuntarily. However, it was re-emphasized that Physician- Nurse and Patients relationship was dependent on effective communication. This was lacking in the system as a result of political instability; mismanagement of funds; poor financing of healthcare sector; poor research; poor coordination among the various stakeholders and healthcare institutions; poor planning, monitoring and evaluation; dilapidated healthcare infrastructures; institutional bureaucracies and management ineptitudes which formed the basis of the discussion. Doctors believed these were issues related to forms of risk communications existing in the healthcare delivery in Sierra Leone. Accordingly, Doctors reiterated that healthcare delivery had always been based on the principles and values of primary healthcare. These were still valid. Moreover, as the health system in Sierra Leone remained comparatively weak, there was need to exploit the current opinion that health was a contributor to national development. Health service delivery remained a key challenge in Sierra Leone. This situation continued to undermine standards, availability and accessibility of services provided. Observations and personal interviews of people revealed that qualitative perceptions from rural communities showed that physical distance to health facilities presented a major access barrier to care. The existing functional health facilities were inadequate and inequitably distributed nationally. Doctors further opined that there was presently a critical shortage of skilled health staff, the impact of which was worsened by the total absence of skilled staff in peripheral health units (PHUs) thus compromising the quality of healthcare provided. Basic necessities and amenities in the form of transportation and accommodation remained inadequate. This was compounded by low remuneration that had negatively affected staff morale. Human resource development still remains to be a major constraint in the healthcare sector.

**5. Conclusions**

**Forms of Risk Communication in the Healthcare Delivery:**

The researchers identified the following prominent forms of risk communication either voluntarily or involuntarily at the Kenema Government Hospital. These include: deceptive investigation of test results and blood group; doubt in medical test being negative/positive; absent mindedness of nurses in the application of intra-venous injections (IVs); wrong or over use of dosage for patients; poor reception from healthcare providers are the major issues affecting healthcare delivery at the Kenema Government Hospital (KGH).

**The Channels of Risk Communication**

Illness and hospitalization are stressful often deeply frightening experiences for patients and their families. The nurse is there to help patients through this experience. Good, clear and supportive communication is an important part of the help required. The care giver’s smile, care and readiness to make contact has the potential to ease the patient’s pain and effects of time spent in the hospital (Leaver et al, 2004). This study revealed the face-to face channel of communication as the major way of communicating with healthcare providers. Prescriptions are written after the face to face consultation with doctors. Written records are meant to fill in gaps in the patient’s history; time drugs and other treatments is the next channel of communicating health messages from the health providers to patients. Cell phones are used mostly by patients who are well to do or are very close to healthcare provider (Doctor). The use of E-mail was
not identified as channel of communication especially in the rural area like Kenema.

Specific Factors associated with Risk Communication
This study has revealed specific factors associated with risk communication; so that the problem of risk communication in the health care delivery among doctors, nurses and patients becomes transparent. In conclusion there are many different potential factors of which some are tied down to poverty. Other factors are also tied to particular situations of the individual patient and subject to constant adjustment. In other words generalization should not be made.

The Impact of Risk Communication
The Kenema Government Hospital (KGH) is ill-equipped to shoulder the burden of these inefficiencies. The inability to contact professionals among staff affects patient care which as a result of malaise claims a lot of lives every day. The continual neglect of patients by doctors, nurses, midwives and the very few specialists was a general concern to the researcher. Additionally, doctors and nurses were identified as having a nonchalant attitude towards patients if they did not have registration or consultation fees or enough money to buy the drugs on the prescription list. Interviews of people revealed that medical doctors have sometimes delayed emergency operations because patients do not have full payment for their operations. Essential drugs meant to be sold in the hospital on cost recovery were often found in the custody of nurses whose cost was sky-rocketed making the drugs unaffordable to patients. But patients most often in critical condition bear the burden. Preferably, if you buy the drug from private pharmacies, ignoring the available drug with the nurse, your patient will be frowned upon throughout his/her stay in the hospital. Medical doctors are sometimes discriminatory when patients are hospitalized. For example, some patients have sometimes been refused attention when their doctor is not present even in times of serious pain as the doctor on call would not be willing to assist. Issues of this nature are conspicuous in the healthcare system of Sierra Leone.

6. Recommendations
1. In order to improve on the current forms of risk communication at the Kenema Government Hospital (KGH), Government of Sierra Leone should endeavour to minimize absolute poverty, lessening income inequalities among Sierra Leonean.
2. Expanding educational opportunities in terms of human resource development must be a priority area, recruiting staff with the right background, aptitudes and commitment of healthcare ethics. This requires skilled medical personnel.
3. The revitalization of risk communication in the healthcare delivery requires the development of hospital management capacities, including skills for strategic planning, pre-appraisal, monitoring and evaluation.
4. Sierra Leoneans should inculcate the spirit of ‘nationalism’ (ones love for his/her country). In terms of neglect, feeling of resentment, impatient, nonchalant attitudes towards fellow Sierra Leoneans especially when they are sick and need help.
5. Government should put in place mechanisms where scientifically approved and unexpired drugs and hospital equipment are available in hospitals.
6. Government should amongst others ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services
7. A Commission should be set at District Council level charged with the responsibility to take firm actions against healthcare practitioners who only pursue profit instead of caring for patients’ welfare.

References.
Author Profile
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