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Stigma in Intimate Partner Relationships Among Ebola Survivors in Monrovia

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Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Stigmatization among Ebola survivors poses a growing problem in Monrovia, resulting in fractured relationships and broken marriages due to the fear of contracting Ebola during intimate moments. This study explores the lived experience of stigmatization in intimate partner relationships among Ebola virus disease (EVD) survivors in Monrovia, guided by stigma theory. By sharing the experiences of survivors, the study sheds light on the effects of stigmatization on their intimate relationships and provides a platform for expressing their personal experiences. It reveals the profound impact of the disease on survivors' lives and their relationships with their partners. Using a qualitative approach, the study captures participants' opinions, perceptions, and lived experiences through semi-structured interviews with 15 purposively and snowball-sampled participants. Braun and Clarke's six-step process was used for data analysis. The study uncovers five overarching themes and six subthemes, such as the influence on intimate partner relationships, the need for awareness, education, and resources, feelings of isolation, rejection, abandonment, and support and acceptance. Educating caregivers about the negative impact of stigmatization is recommended, along with further research and support measures for survivors. These findings provide valuable insights to help caregivers and partners better understand the factors surrounding EVD and enable them to provide survivors with the respect and care they deserve. This study also aligns with the health domain of the social determinants of health, as each participant expressed support of family and community as an important factor for healing and recovery, which may encourage the government and stakeholders to be more supportive of survivors.

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Dedication

To the many Ebola survivors in Liberia who have endured the trauma of not only fighting for their lives but also facing stigmatization and discrimination, this dissertation is dedicated to you. Your resilience and strength in the face of adversity are a testament to the human spirit and a source of inspiration.

To the emergency workers who selflessly put their lives on the line to help contain the Ebola outbreak in West Africa, your bravery and dedication to the cause will never be forgotten. Your sacrifice has undoubtedly saved countless lives and brought hope to a region in crisis.

Finally, to my dear children, whom I had to leave in America during the Ebola pandemic to deploy to Liberia, your unwavering support and understanding throughout this journey have been a source of strength and motivation. I dedicate this dissertation to you and all the loved ones who have supported me in pursuing higher education and service to humanity.

May this dissertation serve as a tribute to all those touched by the Ebola outbreak in West Africa, and may it inspire us all to continue working toward a world where no one is left behind in the face of adversity.

Acknowledgments

First and foremost, I would be remiss if I did not acknowledge the ultimate divine God who has been my constant guide throughout this doctoral journey. This dissertation could not have been crafted, nor the trials surmounted, without the guiding hand of God’s providence, which has generously gifted me with grace, mercy, and unfailing inspiration.

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I must honor my brother, the Rev. P. S. Burgess Kyne. He was my beacon of hope who ushered me from a Liberian Refugee Camp in Ghana to the United States. His unwavering support and love have been an enduring source of strength and motivation. His place in this journey and my heart cannot be overstated.

To my beloved wife and children, I am eternally grateful. Their sacrifice, patience, and unyielding love have buoyed me through the choppy seas of this journey. Their constant encouragement was the lighthouse guiding me toward the harbor of my aspirations.

Lastly, but by no means least, to all those who supported, inspired, and believed in me during this voyage, I offer my deepest thanks. Your kindness and generosity have proven invaluable, imprinting a mark upon me that will never fade.

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Chapter 1: Introduction to the Study

The recent Ebola virus disease (EVD) outbreak created havoc and instilled significant fear among community members regarding the possibility of contracting the disease (Nuriddin et al., 2018). Consequently, stigmatization and rejection became common experiences for EVD survivors from their communities (Dodd et al., 2021; Krzemieniecki & Gabriel, 2019). As a result, trauma was present among EVD survivors due to stigmatization, rejection, and intimate partner violence (Antonaccio et al., 2021; Nuriddin et al., 2018). This study aims to provide unique insights into supporting EVD survivors through societal integration after recovery.

In this chapter, I present background information regarding the purpose of the study. First, the purpose and guiding problem statement of the study are reviewed. The significance of the study is also examined. The chapter also includes sections on limitations, assumptions, key definitions, and a summary of the study’s topics. The chapter aims to provide a comprehensive understanding of the motivation behind this research and the methodology employed for data collection and analysis. I begin by presenting the background of the study in the following section.

Background

In 2014, the outbreak of the Ebola pandemic impacted West Africa (Hapsara, 2014; O'Leary et al., 2018). The Ebola outbreak impacted over ten countries and approximately 11,325 individuals, with 10,675 cases in Monrovia (O’Leary et al., 2018). According to the World Health Organization (WHO), as cited by Nuriddin et al. (2018), individuals who survived EVD suffered from extensive psychological and physical outbreaks (Nuriddin et al., 2018). Over 17,000 survivors in West Africa and Liberian accounted for an estimated 5000 survivors nationwide (Ervin et al., 2018). The Ministry of Health reported 1,500 survivors registered in the national database in Liberia (Ervin et al., 2018).

Researchers have recently explained the psychological impact of EVD on survivors (James et al., 2019). James et al. conducted a quantitative study to determine the psychological impact of EVD on survivors, how family and community members reacted to survivors, and the coping skills used by survivors of EVD. As a result of the exposure and recovery, survivors experienced intense trauma, which resulted in symptoms of depression, self-stigmatization, and many other psychological issues (Dar et al., 2020; Yuan et al., 2022). James et al. also argued that survivors reported being rejected, isolated, and stigmatized by their families and communities. The common themes highlighted in this study were the stigmatization and discrimination of EVD survivors after being discharged from the Ebola treatment unit (ETU) by family and community. Findings from James et al. were relevant to my study as the results revealed the prevalence of rejection and stigmatization perpetrated by families and communities among Ebola survivors in Sierra Leone. Specifically, the study explored the lived experience of this phenomenon and the impact on the quality of intimate partners relationship in Monrovia.

Research also illustrated that EVD survivors are likely to experience poor mental health outcomes due to trauma from stigmatization and rejection (James et al., 2019; Secor et al., 2020). O’Leary et al. (2018) conducted quantitative research exploring EVD survivors' and healthcare workers' mental health challenges after the epidemic. O'Leary et al. found that after medical treatment was discharged, EVD survivors in Sierra Leone experienced stigma from 95% of the community respondents during the beginning of the outbreak. O'Leary et al. argued that EVD required culturally contextual support to respond to improved well-being. Data demonstrated that 20% of survivors met the diagnostical criterion for post-traumatic stress disorder. O’Leary et al. research is crucial as it showed the negative impact of the stigmatization of EVD upon survivors.

Researchers also demonstrated the stigmatization of EVD survivors, which increases trauma and adverse mental and physical health outcomes (James et al., 2019, 2020; Overholt et al., 2018). Data from Overholt et al. (2018) identified that EVD survivors in Liberia reported severe stigmatization, affecting their standard of living, well-being, and ability to integrate within the community (Antonaccio et al., 2021). Antonaccio et al. (2021) further illustrated issues regarding physical and mental distress due to EVD. In tandem, Antonaccio et al. found that increased intimate partner violence and rejection were also linked with stigmatization. As a result, EVD survivors face an increased risk of violence, stigmatization, and trauma due to intimate partner violence and stigmatization of EVD (Antonaccio et al., 2021; Overholt et al., 2018).

The perceptions of EVD survivors also demonstrated the prevalence of stigmatization among intimate partner relationships (Nuriddin et al., 2018). Nuriddin et al. (2018) conducted a qualitative study in Sierra Leone using focus groups to examine individual perceptions, attitudes, and beliefs toward EVD survivors. The researchers found that stigmas against EVD survivors are prevalent in intimate relationships because spouses and partners perceived survivors can transmit the virus during sexual intercourse. The stigma was influenced by a national health protocol that advocated for survivors to abstain from sex or use a condom during the 90 days after discharge from the treatment facilities. Furthermore, community members suggested that EVD survivors abstain from sex for more than five months and that survivors should stay in separate rooms from their partners, as Nuriddin et al. (2018) perceived. Others suggested that EVD survivors be grouped in a designated place to prevent renewed outbreaks (Nuriddin et al., 2018). Findings from the Nuriddin et al. study are relevant to my research because the results underscored individual and societal fear and stigmatization based on the perspectives of EVD survivors. Unlike Nuriddin et al.'s study, the study focused only on the lived experience and impact of EVD survivors in their intimate partner relationship in Monrovia due to stigmatization. Community members indicated a continual fear regarding the disease spread, the infectiousness of EVD survivors, and the cause of Ebola outbreaks (Kelly et al., 2019; Yuan et al., 2022). In Monrovia, there has been ongoing stigmatization and rejection towards EVD survivors, as documented by previous researchers (Kelly et al., 2019; Yuan et al., 2022). Stigmatization of EVD survivors can also impact intimate partner relationships. Researchers indicated that stigmatization and rejection could lead to dissolved intimate partner relationships.

However, there is a gap in the literature regarding the EVD survivors' lived experiences of stigmatization in intimate partner relationships (Dar et al., 2020; Davidson et al., 2022; Singh et al., 2020). The study addressed this gap in the reviewed literature by exploring how EVD survivors in Liberia are affected by stigmatization in their intimate partner relationships. Specifically, this study addressed EVD survivors who are married or in intimate partner relationships and created an intentional space where they shared how the disease has affected their intimate partners. The study is essential, as the information gained may educate researchers, caregivers, and advocates for Ebola about the direct experiences of stigmatization of EVD.

Problem Statement

The problem this study addressed is that stigmatization influenced the intimate partner relationships of EVD survivors (Bonwitt et al., 2018; Nuriddin et al., 2018; Wilson et al., 2018). Survivors of Ebola reported feeling shame and guilt due to being blamed by their communities for transmitting the infectious disease (Singh et al., 2020), which affected the quality of intimate partner relationships for EVD survivors in Monrovia. Ebola survivors in Monrovia continue to experience isolation and stigmatization from their loved ones (Dar et al., 2020). After recovery, EVD survivors cannot share utensils, spoons, dishes, bath buckets, and beds with others (Cunningham et al., 2020; Godwin et al., 2019). Stigmatization is a growing concern in Monrovia, as noted by the increase in broken relationships and marriages because of fear of being infected during intimacy by partners who survived the Ebola virus (Nuriddin et al., 2018; Wilson et al., 2018). There is a gap in the reviewed literature regarding the EVD survivors' lived experiences of stigmatization in intimate partner relationships.

Purpose of the Study

This qualitative study aimed to explore how the lived experience of stigmatization affected the quality of intimate partner relationships for Ebola survivors in Monrovia. The findings of this study illustrated the voices of EVD survivors by allowing them to share their experiences of stigmatization and how the disease has affected them as individuals and their relationships with their intimate partners. Stigmatization and rejection are significant factors that stimulate social problems among EVD survivors (Nuriddin et al., 2018). The study gathered information to educate researchers, caregivers, and advocates for EVD about the direct experiences of stigmatization of EVD survivors and their relationship with their intimate partners.

Research Questions

RQ. How do EVD survivors in Monrovia describe their lived experiences regarding stigmatization and its influence on intimate partner relationships?

Theoretical Framework

The guiding theoretical framework included the stigma framework. In this section, I present seminal work regarding the development of stigma theory as informed by stigmatization. Many terminal diseases like Ebola have historically created trauma for individuals due to stigmatization and rejection (Davidson et al., 2022). Several researchers used trauma theory to explain how stigmatization and rejection of people with serious health challenges were related to trauma risk or symptoms of trauma (Fennell et al., 2021; Mambrol, 2017).

Goffman (2009) underpinned the stigma framework in his historical research. Goffman is the leading theorist of stigma theory. Goffman explored personal rejection, denial, and stigmatization from the community and societal expectations. Goffman viewed stigma as a social label created and perpetrated by those who consider themselves as usual. Stigma is an attribute society creates based on rejecting individual characteristics, personal health-related variables, or deviation from societal norms (Goffman, 2009). The outcome of stigmatization was presented in mental and physical health outcomes, such as anxiety, depression, and suicidal ideation (Goffman, 2009).

The current study used the stigma theory to explain how stigmatization impacted Ebola survivors and their intimate partner relationships in Monrovia, Liberia.

Nature of the Study

For this study, a qualitative methodology was chosen. A qualitative methodology was considered appropriate for this study as it allowed for exploring participants’ opinions, perceptions, and lived experiences through their descriptions (Tracy, 2019). A phenomenological research design was also chosen for this study. A phenomenological design includes exploring the construction of meaning through participants' lived experiences (Moustakas, 1994). The phenomenological design was considered appropriate for this study as it addressed the purpose and research questions regarding participants' lived experiences concerning stigmatization and its influence on intimate partner relationships.

The study did not require site permission as the researcher gained participants' perspectives directly based on voluntary interest in the study. I gained local and international Institutional Review Board (IRB) approvals prior to recruitment or conducting data collection. The data collection for this study included semi-structured interviews that lasted 60-90 minutes. The semi-structured interviews occurred in-person and on the phone (dependent upon the individuals' preference) in compliance with the Coronavirus disease (COVID)-19 regulations per the IRB guidelines.

Definitions

Stigmatization

Stigmatization refers to rejecting individuals based on characteristics or identity that deviates from societal norms (Goffman, 2009). Individuals who experience stigmatization are likely to experience poor mental and physical health outcomes due to dejection from society and local communities (Goffman, 2009).

Rejection

Rejection includes physical and emotional denial of an individual based on differing emotional and social contexts (James et al., 2020). In this study, the term rejection refers to the denial of individuals that survived EVD based upon fear and stigmatization regarding the spread of the disease (Bonwitt et al., 2018).

Trauma

Trauma refers to the experience of lasting negative emotions due to a physical event or verbal abuse. Trauma can impact the individual's mental and physical health outcomes (James et al., 2020). In this study, trauma refers to the lasting experiences of EVD survivors and adverse trauma experienced due to survival, rejection, and stigmatization (James et al., 2020).

Ebola Virus Disease

The EVD is spread from animals to humans through bodily fluids. The initial symptoms include fever, headaches, muscle pains, and chills. The disease progresses through internal bleeding, vomiting, and coughing blood (Beeching et al., 2013). Disease survival depends on access and immediate treatment through qualified healthcare professionals (Beeching et al., 2013).

Post-Ebola Syndrome

Surviving EVD is associated with post-Ebola syndrome (Wilson et al., 2018), in which the individual experiences adverse mental health outcomes, such as depression and anxiety (Wilson et al., 2018). Post-Ebola syndrome is also associated with physical effects, such as chronic nerve pain (Wilson et al., 2018).

Assumptions

The first assumption of this study is that participants were honest in their reflections. It was impossible to empirically verify the participants' honesty (Tracy, 2019). However, using the semi-structured interview guide and the voluntary recruitment of participants ensured that participants were comfortable discussing their reflections with me (Tracy, 2019). The second assumption was that the study research questions, the semi-structured interview guide, and the study protocol were appropriate for addressing the purpose of the study. While this was impossible to verify, I employed methodological alignment (see Tracy, 2019) to ensure that each element of the designed study was appropriate for the study. The third assumption of this study was that the participants included in this study could address questions posed to them during data collection. This was only possible to verify after the completion of the study. However, I employed purposive sampling and an inclusion criterion to ensure the participants could respond to questions regarding EVD stigmatization in the context of intimate partner relationships.

Scope and Delimitations

The study scope included a focus on the lived experiences of EVD survivors regarding stigmatization and the influence on intimate partner relationships. The study was delimited to EVD survivors willing to discuss stigmatization and its impact on intimate partner relationships. The study was also delimited to a qualitative methodology with a phenomenological design. The study delimitation was necessary due to the qualitative nature of the desired data (e.g., perspectives of participants) and the aim of exploring participants' lived experiences. The study was also bounded by the population of individuals with EVD that experienced stigmatization. The study was also delimited to the application of the stigma theory. Survivorship of EVD outside of intimidating partnerships and stigmatization was excluded from the study. Additionally, EVD survivorship and intimate partner violence outside of Monrovia were excluded.

Limitations

The limitation of this study was a focus on the lived experiences of participants, which is only transferable within the study's sample. Exploring the lived experiences provided helpful information to address the purpose of this study and the research questions as it provided information directly from the participants' reflections regarding their experiences with EVD stigmatization as it relates to intimate partner relationships. However, the phenomenological design limited transferability (McCann & Pearlman, 1990; Moustakas, 1994; Tracy, 2019). The study was also limited to the participants' honesty and willingness to share their perceptions regarding stigmatization and rejection among intimate partner relationships after surviving EVD. An additional limitation of this study was the researcher bias. Researcher bias could not be entirely removed from any qualitative study (Tracy, 2019). However, for this study, I employed reflexivity through journaling throughout this study to mitigate and reduce my bias from impacting the outcomes of the study. Further, I used a transparent study methodology in Chapter 3 for study replication and reduction of subjectivity from the researcher.

Significance

The exploration of EVD was largely explored from a physiological perspective (Bonwitt et al., 2018). The findings of this study addressed the following objectives: (a) educate researchers and caregivers about how stigmatization affected the quality of intimate partner relationships for Ebola survivors; (b) establish the baseline for developing a platform of advocacy for EVD survivors by using their voices to share how the disease has affected their intimate partners; and (c) add to the limited body of literature regarding the outcome for Ebola survivors. The findings of this study also provide information that may improve the interventions designed to address the needs of EVD survivors concerning reintegration with previous or future intimate partner relationships.

Summary

This qualitative study examines how the lived experiences of stigmatization affect the quality of intimate partner relationships for Ebola survivors in Monrovia. The guiding research question included assessing how EVD survivors in Monrovia described their lived experiences regarding stigmatization and its influence on intimate partner relationships. The theoretical framework that guided this study is the stigma framework. Data was collected through semi-structured interviews and thematically analyzed. The following chapter, Chapter 2, thoroughly reviews the literature.

Chapter 2: Literature Review

This qualitative phenomenological study aimed to examine how the lived experiences of stigmatization affected the quality of intimate partner relationships for Ebola survivors in Monrovia. Stigmatization and rejection are significant factors that stimulate social problems among survivors of EVD (Nuriddin et al., 2018). While many studies have previously examined the effect of stigmatization among Ebola survivors (Bonwitt et al., 2018; Nuriddin et al., 2018; Wilson et al., 2018), there is a gap in the literature regarding how stigmatization affects intimate partner relationships. Findings from this study addressed this gap and provided practical information on how the lived experiences of stigmatization have affected the intimate partner relationships of survivors of EVD in Monrovia.

The first section of the literature review discussed the search strategy. Subsequently, I provided a discussion of the trauma theory. I discussed EVD stigmatization throughout this literature review. Next, a discussion was provided regarding the influence of EVD on survivors, followed by sub-sections regarding stigma, post-Ebola syndrome, isolation, and the inability to integrate with the community. The following central section review EVD stigmatization and intimate partner relationships. Finally, Chapter 2 summarized the synthesized findings.

Literature Search Strategy

I conducted the literature review to support this study through a holistic literature review. The search strategy for the following review of relevant literature included searching the following academic databases: Google Scholar, EBSCO, Science Direct, SpringerLink, JSTOR, EBSCOHost, Online Research Databases, and Mendeley. I used the following keywords to find relevant literature: *Ebola Virus Disease, Ebola survivors, rejection, Ebola survivors AND rejection, Ebola survivors AND stigmatization, stigmatization, Ebola survivors in an intimate partner relationship, post-Ebola syndrome, post-Ebola syndrome AND intimate partner violence, Ebola in Monrovia, stigma theory, stigma theory AND Ebola syndrome, stigma theory and post-Ebola survivors, stigma theory AND intimate partner relationships with EVD survivors.* The search, as mentioned above terms yielded 75 peer-reviewed research articles.

Using these keywords (both individually and in combinations), I collected relevant research from database searches. Those that were deemed relevant to the current study were included in the literature review. A series of inclusion criteria for this review were established, which included the following factors: (a) English-only text, (b) peer-reviewed literature, and (c) full-text literature. For these inclusion criteria, only English texts were included to ensure translation errors would not reduce the quality of the analysis. In addition, full text only was included to ensure that the synthesis of findings included data collection, analysis, and study findings. Finally, I prioritized peer-reviewed literature due to the robust nature of the peer-review process that ensures the empirical rigor of scholarly literature.

Theoretical Foundation

The theoretical framework for the study was the stigma theory. The stigma theory guided this study concerning the stigmatization among Ebola survivors in Monrovia. Stigma theory was essential to guide the understanding of how recovery from Ebola led to stigmatization, as well as impacted their intimate partner experiences.

Historical Evolution of Stigma Theory

In this first section, I briefly present the historical groundwork established for the stigma theory. Many terminal diseases like Ebola historically resulted in trauma, stigmatization, and rejection (James et al., 2020). Stigma theory was first explored by the neurologist Jean-Martin Charcot, a French physician, during the late 19th century (Mambrol, 2017). Charcot's work focused on hysteria, a disorder diagnosed among women with abrupt amnesia, paralysis, and convulsions. Charcot discovered that the symptoms were more psychological rather than physiological. Charcot proposed that traumatic events could induce a hypnotic state that could create disassociation of consciousness in patients and family members.

Before stigma theory, researchers employed the trauma theory to explain outcomes of significant trauma events for individuals and communities (Canal-Rivero et al., 2022; James et al., 2020; Mambrol, 2017), which is closely related to the foundational work of Sigmund Freud, expanded the theory. Freud in 1951 expounded upon the trauma theory by positing that trauma was a wound created not upon the body but the mind (Smelser, 2004). Freud argued that trauma was healed by ensuring support and resources through therapy psychoanalytical methodology that does not suit the consideration of trauma through the lens of stigmatization (Smelser, 2004). As such, for this study, Goffman's provided an opportunity to understand stigmatization, which is also ideal for the current study.

Stigma theory provides a guideline for exploring the influence of trauma, due to stigmatization, upon an individual's life and well-being. Kleber (2019) provided an overview of the impact of stigma on individuals' lives through an integrative review. According to McCann and Pearlman (1990), stigma can impact individuals psychologically. Stigma may also manifest through physical symptoms such as nervous system distress (McCann & Pearlman, 1990). Stigma theory provides a theoretical stance for exploring how trauma impacts individuals both short- and long-term.

In modern conceptualizations of trauma theory, psychologists and researchers posited that trauma is a form of suffering that impacts individuals uniquely (Russin & Stein, 2021). One individual's trauma response and recovery are different from another individual's (Russin & Stein, 2021). In the case of this study, this information was critical to exploring lived experiences of Ebola survivors as each experience is unique to their own lives.

The stigma theory and seminal trauma-theory authors (E.g., Canal-Rivero et al., 2022; James et al., 2020; Mambrol, 2017) demonstrate that trauma is a result, or direct influence, of the experiences of stigmatization. The resulting trauma from stigmatization may influence an individual's well-being and mental health. In this study, the stigma theory and the work of seminal authors informed the understanding of how EVD survivors' stigmatization and relationship with intimate partnerships were affected through trauma based on their lived experiences explored in this study.

Goffman's Adaption of the Stigma Theory

The primary theoretical framework that guided this study is Goffman's work on stigma theory began in 1963. To fully understand Goffman's sigma theory, it is essential to acknowledge the evolution of the theory, which originated in exploring trauma and the result of a severe illness on the patient's psychological health (Canal-Rivero et al., 2022; Goffman, 2009; James et al., 2020; Mambrol, 2017). Understanding trauma's impact on patients was expanded upon by the work of Freud. Freud posited that trauma was a wound created not upon the body but the mind and further argued that trauma was healed through therapeutic and social support (Ahmad et al., 2023). The work of Freud provides insight into the influence of psychoanalytical procedures and the direct result on the well-being of an individual. However, Goffman would later expand previous trauma research to include the term stigmatization, explore outcomes on individuals, and understand the importance of exploring stigma without purely focusing on trauma events.

Goffman became the leading theorist of stigma theory. In the 1960s and 1970s, Goffman explored individuals' daily interactions and presentations of themselves in public situations (Goffman, 1963, 2009). Goffman posed this theory as a reflection of same-sex attraction in the 1970s, viewed as abnormal and harmful among most of the population (Goffman, 2009). Goffman's work was critical to reducing stigmatization by demonstrating how external processes, such as popular media representation, can harm minority groups that are non-harmful to the general public. In Goffman's first publication, he reviewed the process and meaning making through mundane interactions. Goffman (2009) employed a dramaturgical approach in which he presented the phenomenon in consideration of a larger social context. Goffman argued that performance was shaped by the environment in the audience, which primarily posed to create impressions upon other individuals. Thus, individual identity and persona are developed based on exchanging information and relationships created with the community (Goffman, 2009).

Goffman (2009) also considered stigma through the lens of three critical types of stigma (a) public stigma, (b) self-stigma, and (c) associated stigma. Self-stigma may result from overt or external deformities resulting from injury or birth (Goffman, 2009). Self-stigma may also include personality deviations such as beliefs, sexual orientation, mental health-related disorders, or general personality traits that deviate from an accepted social norm (Goffman, 2009). For example, depression and same-sex attraction are largely stigmatized globally (Goffman, 2009). Current efforts to reduce stigmatization for many of these issues are underway globally and locally (Goffman, 2009). Finally, associated stigma refers to the process of stigmatization from social groups or individuals based on their association with an individual that is either physically or mentally disabled or who holds differing values from values that are normalized in a larger societal context (e.g., sexuality and gender; Goffman, 2009).

Goffman (2009) further expanded upon his ideologies regarding individuality and self. In his publication, stigma notes on the management of spoiled identity, Goffman laid the foundation regarding stigma research relating when individuals respond to challenges (1963). Goffman (2009) later regarded stigma as an “attribute which is deeply discrediting” (p. 3). Goffman argued that discrediting attributes, like skin color, could be discernible or visible, such as mental illness. Goffman focused on the self-image perceived by an individual. Society views stigmatized individuals as abnormal (Goffman, 2009). As a result, they must maintain their self-image and defense mechanisms to cope with stigma (Goffman, 2009). Goffman (2009) argued that the role of stigmatization could impact an individual throughout their entire life. In addition, to physical pain or mental illness, stigmatization from society and others can decrease mental and physical health outcomes (Goffman, 2009).

Goffman (2009) also conceptualized trauma through two key constructs (a) how stigmas are predicated, (b) how stigmas affect the individual. In the first setting, stigmas are predicted by the individual's attributes, which others identify as abnormal. In the second construct, the researchers considered how stigma affects the individual. The effect of the stigma may include mental or physical health issues. Internal and external variables influenced and exacerbated stigma. Individuals experienced discrimination, stereotyping, and labeling (e.g., often incorrect derogatory labeling; Goffman, 2009).

Goffman (2009) also through the lens of three critical types of stigma (a) public stigma, (b) self-stigma, and (c) associated stigma. Self-stigma may result from overt or external deformities that result from birth (Goffman, 2009). Self-stigma may also include personality deviations such as beliefs, sexual orientation, mental health-related disorders, or general personality traits that deviate from an accepted social norm (Goffman, 2009). Finally, associated stigma refers to stigmatization from social groups or individuals based on their association with an individual who has been stigmatized (Goffman, 2009).

Application of Stigma Theory to Current Study

In terms of the current study, individuals who survived Ebola are stigmatized due to erroneous perceptions of individuals' health status after the recovery. Researchers demonstrated that individuals who survived Ebola are most likely to experience self-stigma and associated stigma based on the perception that individuals with this disease are dirty, infectious, and dangerous (Bonwitt et al., 2018). EVD survivors are more likely to experience stigma and shame within their communities, impacting their relationships. The high risk of infection, misinformation, and inadequate information in the community contributed to the origin of stigma toward EVD survivors (Bonwitt et al., 2018). The stigma theory guided the exploration of individuals who survived the EVD and stigmatization in the relationship of intimate partner violence. Stigma theory was important for exploring how recovery from Ebola led to stigmatization and impacted experiences with intimate partners experiences.

Ebola Virus Disease and Social Stigmatization

Individuals who survive EVD are heavily stigmatized in their communities (Obilade, 2015; Overholt et al., 2018). EVD is fatal and has no known cure, according to modern empirical knowledge. Individuals within the community often fear EVD due to misinformation regarding infection (Obilade, 2015). Misinformation, distrust of governmental solutions, and news fabrication in rural communities have increased the stigmatization of EVD survivors (Obilade, 2015). James et al. (2020) further emphasized that EVD survivors are most likely to experience difficulty integrating within their community due to misinformation regarding infection and general mistrust from the community due to EVD survivorship. Ebola survivors faced increased social stigmatization due to societal fear, mistrust, and misinformation (James et al., 2020; Obilade, 2015; Overholt et al., 2018).

As a result of social stigmatization, EVD survivors reported distrustful and hostile experiences from the community based on their previous experiences with the disease. Overholt et al. (2018) explored the mental health characteristics of EVD survivors who reported stigma in Liberia through a longitudinal study with 299 adolescent and adult participants. Overholt et al. identified that EVD survivors reported self-stigma related to shame regarding the disease, recovery status, and lasting physical ailments and disabilities. According to Overholt et al., Ebola-related stigma occurred in survivors after recovering from EVD. Data from Antonaccio et al. (2021) also provided keen insight into the stigmatization of EVD survivors. Antonaccio et al. conducted a case within five of the ten regions of Ghana impacted by Ebola. Antonaccio et al. identified community-level and health system-related stigma among EVD survivors. Antonaccio et al. indicated varying levels of community stigma. First, community-level stigma is directed toward

EVD patients, household members, compound members, and relatives. At the community level, stigma relates to cultural and spiritual beliefs and general perceptions of “uncleanness” among EVD survivors. The effects of the stigma indicated that on the community level, patients are abandoned, patients are hidden, and post-treatment strategies are reduced. Further, stigma can result in denial of the condition and treatment. Overall, Ebola-related stigma included shame and subjugation within the community due to their recovery status. In addition, survivors reported self-stigma during and after EVD recovery (Antonaccio et al., 2021; Overholt et al., 2018).

Health system-related stigma also influences social stigmatization due to the EVD survivors’ relationship with surviving the disease (Antonaccio et al., 2021). The health system stigma is directed toward EVD patients, relatives of healthcare workers, and the health system. Regarding health-related stigma, the outcomes include neglect of patients, refusal to work in EVD treatment centers, and lack of confidence in the health system (Antonaccio et al., 2021). Health system-related stigma was associated with fear of contracting the disease based on proximity to patients and healthcare workers (Antonaccio et al., 2021). Thus, when considering the social stigmatization of EVD survivors, it is crucial to note health-related stigma as this influences the community’s reaction towards EVD survivors’ reentry into the public.

Survivors of EVD are more likely to describe stigmatization based on fear and mistrust in the community (Crea et al., 2022; Keita et al., 2017b). Data from Crea et al. and Keita et al. illustrated that EVD participants experienced various complaints from the community regarding fear of EVD survivors transmitting the disease to other community members. Mainly, misinformation regarding the spread of EVD was rampant within small and rural communities (Crea et al., 2022; Keita et al., 2017b). Community members claimed that if EVD survivors were still infected, it would spread widely to the community (Keita et al., 2017a). Thus, communication within the community increases the stigmatization and rejection of EVD survivors (Crea et al., 2022; Keita et al., 2017b). As a result, EVD survivors were continuously under critique and suspicion from the surrounding community members (Crea et al., 2022; Keita et al., 2017b).

For some EVD survivors, mental health outcomes included depression, anxiety, and PTSD, which may potentially influence the health of intimate partner relationships (O'Leary et al., 2018). For example, O'Leary et al. (2018) conducted quantitative research exploring the mental health challenges EVD survivors faced. The identified mental health challenges included depression, anxiety, and post-traumatic stress syndrome. Data from the study also showed that 20% of survivors met the diagnostic criterion for PTSD. Further, 95% of EVD survivors in Serra Leone experienced stigmatization from the community towards their disease recovery status. These findings illustrated that stigmatization could occur in community settings that foster fear of disease transmission status from EVD survivors (O'Leary et al., 2018). As a result, the potential mental health and well-being impacts may also influence the outcomes of intimate partner relationships based on the health and ability of EVD survivors to integrate socially (O'Leary et al., 2018).

Regarding Ebola, individuals stigmatized due to the erroneous perception of an individual's health status after recovery are most likely to struggle with poor mental health outcomes (James et al., 2020; Overholt et al., 2018). Researchers also indicated an increased risk of stigmatization towards EVD survivors based upon suffering from the disease. In particular, significant research is available regarding the mental health outcomes experienced by survivors (Godwin et al., 2019; Katana et al., 2021). Extended periods of stigmatization can lead to trauma in many individuals (Blum et al., 2019; Delker et al., 2020). Individual therapy can relieve trauma-related mental illness (Blum et al., 2019; Delker et al., 2020). However, many individuals who suffer from trauma experience Post-Traumatic Stress Disorder (PTSD), which can be a life-long struggle (Dodd et al., 2021; Krzemieniecki & Gabriel, 2019).

Stigmatization from EVD can result in various psychosocial outcomes for individuals. Bortel et al. (2016) examined the Ebola virus outbreak's psychosocial outcomes. Bortel et al. found that individuals with EVD developed fear concerning death and trauma related to witnessing surrounding death in their community. EVD individuals are also stigmatized and excluded from the community to their recovery status. The stigmatization resulting from EVD corresponded with the community's blame, guilt, and shame regarding transmitting the virus to others. As a result, EVD survivors experienced critical psychosocial consequences (Bortel et al., 2016). Fischer et al. (2019) similarly explored EVD-related stigma by discussing the known impact of stigma through a meta-analysis approach. According to Fischer et al. (2019), there is a need to develop EVD-targeted interventions to reduce stigma by reducing misinformation that often spreads in small communities and social circles. Together, these findings illustrated EVD related stigma is a critical issue that requires to be addressed through intervention-based assessments.

Stigmatization from EVD can result in various psychosocial outcomes for individuals (James et al., 2020). For example, James et al. conducted a qualitative study through 28 interviews with EVD survivors in Sierra Leone. The study found that survivors reported sadness, guilt, and shame. The most common experience was stigmatization and total rejection from the community. Stigmatization included rejection, isolation, as well as general harassment. Participants noted that intimate partners' perceptions changed from fear to general mistrust and avoidance (James et al., 2020). Participants reported feeling shame, guilt, and sadness at the rejection from their community and intimate partners. As a result, they struggled to reintegrate within their communities and families (James et al., 2020). The finding further showed that survivors faced stigmatization and discrimination from their loved ones and communities.

Other challenges experienced by EVD survivors included mental health issues exacerbated by stigmatization around their disease status from the community and family members (O'Leary et al., 2018). For example, O'Leary et al. conducted quantitative research exploring the mental health challenges EVD survivors faced. The mental health challenges included depression, anxiety, and post-traumatic stress syndrome. O'Leary et al. found that 95% of EVD survivors in Sierra Leone experienced stigma from the community respondents. Data from the study also showed that 20% of survivors met the diagnostical criterion for PTSD. O'Leary et al. demonstrated the lasting impacts of EVD stigmatization.

Researchers also illustrated that stigma could impact individuals' lifeways and well-being after recovery. Nuriddin et al. (2018) conducted a qualitative study in Sierra Leone using focus groups to examine individual perceptions, attitudes, and resultant stigmas developed toward EVD survivors. The authors identified disease-related stigma, sex-related stigma, and social stigma. Nuriddin et al. reported that EVD stigma among community members is prevalent in intimate relationships. After recovery from EVD, intimate partners shamed, avoided, or even physically and mentally harassed survivors. In addition, intimate partners expressed fear regarding the transmission of EVD during sexual intercourse. The sex-related stigma was influenced by a national health protocol that advocated for survivors to abstain from sex or use a condom for 90 days after being discharged from the treatment facilities.

Regarding disease-related stigma, community members feared survivors would continue spreading the disease even after recovery. Finally, the social stigma was a continued fear of the "uncleanness" of survivors, which led to isolation and harassment towards survivors. Findings from Nuriddin et al. (2018) underscored the stigmatization EVD survivors faced after recovery. Due to stigmatization, this proposed study will focus only on the lived experience and impact of EVD survivors in their intimate partner relationship in Monrovia.

EVD stigma can also affect the community due to consistent deceased parents that leave behind children. A consistent element of EVD-related literature is the outcomes of parental death due to EVD. Green et al. (2018) explored a cohort of parents and guardians in Monrovia, Liberia, regarding the 2014 EVD outbreak. The data was gathered by assessing how parents responded to their children harassing or making light of others with EVD. According to Green et al. (2018), differing community policies changed regarding EVD, which included a fear that children or other loved ones would contract the disease. However, each family unit and the community responded uniquely to EVD. Green et al. (2018) illustrated differing social ideologies regarding addressing EVD stigmatization through harassment and bullying. These findings are critical to demonstrating the known stigma-related literature associated with EVD survival.

Researchers demonstrated that EVD survivors are more likely to experience social stigma after recovery. Kelly et al. (2019) explored stigmas among EVD survivors from seven Liberian counties. For the assessment, EVD survivors reported stigmatization on 6- and 18-month follow-up visits with local physicians based on visitations with their local physicians. According to Kelly et al., survivors reported increased EVD stigmatization during the 6-months recovery. However, at 18 months of recovery, stigmatization slightly decreased.

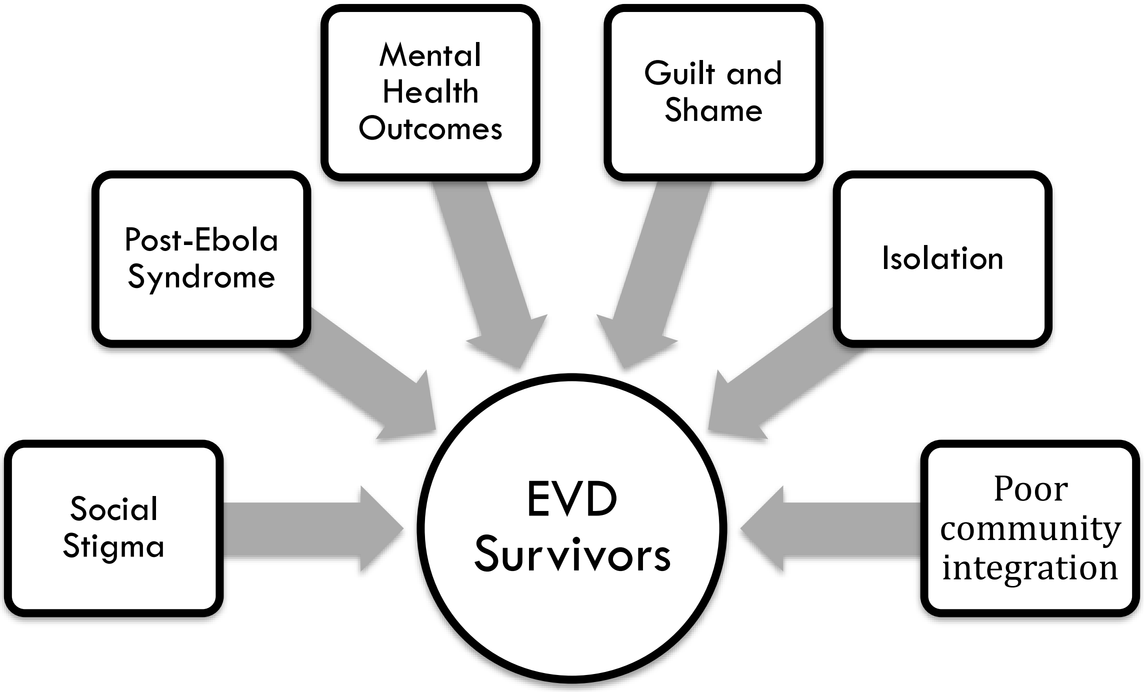
Impact of EVD on Survivors

EVD persistence, in terms of the long-lasting symptoms after recovery from the disease, impacted individuals psychologically and physically after the initial infection

(Scott et al., 2016). As a result, individuals suffered psychologically and physically after the initial infection and recovery (Scott et al., 2016; Wilson et al., 2018). In reviewing the current literature on stigmatization and EVD, a focus across six themes was noted. These themes (see Figure 1) are critical to understanding the current literature about stigma's impact on EVD survivors.

Figure 1

Major Themes of EVD Survivors in Reviewed Literature



Note. Created for this study

As such, in the following sub-sections, each theme is briefly discussed to provide a holistic review of the literature before discussing the stigmatization and rejection of EVD survivors and the impact on intimate partner relationships.

Post-Ebola Syndrome

The outcomes of EVD recovery are referred to in empirical literature as post-Ebola syndrome (Wilson et al., 2018). The outcomes included mental and physical health outcomes, such as depression, anxiety, fear, and physical ailments, such as chronic nerve pain (Scott et al., 2016; Wilson et al., 2018). In addition, due to physical disabilities, survivors may experience a sense of "uncleanliness" that perpetuates stigmatization from the community and family members. Wilson et al. (2018) examined the prevalence of post-Ebola syndrome among EVD survivors in Liberia using a cross-sectional study design. Wilson et al. found that post-Ebola syndrome was presented among 90% of the survivors in the sample.

Almost half of the EVD survivors in West Africa reported various experiences of psychological and physical symptoms, also known as post-Ebola syndrome (Himiede, 2016). Himiede sought to determine the duration, types, and socio-economic challenges of surviving Ebola. Himiede states that post-Ebola syndrome symptoms include neurological and musculoskeletal symptoms. Survivors were also likely to report decreased mental health due to increased physical pain. Himiede findings demonstrated that the outcome of Ebola could be stressful after recovery and discharge from the hospital and contribute to stigmatization due to lasting physical ailments and the inability to work.

Isolation

Isolation is associated with reduced mental health outcomes among EVD survivors. Extended isolation is central to EVD survivors’ mental health (Mohammed et al., 2017). According to Qureshi (2016), EVD survivors are troubled by a lack of contact with their loved ones during hospitalization under the ETU (Qureshi, 2016). The quarantine policy of the government also increased isolation as patients were separated from their families and the community (WHO, 2018). According to Baah et al. (2019), isolated loved ones experienced increased feelings of grief, distress, loss, and helplessness. According to Baah et al., isolation can result in prolonged psychological trauma among EVD survivors.

Ebola survivors are most likely to experience isolation from the community due to fear of disease transmission (Ervin et al., 2018). For EVD survivors, the time spent secluded from their community can increase their depression and anxiety (Keita et al., 2017b). However, the survivors often received little mental health support from the community due to fear of contagion. According to Keita et al. (2017b), EVD survivors' exposure to isolation and rejection may lead to suicidal ideation, depression, and anxiety. Thus, EVD survivors who experienced isolation-related mental health issues struggle to recover and re-integrate within the community, which may include their intimate partner relationships (Cunningham et al., 2020; Godwin et al., 2019).

Isolation can also occur from the community and family life, as the survivors of Ebola are often excluded from average community and social settings (Ervin et al., 2018). EVD survivors must spend time healing, recovering from lasting neurological symptoms, and social distancing (Keita et al., 2017b). However, due to fear of contagion, EVD survivors often receive little support and experience increased isolation. For some survivors, isolation increases suicidal ideation (Keita et al., 2017b).

EVD survivors are more likely to experience stigma and shame within their communities, which impacts their relationships. Cultural beliefs, such as believing individuals became bewitched, contributed to the stigma and fear of EVD in Monrovia (Bonwitt et al., 2018). The high risk of infection, misinformation, and inadequate information about the disease contributed much to the cause of stigma among individuals (Bonwitt et al., 2018). According to Bonwitt et al., intimate partner relationships are negatively affected due to cultural beliefs and general misinformation. In the proceeding sections, a review of intimate partner relationships impacted by the stigma of Ebola is discussed.

Isolation is also associated with feelings of rejection (Baah et al., 2019). In turn, rejection from EVD, for some survivors, can mean isolation from family, intimate partner relationships, and the community (Baah et al., 2019). For some EVD survivors, isolation led to divorce and general rejection from the community (Ervin et al., 2018; Keita et al., 2017b). For example, some individuals could not return to school or work and could not sell goods and wares in local markets (Ervin et al., 2018). Rejection resulted in avoidance from family and friends (Ervin et al., 2018). Public restrooms, water, and religious meetings were restricted (Keita et al., 2017b). Further, community members gossiped about the survivors, which led to the decreased mental health of the EVD survivors (Ervin et al., 2018). As a result, the isolation and rejection led to decreased mental health and increased suicidal ideation (Ervin et al., 2018)

Inability to Integrate With the Community

Ebola survivors from the recent outbreaks reported that treatment and recovery barriers to resuming lives (Bortel et al., 2016). Adverse outcomes in the form of lost professions, health issues, emotional distress, and difficulty regaining their livelihoods were accompanied by the isolation situations after the Ebola treatment (WHO, 2018). In addition, Ebola survivors were accustomed to violence and stigma (Bortel et al., 2016). However, some challenges to EVD survivors' reintegration into communities during the West African outbreak have been complicated and different from other outbreaks, as reported by various media coverage of the Ebola epidemic (Baah et al., 2019). For example, gaining a new job and re-integrating into the community can be challenging after continued isolation and recovery. However, there is a need for further exploration that considers how individuals recount their experiences after EVD recovery.

EVD survivors are also perceived as community threats due to their highly contagious status (Crea et al., 2022). According to Keita et al. (2017b), suspicion of contagion is a common complaint among citizens. Thus, messages from the organizations and government about the transmission of Ebola fostered confusion among the community members regarding survivors (WHO, 2019). As a result, survivors faced job losses and emotional distress and could not integrate within the community (Bortel et al., 2016; WHO, 2018).

The psychological impact on EVD survivors can result in isolation and permanent separation from families, friends, and intimate partners. For example, James et al. (2019) conducted a quantitative study to determine the psychological impact of EVD on survivors, how family and community members reacted to survivors, and the coping skills used by survivors of EVD. The findings indicated that EVD survivors reported symptoms of depression, self-stigmatization (due to disease status), and many other psychological issues, such as depression and anxiety. The researchers found that survivors reported rejection, isolation, and stigmatization by families and their communities. The common themes highlighted in this study were the stigmatization and discrimination of EVD survivors after being discharged from the ETU by family and community. Intimate partner relationships were also negatively impacted due to fear from partners of transmission of the disease. Data from Kaggiah et al. (2022) revealed information regarding these relationships through assessing focus group discussions. The authors aimed to explore the lived experiences of Ebola survivors in West Africa after being discharged from the ETU. The findings indicated that EVD survivors faced internal stigmatization and stigmatization from their partnerships due to fear of disease transmission, broken trust and love, and increased risk of physical violence or abandonment after recovery from EVD. James et al. (2019) and Kaggiah et al. (2022)

findings are relevant to my proposed study. The results revealed the prevalence of rejection and stigmatization perpetrated by families and communities among Ebola survivors in Sierra Leone.

Survivors’ recovery can ultimately impact their ability to continue integrating with society, which has lasting psychological symptoms. According to Elsinga et al. (2017), EVD survivors reported physical harassment and bullying. Some survivors reported encounters of hostility and exclusion from their homes and communities. Several survivors returned home and found they were removed or terminated from their jobs. Loss of income and isolation further occurred due to fear and distrust of the Ebola survivors by the members of the communities (Elsinga et al., 2017). As individuals were unable to integrate within the community, they were also unable to obtain jobs, which resulted in the loss of income (Elsinga et al., 2017). In addition, loss of income and unemployment among the survivors of Ebola-affected their livelihoods, resulting in family conflicts and breakups in general. The survivors lost self-esteem in society and their families, which negatively affected their relationships (Elsinga et al., 2017). One outcome of trauma from EVD is the lasting stigma and mental health-associated issues. Mambrol (2017) argued that this caused persistence in the surroundings of the general mental health stigma. Ebola patients with no access to thoughtful and honest mental health information, thus, refuting the significant misconceptions. Inadequate information within the community led to disease-related stigma. As a result, survivors experienced severe mental disorders and lasting trauma. The reviewed findings of Elsinga et al. and

Mambrol are essential to consider when exploring EVD survivors’ experiences. Loss of income, lack of societal integration, and hostility may result in EVD survivors lasting trauma.

In this section, the multiple variables related to the impact of EVD upon survivors were reviewed. Poor physical and psychological symptoms can lead to isolation, which is necessary for recovery, but increased stigmatization from their local communities regarding erroneous beliefs that EVD survivors were “unclean” (Keita et al., 2017a; Qureshi, 2016). These studies provided general oversight of some issues that EVD survivors reported. The findings in this section also demonstrated that the burden of research is within topics such as physical and psychological symptoms without focusing on the lived experiences of EVD survivors and the impact on intimate partner relationships.

Ebola and Intimate Partner Relationships

The EVD status can result in societal stigmatization, impacting how these survivors can maintain or gain new intimate partner relationships. This section will review the research that discussed rejection, stigmatization, and the impact of intimate partner relationships among EVD survivors. Researchers indicated that Ebola had a lasting impact on survivors and associated intimate partner relationships. According to Godwin et al. (2019), Ebola survivors in Liberia have experienced differing social impacts on their intimate partner relationships. Godwin et al. (2019) explored in-depth interviews with 69 female survivors for the assessment. The female participants indicated various struggles with intimate partner relationships, such as the inability to communicate, difficulty with sexual intimacy, and fear and stigmatization regarding the experiences of discussing their disease diagnosis.

Similarly, Cunningham et al. (2020) examined faculty duties in Ebola survivors' challenges concerning intimate partner survivorship. The authors gathered data from February to March 2020. The data included 30 women surveyed regarding sexual behaviors and their consideration of risk concerning the transmission of his ease with their intimate partners. The results indicated that women struggled with intimate partner relationships after surviving Ebola due to fear of transmission to their partner. Additionally, the participants reflected misinformation regarding the transmission of the disease to their partners. It is indicated that we need women most likely to use strategies such as abstinence to reduce the possibility of transmitting the disease to their partners. These findings illustrated that individuals battles that suffer from Ebola belated stigma are most likely to discuss various difficulties regarding intimate partner relationships. However, these lack a particular ticket perception towards intimate partner relationships among Ebola services. Further, these findings reduced our understanding of how stigmatization impacts intimate partner relationships and leads to, if at all, rejection.

The reviewed literature regarding intimate partner relationships and EVD indicated that the disease outcomes are associated with reduced trust and loss of income among relationships. As a result, loss of income and trust from the intimate partner increased the inability of the EVD survivor to integrate within the community, and their previous intimate partner relationship also led to difficulty in societal reintegration. According to Keita et al. (2017b), loss of trust was a shared experience of EVD survivors that led to the dissolution of relationships and marriages. Additionally, many members lost their relationships due to partner infidelity or loss of love for each other (Keita et al., 2017b). The findings of Keita et al. further illustrated the continuing struggle of EVD survivors and the impact on intimate partner relationships. However, data need to be gathered considering how EVD survivors reflect the impact on intimate partner relationships regarding stigmatization.

Researchers illustrated that initiated partner relationships are negatively impacted due to stigma. According to Wilkinson and Fairhead (2017), EVD survivors are rejected and isolated from their communities. As a result, fear and anxiety manifest among survivors, accompanied by the grief of those lost (Wilkinson & Fairhead, 2017). Combined, EVD survivors are isolated and depressed. As a result, many intimate partner relationships in Monrovia were dissolved (Wilkinson & Fairhead, 2017).

One of the changes during EVD is the intimate partner's increased fear of the survivor. Katana et al. (2021) examined psychosocial changes and relationships between EVD survivors with intimate partners. The authors identified that the continued isolation experienced by survivors during the quarantine period led to an increased psychosocial change in the relationship between the survivor and their intimate partners. Thus, data indicated that EVD survivors are more likely to be isolated due to the medical need regarding their condition and fear and mistrust from their intimate partner concerning the transmission of the disease (Katana et al., 2021).

The reviewed literature indicated that EVD survivors are isolated from their communities, which dissolution intimate partner relationships (Katana et al., 2021; Wilkinson & Fairhead, 2017). In addition, the reviewed findings demonstrated that continued social distancing (due to the need to quarantine during EVD treatment) also complicated intimate partner relationships. However, further exploration is needed to discuss the impact of EVD-related stigmatization on intimate partner relationships from the survivor's perspective. Next, a summary of this literature review is provided in the following section.

Survivors of EVD faced societal stigmatization, impacting how survivors interacted with intimate partner relationships. Researchers illustrated that initiated partner relationships are negatively impacted due to stigma. According to Wilkinson and Fairhead (2017), EVD survivors are rejected and isolated from their communities due to fear of disease transmission. As a result, fear and anxiety manifest among intimate partners (Wilkinson & Fairhead, 2017). Further, EVD survivors are isolated and depressed. As a result, many intimate partner relationships in Monrovia were dissolved (Wilkinson & Fairhead, 2017).

Loss of income and trust from the community also led to difficulty in societal reintegration (Keita et al., 2017b). According to Keita et al., loss of income and trust was a shared experience of EVD survivors. After ETU discharge, survivors could not return to their "normal lifeways" due to societal exclusion, loss of jobs, and inability to integrate within the community. These issues reduced relationship trust and increased the risk of partner infidelity or loss of love (Keita et al., 2017b). The findings of Keita et al. illustrated the ongoing struggle of EVD survivors and the impact on intimate partner relationships. However, there is a need to gather data considering how EVD survivors reflect the impact on intimate partner relationships.

To summarize this section, the known data regarding rejection, stigmatization, and intimate partner relationships among EVD survivors are lacking. The current data reviewed illustrated that EVD survivors are isolated from their communities, leading to mental health distress and later dissolution of relationships and marriages (Wilkinson & Fairhead, 2017). In addition, coping with EVD is difficult for many individuals, increasing stress in intimate partner relationships (Walker & Fox, 2018). Further, the COVID-19 social distancing measures exacerbated loneliness and isolation, which may have increased stress on intimate partner relationships (Katana et al., 2021). However, further exploration is needed to discuss the impact of EVD-related stigmatization on intimate partner relationships from the survivor's perspective. Next, a summary of this literature review is provided in the following section.

Summary and Conclusions

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Fairhead (2017), EVD survivors are rejected and isolated from their communities due to fear of disease transmission. As a result, fear and anxiety manifest among intimate partners (Wilkinson & Fairhead, 2017). Further, EVD survivors are isolated and depressed. As a result, many intimate partner relationships in Monrovia were dissolved (Wilkinson & Fairhead, 2017).

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To summarize this section, the known data regarding stigmatization in intimate partner relationships among EVD survivors are lacking. The current data reviewed illustrated that EVD survivors are isolated from their communities, leading to mental health distress and later dissolution of relationships and marriages (Wilkinson & Fairhead, 2017). In addition, coping with EVD is difficult for many individuals, increasing stress in intimate partner relationships (Walker & Fox, 2018). Further, the COVID-19 social distancing measures exacerbate loneliness and isolation, which may have increased stress on intimate partner relationships (Katana et al., 2021). However, further exploration was needed to discuss the impact of EVD-related stigmatization on intimate partner relationships from the survivor. In the reviewed literature, the main headings reviewed were (after the theoretical foundation) EVD and social stigmatization, the impact of EVD among survivors, stigma, post-Ebola syndrome, mental health outcome, guilt and shame, isolation, inability to integrate with the community, EVD rejection, stigmatization, and intimate partner relationships, summary. In the first section, the EVD survivors reported outcomes were reviewed. These included issues that ranged from stigmatization to poor mental health outcomes (James et al., 2020; Overholt et al., 2018; Wester & Giesecke, 2019). EVD survivors are more likely to experience social stigmatization due to misinformation, cultural beliefs, and fear and mistrust of the survivors (Bonwitt et al., 2018). Mental health outcomes ranged from depression, anxiety, and posttraumatic stress syndrome (O'Leary et al., 2018). Survivors also experience immense guilt and shame due to their fear of transmitting the disease or watching others around them die (Baah et al., 2019; Bonwitt et al., 2018). Additionally, outcomes included isolation from loved ones and community exclusion, which exacerbated psychological issues (Elsinga et al., 2017; Keita et al., 2017b; Mambrol, 2017; Qureshi, 2016; WHO, 2019).

The available data illustrated that EVD could impact intimate partner relationships through a divorce and increased fear from the partner in terms of contracting the disease (Wilkinson & Fairhead, 2017). The increased isolation (recovering from the disease and the COVID-19 pandemic) also increased the risk of relationship dissolution (Keita et al., 2017b). Finally, the current data illustrated that there is lacking assessments that considered how EVD survivors recounted the impact of the disease and stigmatization upon their intimate partner relationships.

Most of the past studies conducted during the 40 years of the Ebola outbreaks demonstrated that Ebola survivors suffered psychological stigma due to social rejection and alienation (Crea et al., 2022; Etard et al., 2017; WHO, 2019). However, there is a gap regarding how stigma influences intimate partner relationships among Ebola survivors—especially in Monrovia. Therefore, more research is needed to unravel the lived experiences of stigma in intimate partner relationships among Ebola survivors in Monrovia, which this study will address.

The research mentioned above has presented the impact of EVD on survivors but do not critically give an accurate picture of how stigma has affected intimate partner relationship among EVD survivors in Monrovia, Liberia. This proposed study will differ from the research presented in this prospectus as it will explore the lived experience of EVD survivors in Liberia and how they are affected by stigmatization in their intimate partner relationships. The study specifically targeted EVD survivors who are married or in intimate partner relationships and created an intentional space where they shared how the disease has affected their intimate partners. In the following section, the researcher presented the design and research methodology that guided this study. Chapter 3 discussed research design justification, methodology, sampling and recruitment, and data analysis and collection methods.

Chapter 3: Research Method

This qualitative study aims to determine how the lived experiences of stigmatization affected the quality of intimate partner relationships for survivors of EVD in Monrovia. This chapter provided an overview of the research methodology and the justification of the research design. This chapter also presented the targeted population, sample size, recruitment strategies, and instrumentation and discussed the data analysis plans in detail. The chapter also details the trustworthiness issues and the ethical considerations that guided this study. Chapter 3's final section summarized the methods used to accomplish this study.

Research Design and Rationale

RQ. How do EVD survivors in Monrovia describe their lived experiences regarding stigmatization and its influence on intimate partner relationships?

The study gave voices to survivors of Ebola by allowing them to share their experiences of stigmatization and how the disease has affected them as individuals and their relationships with their intimate partners. A qualitative research design with a descriptive phenomenological method guided this study. The qualitative research design was used to gain rich and exploratory information on participants' lived experiences of a phenomenon (Prosek & Gibson, 2021; Sibeoni et al., 2020). Conversely, a quantitative approach was used to explore a testable phenomenon later assessed through descriptive or inferential statistics (Prosek & Gibson, 2021). For this study, the qualitative methodology was ideal for exploring the lived experiences of stigmatization and the potential influence upon intimate partner relationships of Ebola survivors in Monrovia due to the ability to gather textual data grounded within the participants' perceptions as reported to the researcher.

Regarding the research methodology, multiple options were considered but not chosen as they were unsuitable for the study. For example, a case study and ethnographic approach were considered. A case study explores a specific social phenomenon in a particular context through multiple data sources (Rashid et al., 2019). The case study was not chosen, as this research aims not to explore how the phenomenon occurs within a specific context but to describe participants' lived experiences. The researcher documented cultural traits and characteristics between or within a distinct group (Godwin et al., 2019). The ethnographic approach was not chosen as this study aimed not to document or explore the cultural characteristics of individuals or groups.

The final consideration was the phenomenological approach. The phenomenological approach entailed exploring the construction of meaning towards specific experiences through the reported lived experiences of individuals (Husserl, 1970; Moustakas, 1994). I employed a transcendental phenomenological approach ideal for understanding human experiences and constructing experiences based upon a shared social phenomenon: EVD survivorship, stigmatization, and intimate partner relationships. The transcendental phenomenological approach was developed through Moustakas (1994) to explore the human experience as reported by the lived experiences of individuals. The phenomenological approach was ideal for this study to examine how the lived experiences of rejection and stigmatization affected the intimate partner relationships of Ebola survivors in Monrovia. In the following section, the researcher discussed the population and sample chosen for this study.

Role of the Researcher

The researcher's role in this study was to collect and analyze data. I conducted interviews with participants and analyzed the resulting data. Additionally, I performed each semi-structured interview and analyzed data without the assistance of other researchers or assistants. I did not know any of the participants in this study. If I recognized the participants within the study, I planned to exclude them to ensure that our relationship did not impact the study’s findings or the participant’s reflections. I also employed empathetic listening when I interviewed participants.

In a phenomenological approach, it is imperative to note that bias and researcher opinions are inevitable elements of research (Moustakas, 1994; Tracy, 2019). I used two forms of methods to mitigate personal research bias. The first was bracketing, or epoché, which Edmund Husserl (1970) created in his phenomenological approach. During data collection analysis, the bracketing process was guided to suspend personal bias towards social phenomena. This process required I set aside my personal bias regarding EVD stigmatization and the participant's reflections during the study. The method of bracketing was employed as a means of impartially analyzing the findings of the study. I also suspended personal biases during data collection to ensure that personal bias did not impact the study (Tracy, 2019).

I used reflexive journaling. Patton (1987) indicated that the process of reflexive journaling was necessary for the researcher to identify and deeply consider the potential impact on the study's findings. A process of reflexive journaling was also used in alignment with bracketing (Patton, 1987). The reflexive journaling process is essential as novice researchers may be unaware of biases until they physically identify them (Tracy, 2019). The reflexive journaling aided me in noting personal opinions and biases and separated personal thoughts from the findings that the participants reflected. I used the reflexive journaling process in alignment with bracketing to boldly document and suspend my biases throughout the data analysis and collection (Tracy, 2019). In the following section, the methodology of this study is introduced with a focus on participants, sampling, recruitment, data collection, and data analysis.

Methodology

In this section of Chapter 3, I defined and gave an overview of the population, sample, recruitment, and data saturation, and finally discussed the data collection and analysis procedures. Throughout this section, the details for data collection are provided in detail to ensure the dependability and credibility of the research design and methodology.

Population and Sample

The participants in this study are EVD survivors in Monrovia. Participants included in the study were willing to discuss stigmatization from their intimate partners due to lived experiences with EVD. An inclusion criterion was developed to ensure that participants included in the study were reflected upon the questions provided in this study. The inclusion criteria for participating in the study are presented below:

1. Must be located in Monrovia and have a diagnosis of EVD.
2. Must be in an intimate partnership relationship before and after the diagnosis.
3. Must have experienced EVD stigmatization.
4. Must be willing to be interviewed and audio-recorded for 60-90 minutes.

Individuals who did not meet the inclusion criteria were excluded from participating and thanked for their time in expressing interest in the study.

Sampling Strategy

Purposive sampling was used to select participants with specific eligibility to be included in a study (Tracy, 2019). Snowball sampling was used to recruit participants from an initial volunteer to know others interested in study participation (Tracy, 2019). Snowball sampling still relies on inclusion criteria but pulls from the knowledge of initially recruited participants to identify other participants (Tracy, 2019). Purposive sampling and snowball sampling were used to recruit participants for this study. Purposive sampling was chosen as an appropriate model to ensure that participants were eligible to discuss their experiences with rejection and stigma during EVD.

Sample Size

The minimum sample size for a phenomenological study is generally considered 12-15 participants (Tracy, 2019). Vasileiou et al. (2018) argued that sample sizes in phenomenological studies are characteristically small while focusing on the richness of the gathered data. However, it is also important to consider sample saturation and attrition (Chakrabarti & Markless, 2022). The process of sample saturation refers to gaining sufficient information to address the research questions, which is thematic analysis, which refers to gaining data until no new themes arise (Tracy, 2019). Therefore, this study addressed sample saturation by gathering data until no new themes were presented (Chakrabarti & Markless, 2022; Tracy, 2019).

Instrumentation

For this study, I developed an interview guide. Instrumentation was also considered an essential element of trustworthiness to ensure that the data collected addressed the research questions (Malmqvist et al., 2019; Tracy, 2019). For this purpose, the researcher addressed the validity of the instrumentation through methods such as an expert panel that reviewed the questions created by the researcher (Fusch et al., 2018; Malmqvist et al., 2019; Tracy, 2019). The developed interview guide included ten questions regarding EVD survivorship, stigmatization, and the influence on intimate partner relationships. The creation of the interview guide followed previous recommendations regarding ideal interview guides for novice researchers (Fusch et al., 2018; Tracy, 2019).

Recruitment

After IRB approval was gained, recruitment commenced. After an appropriate arrangement, participants were recruited from the only National Ebola Survivor Network of Liberia (NESNL) based in Monrovia. This location was strategically selected because it hosted the only NESNL office; most survivors lived in this city and spoke English. Also, this was the only easily-reach city with a good road network. I posted physical flyers on the designated bulletin at the NESNL office in Monrovia to recruit individuals. Also, I distributed flyers within the weekly group sessions at the NESNL office.

Depending on their preference, participants contacted me through email, phone, or in person. The participants were provided with my contact information through the recruitment flyers. My recruitment information included phone and email information which the participants could access. Upon initial contact, I asked participants the screening questions to determine if they met the inclusion criteria to ensure eligibility. If a participant was eligible, I asked for their email address and provided them an informed consent form or met them in person to present the form. I then emailed the informed consent form electronically to be signed through DocuSign or asked those in person to sign the hard copy. The interview was conducted at the NESNL office—in the available individual session room and designated community hub for survivors. During the meeting for the interview, I arranged a mutually beneficial time for myself and the participants to engage in a semi-structured interview. The interview also reminded them of their voluntary inclusion in the study per the written documentation in the informed consent form signed before the interview. I reminded participants to return the consent form before the interview.

Data Collection

Data collection occurred by first gaining IRB approval for this study. After IRB approval, recruitment commenced. Data were collected through semi-structured interviews. The interviews lasted approximately 60-90 minutes with 15 individuals. Saturation was achieved after the researcher determined that no new themes or information occurred through the data collection procedures (Patton, 1987). The interviews were conducted in person, and a backup recorder device was available to prevent data loss. Each interview was provided pseudonyms, such as Participant [P1] and Participant [P2]. The pseudonyms ensured participants' confidentiality and compliance with IRB regulations regarding ethical conduct in study procedures. Each interview was uploaded into NVivo 12 for data analysis, discussed in the proceeding section.

Data Analysis

Data analysis processes occurred following the guidelines developed by Braun and Clarke (2019). NVivo 12 was used to organize and code the data to aid in this process. NVivo 12 is an organizational software that offers tools such as “tagging” similarities and accessing these quotes easily within the software. After upload, data analysis proceeded with the procedures defined by Braun and Clarke’s six-step guide to thematic analysis. The thematic analysis involved tagging similarities in words, phrases, and phrases across each interview (Braun & Clarke, 2019). This process is generally defined as producing codes, categories, and themes to address the guiding research question (Braun & Clarke, 2019). The six-step guide provided by Braun and Clarke is described in the following sub-sections to demonstrate the exact methodology used to analyze the data gathered from this project.

For the data analysis, I used axial coding. Axial coding breaks data into discrete parts (Tracy, 2019). After breaking the data into parts, I then organized those parts into broad categories and themes (Tracy, 2019). For this process, the created categories revolved around axes that supported the codes. First, developing codes and categories completed this process, and finally, assessing the emergent themes based on the actual coding process (Tracy, 2019). The axial coding process was guided by inductive coding. Inductive coding includes considering analysis grounded within the data gained from participants (Tracy, 2019). This process included the creation of codes as the researcher completed the data analysis process. Codes were based on the participant's reflections which differs from predetermined codes in a deductive approach (Tracy, 2019).

Phase 1: Gaining Familiarity With the Data

The first phase of thematic analysis involved familiarization with the data. In this step, I read and re-read the transcripts to deeply understand each participant's reflection (Braun & Clarke, 2019). This first step was crucial to guiding the development of codes, categories, and themes in the proceeding phases of thematic analysis (Braun & Clarke, 2019).

Phase 2: Creation of Initial Codes

The second phase of the process involved identifying initial codes by reviewing any similarities between the texts (Braun & Clarke, 2019). The similarities included phrases, words, or paragraphs. Each code was marked within NVivo 12. The codes were the building block of the thematic analysis process, which was later used in the following phase to develop categories (Braun & Clarke, 2019).

Phase 3: Grouping Codes into Categories

The third phase involved initially grouping codes into "categories" (Braun & Clarke, 2019). These categories were grouped based on similarity and were the building block for the identification of emergent themes which occurred in the proceeding step (Braun & Clarke, 2019).

Phase 4: Identifying Emergent Theme

The fourth phase of the thematic analysis develops emergent themes by assessing the similarity in categories created from the initial codes (Braun & Clarke, 2019). Finally, the initial themes were discussed with the chair to ensure the credibility of the developed themes (Braun & Clarke, 2019).

Phase 5: Defining and Naming Emergent Themes

The fifth phase of the thematic analysis process included defining each theme and providing a descriptive and accurate title (Braun & Clarke, 2019). Finally, these themes were used to present results that occurred in phase six (Braun & Clarke, 2019).

Phase 6: Producing Results

The final phase included producing the results in the final sections of this project, including the codebook, which detailed the codes, categories, and final themes. The codebook was central to detailing an audit trail that details the processes used to develop the final findings (Braun & Clarke, 2019).

Issues of Trustworthiness

The variables of trustworthiness: credibility, dependability, transferability, and confirmability, were crucial for establishing the rigor of a qualitative study (Rose & Johnson, 2020). The trustworthiness issues were essential to understanding the quality of qualitative research as employed by my methods and approaches (Rose & Johnson, 2020). Trustworthiness was insurance for the validity of the research based on a qualitative perspective (Fusch et al., 2018). Trustworthiness was also crucial for ensuring that qualitative research accurately represented participants' reflections and the implications of the findings (Fusch et al., 2018). The following sub-sections discussed credibility, dependability, transferability, and confirmability and their relationship to this study.

Credibility

The process of credibility ensured that the findings from a study accurately represent the perspectives provided by participants (Rose & Johnson, 2020). Threats to credibility included misrepresenting data, my bias, sampling strategy, and the design used to collect and analyze data. I used reflexivity and member-checking to increase the study's credibility (Rose & Johnson, 2020). Research reflexivity documented and discussed my bias throughout the data collection and analysis (Rose & Johnson, 2020). I used reflexivity throughout the entire data collection process to increase the credibility of the findings and remove bias from the setting. The second method is the process of member checking. Member checking was used to increase credibility by ensuring that participants reviewed the transcripts before the data analysis process (Rose & Johnson, 2020). The member-checking process was essential to increasing the study’s credibility, ensuring that participants could clarify their responses after the interviews (Lemon & Hayes, 2020). Additionally, a codebook was displayed in the appendix to ensure the transparent representation of the findings through the thematic analysis procedures (Lemon & Hayes, 2020).

Dependability

Dependability refers to the techniques and methods to ensure that future researchers' study findings are consistent and replicable (Lemon & Hayes, 2020). Two methods were used to ensure the dependability of this study. The first method was an audit trail. An audit trail demonstrated how codes, categories, and themes were clearly in with the participant’s reflections (Nowell et al., 2017). In addition, the audit trail ensured a thorough discussion of the research process and the methods used to justify the findings of this study. The second method was ensuring dependability using a dependability audit trail (Nowell et al., 2017). The dependability audit trail involved using an independent auditor to review the audit trail. The dependability audit trail included a review of the participant’s and my bias reflexivity, field notes used within the audit trail, and the information that justified the findings of the study by the dissertation committee (Carcary, 2020).

Transferability

Transferability is a crucial issue of trustworthiness that refers to transferring findings beyond the sample recruited for a study (Lemon & Hayes, 2020). In this study, a phenomenological approach limited the transferability of findings as each lived experience was unique. Therefore, two methods were employed to increase the transferability of this study. The first method was purposeful sampling (Nowell et al., 2017). The use of purposeful sampling increases transferability as I select participants based on criteria that can be replicated by future researchers (Palinkas et al., 2015). The second method used for increasing transferability was thick descriptions of the data through direct quotes from participants in the data collection process. Including direct quotes from participants increased the transferability of the study by demonstrating the extent to which the findings were used or replicated by future researchers studying a similar phenomenon (Palinkas et al., 2015).

Confirmability

The final issue of trustworthiness is confirmability which refers to the replication of the study by future researchers through a clear demonstration of methods and study design (Rose & Johnson, 2020). To increase the confirmability of the study, the interviews were transcribed and recorded (Nowell et al., 2017). I recorded the interviews using an audio-recording device. This audio recording device transcribed the recordings to textual data (Carcary, 2020). I read and re-read the transcripts multiple times to ensure they knew the nuances within each participant's reflections (Lemon & Hayes, 2020). The confirmability of the study was also increased through the triangulation of the findings with similar literature in Chapter 5. I prevented the present congruence of the findings with previous scholarly assessments to increase the confirmability of the study's findings (Nowell et al., 2017). Confirmability for this study was produced through a clear demonstration of methods in Chapter 3 and an interview guide presented in Appendix B. Additionally, all (if any) changes to the study methodology were discussed in Chapters 3 and 4.

Ethical Procedures

The first ethical assurance of this study was that IRB approval was obtained before any form of recruitment or data collection. The ethical assurance of this study followed the Belmont Report (1978), which delineated the following three principles (a) persons, (b) beneficence, and (c) justice (Ascencio-Carbajal et al., 2021). In the first principle, pseudonyms were used to protect all persons, and all personal identifiers were removed from the transcripts and final findings. Additional ethical procedures included protecting persons by an informed consent form signed at the first of the study.

The principle of beneficence was also addressed through the distribution of risk. There was little to no harm expected in this study (Patton, 1987). However, some participants experienced feelings that were uncomfortable to recall. When discomfort arose during the interviews, I encouraged the participant to take a break or even stop the interview for the day (Tracy, 2019). The participants were encouraged to complete the interviews later or withdraw from the study when the discomfort persisted. Finally, ethical procedures were guided by the assurance of data storage and protection (Tracy, 2019). For this purpose, the data was stored on a password-protected USB drive that is only accessible to the researcher within a personal office. This password-protected USB drive will be destroyed five years (after dissertation completion) in consideration of guiding IRB regulations.

Summary

This qualitative study aimed to examine how the lived experience of stigmatization affects the quality of intimate partner relationships for Ebola survivors in Monrovia. For this study, a qualitative methodology was chosen with a phenomenological design which was justified in this chapter considering other design options. Participants included 15 Ebola survivors in Monrovia who perceived that they had experienced stigmatization from their intimate partners because of their lived experience with Ebola. Recruitment occurred by posting flyers on the designated bulletin or distributing flyers within weekly group sessions at the Ebola Survivor Network Organization based in Monrovia. Data was collected through semi-structured interviews that were thematically analyzed using Braun and Clarke’s (2019) six-step guide to thematic analysis. In the following chapter, the findings of this study are presented.

Chapter 4: Results

This chapter contains the findings from the thematic analysis of the interviews with 15 EVD survivors. This qualitative study explored how the lived experiences of rejection and stigmatization affect the quality of intimate partner relationships for Ebola survivors in Monrovia. The findings of this study illustrated the voices of EVD survivors by allowing them to share their experiences related to how having survived the Ebola disease has affected them as individuals and in their relationships with their intimate partners. The main research question asked: How do EVD survivors in Monrovia describe their lived experiences regarding stigmatization and the influence upon intimate partners' relationships? I coded the 15 transcripts to uncover the most common but meaningful themes across the data collected.

In this chapter, I will discuss the participants' demographics to gain a better insight and understanding of their responses. I will also describe the data collection process and data analysis and discuss whether there were any changes to this process from what was proposed. I will then present the evidence of trustworthiness to demonstrate the practices applied to achieve credibility, transferability, dependability, and confirmability. This section will be followed by the results of the thematic analysis supported by the participant's actual response. Finally, the chapter concludes with a summary of the results and an introduction to the fifth and last chapter of the research.

Setting

The interviews were conducted in person at the NESNL office and designated meeting hubs for survivors within the communities, which were extensions of the NESNL office. Each participant had their schedule in a private room, ensuring that the interview times did not coincide to avoid privacy and confidentiality concerns. After receiving approval to conduct interviews in these designated spaces provided for the interviews, it was determined that the areas were appropriate to uphold the confidentiality of participants because of the location (private room) and separate entry and exit into the facilities. The interviews lasted from 60 to 90 minutes, the expected length reported in Chapter 3. All participants were advised they would be assigned a pseudonym to mask their identity in the form of a participant number, such as Participant 1 would be referred to as P1, Participant 2 as P2, and so on.

Demographics

A total of 15 participants were interviewed for the study, of which eight were men and seven were women. Participants were Ebola survivors in Monrovia diagnosed with EVD and received treatment at the ETU. All participants had an intimate partner relationship before and after the diagnosis and reported experiencing EVD stigmatization. No other demographic information was collected.

Data Collection

I began recruiting data after receiving approval from Walden University and ACRE IRBs to conduct the study. I also received approval to access the National Ebola

Survivors Network of Liberia database and posting of recruitment flyer in their facility. Nineteen individuals contacted me to participate in the study. After screening for eligibility, I then scheduled interviews with those who self-reported as meeting the criteria. All interviews were scheduled based on the availability and convenience of the participants over 3 weeks, 5 days period. A total of 15 individuals met the criteria and participated in the study, which aligned with the proposed sampling strategy to provide enough data to reach saturation.

After the recruitment yielded a representative sample, data were collected via semi-structured interviews. Before the interviews, participants were advised of the purpose of the study and provided with informed consent. Each participant provided consent and agreed to record their interview before I began asking the interview questions. At the conclusion of each interview, I thanked each participant for their time and informed them of subsequent steps of asking them to review their transcripts for accuracy. Member checking was completed by emailing copies of the respective transcripts to individuals for corrections, as needed. No changes were made to any of the transcript. No participant called back for a second interview or to clarify any of the responses provided during the interview.

Data Analysis

A qualitative thematic analysis was used to analyze the participant responses to the interviews conducted with the 15 EVD survivors. Braun and Clarke (2019) defined thematic analysis as a method for “identifying, analyzing, and reporting” the patterns found across the qualitative data (p. 79). For this research study, I followed the six-step process of thematic analysis outlined by Braun and Clarke, which includes familiarization with the data, generation of initial codes, searching for themes across the data, reviewing themes, defining and naming themes, and generating the final report (p. 87).

First, to familiarize myself with the data, I read and reread the 15 interview transcripts, noting initial concepts related to the study's purpose and research questions. I also reviewed the recorded interviews from the backup recorder, noting essential responses. Additionally, I revisited my journal kept during the interviews for any specific notes about participants or reflexive views related to their responses. After member-checking to ensure there was no new information to be added, each transcript, identified by participant pseudonym, was uploaded into NVivo 12 for data organization.

During .the second data analysis stage, I created codes based on verbatim quotes from participant responses using axial coding, as described in Chapter 3. Several codes were related to more than one category, indicating overlapping themes. For example, participant P4 stated, “My family at home were hated by the community people. When I got there, too, they hated me. They refused for me to enter the community,” which represented both feelings of rejection and stigmatization. The process of assigning initial codes continued until all 15 interviews were coded. A total of 108 codes were created from verbatim quotes (see Appendix I). The codes were then organized into categories (nodes in NVivo) to facilitate data management. Throughout this process, I revisited the transcripts multiple times to ensure proper alignment of codes with categories and to maintain the context of participants’ experiences.

After categorizing the codes, I searched for emerging themes across the data using NVivo. The software allowed me to determine the hierarchy of themes based on the frequency of quotes and the number of participants with similar responses. The next stage involved reviewing the themes by revisiting the transcripts to ensure consistency with the essence of participants’ experiences. This review also provided an opportunity to identify any missing data and confirm that the themes accurately reflected the context and meaning of the verbatim quotes.

Following the themes review, I named and described each theme using codes and categories generated from participants' direct quotes (see Appendix J, Hierarchy of Themes). Five main themes and six subthemes emerged: Theme 1: Stigmatization Experiences; Theme 2: Influence on Intimate Partner Relationships; Theme 3: Need for Awareness, Education, and Resources; Theme 4: Feelings of Isolation, Rejection, and Abandonment; and Theme 5: Support and Acceptance. The final stage of the data analysis process involves presenting an extensive report in the Results section, discussing each theme, and providing substantiating verbatim responses.

Evidence of Trustworthiness

Credibility

To establish credibility, the variables of trustworthiness, including credibility, dependability, transferability, and confirmability, were applied. Credibility ensures that the findings accurately represent participants' perceptions and experiences (Rose & Johnson, 2020). I employed reflexivity and member checks in this study to enhance credibility. Through reflexivity, I openly acknowledged and documented potential biases in producing the study’s findings. Member checking allowed participants to review and verify their responses during the interviews. Transcribed interviews were emailed to participants for review, allowing them to request changes or modifications as necessary.

Dependability

Dependability focuses on the coherence and replicability of study findings (Lemon & Hayes, 2020). To address this, I maintained an audit trail and conducted a dependability audit. The audit trail provided a detailed discussion of the research processes and methods, ensuring that the findings were derived from participants’ actual answers rather than personal views or biases. The dependability audit involved an independent auditor who reviewed and assessed the audit trail.

Transferability

Transferability pertains to the applicability of research results beyond the sample recruited for the study (Lemon & Hayes, 2020). To ensure transferability, I employed purposeful sampling, selecting participants based on their unique knowledge of the phenomenon under investigation. Additionally, I provided thick and meaningful descriptions to facilitate understanding and replication of the research process by other researchers. The presentation of established themes includes verbatim responses or quotes from the interviews, demonstrating that the themes were derived from the raw data collected.

Confirmability

Confirmability refers to the ability to replicate the study to future scholars, demonstrating clear research methods and study design (Rose & Johnson, 2020). To achieve confirmability, I employed two key strategies. First, the audio recording and transcription of interviews allowed for thorough reading and rereading of the raw data. Additionally, I triangulated the findings to confirm or disconfirm the identified themes with previously reviewed literature.

Results

This section presents the complete results of the thematic analysis of the 15 interviews. The themes and subthemes are ranked and presented based on the number of participants and frequency of references to each subject area.

Table 1

Hierarchy of Themes

Theme	Subtheme	Description
Theme 1: Stigmatization Experiences	Subtheme 1: Dealing with Labeling and Stereotypes	The data analysis revealed that stigmatization experiences occurred upon diagnosis and after release from the ETU, which contributed what the participants described as leading to traumatization and thoughts of suicide and death. The data also revealed consistent

		experiences of being labeled, subject to name-calling, and stereotypical behaviors due to EVD status.
Theme 2: Influence to Intimate Partner Relationships	Subtheme 1: Impacts on Relationships Subtheme 2: Impacts to Sexual Relations	In the context of specific influences to intimate partner relationships occurring due to recommend abstinence from intimacy and sexual activity after release from ETU beyond the prescribed period due to fear of passing the disease. Dealing with physical and sexual dysfunctions was also reported as an experience after treatment that influenced intimate partner relationships.
Theme 3: Need for Awareness, Education, and Resources		The data revealed that there is a need for the general public to be made aware. They educated about the disease, treatment, and aftercare of survivors of EVD, especially through social media to reduce stigmatizing experience due to lack of information. There were also consistent references to the need for counselling services and knowledge about the post-treatment certificates for re-entry to communities and relationships.
Theme 4: Feelings of Rejection, Isolation, and Abandonment	Subtheme 1: Permanent Fractures in the Marriage or Relationship	In this context, the data revealed feelings of rejection, isolation, and abandonment may occur

		singularly or concurrently depending on the experiences in the marriage, or relationshi, related to contact with and access to their children, as well as how the community members react to the diagnosis or re-entry to the community.
Theme 5: Support and Acceptance	Subtheme 1: Survivor-to-Survivor Relationships Subtheme 2: Supportive Relationships	It was evident from the participants who were able to sustain supportive relationships after treatment or find new romantic relationships with fellow survivors contributed to feelings of being supported and accepted.

The main research question explored how the EVD survivors in Monrovia describe their lived experiences regarding stigmatization and its influence on intimate partner relationships. From the analysis, the experiences could be summarized into five key themes. These themes and the subthemes are found in the corresponding sections.

Theme 1: Stigmatization Experiences

The first theme discussed the stigmatization experiences of the participants as EVD survivors. From the analysis, most participants shared that they were perceived as “virus spreaders,” where community members stayed away from them upon learning about their Ebola diagnosis or even after they had proven that they were free from EVD already. Some participants noted that they were forced to stay away from their children as their partners and families feared them.

Subtheme 1: Dealing With Labeling and Stereotypes

The first subtheme that emerged from the thematic analysis was the experience of being perceived as 'virus spreaders,' leading to social isolation from the community. Among the participants, fourteen individuals shared how their lives underwent a complete transformation after receiving the diagnosis. Many described feeling a strong sense of being “hated” and “rejected”' by people literately “running away” from them. For instance, Participant 4 narrated his experience where not only he but his entire family faced hatred and rejection from their community. Despite a certificate confirming that he was free of the virus, he found himself isolated in his apartment, devoid of social interaction, saying:

> “My family at home was hated by the community people. When I got there too, they hated me. They refused for me to enter the community.
>
> When I got home it was very bad. My children were fine because they were not closer to their mom. –The community people rejected for me to enter the community. They only accepted me when they read the certificate. My condition got bad afterward—my foot got big and cut by itself. I am crippled because of the condition. Everybody in the apartment left.”

Participant 1 recounted how his life underwent a significant shift upon receiving the EVD diagnosis. He shared how his family, including his wife and children, ceased to interact with him even after he completed treatment for EVD at the ETU. Participant 1 described how his wife eventually found another man and would hastily “run away” with the children whenever he attempted to visit them in the community. He started:

> “By the time I came back from the ETU my wife found a guy and was already dating and she started stigmatizing me that my sperm and spit have the virus. If I kiss her or have sex with her, she was going to get the virus. Even her parents told her not to come back to me because I have the Ebola. She even stopped me from seeing my children. Whenever I got in the community they will call her, and she will run away from me with the kids. She didn’t even agree to meet me.”

Participant 1 also attempted to move on by starting to date after some time. Unfortunately, this new relationship did not endure either. When his girlfriend discovered that he was an EVD survivor, she accused him of giving her Ebola and even threatened to take legal action against him. This incident further compounded the challenges he faced due to his EVD experience. During the interview, Participant 1 emphasized the difficulties of such encounters, expressing:

> “However, I met another girl the moment we were walking in the community and one of her friends saw me with her. She introduced me as her boyfriend. Later the friend called her back on the phone and told her I was a survivor. That day she came home, and I was sleeping, and she woke me up in anger and started shooting that I gave her Ebola. She was knocking on me and said you know your sperm has Ebola. I will sue you in court. She stated hitting everything in the room. Even the flat-screen Tv a friend gave me who was traveling he felt for me. She

> knocked it down. I felt so discourage and sad that after the first relationship broke down now another stigmatization again. I felt very bad. That entire day I felt so bad. I was only asking God to take my life. I went to the mosque and told the Ima that if they didn't see me that me, I am dead."
>
> "Very challenging –I pray to never have that experience. Imaging due to this I have never seem my children and my ex-wife. Some people say they are out of the country –only God one knows."

Participant 10 confirmed previous participants' experiences, recounting that she faced widespread rejection. She revealed how her EVD status led community members to shun her small business, causing her significant distress. Faced with such overwhelming stigma and isolation, she eventually made a difficult decision to leave the city altogether. In her own words, she expressed:

> "Everyone rejected me. Only my children and I were together. My husband said he never wanted the relationship. I got some money in Lofa from the ETU to make business. But no one wanted to purchase anything from me. So, I left and went to Monrovia. I met a man who said he wanted me."

Meanwhile, Participant 11 faced rejection from his landlord upon revealing his EVD diagnosis. Fortunately, he found some support through his mother's friend, who offered him accommodation during this challenging period. However, the stigma surrounding his condition extended beyond the landlord's reaction. As news of his EVD diagnosis spread throughout the community, he experienced widespread avoidance from nearly everyone.

This included his struggles to find a romantic partner or even establish meaningful relationships. He shared the following poignant account:

> "When I got home, my landlord told asked me not to come to the house. Even though I paid my rent that month. She said I was a survivor. My mother friend children asked me to stay with them. After one month I started feeling good. Everybody in the community decided not to date me…. I could not get any girl from the community, so I went to other communities. Once they heard I was survivor they left me."

Participant 12's experience paralleled that of Participant 11, as he, too, encountered rejection from his landlord after disclosing his EVD diagnosis. The repercussions were severe, with his wife and children leaving him in the aftermath. He vividly recounted the following distressing events:

> "By the time I got home, I never had anything. The landlord told me they sprayed the room and thief broke into the house and stole everything. I was asked by the landlord told me to leave the room. So, I move far away. There I was getting treatment. My children mother broke up with me."

Participant 14 was fortunate to have an accepting husband. However, all the other individuals around her refused to be with her after her diagnosis. She expressed how it was challenging to manage life due to the stigma of EVD, saying:

> "I was treated at the ETU—a special place—where Samaritan Pulse was taking care of people with EBOLA. For my family few of them supported me especially

> my husband. Some of my friend when they see me, they ran away from me. So, I had to stay away from everybody. There were lot of challenges when it came to stigma. They fear that if they came around me, they will get the virus. So, it was just my husband and I."

As for Participant 15, despite his EVD survival, the discrimination and desertion persisted. The main source was also the lack of accurate information about the disease, saying:

> "Despite surviving the EVD, the survivor suffered discrimination and neglect from family members and community dwellers based on the rumor that anyone who interacts with an EVD survivor is likely to contract it. It was also a challenge getting food to eat, and the survivor had to do everything alone."

Participant 3 was also discriminated by her family members, fiancé, and community members. She shared how everyone seemed to be afraid of her. At the same time, her fiancé had misconceptions about the virus. He then refused to have a physical relationship with her and did not trust her after, stating the following:

> "At home when people noticed they started running from me and calling Ebola they were afraid of me… Did you have a Relation? I had a relationship—my fiancé was afraid because there were whole lot of saying that the Ebola virus was in my blood --it cannot leave the blood. He never had sex with me he got afraid. He thought he would have gotten the virus through sexual intercourse. So, he

> abundant me and left the relationship. He never trusted me. I tried to talk to him, but he did not listen. He never trusted me. He said I was lying to him."

Participant 5 believed that she had a better experience at the ETU versus at home and in the community. She shared that at the ETU, she was cared for and had food and other necessities. However, in the community, despite being in dire need, she did not have people to assist her; instead, they stayed away from her.

> "When I came home, I think it was better I stay at the ETU because—I was cared for and well taken care of and could eat whatever I wanted. But at home, I was highly stigmatized by the entire community. Even my name was on the radio that I was walking and I dropped and fainted. When I got hope, people who used to come around for help and visit stay away. No one came around to extend sympathy for the loss of my parents. They even refused to even call me on phone".

She shared another experience where she felt the difference in treatment, narrating:

> "When I got home, the county health team spray my entire home, destroying almost everything and the chlorine was too much. My mother had a little clinic—so we had to move in it and locked ourselves up so no one can come close to us. Even if I had to buy greens to eat, I have to wrap the money in plastic bag and the girl who came to get the money had to put glove on to receive the money. The girl who was helping us was warned by the landlord that if she kept coming around me, she was going to be given notice to vacate the residence."

At the same time, she also experienced discrimination from the family of his partner, saying:

> "The church people, his mother, and everybody never wanted us to be together. After I survived, I went to the church to give testimony and but the time I came back to my seat, everybody on our pew left. We were stigmatized. After the Ebola epidemic he refused to go back to the church—but I told him No. I am still in that church. His mom never wanted to see us together. She even stops him from seeing his own daughter."

Participant 6 shared that his experience was both good and bad. Despite being accepted and welcomed by his friend, he experienced discrimination from the community. He shared how his entire household was treated differently, and almost everyone stayed away from him and his daughters. He expressed that this was a brutal and shameful experience:

> "It was good and bad—first my friend who were hoping for my returned were happy. But the community never excepted me --stigmatized me and my household. They called my house EBOLA zone. And said no one should interact with my children. My friend stayed away from me. even if they came to visit, they stay away. My daughters were stopped from going to the community pump to draw water. So, I was forced to dig my own well. I got sick in the leg and when to one of the community clinics--I do not want to call their name here. But by the time I got to the clinic, one of the Nurses who knew me as a survivor, I could see

> her spreading the news from Office to office that an Ebola survivor was here. Everybody got afraid and looking at me- so I felt shame, I had to leave without getting the treatment. I used the pharmacy to get treatment."

Furthermore, Participant 7 echoed the experience of not being able to access simple necessities such as food. She also added how she lost the important people in her life in the process, saying: "I could not even get food. Everybody stayed away from me including my husband. I lost two children to Ebola. Everything I had was burned. All my friends rejected me. My husband left." Participant 8 added how: "They started rejecting me. My wife left and went out of time, but she never knew I was sick. My wife came later, and she helped me. My children help me too, but the community rejected me." As for Participant 9, one her symptoms were visible, everyone started to reject her to the point of being thrown food to feed her. She continued to share how she was not able to be in a normal relationship after, saying:

> "Once I started showing symptoms—everybody rejected me. No one came around me. They threw my food under the table to feed me. The Boyfriend I had left me once I came back from the ETU. Everybody rejected me-they even refused to take money from me to purchase food. I had kid after I returned but once he heard I was a survivor—he left me. Up to now, I have no relationship."

Finally, Participant 16 had the same and difficult experience of: "Everybody stayed away from me. They all called me Ebola survivor. I felt so bad. I was stigmatized."

Theme 2: Influence to Intimate Partner Relationships

The second theme sought to address the influence of the participants' EVD diagnosis on their intimate partner relationships. From the analysis, the researcher established that most participants reported being stigmatized by more than one partner. As a result, these participants had difficulty maintaining or sustaining relationships. Further, 11 participants said that their partners abandoned them upon diagnosis. Another five participants found it necessary to use contraceptives even after their EVS clearance for the safety of their partners.

Subtheme 1: Impacts to Relationships

The first subtheme that emerged was the experience of being stigmatized by more than one partner, where the 13 participants shared that they have since found it difficult to be in a relationship and maintain one as their partners would leave them upon becoming aware of their EVD history. As Participant 1 narrated, four girls have rejected him because of his status. With his current relationship, he admitted that his current partner is afraid of him and thinks that he still has Ebola.

> "So, did your wife leave you? Yes. How about the other girl? She left me too. Even the fifth one left me. So now I have to tell every woman I met. Before, because of the stigmatization I hide my Ebola status. If you like me and agreed with my status than we can love. Even the relationship am in—the fifth one always reminds me about my status—you know you are an Ebola survivor, everybody rejected you beside me."

> Did you pass the virus onto anyone of them? "I think the girl I am with got pregnant and she had a still baby and the community people started telling her it was because I give her Ebola. It was the virus that made the child still. Later the doctor called them and told them it was because of me. I also experienced the same still birth and miscarriage with two other girls. After the fifth girl, the doctor started doing sperm test."

Furthermore, Participant 1 added difficulty finding a partner who would understand and accept him and his previous EVD condition. This participant reiterated that the "stigma is forever" he added how it would be ideal to find a "survivor to survivor" relationship, hoping that the understanding and trust would be higher, saying:

> "I had been in more than 4 relationships, and all was stigmatizing. As we speak—I am planning to leave the house right now. Because the woman I am with still thinks I have Ebola. The stigma cannot go away—it is forever. We the man have two relationships now. So, if this person say they don't want us we go to the other relationship. Because we don't want to be passing around. This is creating mental illness for most of us. You invest everything in a woman than she just leaves you. It is too much, and we are tired with it. Survivor to survivor is the best. I praying to get a survivor."

Meanwhile, Participant 10 shared a similar pattern in a relationship, noting: "My husband left me, and later I fell in love with someone in Monrovia who never knew my status. We had two kids. Once he found out I was a survivor, he left me alone with my kids." At the same time, Participant 11 shared how his community turned their backs on him. With this, he found it challenging to find a woman to date and could not sustain a relationship after, stating:

> “Everybody in the community decided not to date me. I could not get any girl from the community, so I went to other communities. Once they heard I was survivor they left me. I felt I couldn’t get anyone. I have had multiple relationship. And even up to now—I don’t have anyone.”

Participant 12 admitted that he has since developed a trauma in relationships. He has had multiple partners after surviving EVD, but each one left due to the same reason, the fear of being with an EVD survivor, saying:

> “I could not have sex with my children’s mother because she left me. I started experiencing sexual problem. I met another girl but once I told her my status—she left. The third person, I didn’t tell her. But when she heard I was a survivor she left me. It made me traumatized. I have a relationship now but we are not having sex. I have had multiple relationship because no one wanted a relationship with me because I was a survivor.”

Participant 3 echoed that she also struggled to maintain a relationship. She stated that her partners would leave once her EVD history is brought up, sharing the following:

> “I struggle to stay in a relationship. I had another relationship it was long time after the first one and it did not last long. He later left me because of my status as

> an Ebola survivor. Right now, I have another relationship… No. and even the second guy left me."

Finally, Participant 9 commented: "I cannot find anyone to stay in a relationship with me. Everyone think, I have Ebola and I will give it to them."

Subtheme 2: Impacts to Sexual Relations

Another subtheme that followed was the participants' decision to use contraceptives for the safety of their partner. According to them, as the fear of passing the virus is still present, they would use contraceptives in order for their partners to be more comfortable. Participant 2 commented: "After I went through the recommended months—I still use condom." Meanwhile, Participant 4 reiterated how the use of condom helps in reducing the fear of his partner who also had an ex-husband who was diagnosed with EVD. The participant stated:

> "Since my wife died, I am just having a girlfriend. People were afraid to date me because of my condition. Even now my girlfriend is afraid to have sex with me. She said her husband passed away from the Ebola too. 2-3 month now we only have sex with condom. But she is getting used to me now… My wife passed. I have not had any other relationship until now. Three months ago. Right now, the fear is still there, so we use condom."

Theme 3: Need for Awareness, Education and Resources.

The third theme discussed the participants' recommendations for improving their conditions and experiences as EVD survivors. For the majority or 12 of the 15 survivors, there must be increased education and awareness on the media about the disease. According to them, there is too much information and a lack of accurate knowledge about EVD. Meanwhile, three minor themes were formed but may need further research due to the limited number of references and participant responses coded.

The third theme of the study was the recommendation of the participants for an enhanced awareness and education about EVD through the media. For them, there are too may false news and information about the disease. As a result, survivors are discriminated and stigmatized. These participants then called for the education of the society in order to reduce the stigma. Participant 4 simply suggested for: "Communication and educating the other people." Meanwhile, Participant 1 believed that currently, there is a lack of focus on EVD education. A proper and targeted educational campaign would help in addressing this problem, stating:

> "I think what would have help at that time-there was poor education on the media. There was too much information. Thank God for [name]—who tutor us and we had to tell the rest of the community. Imaging a girl married a survivor (female) and once he found out she was a survivor he divorced her in one week. He packed the thing in the house and left."

As for Participant 11, there must be: "education and awareness." For Participant 12, a message that could be conveyed is: "People need to know that I deserve a second chance." Similarly, Participant 15 wanted others to know that: "If the partner would have believed that the Ebola virus is not transferable from a survivor, it would have helped to alleviate stigma in the relationship." Furthermore, Participant 3 called for: "Counseling and education." From Participant 5's experience, people need to be more aware and knowledgeable of the disease. This participant also touched on the importance of reintegration, saying:

> "Awareness –people needed to be educated. The religious community, because some of our friend who survived had to get out of the ETU at night so that no one get to know. I think when people survive there should be a special program for them. Reintegration should be grand. Imaging 9 persons died from me and coming in the community and was stigmatized really traumatized me."

Participant 6 added how advanced education should be made available. This participant provided examples, saying:

> "People should be educated in advanced. Education should also be how people should interact with people with Ebola. There media need to be used –and translated in the local dialects. So many people lost their relationship than. Now they want to come back but the other partner will not agree."

Similarly, Participant 7 suggested for: "Maybe education and awareness." Participant 9 echoed the need for: "Education." Lastly, the same recommendation was provided by Participant 16, calling for: "awareness and counseling."

Theme 4: Feelings of Rejection, Isolation, and Abandonment

The fourth theme that emerged discussed the feelings of rejection, isolation, and abandonment. Under this theme, the participants shared how their EVD led to permanent fractures in the marriage and relationships of the participants. The examples are shared below.

Subtheme 1: Permanent Fractures in the Marriage or Relationship

The first subtheme that followed discussed the experience of being abandoned by the survivors' partners. According to them, upon going home from the ETU, their partners had already decided to leave and start a new life without them. Participant 1 shared how his wife was afraid of him and asked him not to come home anymore. She took their kids and this prompted Participant 1 to think about taking his own life, saying:

> "By the time I came back from the ETU my wife found a guy and was already dating and she started stigmatizing me that my sperm and spit have the virus. If I kiss her or have sex with her, she was going to get the virus. Even her parents told her not to come back to me because I have the Ebola. She even stopped me from seeing my children. Whenever I got in the community they will call her, and she will run away from me with the kids. It was so bad, I almost had suicide. I bought the rope and wanted to just take my life."

Participant 10 added how her husband and her partner after him both left due to her status as a survivor. She expressed the difficulty of being in a relationship as an EVD survivor, saying:

> "I had three children by my husband. He left me. I was taken in the ETU. My husband left me and later I felt in love with someone in Monrovia who never knew my status. We had two kids. Once he found out I was a survivor, he left me

> alone with my kids. I feel very bad. My husband left me and called be Ebola survivor."

Meanwhile, Participant 11 simply commented: "Bad off—nobody wanted me. I feel hopeless again. The girl I had a child by left me." At the same time, Participant 12 experienced how:

> "By the time I got home, I never had anything. The landlord told me they sprayed the room and thief broke into the house and stole everything. I was asked by the landlord told me to leave the room. So, I move far away. There I was getting treatment. My children mother broke up with me."
>
> "I could not have sex with my children mother because she left me. I started experiencing sexual problem. I met another girl but once I told her my status—she left. The third person, I didn't tell her. But when she heard I was a survivor she left me. It made me traumatized. I have a relationship now but we are not having sex."

Participant 3 shared the rejection and abandonment she experienced with her status as an EVD survivor. The following experiences were narrated during the interview:

> Did you have a Relation? "I had a relationship—my fiancé was afraid because there were whole lot of saying that the Ebola virus was in my blood --it cannot leave the blood. He never had sex with me he got afraid. He thought he would have gotten the virus through sexual intercourse. So, he abundant me and left the

> relationship. He never trusted me. I tried to talk to him, but he did not listen. He never trusted me. He said I was lying to him.
>
> I felt very bad. I thought I wouldn't find love. I felt rejected and was down hearted. He suddenly neglected me. It was not an easy task I was also thrown out of my house. The landlord put my things out once my first relationship left me."

Similarly, Participant 7 added: "By the time I came home he left. Since then—I have not had any relationship. I felt totally rejected." Lastly, Participant 9 echoed: "The Boyfriend I had left me once I came back from the ETU. Everybody rejected me-they even refused to take money from me to purchase food."

Theme 5: Support and Acceptance

The fifth theme of the study discussed the support and acceptance of the partners and even community members to some of the EVD survivors. According to one participant, it has worked better when they have chosen to be in survivor-to-survivor relationships. Two participants did not experience negative EVD implications as they found supportive partners.

Subtheme 1: Survivor-to-Survivor Relationships

The first subtheme identified the positive impact of being in survivor-to-survivor relationships. For P1, his relationships with non-EVD survivors did not work out. He found that being with EVD survivors was more loving and accepting, saying:

> "Because of that—I some time wanted to cut my dick. People come around but once they hear I am a survivor—they run away. So, at the moment, we decided to

> date survivors---survivor to survivors. Survivor to survivor is sweet and make it take. So, we were just loving to each other.”

Subtheme 2: Supportive Relationships

The second subtheme revealed that two participants had supportive relationships. For P2, he shared how the community members were accepting and were especially happy when he returned to the community. He narrated:

> “Actually, the people in the community were happy for me. They didn’t stigmatize me. They were happy for me to come back. After I return, --because my wife died. I never had relationship in a long time. I met a woman; she was a nurse. She didn’t stigmatize me. I was bold enough to tell her I was an Ebola survivor. She was supportive.”

Meanwhile, P14 was grateful for her husband’s constant care and support, saying:

> “For me, my husband never had problem with me at all. I was afraid—I thought I was not well yet. I was not to show. I was in fear so he can’t contract the virus. When we slept in bed, I put a pillar between us. So, I told him to stay away. But for him he was in denial—he felt nothing happened to me. He encouraged me and was happy with me. He supported me.”

Summary

Chapter 4 of this study presents the analysis results of 15 interviews conducted with Ebola Virus Disease (EVD) survivors. The objective of this qualitative study was to investigate the impact of rejection and stigmatization on the quality of intimate partner relationships among EVD survivors in Monrovia. The findings provide insights into the personal experiences of survivors, highlighting their encounters with rejection, stigmatization, and the effects of the disease on their individual well-being and intimate relationships. The analysis, facilitated by NVivo12 by QSR, revealed five themes and several subthemes that address the central research question. Chapter 5 will delve further into these themes, discussing their implications, providing recommendations, and presenting the study's conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This chapter presents the findings of a comprehensive exploration into the lived experiences of rejection and stigmatization among Ebola survivors in Monrovia, focusing specifically on the impact of these experiences on intimate partner relationships. The study aimed to provide a platform for EVD survivors to share their personal narratives, shedding light on the challenges they faced and how the disease affected both their individual lives and their relationships with their intimate partners. By examining the participants' lived experiences of stigmatization and investigating the influence of these experiences on their intimate partner relationships, this study offers valuable insights that can inform recommendations for improving the condition of Ebola survivors.

The key findings of this study can be summarized as follows: First, regarding the participants' experiences of stigmatization, 14 out of the total participants shared accounts of being perceived as virus spreaders within their communities, resulting in community members distancing themselves from them. Additionally, the participants revealed the distressing experience of being separated from their children due to the effects of stigmatization. Second, the study found that an Ebola diagnosis had far-reaching impacts on the participants' intimate partner relationships. Thirteen out of the fifteen participants reported experiencing stigmatization from multiple partners due to their Ebola infection diagnosis, indicating a pervasive pattern of stigma across different relationships. The study also uncovered instances of abandonment by the participants' partners. Furthermore, the results showed that five partners resorted to contraceptive use as a precautionary measure to protect themselves from their Ebola-infected partners.

When asked about recommendations to improve their conditions and experiences, most participants (12 out of 15) stressed the importance of implementing proper and accurate education programs through the media specifically focused on the Ebola virus (Mitchell et al., 2021). These education programs, by providing comprehensive and accurate information, would empower survivors with the knowledge and understanding necessary to navigate the challenges associated with the virus. By equipping survivors with this knowledge, they can be better prepared to face the societal and relational difficulties arising from their condition.

These significant findings offer a deep understanding of the experiences of rejection and stigmatization among Ebola survivors, highlighting the urgent need for interventions and support mechanisms to address their unique challenges. The subsequent sections of this chapter will present recommendations that draw upon these findings, aiming to improve the condition of Ebola survivors and foster a more compassionate and inclusive society. By implementing these recommendations, stakeholders can actively contribute to positive social changes, supporting the well-being and resilience of Ebola survivors in their intimate partner relationships and beyond.

Interpretation of the Study Findings

This session delved into the profound impact of stigmatization experiences among survivors of EVD. The findings shed light on the detrimental effects of stigmatization on the well-being, relationships, and social interactions of EVD survivors. The participants' narratives have vividly illustrated the pervasive and damaging nature of stigmatization, including labeling, discrimination, social exclusion, and rejection. This session briefly highlights the themes and subthemes that will be explored within the context of stigmatization experiences.

Theme 1: Stigmatization Experiences

The first theme, Stigmatization Experiences, illuminates the profound impact of stigmatization on the well-being, relationships, and social interactions of EVD survivors. The participants shared their accounts of being stigmatized as "virus spreaders" by their communities, leading to social exclusion and rejection. They encountered labeling, discrimination, and stereotypes due to their Ebola diagnosis, resulting in profound emotional and relational consequences. The participants' narratives highlight the adverse reactions they faced from community members, including being "hated," "rejected," and avoided (James et al., 2019). They experienced isolation, with their own families, partners, and children distancing themselves due to the fear of transmission and the association of Ebola with their identity. Their accounts vividly illustrate the pervasive and damaging effects of stigmatization on their personal and social lives. Participants described how their lives were utterly transformed after their diagnosis, with fractured relationships, abandonment, and even the breakdown of marriages or partnerships due to the stigma they encountered.

The experiences described align with Goffman’s stigma framework and studies in the peer-reviewed literature presented in Chapter 2 (James et al., 2019; Obilade, 2015; Overholt et al., 2018), which emphasize the process of labeling, stereotyping, and social exclusion based on a specific characteristic or condition. The participants’ accounts demonstrate the need for greater awareness, education, and support to combat the stigmatization of Ebola and its survivors. The findings highlight the urgency of challenging stereotypes, providing accurate information, and fostering inclusive communities that accept and support EVD survivors.

Subtheme 1: Dealing With Labeling and Stereotypes

Consistent with the peer-reviewed literature presented in Chapter 2 (Baah et al., 2019; Nuriddin et al., 2018; O'Leary et al., 2018), the participants' experiences revealed that after being diagnosed and released from the ETU, they faced stigmatization, which led to traumatization and thoughts of suicide and death. They consistently reported being labeled, subjected to name-calling, and encountering stereotypical behaviors due to their EVD status. This stigmatization profoundly impacted their relationships, as even their loved ones left them due to the fear and negative perceptions associated with Ebola. The participants felt hated and rejected and experienced significant changes due to the stigma.

The participants' experiences align with Goffman's stigma framework and other studies in the peer-reviewed literature presented in Chapter 2, which emphasize the process of labeling, stereotyping, and separating individuals based on a specific characteristic or condition (Baah et al., 2019; Goffman, 2009; Nuriddin et al., 2018;

O’Leary et al., 2018). According to Goffman (2009), stigma involves a discrepancy between a person's actual identity and the “virtual” identity ascribed to them by others. This discrepancy can lead to social exclusion and discrimination, resulting in the profound emotional and relational consequences described by the participants.

Most studies in the peer-reviewed literature presented in Chapter 2 support these experiences. O’Leary et al. (2018) found that individuals diagnosed with Ebola faced stigmatization characterized by labeling, name-calling, and stereotypical behaviors. Nuriddin et al. (2018) also observed similar experiences, where participants reported being subjected to negative perceptions and stereotypes due to their EVD status. Baah et al. (2019) further supported these findings, highlighting the profound impact of stigmatization on relationships and individuals’ well-being. The participants' experiences exemplify the damaging effects of stigmatization on their relationships and overall well-being.

Theme 2: Influence on Intimate Partner Relationships

The second theme, the Influence on Intimate Partner Relationships, underscores the profound impact of stigmatization on the participants’ intimate partner relationships and subsequent challenges. This study analysis showed that the participants reported significant difficulties maintaining and sustaining relationships due to stigmatization. Many participants shared experiences of being stigmatized by multiple partners, which led to relationship breakdowns and abandonment. Partners often left upon learning about the participants’ EVD history, perpetuating the stigma associated with the disease.

The theme highlights the need for greater awareness and education to dispel misconceptions about EVD transmission and foster acceptance and support within intimate relationships. The participants’ narratives emphasize the importance of survivor-to-survivor relationships as potential sources of understanding and resilience in the face of stigmatization. These relationships offer a unique understanding of the challenges and experiences faced by EVD survivors and provide a supportive environment for navigating the complexities of stigmatization within intimate partnerships.

The findings of this theme align with the consistent patterns observed in stigma theory. The participants' experiences demonstrate the impact of stigmatization on intimate partner relationships, as societal fears, misinformation, and the association of Ebola with negative stereotypes influenced partners' reactions (Baah et al., 2019; Kaggiah et al., 2022; Qureshi, 2016). The theme highlights the need to address these factors through education, awareness, and promoting empathy and support within intimate partnerships.

Subtheme 1: Impacts on Relationships

Researchers (Baah et al., 2019; Kaggiah et al., 2022; Qureshi, 2016) corroborated that participants' experiences revealed that stigmatization significantly influenced their intimate partner relationships. Most participants faced abandonment by their partners after being diagnosed with Ebola, creating a sense of fear and mistrust that led to the breakdown of these relationships. The fear of transmission and rejection due to the Ebola diagnosis affected the participant’s ability to establish and maintain healthy intimate partner relationships. This included challenges in maintaining trust, open communication, and emotional support within the relationship.

Consistent with the studies in Chapter 2 concerning intimate partner relationships, the participants’ experiences reflect the social consequences of stigma, including the disruption of these relationships. Goffman (2009) argued that individuals with stigmatized identities are often subject to negative social attitudes and discrimination, leading to challenges in trust, communication, and emotional support within the relationships. Qureshi (2016) documented the experiences of individuals with Ebola, revealing that stigmatization significantly influenced their intimate partner relationships, leading to abandonment and relationship breakdown. Baah et al. (2019) also corroborated these findings, noting that fear of transmission and rejection due to the Ebola diagnosis created barriers to establishing and maintaining healthy intimate partner relationships. Kaggiah et al. (2022) highlighted similar impacts, emphasizing the detrimental effects of stigmatization on these relationships. The participants’ experiences of abandonment and mistrust reflect the social consequences of stigma, including the disruption of intimate relationships. The participants’ struggles highlight the barriers to establishing and maintaining healthy intimate partner relationships when stigmatization becomes pervasive.

Subtheme 2: Impacts on Sexual Relations

The stigmatization associated with Ebola also significantly impacted the participants' sexual relations within their intimate partner relationships. The recommendation for abstinence from intimacy and sexual activity after release from the ETU and the fear of passing on the disease created barriers to sexual intimacy and trust. The participants described anxiety, guilt, and fear associated with sexual activity. Some participants reported using contraceptives even after their EVD clearance, highlighting the lack of trust and the lingering impact of the stigma.

Stigma theory helps explain the impacts of stigmatization on sexual relations within intimate partner relationships. The fear of disease transmission and the recommendation for abstinence can be understood as strategies to manage the potential risks associated with the stigmatized condition (Goffman, 2009). Qureshi (2016) documented the experiences of individuals with Ebola, highlighting the anxiety, guilt, and fear associated with sexual activity due to the stigma. Baah et al. (2019) further supported these findings, noting the lingering effects of stigmatization on sexual intimacy and trust. These experiences reflect the disruption of social relationships and the barriers to trust and intimacy faced by individuals with stigmatized identities, as explained by Goffman's stigma framework. The participants' experiences illustrate the complexities and challenges of navigating sexual relations within stigmatization, where fear and mistrust can significantly impact the intimate aspects of their relationships.

Theme 3: Need for Awareness, Education, and Resources

The participants emphasized the need for awareness, education, and resources to combat stigmatization associated with Ebola. They recognized the importance of accurate and proper education through the media to address misconceptions and promote understanding among community members. The participants also expressed the need for increased awareness campaigns, counseling services, and knowledge about post-treatment certificates for re-entry into communities and relationships. They highlighted the lack of information and misconceptions as contributing factors to the stigmatization they experienced.

This theme is affirmed within the studies of Kelly et al. (2019) and Walker and Fox (2018) in Chapter 2, emphasizing information and education's role in reducing stigma. By addressing misinformation and providing accurate knowledge about Ebola, its transmission, and the experiences of survivors, it is possible to mitigate the stigmatization experienced by survivors. O'Leary et al. (2018) highlighted the importance of accurate and proper education through the media to address misconceptions and promote understanding among community members. Baah et al. (2019) further emphasized the need for increased awareness campaigns, counseling services, and knowledge about post-treatment certificates for re-entry into communities and relationships. These findings reflect the stigma framework's focus on the social and relational consequences of stigmatization and the importance of comprehensive support and resources to aid in the reintegration of survivors.

Theme 4: Feelings of Rejection, Isolation, and Abandonment

The fourth theme, Feelings of Rejection, Isolation, and Abandonment, underscores the profound emotional impact experienced by EVD survivors as a result of stigma. The participants' accounts reflect the deep emotional turmoil and long-lasting effects of the stigma and discrimination they faced. They described feelings of hopelessness, trauma, and societal rejection. The loss of partners and subsequent isolation caused profound distress, with some participants even contemplating suicide. Financial instability and home eviction were also highlighted as consequences of these experiences.

The findings of this theme align with the extensive literature on the psychological and emotional effects of stigma on individuals' well-being and relationships (Bortel et al., 2016; Fischer et al., 2019). The participants' experiences demonstrate the detrimental impact of stigma-related rejection, isolation, and abandonment on their mental health and overall quality of life. The theme underscores the urgent need for comprehensive support systems, including mental health services and financial assistance, to address the emotional and practical consequences of stigma faced by EVD survivors.

Subtheme 1: Permanent Fractures in the Marriage or Relationship

The participants' experiences revealed deep feelings of rejection, isolation, and abandonment that could result in permanent fractures in their marriages or relationships. These feelings may occur singularly or concurrently, depending on the experiences within the relationship and the community's reaction to the diagnosis or re-entry. Participants reported difficulty maintaining contact with and accessing their children, exacerbating isolation and rejection.

Stigma theory helps explain the participants' deep feelings of rejection, isolation, and abandonment, which can lead to permanent fractures in their marriages or relationships. Goffman (2009) argues that stigma involves a discrepancy between a person's actual identity and the "virtual" identity ascribed to them by others, resulting in social exclusion and discrimination. Researchers in the peer-reviewed literature in Chapter 2 support these experiences. Qureshi (2016) documented the participants' challenges in maintaining contact with and accessing their children, exacerbating isolation and rejection. Baah et al. (2019) also highlighted the profound emotional impact of being ostracized by their community and loved ones, leading to fractured relationships and strained connections with children. The participants' experiences highlight the profound emotional impact of being ostracized by their community and loved ones. The feelings of rejection, isolation, and abandonment contribute to a sense of otherness and exclusion, leading to fractured relationships and strained connections with their children.

Theme 5: Support and Acceptance

The fifth theme, Support and Acceptance, presents the experiences of support and acceptance among EVD survivors. This theme highlights the positive relationships and the impact of support from partners and community members. It emphasizes the importance of survivor-to-survivor relationships, which provide a sense of belonging, understanding, and resilience in the face of stigma and discrimination. The presence of supportive partners and communities was also noted as crucial for survivors' well-being and social reintegration.

The findings of this theme align with the principles of stigma theory, as they underscore the significance of supportive relationships and community acceptance in mitigating the adverse effects of stigma (Green et al., 2018). The theme highlights the need for creating an environment that fosters support, acceptance, and empathy for EVD survivors, promoting their well-being and facilitating their successful reintegration into society. It emphasizes the importance of building inclusive communities that challenge stigmatizing attitudes and provide a supportive network for survivors.

Subtheme 1: Survivor-to-Survivor Relationships

Amidst the experiences of stigmatization, the theme of support and acceptance emerged as a crucial factor in the participants' lives. Some participants were able to sustain supportive relationships after treatment or find new romantic relationships with fellow survivors. These survivor-to-survivor relationships played a significant role in providing support and acceptance. Sharing similar experiences and understanding the challenges associated with stigma fostered feelings of support and belonging.

As reported by the participants, the survivor-to-survivor relationships align with the peer-reviewed literature in Chapter 2. Qureshi (2016) documented the positive impact of survivor-to-survivor relationships in providing support and acceptance. Nuriddin et al. (2018) further supported these findings, emphasizing the role of supportive relationships in mitigating the adverse effects of stigmatization. Supportive relationships, particularly among fellow survivors, can provide a unique source of understanding, empathy, and validation. The participants' experiences highlight the potential for positive outcomes when individuals are met with understanding, empathy, and encouragement from others who have shared similar stigmatizing experiences.

Subtheme 2: Supportive Relationships

Stigma theory helps explain the importance of supportive relationships in mitigating the adverse effects of stigmatization. Understanding, empathy, and encouragement from loved ones and the community contribute to positive outcomes and a sense of acceptance (Goffman, 2009). The peer-reviewed literature in Chapter 2 supports these experiences. Qureshi (2016), Kelly et al. (2019), and Kaggiah et al. (2022) documented the mitigating effect of supportive partners on the negative impacts of stigma. Baah et al. (2019) highlighted the transformative power of supportive relationships in helping individuals cope with stigmatizing experiences. These findings reflect the stigma framework's emphasis on the role of supportive relationships in preserving individuals' sense of self and fostering resilience.

Recommendations on How to Improve the Condition of Survivors

The participants' responses highlighted several key recommendations to enhance the condition of Ebola survivors. Among these, most participants (12 out of 15) emphasized the critical need for increased awareness and education about the disease, mainly through the media (James et al., 2020). While acknowledging the abundance of information available, participants emphasized the importance of ensuring accurate knowledge about the disease reaches the public. By disseminating education and awareness efforts through the media, individuals can make informed decisions, and stakeholders can effectively handle Ebola patients. Proper knowledge and understanding would also contribute to the treatment and acceptance of survivors, fostering sustainable relationships with society, including their partners.

Another significant recommendation from the participants was the provision of counseling services to survivors, along with the issuance of clearance certificates for Ebola (Bah et al., 2020). Counseling services are crucial in supporting survivors to reclaim their place in society and cope with their challenges. By addressing the psychological impact of the disease, counseling can reduce the level of rejection and facilitate survivors’ acceptance. Additionally, participants emphasized the importance of treating survivors with genuine love and care, particularly by those around them, including their partners (Little, 2021). Ensuring accurate information about the disease is available through the media can contribute to the well-informed and compassionate treatment of survivors, minimizing the impact of ignorance.

Limitations of the Study

Despite the valuable insights gained from this study, certain limitations should be considered. Firstly, the focus on the lived experiences of the participants limits the transferability of the findings beyond the study’s sample. While the exploration of lived experiences provides valuable information pertaining to the study’s purpose and research questions, the phenomenological design restricts generalizability. Secondly, the study’s outcomes depend on the participants’ honesty and willingness to share their perceptions of stigmatization and rejection in intimate partner relationships after surviving Ebola.

Lastly, my bias may have influenced the study, although efforts were made to minimize it through reflexivity and journaling (McDonald et al., 2019).

Recommendations

Building on the findings of this study, several recommendations for future research can contribute to a deeper understanding of the experiences and needs of EVD survivors and inform interventions and support systems. Further research should focus on developing and evaluating educational interventions targeting caregivers of EVD survivors. Investigating the impact of caregiver education programs on their knowledge, attitudes, and behaviors regarding stigmatization and its effects on survivors' quality of life would provide valuable insights. This research can inform the design of effective educational initiatives that equip caregivers with the necessary tools and understanding to support survivors effectively (James et al., 2020).

Also, comprehensive research is needed to explore the long-term outcomes of EVD survivors and identify appropriate actions to assist them. This could include assessing their physical, mental, and social well-being, as well as their reintegration into society. Quantitative studies measuring health outcomes, quality of life, and social functioning would complement the qualitative findings of this study and provide a more comprehensive understanding of survivor experiences (Bah et al., 2020).

Advocacy efforts could be expanded to ensure that the voices of EVD survivors are heard, and their unique needs and challenges are addressed by exploring the lived experiences of EVD survivors and aligning with local policies. The research would explore strategies for amplifying survivor voices, such as engaging survivor-led organizations, involving survivors in policy-making processes, and promoting community awareness and understanding of their experiences. These efforts can contribute to reducing stigma, improving support systems, and driving positive social change (Mitchell et al., 2021).

Along with advocacy efforts, further research should focus on program evaluations examining interventions used to address the fractures in intimate partner relationships experienced by EVD survivors. This could involve exploring relationship counseling approaches, trauma-informed care, and communication strategies to rebuild trust and facilitate healthy relationship dynamics. Evaluating the effectiveness of these interventions in promoting relationship resilience and improving the well-being of survivors would be beneficial (Little, 2021).

Research could also investigate the role of survivor-to-survivor networks in providing support and acceptance to EVD survivors. Understanding the dynamics, benefits, and challenges of these networks can inform the development of peer support programs and initiatives that foster resilience and empowerment among survivors. Additionally, exploring the potential for survivor networks to influence community attitudes and perceptions toward EVD survivors would be valuable (Qureshi, 2016).

Another recommendation for further research is to focus on assessing the mental health needs of EVD survivors and developing appropriate interventions. This could include exploring the prevalence of mental health disorders, such as depression and post-traumatic stress disorder, among survivors and evaluating the effectiveness of psychological interventions in addressing their mental health concerns. Integrating mental health support into survivor care pathways and providing access to counseling services would contribute to their overall well-being (Baah et al., 2019).

Lastly, research should assess the effectiveness of community-based support programs in reducing stigma and facilitating the social reintegration of EVD survivors. Evaluating the impact of community awareness campaigns, educational initiatives, and inclusive community interventions can provide insights into the most effective strategies for fostering acceptance and support. This research can guide the development and implementation of evidence-based programs that promote inclusive communities (O’Leary et al., 2018).

In conclusion, these recommendations for future research aim to deepen our understanding of the experiences and needs of EVD survivors, inform interventions, and support systems, and drive positive social change. By addressing the gaps in knowledge identified in this study, researchers and stakeholders can work towards enhancing the well-being and quality of life of survivors, reducing stigma, and fostering inclusive communities.

Implications

The research findings from this study on Ebola survivors have significant implications for various stakeholders involved in supporting and caring for survivors. These implications can drive positive social changes, enhance caregiver understanding, and inform policy and regulatory measures. The implementation of these implications can be summarized as follows:

Empowering Ebola Survivors: The study findings play a crucial role in empowering Ebola survivors by providing them with a clear understanding of the challenges they may face within society. By equipping survivors with knowledge about societal expectations and potential obstacles, they can develop resilience and psychological preparedness. This empowerment enables survivors to navigate social interactions with confidence, reducing the impact of stigma, and fostering a sense of belonging within their communities.

Enhancing Caregiver Support: The study’s results contribute to a deeper understanding of the disease and its associated factors among caregivers and partners of survivors. This increased understanding enables caregivers to provide comprehensive and compassionate support to survivors. By recognizing the unique needs and experiences of survivors, caregivers can offer tailored care, respect survivors’ dignity, and provide the necessary emotional and psychological support.

Informing Policy and Regulation: The study’s findings hold the potential to inform and shape policies and regulations concerning Ebola survivors. By shedding light on the suffering and experiences of survivors, policymakers and stakeholders can develop a comprehensive understanding of their needs. This understanding can guide the formulation of favorable regulations and policies that address the specific challenges faced by survivors. By implementing supportive measures, such as access to healthcare, social services, and employment opportunities, the government can ensure that survivors receive the necessary attention and support they deserve.

Promoting Public Awareness and Understanding: The study's implications extend to broader society by fostering public awareness and understanding of the experiences of Ebola survivors. By disseminating the study's findings through various channels, such as media campaigns and educational programs, society can develop empathy and reduce stigmatization towards survivors. This increased awareness can encourage supportive attitudes and behaviors, fostering an inclusive environment where survivors are accepted and embraced.

In conclusion, the implementation of the study's findings has far-reaching implications for Ebola survivors, their caregivers, policymakers, and society as a whole. By empowering survivors, enhancing caregiver support, informing policy decisions, and promoting public awareness, positive social changes can be realized. This includes reducing stigma, ensuring access to necessary resources, and fostering an inclusive society where Ebola survivors can thrive and live fulfilling lives.

Conclusion

This qualitative study has provided valuable insights into the impact of stigmatization on the quality of intimate partner relationships among Ebola survivors in Monrovia. The findings shed light on the pervasive nature of stigmatization, as 14 out of the total participants shared their experiences of being viewed as virus spreaders, leading to social distancing within their communities. Additionally, participants highlighted the challenges of being separated from their children due to stigmatization effects. The study also revealed the significant impact of an Ebola diagnosis on intimate partner relationships, with 13 out of 15 participants reporting stigmatization from multiple partners and instances of abandonment.

Moreover, the study emphasized the urgent need for comprehensive and accurate education programs through the media to address misconceptions about Ebola. The majority of participants (12 out of 15) emphasized the importance of such programs in enhancing survivors' understanding and equipping them to navigate the challenges associated with the virus. By providing survivors with accurate information and empowering them with knowledge, society can foster a more supportive and inclusive environment, thereby reducing the negative impact of stigma on intimate partner relationships.

The findings of this study highlight the profound consequences of stigma experienced by Ebola survivors and underscore the importance of addressing stigma at both the individual and societal levels. Efforts to combat stigma should involve raising public awareness, promoting empathy, and challenging discriminatory beliefs and behaviors. Creating a society that values and respects the experiences of Ebola survivors is crucial for their well-being and the establishment of sustainable intimate partner relationships.

Policymakers, healthcare professionals, and stakeholders should consider the significance of the study's findings and work towards implementing targeted interventions and support programs. These initiatives can help alleviate the burden of stigma on survivors and their intimate partner relationships. By fostering a climate of acceptance, providing comprehensive care, and promoting social inclusion, survivors can regain a sense of belonging and rebuild their lives in the aftermath of Ebola.

Further research is warranted to delve deeper into the experiences of Ebola survivors and explore the long-term effects of stigmatization on their overall well-being. Additionally, investigating the efficacy of intervention strategies and exploring the perspectives of healthcare providers and policymakers would contribute to a comprehensive understanding of the issue. By expanding the knowledge base and engaging in ongoing dialogue, we can continue to improve the conditions and experiences of Ebola survivors, fostering a society that embraces and supports individuals affected by infectious diseases.

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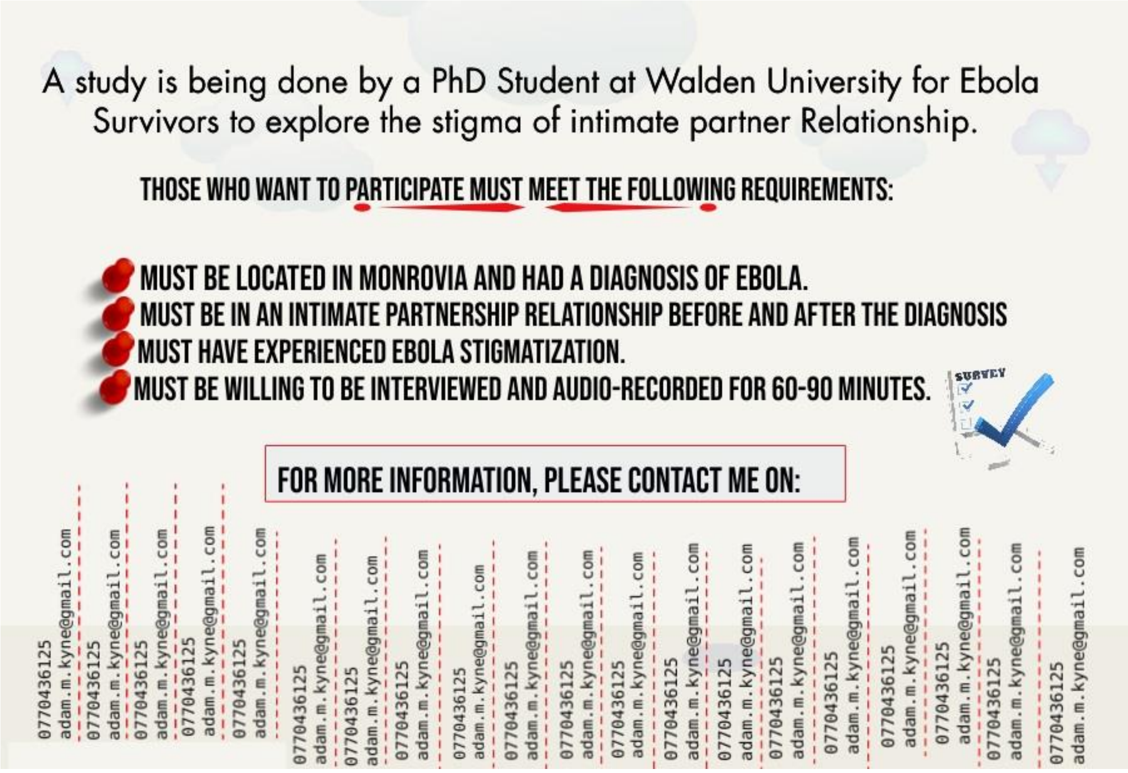
Appendix A: Flyer for Participants' Recruitment



A study is being done by a PhD Student at Walden University for Ebola Survivors to explore the stigma of intimate partner Relationship.

THOSE WHO WANT TO PARTICIPATE MUST MEET THE FOLLOWING REQUIREMENTS:

- MUST BE LOCATED IN MONROVIA AND HAD A DIAGNOSIS OF EBOLA.
- MUST BE IN AN INTIMATE PARTNERSHIP RELATIONSHIP BEFORE AND AFTER THE DIAGNOSIS
- MUST HAVE EXPERIENCED EBOLA STIGMATIZATION.
- MUST BE WILLING TO BE INTERVIEWED AND AUDIO-RECORDED FOR 60-90 MINUTES.

FOR MORE INFORMATION, PLEASE CONTACT ME ON:

0770436125
adam.m.kyne@gmail.com

0770436125
adam.m.kyne@gmail.com

0770436125
adam.m.kyne@gmail.com

0770436125
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0770436125
adam.m.kyne@gmail.com

Appendix B: Interview Questions

Questionnaire for the Semi-structure interview

1. How did you contract the Ebola Virus Disease (EVD)?
2. How was your experience at home when you started showing symptoms of EVD?
3. How were you personally imparted by your diagnosis?
4. How was your experience when you returned home from the Ebola Treatment Unit (ETU)?
5. What was it like being in the same bedroom with you partner as an Ebola survivor?
6. How did it influence your intimate partner relationship?
7. If you were stigmatized in your intimate relationship, how do you describe that experience?
8. Are you still in the same relationship when you were diagnosed with Ebola?
9. What do you think would have helped alleviate your feeling of stigma in your intimate partner relationship?
10. Where there any concern from you or your partner concerning your full recovery?

Additional probes:
Can you give me an example?
Could you describe what you meant?
Please tell me more about that.
What was that like for you?
How did you feel?
How has that changed over time?
Is there anything else you would like to add?
Do you know any other survivor who may be willing to participate in an interview?

*If you want a summary of the report—can you please provide me your email address.

Appendix C: Certificate of Completion from the Collaborative Institutional Training Initiative (CITI)

CITI PROGRAM

Completion Date 20-Jun-2022
Expiration Date N/A
Record ID 49705488

This is to certify that:

Adam Kyne

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w003ba979-2a6a-4f39-a504-4a555868e346-49705488

Appendix D: Local IRB Consent Form for Participants

ACRE INSTITUTIONAL REVIEW BOARD (Formerly UL-PIRE IRB)
INFORMED CONSENT TEMPLATE FOR RESEARCH

PARTICIPATION

Study Title: Stigma in Intimate Partner Relationships Among Ebola Survivors

Principal Investigator: Adam M. Kyne

Student Researcher: Adam M. Kyne

I am a Human and behavioral Service student at the Walden University. I am planning to conduct a research study, which I invite you to take part in. I am doing this study alone. This form has important information about the reason for doing this study, what we will ask you to do if you decide to be in this study, and the way we would like to use information about you if you choose to be in the study.

<u>Why are you doing this study? (Purpose)</u>
You are being asked to participate in a research study about Stigma in Intimate Partner Relationships Among Ebola Survivors
The purpose of the study is to explore how the lived experience of stigmatization affects the quality of intimate partner relationship for Ebola survivors in Monrovia

<u>What will I do if I choose to be in this study? (Procedure)</u>
You will be asked to

- Participate in a- 60-90 minutes face to face or phone interview (conversation will be audio recorded.

Study time: 60-90 Minutes-- only one meeting for interview.

Study location: All study procedures will take place at the office of the Ebola Survivor Network. (I will also be available to come to an appropriate space selected by the participant).
I would like to audio-record this interview to make sure that I remember accurately all the information you provide. I will keep these tapes in secure locker/storage, and they will only be used by me. If you prefer not to be audio-recorded, I will take notes instead. However, it will be preferable to audio record for accuracy of information.

I may quote your remarks in my dissertation resulting from this work. A pseudonym will be used to protect your identity.

What are the possible risks or discomforts?

Your participation in this study does not involve any physical or emotional risk to you beyond that of everyday life. If at any time and for any reason, you feel discomfort to answer any question during interview, please tell me and feel free to stop participating, we can take a break, stop, and continue at a later date, or stop altogether.

As with all research, there is a chance that confidentiality of the information we collect from you could be breached – we will take steps to minimize this risk, as discussed in more detail below in this form.
I am also providing a number and address of a free counseling session: **The Clinical Anonymous Program, 12 Street Sinkor—0775138784.**

What are the possible benefits for me or others?

You are not likely to have any direct benefit from being in this research study. This study is designed to learn more about Stigma in intimate partner relationship among Ebola survivors. The study results may be used to help other people in the future. For example, result could be used to educate researchers, caregivers, and advocates for Ebola Virus Disease about the direct experiences of stigmatization of survivors and their relationship with their intimate partners. Once the analysis is complete, the researcher will share the overall results by emailing you a 1-2 page.

How will you protect the information you collect about me, and how will that information be shared? (Confidentiality & Privacy)

Results of this study may be used in publications and presentations. Your study data will be handled as confidentially as possible. If results of this study are published or presented, individual names and other personally identifiable information will not be used.

If we think that you intend to harm yourself or others, we will notify the appropriate people with this information.

Financial Information

Participation in this study will involve no cost to you. You will not be paid for participating in this study.

What are my rights as a research participant? (Voluntarism)

Participation in this study is voluntary. You do not have to answer any question you do not want to answer. If at any time and for any reason, you would prefer not to participate in this study, please feel free not to. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether. You may withdraw from this study at any time, and you will not be penalized, neither denied due benefits in any way for deciding to stop participation.

If you decide to withdraw from this study any information collected from you will not be used for this study.

<u>Who can I contact if I have questions or concerns about this research study?</u>

If you have questions, you are free to ask them now. If you have questions later, you may contact the researchers at 0770436125 or email: adam.m.kyne@gmail.com.

If you have any questions about your rights as a participant in this research, you can contact the following persons:

Mr. Edward G. Smith
Chairperson
ACRE IRB
Graduate School Building
University of Liberia Capitol Hill Campus
Campus
Monrovia, Liberia
Phone: (088) 654-7343 | (077) 754-7343
(077) 758-3774
Email: smithedwardg@yahoo.com

Mr. Jemee K. Tegli
Coordinator
ACRE IRB
Graduate School Building
University of Liberia Capitol Hill

Monrovia, Liberia
Phone: (088) 658-3774 |

Phone: jktegli@yahoo.com

<u>Consent</u>

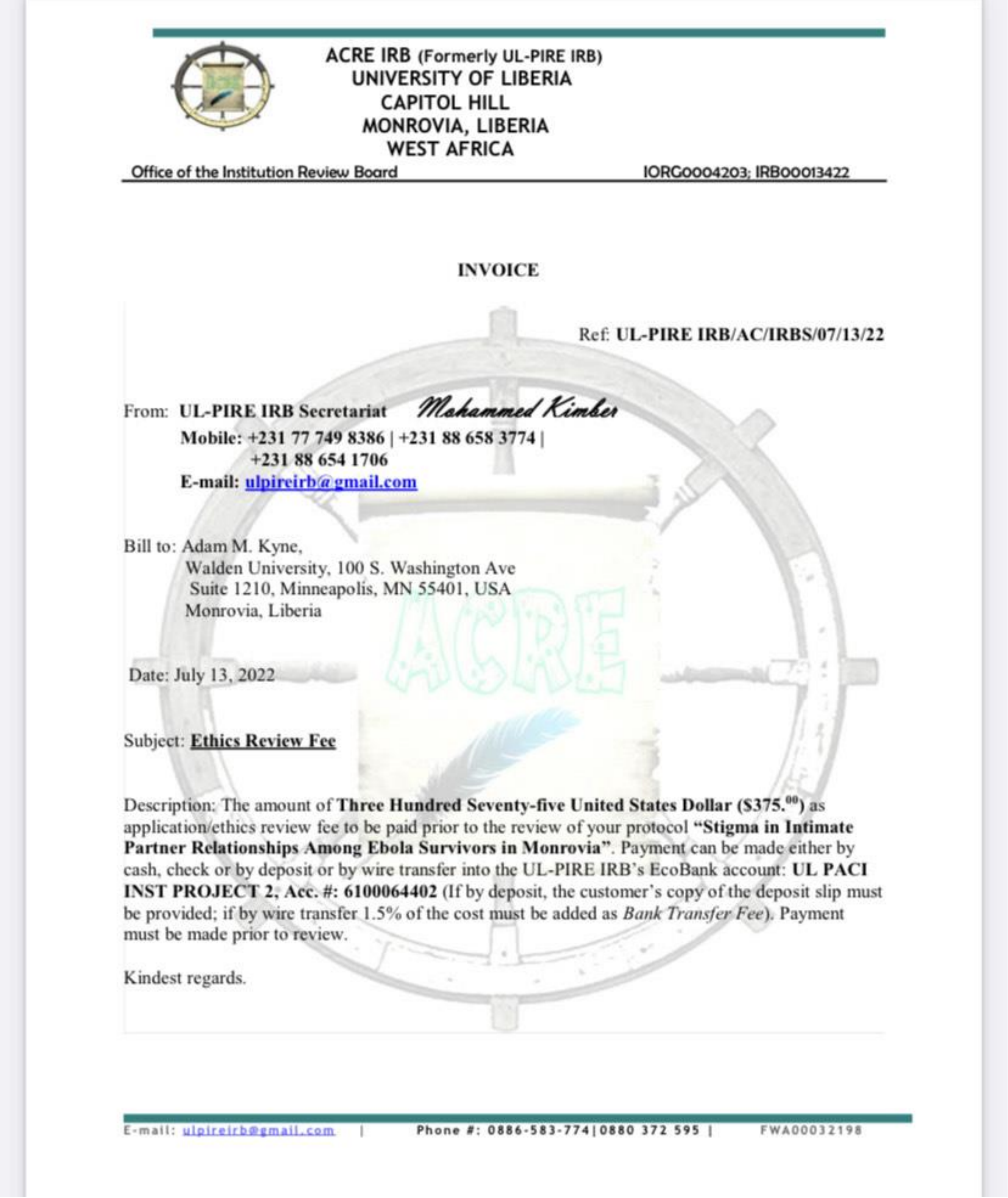
I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been adequately answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form.

Participant's Name (printed)

Participant's Signature Date

Person Obtaining Consent Date

Appendix E: Local IRB Invoice



ACRE IRB (Formerly UL-PIRE IRB)
UNIVERSITY OF LIBERIA
CAPITOL HILL
MONROVIA, LIBERIA
WEST AFRICA
Office of the Institution Review Board IORG0004203; IRB00013422

INVOICE

Ref: **UL-PIRE IRB/AC/IRBS/07/13/22**

From: **UL-PIRE IRB Secretariat** Mahammed Kimber
Mobile: +231 77 749 8386 | +231 88 658 3774 |
+231 88 654 1706
E-mail: ulpireirb@gmail.com

Bill to: Adam M. Kyne,
Walden University, 100 S. Washington Ave
Suite 1210, Minneapolis, MN 55401, USA
Monrovia, Liberia

Date: July 13, 2022

Subject: **Ethics Review Fee**

Description: The amount of **Three Hundred Seventy-five United States Dollar ($\$375.^{00}$)** as application/ethics review fee to be paid prior to the review of your protocol **"Stigma in Intimate Partner Relationships Among Ebola Survivors in Monrovia"**. Payment can be made either by cash, check or by deposit or by wire transfer into the UL-PIRE IRB's EcoBank account: **UL PACI INST PROJECT 2, Acc. #: 6100064402** (If by deposit, the customer's copy of the deposit slip must be provided; if by wire transfer 1.5% of the cost must be added as *Bank Transfer Fee*). Payment must be made prior to review.

Kindest regards.

E-mail: ulpireirb@gmail.com | **Phone #: 0886-583-774|0880 372 595 |** FWA00032198

Appendix F: Local IRB Letter of Request

June 29, 2022

Adam M. Kyne (PhD Student-Walden University, USA)
11 Street Sinkor
Monrovia, Liberia

Prof. Edward G. Smith
Chairman, UL-PIRE IRB
Ground Floor, GD Bldg.
University of Liberia
Capitol Hill

Ref: Request for IRB Approval

Dear Prof. Smith:
I intend to carry out a qualitative research study entitled, “Stigma in Intimate Partner Relationship Among Ebola Survivors in Monrovia.” The purpose of the study is to explore how the lived experience of stigmatization affects the quality of intimate partner relationship for Ebola survivors in Monrovia.

The Following documents are enclosed (as per IRB requirements).

1	Proposal	x
2	Consent	x
3	Semi-structure Interview Questions	x
4	CITI Certificate	x
5	Resume	x
6	Inform Consent	x

As a student and a volunteer Director at the A. M. Kyne Collegiate Resource Center without income, I do kindly solicit a reduction of the IRB fee. At the moment, I can afford two hundred United Stated Dollars ($200). With the urgency to complete this milestone, I appeal to you for a kind consideration.

Thank you so kindly for your consideration. With best regard, I remain.

--A.MKyne--

Adam M. Kyne (PhD Student)
Principal Investigator

Appendix G: Local IRB Letter of Request

Adam M. Kyne
PhD Student Walden University
12 Street Sinkor
Monrovia, Liberia

The President
National Ebola Survivor Network of Liberia
Monrovia, Liberia

Ref: **Letter of Cooperation/ Permission**

Dear Sir/Madam:
I am Adam M. Kyne, PhD student at Walden University (USA). I am kindly asking your cooperation/permission to conduct research at your institution and with your members. This cooperation will include allowing me to post a flyer on your bulletin for recruitment, make announcement in your group meeting, and use your individual counseling session-room to conduct interview.

The title for my research is “Stigma in Intimate Partner Relationship among Ebola Survivors.” The purpose of this study is to explore how the lived experience of stigmatization affects the quality of intimate partner relationship for Ebola survivors in Monrovia. This study seeks 12-15 volunteers who

- Must be located in Monrovia and had a diagnosis of EVD.
- Must be in an intimate partnership relationship before and after the diagnosis
- Must have experienced EVD stigmatization.
- Must be willing to be interviewed and audio-recorded for 60-90 minutes.

I can assure you this study will indirectly benefit individual volunteers—information gathered will help educate researchers, caregivers, and advocates for survivors and their relationship with their intimate partners. Please be informed this study will adhere to all ethical principles governed by the Liberia national research ethic board: University of Liberia Pire Institutional Review Board (IRB). Please find attached the IRB Consent form and approval to conduct this study. For more information, please feel free to contact me at 0770436125 or email:adam.m.kyne@gmail.com.

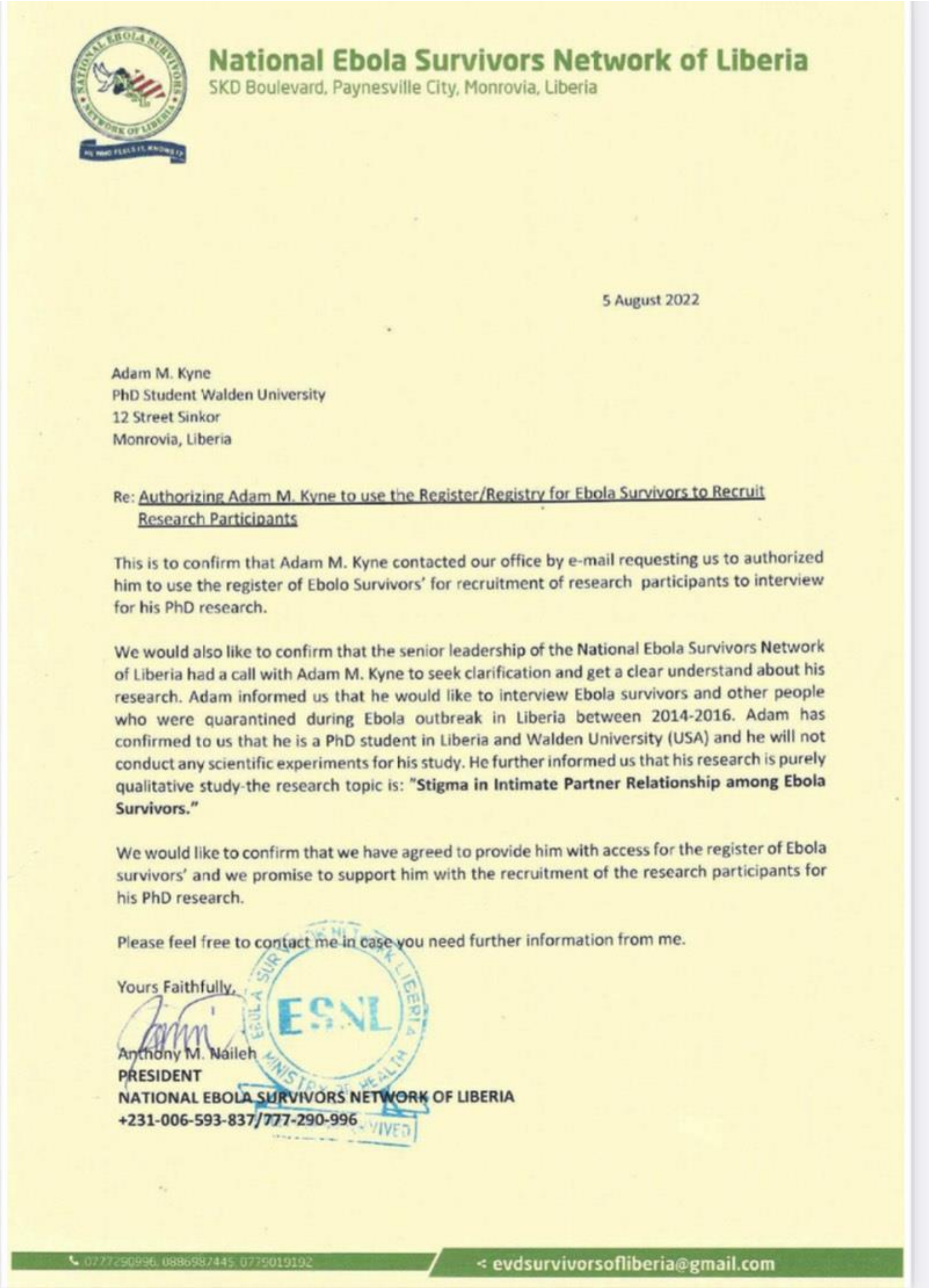
Sincerely Yours,

- - A. MKyne - -

Adam M. Kyne

Researcher (PhD Student)

Appendix H: National Ebola Survivors Network Of Liberia Letter



National Ebola Survivors Network of Liberia
SKD Boulevard, Paynesville City, Monrovia, Liberia

5 August 2022

Adam M. Kyne
PhD Student Walden University
12 Street Sinkor
Monrovia, Liberia

Re: <u>Authorizing Adam M. Kyne to use the Register/Registry for Ebola Survivors to Recruit Research Participants</u>

This is to confirm that Adam M. Kyne contacted our office by e-mail requesting us to authorized him to use the register of Ebolo Survivors' for recruitment of research participants to interview for his PhD research.

We would also like to confirm that the senior leadership of the National Ebola Survivors Network of Liberia had a call with Adam M. Kyne to seek clarification and get a clear understand about his research. Adam informed us that he would like to interview Ebola survivors and other people who were quarantined during Ebola outbreak in Liberia between 2014-2016. Adam has confirmed to us that he is a PhD student in Liberia and Walden University (USA) and he will not conduct any scientific experiments for his study. He further informed us that his research is purely qualitative study-the research topic is: **"Stigma in Intimate Partner Relationship among Ebola Survivors."**

We would like to confirm that we have agreed to provide him with access for the register of Ebola survivors' and we promise to support him with the recruitment of the research participants for his PhD research.

Please feel free to contact me in case you need further information from me.

Yours Faithfully,

ESNL

Anthony M. Naileh
PRESIDENT
NATIONAL EBOLA SURVIVORS NETWORK OF LIBERIA
+231-006-593-837/777-290-996

☎ 0777290996, 0886987445, 0779019192 evdsurvivorsofliberia@gmail.com

Appendix I: Coding Table

Codes	Overall Category	Detailed Category	Themes	Number of References	Number of Participants
"hated", "hated by community people", "refused to enter community", "asked not to come back", "stopped from seeing children", "very challenging experience", "never see my children, my wife", "virus spreader", "discrimination", "neglect", "running away from me", "afraid of me", "never trusted me", "highly stigmatized", "EBOLA zone", "shamed", "stayed away", "rejected", "Ebola survivor"	Stigmatization Experiences	Isolation and Rejection	Being perceived as a 'virus spreader', community members stayed away **Being separated from children*	24	14
"People in the community were happy for me", "did not stigmatize me", "happy for me to come back", "supportive", "never had a problem", "encouraged", "no problem"		Support and Acceptance	Being supported and accepted by partner and community members	3	2
"Almost committed suicide", "bought the rope", "wanted to take my life", "if they did not see me, I am dead"		Developing Thoughts about Death	Having suicidal thoughts due to stigmatization	2	1
“Accused of miscarriage”, “accused of stillbirth due to Ebola”		False Accusations	Being accused of the cause of partners' miscarriage and stillbirth	1	1

"my wife left me", "the other girl left me too", "even the fifth one left me", "openness to sharing status because of stigmatization", "more than four relationships, all stigmatized", "they think I still have Ebola", "stigma is forever", "invest in woman and the she leaves", "survivor to survivor is best", "husband left me", "once he found out, he left me", "everybody in the community decided not to date me", "could not get anyone", "multiple relationships, all left", "traumatized, everyone left", "it is a struggle to stay in a relationship", "partners think I will give my Ebola to them"	Influence on Intimate Partner Relationships	Stigmatization by All Partners	Being stigmatized by more than one partner	6	13
"Run way from me", "he left me", "left me and the others left me as well", "left and called me an Ebola survivor", "nobody wanted me", "she left me and left me traumatized", "my relationship left me", "left me upon coming back from ETU"		Abandonment	Being abandoned by a partner	6	11
"After the recommended months, I still use condom", "we only have sex with condom", "there is		Practicing Safe Sexual Intercourse	Using contraceptives for the safety of partner	7	5

still fear so we use a condom", "not to have sex without a condom for six months"					
"Recommended to take some drug", "taking a pill"		Need For Medications	Taking medication for the safety of the partner	3	3
"Asked to stay away from sex for three months", "partner was not comfortable being in bed", "feeling distanced physically and emotionally", "		Physical and Emotional Impacts on Relationship	Staying away from sexual intercourse affected their relationship	2	3
"Not had sex since", "I am disabled", "as a survivor, it has become impossible to get a partner", "nobody wants me"		Lack of Intimate Relationship	No intimate relationship became disabled due to the virus	2	3
"Decided to date survivor to survivor", "survivor to survivor is sweet", "we are loving to each other", "make it work", "survivor to survivor is the best", "praying to get a survivor"		Survivor-to-Survivor Relationship	Realizing the positive impact of dating co-survivors	1	2
“Sexual dysfunction”, “Needing pills to erect”		Private Part Dysfunction	Experiencing dysfunction of private part	1	1
“Supported”, “Encouraged”, “No issues”		Supportive Partner	No influence was encouraged and supported by the partner	1	1
"Communication", "educating other people", "poor media education is an issue", "too much information", "tutor me and the rest of the community", "education and awareness", "need a second chance", "help alleviate	Recommendations on How to Improve the Condition of Survivors	Awareness and Education	Needing correct and proper education on the media	12	12

stigma", "counselling", "awareness", "people need to be properly educated", "reintegration must be given importance", "education in advance"					
“Counselling for support”			Providing counseling to survivors	3	3
"Needing certificate to enter community", "card and certificate"			Having a certificate to prove Ebola clearance	2	2
“Love”, “concern”, “support”			Receiving genuine love and concern from their partner and others around them	1	1