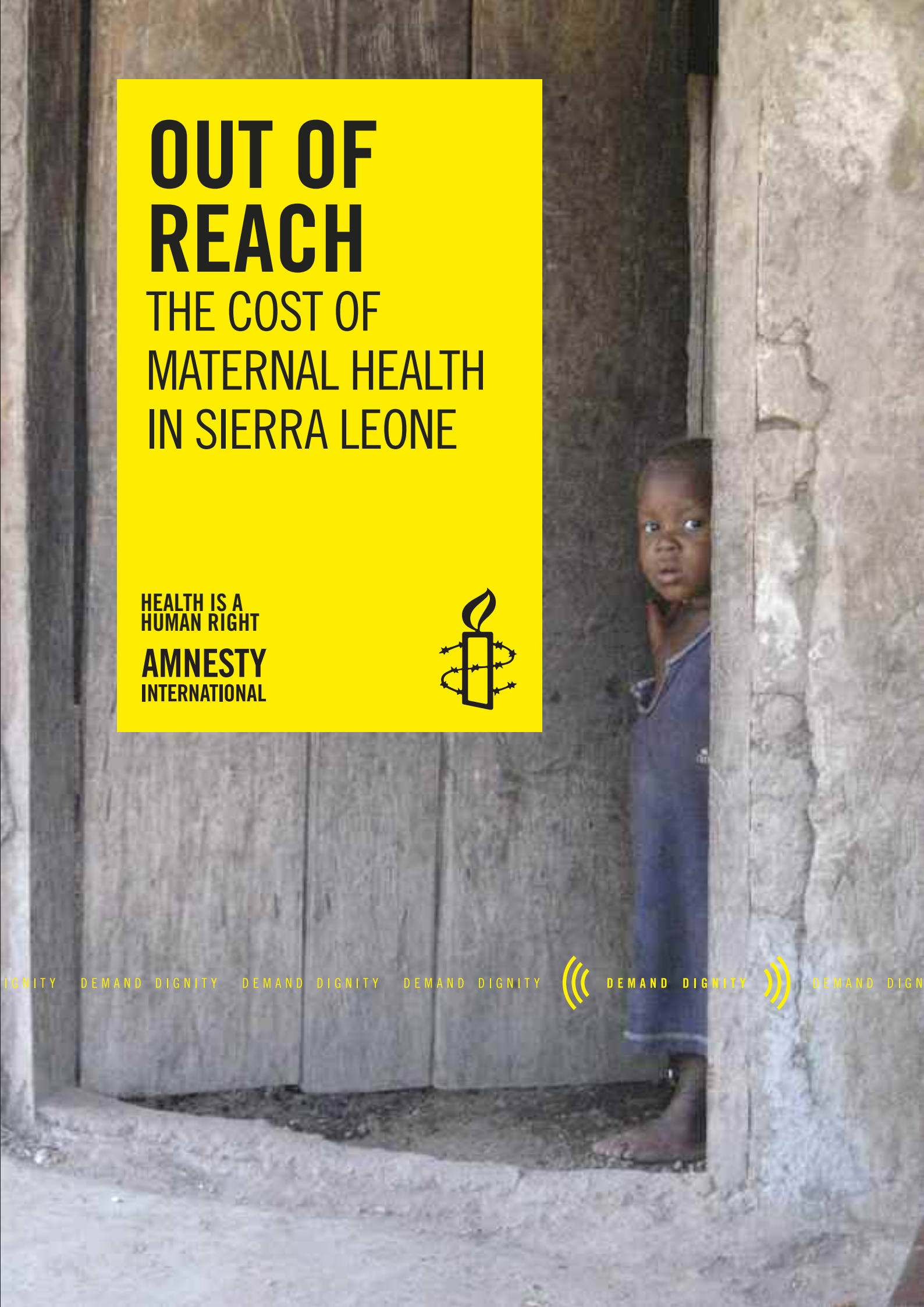
OUT OF REACH

THE COST OF MATERNAL HEALTH IN SIERRA LEONE

HEALTH IS A HUMAN RIGHT

AMNESTY INTERNATIONAL



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Cover photo: One of the surviving children of Hawa Dabor, who died in 2008 after giving birth to twins, before her family could find money and transport to take her to hospital.

OUT OF REACH

THE COST OF MATERNAL HEALTH IN SIERRA LEONE

CONTENTS

PREFACE

This report is about maternal mortality as a human rights issue. It focuses on:

- the urgent need to remove financial barriers to health care and in particular emergency obstetric care;

- the accountability of the government of Sierra Leone, given its obligations to address maternal health care and to ensure the availability, accessibility, acceptability and quality of health care services, facilities and goods;

- discrimination and other social factors that contribute to undermining women's right to health.

The introduction to this report gives an overview of maternal mortality as a human rights issue in Sierra Leone; Chapter 2 examines social, cultural and economic factors that affect maternal mortality; Chapter 3 describes systemic failures in the health care system; Chapter 4 highlights health costs as a major cause of maternal death; Chapter 5 points to lack of accountability as an issue that has to be addressed; Chapter 6 focuses on Sierra Leone's international legal obligations to address maternal mortality. In conclusion, Amnesty International recommends steps that should be taken by the government and the international community to reduce maternal mortality and increase respect for women's human rights.

Methodology

The research for this report began in March 2008 and includes four missions to Sierra Leone. In March 2008, Amnesty International visited the capital, Freetown, as well as Kambia and Lunsar. In January/February 2009, Amnesty International carried out research in Kambia, Koinadugu, Makeni, Lunsar and Freetown. Among Amnesty International's delegates were a medical doctor and a human rights lawyer and public health expert. In April 2009, Amnesty International visited Freetown and Koinadugu, and in July 2009 Amnesty International visited Freetown.

During the course of its research, Amnesty International investigated more than 25 cases of maternal mortality in the last two years. Amnesty International delegates interviewed family members, health care staff, and members of the community, and collected hospital and health care records on each of the cases. The women who died lived in towns and villages across northern Sierra Leone, as well as in and around Freetown.

Amnesty International held focus group discussions with health personnel, with community members and with groups of women in various parts of the country. Amnesty International also spoke to ministers and staff from the Ministries of Health, of Finance and of Gender, and staff from donors including the UK government aid agency DFID (Department for International Development), the World Bank, Irish Aid and the European Commission, UN agencies, international NGOs and national NGOs. This report would not have been possible without the help of numerous health staff, experts and activists within Sierra Leone. Amnesty International wishes to thank them and, in particular, the families of the women whose stories are told in this report.

SIERRA LEONE
MAP

ABBREVIATIONS

ADB	African Development Bank
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHC	Community Health Centre
CHO	Community Health Officer
CHP	Community Health Post
DFID	Department for International Development, UK government aid agency
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMO	District Medical Officer
EmOC	Emergency obstetric care
EU	European Union
FGM	Female genital mutilation
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
INGO	International non-governmental organization
JICA	Japan International Cooperation Agency, Japanese government aid agency
MCH aide	maternal and child health aide
MCHP	Mother and Child Health Posts
MDGs	Millennium Development Goals
MOHS	Ministry of Health and Sanitation (Ministry of Health)
NGO	non-governmental organization
PHU	peripheral health unit
RCHSP	Reproductive and Child Health Strategic Plan
SECHN	State Enrolled Community Health Nurse
TBA	traditional birth attendant
UNAIDS	Joint UN Programme on AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WFP	World Food Programme
WHO	World Health Organization

In Mannah, which is 15 miles from Kabala hospital in Koinadugu district, women who are 40 weeks into their pregnancy stay in a maternity waiting house at the clinic for up to one week.

1/INTRODUCTION

'Maybe I will die'

A pregnant 16-year-old, the third wife of an older man, talking about her forthcoming childbirth

Yerie Marah was just 22 when she died in November 2008, the day after giving birth to a baby girl. The baby, Mariama, was just 40 days old when she, too, died. Yerie Marah's husband, Mahmoud, told Amnesty International, "It is because of poverty that these things are happening." The story of Yerie Marah and her family, described in more detail in this report, is one of the daily tragedies that afflict families in Sierra Leone, where maternal mortality is among the highest in the world.

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Yerie Marah, who died at the age of 22 in November 2008.

Thousands of women and girls die every year in Sierra Leone as a result of treatable complications of pregnancy and childbirth. Most die in their homes. Some do not survive the journey to hospital, dying in taxis or on motorbikes or on foot. Even if they reach a health facility, many do not receive the treatment they need to save their lives. A Sierra Leonean woman faces a one in eight[1] chance of dying from complications of pregnancy and childbirth.

The cases Amnesty International documented during its research into maternal mortality in Sierra Leone demonstrate the three delays which lead to women dying needlessly. First is the delay in seeking medical care because women have not been informed of the symptoms of life-threatening complications, because of concerns about costs and because male decision-makers in the household do not always prioritize the woman's health. Second, once the decision is taken to seek medical care, there are often significant delays getting the woman to a clinic or hospital, because of the distances involved, the costs of transport and the lack of transport infrastructure. Third are delays in treatment once the woman has arrived at the clinic or hospital, because treatment will only be offered after payment, unavailability of trained staff, lack of electricity or clean water or lack of medical supplies.[2]

The primary direct causes of maternal death in Sierra Leone are obstructed labour (15 per cent), haemorrhage (15 per cent), anaemia (15 per cent), ruptured uterus (11 per cent), complications from unsafe abortion (8 per cent), and eclampsia (an emergency associated with excessively high blood pressure) (7 per cent).[3] The lack of safe blood for transfusions is also a major cause of death.[4] These complications are overwhelmingly treatable. The deaths of thousands of women and girls each year are therefore preventable.

Access to reproductive health services is crucial to efforts to reduce maternal mortality and is a human right. Evidence shows that the critical interventions that contribute most to the reduction of maternal mortality are skilled attendance at birth, emergency obstetric care, and an effective referral network together with family planning.

Respecting human rights is also critical to addressing the three delays that drive maternal mortality. Women and girls need access to education as well as reproductive health information and services. They need to be able to access health services on a non-discriminatory basis. States need to ensure that facilities that provide health care services are adequately staffed by trained personnel and adequately resourced with essential drugs and medical supplies, as well as infrastructure such as electricity and water.

In Sierra Leone, fewer than half (42 per cent) of deliveries are attended by a skilled attendant[5] and less than one in five deliveries are carried out in health facilities.[6] Almost one fifth of women receive no antenatal care[7] and the fertility rate is estimated at 5.1-6.1 children per woman.[8] Six of Sierra Leone's 13 districts have no emergency obstetric care at all, depriving women in these districts of access to life-saving caesarean sections and blood transfusions.[9]

The government itself has acknowledged that resources for the health sector are woefully inadequate, even to deliver a basic level of care. It has also recognized that health services are unevenly distributed throughout the country, giving rise to inequities.[10]

The Sierra Leone health care system suffers from a lack of trained and sufficiently motivated staff, insufficient drugs and medical supplies, grossly inadequate provision of emergency obstetric care for complications, poor infrastructure, and an ineffective referral system. There is little or no accountability at the local or national level to ensure that the health care system functions effectively.

Women are particularly adversely affected by the failures of the health system because of their need for health care during pregnancy and childbirth. The low status of women in Sierra Leone is reflected in the low priority placed upon meeting their health care needs, as well as having a direct impact on their access to health services.

Girls and women in Sierra Leone face discrimination and violence that directly affect their right to health. They face many barriers that prevent them from accessing the health services they need during pregnancy and childbirth. These include women's lack of power, which undermines their right to decide when and how many children to have, compounded by a lack of information on sexual and reproductive rights.[11] Fewer than 10 per cent of women in Sierra Leone use contraception, restricting their ability to choose responsibly and freely the number and spacing of their children. There are also geographical barriers – with long and arduous journeys to health facilities and poor transport links – and financial barriers.

RIGHT TO HEALTH

Sierra Leone has ratified many of the human rights treaties that guarantee the right to the highest attainable standard of health, including the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women. The right to health includes the right to maternal, child and reproductive health. (See Chapter 7.)

The government of Sierra Leone has an obligation to realize the right to health, including the right to maternal, child and reproductive health. The government is also under a duty to prioritize the most vulnerable and marginalized groups when allocating resources, and to address discrimination in health services and information. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.

Health care facilities, goods and services have to be available, accessible, acceptable and of good quality.[12] In practice, these four interrelated and essential elements of the right to health mean:

1. Availability – the Sierra Leonean government is obligated to ensure that functioning public health and health care facilities, good and services, as well as programmes, are available. This includes the underlying determinants of health: hospitals, clinics and other facilities; trained medical and professional personnel receiving domestically competitive salaries; and essential drugs.

2. Accessibility – health facilities, goods and services have to be accessible to everyone without discrimination.

3. Acceptability – all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

4. Quality – health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs, and hospital equipment.

Health facilities are not only inadequate; they are also unequally distributed around the country. As noted by the government itself: "With an 11 mile average distance to the nearest health facility and the inadequate distribution of health facilities due to poor planning and self interests combined with difficult terrain and a poor road network, there are formidable barriers to accessing health care."[13]

Health care is inaccessible to much of the population because of its cost. Given that the fees charged are often arbitrary and unpredictable, fear of the cost inhibits many more women from seeking health care. As a result, the numbers actually using the health care system are extremely low.

In 2002 the government adopted a Presidential Decree that exempts pregnant and lactating women (and certain other groups) from having to pay for health care. However, these exemptions have not been implemented in practice and costs continue to be a major barrier to women's access to health services.

In August 2009 the Minister of Health announced plans for providing free care for pregnant women and children and established an advisory committee of international NGOs and donor agencies.

Several international donors active in Sierra Leone told Amnesty International that they were ready to support the government of Sierra Leone in removing financial barriers in order to increase women's access to health care. Cost is not the only problem, however. The health care system is weak and unco-ordinated and mismanagement and corruption are widespread. International donors have been reluctant to disburse some of the funds without evidence of changes to strengthen the system.

President Ernest Bai Koroma was committed by his party's 2007 election manifesto "to providing affordable health care",[14] and since coming to office he has made ridding the country of corruption one of his three main priorities. The Anti-Corruption Commission is the vehicle for achieving this, and it has identified the Ministry of Health as a priority for its work.[15]

In early 2008 the government announced a Reproductive and Child Health Strategic Plan to reduce maternal, under-five and infant mortality rates by 30 per cent between 2005 and 2015. The main elements of the strategy are:

- significantly increasing the number of trained health staff,
- ensuring that facilities have essential equipment and are functioning,
- increasing the utilization of reproductive and child health services,
- ensuring that appropriate laws, regulations and guidelines are developed and enforced,
- contributing to effective monitoring and evaluation,
- ensuring effective government and management across the health care system,
- and ensuring adequate co-ordination of work at all levels of the health system.

The President endorsed the Reproductive and Child Health Strategic Plan in February 2008. Donors including DFID, the World Bank and UNICEF have committed to funding it. The Reproductive and Child Health Strategic Plan is widely acknowledged to be comprehensive, but since its launch little has been done to implement it.

The government is committed to meeting the UN Millennium Development Goals (MDGs) – the internationally agreed targets to reduce poverty and its impact, including maternal mortality. Since the government reported in 2005 to the UN on its progress towards meeting the MDGs, there have been some improvements. However, much more remains to be done. Although the government's budgetary commitments to health have increased every year, it is estimated that less than half of what is promised is received by the Ministry of Health. In a decentralized system, districts also complain that they rarely receive the funds promised in full and on a consistent basis.

Substantial reductions in maternal mortality can only be achieved by prompt access to good quality emergency obstetric care. Consensus UN indicators on the availability and use of emergency obstetric care provide a clear picture of what the government needs to do to reduce maternal mortality. In 2008, the Ministry of Health, with the help of UN agencies, carried out a nationwide needs assessment of maternal health care provision (referred to in this report as the needs assessment survey).[16] The study showed that six of the country's 13 districts had no emergency obstetric facilities at all, leaving hundreds of thousands of women without access to life-saving treatment. This survey gives the government evidence and baseline information about the availability of emergency obstetric care services throughout the country, information that can be monitored to measure progress.

In response to the needs assessment survey, UNFPA, with support from the African Development Bank, began working with the Ministry of Health to provide comprehensive emergency obstetric services in five districts. DFID and the EU have also made funds available to ensure that emergency obstetric services are available in other districts.

The government of Sierra Leone needs to intensify its efforts to save women's lives. It must make good quality health care available and accessible to all pregnant women.

The story of Yerie Marah shows how suspicion of the health care system, ignorance of pregnancy-related danger signs and financial barriers to health care can cost lives.

YERIE MARAH

was 22 when she died near her home in the village of Sokralla in Koinadugu district on 5 November 2008. Her baby died some 40 days later.

Yerie Marah and Mahmoud Sawaneh had been together for six years, since they were teenagers. They were both Mandingo, one of the 16 ethnic groups in Sierra Leone, and came from the same community. Neither had attended school. Yerie was one of six children and was close to her mother who lived nearby. Mahmoud and Yerie lived in a small, one-room structure in the centre of the village of Sokralla, close to relatives on both sides of the family.

Mahmoud, like many Sierra Leoneans, relies on subsistence farming for his living but it does not provide him with any disposable income. During the rainy season (May to October) money is most difficult to come by, because there are no crops to harvest.

This was Yerie's second pregnancy. Mahmoud told Amnesty International, "Her first pregnancy had been normal and our daughter, now five, was born at home."

On 4 November 2008, Yerie went into labour. Mahmoud said, "It was about 8am when Yerie went into labour. By 11am, I had hired a motorbike to take her to the clinic [Peripheral Health Unit, Heremakono] and she gave birth just after we arrived there."

According to the traditional birth attendant (TBA) who was present at the birth, the placenta was delivered intact. However, Yerie began to bleed after the delivery. The maternal and child health aide staffing the clinic, Rebecca, administered ergometrine, a drug that causes contraction of the uterine muscles and lowers placental blood loss, in an attempt to stop the bleeding and Yerie expelled several large clots. Rebecca told Amnesty International, "After Yerie gave birth she was bleeding a lot. I urged them to go to Kabala Hospital, but both Yerie and Mahmoud refused. I think they did not have the money to go. I was really worried though. I even told the TBA who was there during the pregnancy that they were asking for trouble by not taking her to the hospital."

Rebecca said that she warned Yerie, "If there's a problem, he'll marry another woman, but you'll be gone." She told Amnesty International, "I think Yerie did not want to be a burden and knew that her husband did not have any money and that is the reason that she did not insist on going to the hospital. It is common here." Amnesty International's discussions with Yerie's family members and staff of CARE, an international aid agency, confirmed that money was a serious problem.

Shortly after the delivery, Mahmoud left Yerie and the baby to purchase a few things for the child and to make arrangements for a meal for Yerie when she came home. Rebecca said, "Yerie wanted to accompany him on the errands, but I protested and told her to stay at the clinic."

Sirrah Gibateh, the mother of Yerie Marah who died after giving birth in November 2008, together with Yerie's surviving daughter.

When Mahmoud returned to the clinic in Heremakono a few hours later, Rebecca told Amnesty International, "Yerie asked me again if she could leave. I found only lochia, a normal post-partum discharge containing blood and mucus. Yerie looked very pale and weak and I knew she had lost a lot of blood. But Yerie seemed anxious to get home. I think she just wanted everything to be back to normal. The next thing I know she stood up and told everyone she was OK. It was about 3pm and I said they could go home."

Mahmoud told Amnesty International, "After Yerie was discharged from the clinic we all walked home. Everything seemed to be all right. When we got home Yerie took a nap and when she woke up the two of us were talking and joking about what to name the child. We decided to name the little girl Mariama."

Later that evening, Yerie went to urinate and her mother saw that she was bleeding heavily. Yerie's mother, Sirrah Gibateh, spoke through her tears, "I knew then that there was something seriously wrong. She bled all night. We suggested that she breast feed because it often alleviates bleeding. After she finished nursing the child she insisted on going to the river to bathe herself."

Mahmoud told Amnesty International, "I told her to wash herself at home but Yerie insisted on going to the river. She went alone. Soon after she got there a neighbour saw her and said that she was crying out complaining of a headache and dizziness. A few minutes later Yerie's uncle arrived. He said she was stiff and complained again of headache and dizziness. She asked him to get her mother and sister."

Her mother, Sirrah, and her sister came running to help Yerie. Sirrah told Amnesty International, "We found her collapsed on the ground, her body stiffened. As we carried her to the house she really stiffened up."

The traditional birth attendant told Amnesty International, "Yerie had lost a lot of blood, she was dry, pale, and weak. Mahmoud's brother sent a motorbike for the maternal and child health aide who said, 'When I arrived at the house Mahmoud was hysterical. I found Yerie dead and told the family. Yerie was later buried in the village.'"

Another tragedy hit the family 40 days later, when the baby, Mariama, died, apparently of malnutrition.

Mahmoud said, "I am still in mourning about Yerie and my daughter's deaths. It is because of poverty that these things are happening. I now have to pay attention to the child who is still alive and make sure she goes to school."

The challenges of addressing maternal mortality in Sierra Leone are enormous, given the country's inadequate infrastructure, high levels of poverty and the continuing aftermath of civil war. Despite these challenges, however, the government of Sierra Leone has an obligation to take targeted steps to guarantee the highest attainable standard of health, using its available resources to the maximum, including those available through international co-operation and assistance.

Amnesty International is calling on the government of Sierra Leone to address maternal mortality by removing financial barriers to accessing health care, and in particular emergency obstetric care, and by ensuring that such care is available and equitably distributed throughout the country. Amnesty International is calling on the government to continue to seek international co-operation and assistance where necessary in order to strengthen the health system and ensure the provision of maternal health care and emergency obstetric care to all women who need it.

2/POVERTY, DISCRIMINATION AND MATERNAL MORTALITY

Sierra Leone is still recovering from a brutal 11-year war that ended in 2002, and many of the causes of the conflict have not been addressed, including widespread corruption, poor governance, the marginalization and disempowerment of rural communities, and inefficiency in the delivery of public services.[17]

The impact of the war on the country's infrastructure and the flight of civil service personnel, including health care professionals, have had a huge impact on all services. Just before the onset of the war there were close to 300 doctors employed by the government.[18] In mid-2009 there were only 78.[19]

Sierra Leone is an extremely poor country with a GDP per capita of only US$330,[20] an external debt of US$1.5 billion and an economy that is highly dependent on donor funding.[21] The government of Sierra Leone has the obligation to take concrete and targeted steps to guarantee the highest attainable standard of health, using its available resources to the maximum, including those available through international co-operation and assistance. Sierra Leone was ranked lowest in the UNDP Human Development Index in 2007, largely because of the gross inadequacy of its health and education sectors.[22] Approximately 70 per cent of the population live below the poverty line on less than US$1 per day, with the majority of the population in rural areas.[23]

DISCRIMINATION AGAINST WOMEN

"It seems that faith and traditional culture are locked in an ambivalent embrace in Sierra Leone in which both collude to assign privilege to men and inferior status to women."[24]

Women in Sierra Leone face discrimination in virtually every aspect of their lives, with unequal access to education, economic opportunities and health care.

For example, the literacy rate for young men aged 15 to 49 is approximately 64 per cent, while for young women of the same age it is 44 per cent.[25] Despite some government efforts to increase participation, such as legislation for free education, many girls still do not attend school. "Bush schools"[26] are an important source of education for both boys and girls,

Girls working, Lengekoro village, northern Sierra Leone, February 2009.

especially in rural areas. However, these schools often reinforce stereotypical expectations of girls' submissiveness and subordination.[27] Furthermore, when girls become pregnant, they are often excluded from school, either as a result of societal pressures or in some cases because of local by-laws that deny pregnant girls their right to education.[28]

Although women are responsible for taking care of the home and family and carrying out the bulk of the chores, most have little power within their own communities.

Women have faced significant legal discrimination in the areas of marriage, ownership of land and inheritance. Marriage, divorce, maintenance, property and inheritance are often governed by customary laws that discriminate against women. Their effect is often to reinforce gender stereotypes that disadvantage women, denying them access to justice and to a fair allocation of entitlements and resources.[29]

Under customary law, which operates in all areas outside Freetown, a woman's status in society is equivalent to that of a minor. Before marriage, a woman is subordinate to her father or brother, and after marriage, to her husband. If her husband dies, she is subordinate to her male relative, usually a brother, until she remarries. The husband takes most decisions within the family. A woman's social standing depends on her role as a mother, and it increases as she has more children.

Pregnant women and girls, some as young as 16, in a village in Koinadugu district, northern Sierra Leone, February 2009.

In an effort to address discrimination against women and early marriage, in 2007 three gender laws were passed: the Domestic Violence Act, the Devolution of Estates Act, and the Registration of Customary Marriage and Divorce Act.[30] However, a government body[31] set up to assist in their implementation has found that there is very little understanding within communities of the details of these laws, and they have largely not been implemented. For example, while customary marriages and divorces are supposed to be registered, in reality the process for doing this has not been set up.

Forced marriages are also common, especially in rural areas, linked to both social practice and poverty.

TRADITIONAL PRACTICES

Approximately 94 per cent of Sierra Leone's female population have been subjected to female genital mutilation (FGM), which according to the World Health Organization (WHO) greatly increases the risks for women during childbirth.[32] Although there have been some efforts among civil society to campaign for its abolition, the government has done little to prevent FGM.

Since 2007, when the Child Rights Act was passed, it has been illegal for children under the age of 18 to undergo FGM. However, it is still widely practised despite lobbying from human rights groups.[33] Currently, Amnesty International members from Sierra Leone are working with civil society groups and local communities to abolish the practice completely.

Early marriage has been prohibited by both the Child Rights Act of 2007 and the Registration of Customary Marriage and Divorce Act which prohibits marriage under the age of 18.[34] The penalty for breaching this provision is a fine of up to Le30 million (US$10,000)[35] or a prison term of up to two years. However, the laws prohibiting domestic violence and early marriage are widely ignored. Girls as young as 10 are often married. In these marriages, girls are powerless to make decisions about their sexual and reproductive health. Denied control over their sexuality and lacking education and information, these girls are at particular risk.

Early pregnancy is a major consequence of early marriage. The earlier a girl becomes pregnant, the greater the risk to her health and life and that of the baby; pregnancy-related deaths are the leading cause of mortality for 15 to 19-year-old girls worldwide.[36] International studies have found that maternal mortality ratios for girls who give birth between the ages of 15 and 19 are twice as high as for women in their 20s, and four times as high for girls aged 10 to 14 as for women in their 20s.[37] Similarly, fistula[38] rates are much higher among teenage mothers.[39]

An estimated 23 per cent[40] of households, both Muslim and Christian, are polygamous, the majority in rural areas. In Sierra Leone a man can have as many wives as he chooses and feels he can afford, and it is widely believed that the larger a man's family, the greater his

prestige, wealth and power. However, in reality household studies have shown that the larger the household, the greater the degree of poverty.[41]

DISCRIMINATION AND HEALTH CARE

"Gender inequality in health care is significant and pervasive. Women in Sierra Leone have unequal access to basic health services and unequal opportunities for the protection, promotion, and maintenance of health."[42]

The low status of women in Sierra Leone has a direct impact on the state's failure to ensure that their health care needs are met.

The critical delays that increase the risk of maternal death start at the household level where women hold little decision-making power in relation to their reproductive lives. Given their low status and lack of economic independence, women are rarely able to decide for themselves to go to a health care facility, whether for family planning, antenatal care, deliveries or emergency services. Such a decision is normally in the hands of the husband, and is often dependent on his assessment of whether they have or can raise sufficient money. A study by CARE found that 68 per cent of mothers said that the decision on where to deliver a child was usually made by the husband at the onset of labour.[43]

ADAMA TURAY,
who died in December 2008, stopped going to antenatal care because her husband lost his job and there was no money for her to pay for the visits.

Early in her pregnancy Adama Turay had been attending the local antenatal clinic for check-ups, but she had to stop going because she could not afford the fee for each visit. "The fear of what it would cost prevented her from seeking the medical attention that she really needed", said her sister Sarah Kabbia.

Sarah told Amnesty International "When Adama got all puffy and her feet swelled up we didn't know that was some kind of danger sign. We just thought she was fat because she was pregnant. I think if she had kept going to the antenatal clinic the nurse would have detected something, told her what to do, and she might not have died".

She added, "I believe that Adama would be alive today if she had continued to go to antenatal care. It was because her husband lost his job that she did not have enough money to go. She had no money of her own."

Sierra Leonean women spend a significant amount of their life pregnant. Despite this, Amnesty International was told in various focus group discussions and interviews with women, their families and health workers that there is little awareness of specific pregnancy-related complications and the need for timely interventions.

The overwhelming majority of women give birth at home without a skilled attendant. The responsibility for taking critical and time-sensitive decisions during delivery lies largely in the hands of family members and traditional birth attendants, many of whom are also unaware of danger signs in pregnancy and childbirth.

Women's lack of decision-making power, the fact that Sierra Leonean women are not expected to complain when suffering personal hardship, and their lack of information on danger signs in pregnancy, together form a dangerous combination. The high incidence of death in childbirth leads to assumptions that this is "normal", or inevitable, rather than preventable.

TRADITIONAL BIRTHING PRACTICES

Traditional birth attendants (TBAs) are present in every village and community in Sierra Leone. Typically the TBA is the wife of the chief or another prominent woman. In polygamous families, the TBA is often the first wife. In many remote areas they carry out a vital role in the community, assisting women during pregnancy, labour and delivery and providing care during the immediate postpartum period for the woman and baby. However, TBAs are not midwives and do not have the training to constitute skilled birth attendants.[44]

Symptoms of complications during pregnancy and childbirth are not always recognized or seen as life-threatening emergencies. For instance, it is a widely held belief in rural areas that obstructed labour is caused by a woman's infidelity.[45] This dangerous misconception values a women's chastity more highly than her health or her life. Often, time and energy are wasted in trying to obtain a confession instead of ensuring that the woman, who is in agony as the baby fails to emerge, has access to the necessary emergency obstetric care.

OBSTACLES TO FAMILY PLANNING

Few women in Sierra Leone can exercise their right to determine the number, spacing and timing of their pregnancies. Women often have little choice over whether or when to have sex, and contraceptive use is extremely low. Estimates of the proportion of women using contraception vary between five and eight per cent.[46] Whatever the true figure, this is far lower than the average for the West Africa region and among the lowest rates in the world. Recent studies found that women with more education were more likely to practise family planning and tended to have smaller families.[47]

Hospitals and health centres are supposed to carry out family planning education, with hospitals targeting women who come in for care and health centres responsible for family planning education in communities. Contraceptive options include injections, condoms or the pill, with injections the most popular option because a woman can have one without the knowledge of her husband. By law, contraceptives are supposed to be freely available; however, as with other medical supplies there are rarely enough to meet the need. Contraceptives are also available in pharmacies, but women rarely buy them as they are not a priority when money is scarce.

Progress on family planning has largely been made by NGOs such as Marie Stopes International, a UK-based NGO that provides sexual and reproductive health care services. Marie Stopes has expanded its network of clinics in Sierra Leone and has introduced the

contraceptive implant[48] and made intrauterine devices and tubal ligations, with the informed consent of women, widely available. It reported an increase in the number of its clients of 53,000 in 2008.[49]

Women are often reluctant to practise family planning for fear of being abandoned or rejected by their families. Amnesty International learned of several cases where women were unwilling to tell their husbands they should not have another child despite the risks to their health if they were to have another child too soon after a previous pregnancy. Women also reported that when they did bring up family planning practices such as condom use, their husbands or partners were not in favour and therefore they did not use them. In Amnesty International's discussions with men and other community members in different rural communities, many revealed that they were unaware of the health risks to women of repeated and frequent pregnancies.

EMMAH BANGURA

died in Kambia Hospital in April 2008 of sepsis after an obstructed labour. The baby was born dead.

Emmah met her second husband, Hassam Kargbo, after the war. She already had three chidren from her first marriage. Her relatives did not think highly of Hassam because of his lack of steady employment. According to her aunt, Beatrice Bangura, Emmah was always asking for rice and money because Hassam never had enough money. However, Emmah by all accounts had fallen for Hassam and was very eager to please him, including by acceding to sexual relations whenever he liked, even very shortly after the delivery of her last child.

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Laying Emmah Bangura to rest, April 2008.

Even though Hassam was Muslim, Emmah, who was Christian, was his only wife, and therefore, Beatrice Bangura said, "He wanted a lot of sex… he couldn't even wait until she had finished breast-feeding." Sexual relations when a woman is still breastfeeding are culturally proscribed in Sierra Leone.

Her first child with Hassam was not yet one year old when Emmah became pregnant again. At first she denied she was pregnant "because she was protecting her husband", according to Beatrice Bangura. The nurses at Kambia Hospital, where her other aunt, Isatu Turray, worked and where Emmah had delivered her previous babies, chastised her for having babies too close together.

Emmah Bangura was a diminutive woman. Her nickname was "Kinkini", which connotes that she was petite. Hassam is a tall man – approximately six feet – and her previous delivery had been difficult because of the size of the baby. She did complain of pains in her back and side during this pregnancy but was never told that anything was out of the ordinary at the antenatal checks, nor that she was carrying a particularly large foetus.

ABORTION

In Sierra Leone, abortion is legal in circumstances where it is necessary to save the woman's life or preserve her physical or mental health.[50] Yet women who need a safe abortion in these circumstances may not be able to obtain one. The Reproductive and Child Health Strategic Plan points out that complications due to unsafe abortions are among the main causes of maternal mortality. Accurate data is difficult to collect but it is estimated that between 8 and 13 per cent of maternal deaths may be linked to unsafe abortions.[51]

3/THE HEALTH CARE SYSTEM: A CATALOGUE OF FAILURE

The health care system in Sierra Leone is decentralized, with service delivery the responsibility of the 13 districts, each of which has at least one government hospital and a network of peripheral health units (PHUs) which provide primary health care. Secondary-level care is provided by district hospitals and regional hospitals. Tertiary health care services are provided by specialist hospitals in Freetown. The Princess Christian Maternal Hospital (PCMH) is the tertiary institution for maternal and child health. There are also a number of private hospitals and health care centres run by religious organizations and other national and international organizations. In 2007, 97 NGOs were registered within the health sector. For more details of Sierra Leone's health system, see Appendix 1.

SYSTEMIC FAILURES

Despite committed work by a number of individual doctors, nurses and midwives, there are a number of systemic failures within Sierra Leone's health care system which prevent women from having access to the reproductive and maternal health care they need.

These systemic failures include:

- poor infrastructure;
- gaps in leadership and co-ordination;
- an inadequate number of trained staff;
- inequalities in distribution of health facilities and resources;
- insufficient drugs, medical equipment and other supplies;
- grossly inadequate provision of emergency obstetric services;
- an ineffective referral system; and
- lack of effective monitoring and accountability mechanisms.

Above: **A ward in the Princess Christian Maternity Hospital, the country's highest level referral hospital.**
Right: **The scrub area for the operating theatre in Makeni hospital, which has no running water.**

POOR INFRASTRUCTURE

"We must be the only tertiary level maternity hospital on the planet without a functioning sonogram (ultrasound) machine."
A doctor at Princess Christian Maternity Hospital[52]

Basic utilities are in short supply everywhere in Sierra Leone, including in hospitals and health care centres. Many government hospitals have no running water (including those visited by Amnesty International in Kambia, Makeni and Kabala). Lack of electricity is a country-wide problem. Only 10 per cent of hospitals and Community Health Centres have a reliable electricity supply, limiting their capacity to provide 24-hour emergency obstetric care.[53] Patients often have to pay for the fuel to run a generator if they need an operation.

Surgeons told Amnesty International of operating by the light of a mobile phone when the generator cut out. Routine hospital equipment is missing. Makeni hospital, a regional referral hospital, has no X-ray machine and no operating light in the operating theatre. There is no compressed oxygen available throughout the country.

GAPS IN LEADERSHIP AND CO-ORDINATION

Leadership and co-ordination gaps impair all levels of the health care system. Commonly identified problems include the need to clarify accountability, roles and responsibilities, the need for more effective budgeting and accounting systems and the need to clarify the functions of local councils and hospital boards.[54] While the decentralization of functions from the Ministry of Health to district-level bodies is generally viewed in a positive light, the process, begun in 2004, needs much more clarity and cohesion.

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Emmah Bangura's daughter – her mother died when no doctor was available to operate.

When Emmah Bangura was taken to Kambia hospital in April 2008, she was suffering from obstructed labour and urgently needed a caesarian section. However, the only doctor assigned to the hospital happened to be away on another assignment so there was no one to perform the operation. Despite the urgency of the situation, the hospital staff waited until the following day to call the doctor who was also the district medical officer. The baby was born dead later that day, and Emmah died of sepsis two days later.

The slow response of the government to the inequitable distribution of health care resources and services has left wide disparities within the different districts. For example, while six health districts have no emergency obstetric care facilities, Western Area has five, Bombali has three and Port Loko has two.[55]

The human resource capacity of the districts varies enormously.[56] Unsurprisingly, Freetown and the Western Area have a preponderance of skilled personnel compared to the rest of the country.[57]

Far from the government seeking to ensure greater co-ordination between districts, Amnesty International was told that during the last planning cycle, the transfer of district medical officers from one district to another seriously disrupted the process.

Another major reported problem is the fact that District Health Management Teams rarely receive all the funding promised to them, making it impossible for them to carry out the plans they have from year to year.

Given the importance of NGO and donor activities to the Sierra Leone health system, communications and co-ordination among donors themselves and between donors and the Ministry of Health is also critical. Results for Development, a partner in the Ministerial Leadership Initiative for Global Health,[58] is working with the Ministry of Health to help improve co-ordination with key donors to design and fund a common health "sector wide" programme.

PERSONNEL SHORTAGES, ESPECIALLY IN REMOTE AREAS

Due to the protracted civil war and the country's economic constraints, there is a dearth of medical staff in Sierra Leone. In the entire country, with a population of 5.5 million, as of 2007

there were only 64 medical officers, seven clinical medical specialists, 21 public health specialists, 87 midwives, 225 clinical nurses, 17 pharmacists and 1,228 maternal and child health aides.[59] Despite the fact that there are so few medical doctors in the country, many of them are working in administrative positions in the Ministry of Health or as district medical officers with large administrative workloads.

Remote areas are particularly hard hit by personnel shortages, with staff reluctant to work there because of the poor infrastructure, lack of educational opportunities for their children and low quality of life. For instance, in Bonthe and Moyamba district in the south and Tonkolili district in the north, there were no midwives in 2008.[60] A disproportionately high number of health staff work in Freetown and the Western Area and as a result only the Western Area meets WHO staffing ratios of one doctor per 12,000 population. By contrast, in Kailahun district, in the east of the country, there is one doctor per 191,346.[61]

There are also a number of "ghost workers" in the system (people who are paid, although not working) and absenteeism is common. A 2007 survey estimated the absenteeism rate to be as high as 42 per cent.[62]

POOR STAFF PAY AND CONDITIONS

The Ministry of Health finds it difficult to attract and retain well-trained and motivated staff. Private hospitals pay approximately three times as much as the government, especially for the more skilled jobs such as doctor or midwife.[63] The conditions of service are also much more attractive in other parts of West Africa. A doctor said, "You can spend up to two years not being paid at all, then earn US$100 per month as a doctor. In Ghana, you can get a job for US$1,500 per month with no problem. There are also opportunities for post-graduate training."[64]

In hospitals and health care centres throughout the country, some staff have been hired and are on the government payroll, some have been hired but are not yet a part of the civil service and are not being paid, and some have not been hired but are working voluntarily. Between five and 18 doctors generally qualify in Sierra Leone each year but, like other health staff, they are not given jobs right away; there is usually a three-year delay.[65] As a result, many work without a government salary.[66] In Koinadugu district, 48 per cent of the maternal and child health aides and community health officers were not being paid as of the end of 2008.[67] They survive by charging for their services and for drugs, some of which are supposed to be free for patients. These charges are completely unregulated, although Amnesty International found that in general members of the community were aware of health workers' situation and did not object to paying for services as long as the charges were reasonable.

Even for those getting paid, the overall conditions of service are poor. In remote areas, health staff are not always provided places to live, they have no vacation entitlements, and salaries are often paid late or not at all. In government service, doctors earn about US$100, midwives US$60-80 and nurses US$40-60 per month. Given that the cost of a 50-pound bag of rice is close to US$40, it is very difficult for families to live on these incomes.

LACK OF EMERGENCY OBSTETRIC CARE

R., shown vaccinating a baby, has been working at a health post for four years and has never been paid by the government. She told Amnesty International, "I work six days a week. I have three children and they live with my husband. I see them once a month." She sells the drugs she dispenses for a small profit and charges for attending patients.

Access to emergency obstetric services has been identified as a component of the right to maternal, child and reproductive health, guaranteed by the International Covenant on Economic, Social and Cultural Rights.[68]

Guidelines developed by UN agencies[69] define the components of emergency obstetric care and recommend a minimum of four basic emergency obstetric care facilities and one comprehensive emergency obstetric care facility per 500,000 people. Basic emergency obstetric care covers the administration of antibiotics, oxytocic drugs and anticonvulsants; manual removal of placenta, removal of retained products; and assisted vaginal delivery. Comprehensive emergency obstetric care also includes blood transfusions and caesarean deliveries.

The 2008 needs assessment of maternal health care provision used UN process indicators that analyze routine service records to measure the availability of emergency obstetric services, their use and the quality of these services.[70] The study found that only 14 of Sierra Leone's 38 hospitals providing maternal health services were able to offer comprehensive emergency obstetric care, and that six of the country's 13 districts had no emergency obstetric facilities at

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A woman who has given birth to twins and needs a blood transfusion, Princess Christian Maternity Hospital, Freetown, February 2009. The hospital has no blood bank.

all, leaving hundreds of thousands of women without access to life-saving treatment.

Not a single one of the peripheral health units (the clinics and health posts that provide primary care) in the entire country provides basic emergency obstetric care, because staff are not trained or equipped to perform assisted vaginal deliveries.

Not only is there inadequate coverage of comprehensive emergency obstetric care, but the available services are inequitably distributed. For example, the needs assessment found that there are three hospitals providing emergency obstetric care in Bombali district, with a population of 400,000, but only one in the south and east with a combined population of 1.2 million. Ensuring an equitable distribution of all health facilities, goods and services is a core obligation of the government of Sierra Leone,[71] an obligation which is not dependent on the level of resources in the country.

The survey found that only about 10 per cent of expected births took place in health facilities and only 2 per cent in hospitals providing emergency obstetric care.[72]

The WHO estimates that worldwide, 5-15 per cent of pregnancies will require a caesarean section. Between July 2007 and July 2008, according to the needs assessment survey, only 1 per cent of births in Sierra Leone were by caesarean section, with the highest proportion in the Western Area at 1.4 per cent and none in the southern district of Pujehun. These numbers imply that a very high percentage of women needing life-saving surgery are not obtaining it.

Even when women are able to access health facilities, they may still not receive life-saving treatment. Case fatality rates, which measure the proportion of deaths among women admitted to a facility with obstetric complications, are extremely high in Sierra Leone.[73]

INSUFFICIENT DRUGS, MEDICAL EQUIPMENT AND SUPPLIES

Drugs, medical equipment and supplies, blood and blood products are in chronically short supply.

There is effectively no blood bank system in Sierra Leone, even though an estimated 80 per cent of women and children suffer from anaemia due to high rates of malnutrition and malaria. If a patient needs blood, her friends or relatives must donate it, either to be given to the patient, if compatible, or to replace blood of the appropriate type taken from hospital stocks. The problem is that people are generally reluctant to donate blood, in part because of widely held misconceptions that it is dangerous to do so. No incentives are provided, and as a result there are few blood donors. In addition, few hospitals have functioning storage facilities for blood. Even the Princess Christian Maternity Hospital, the main referral maternity hospital in the country, does not have a functioning blood bank.[74] As a result, many women die because they cannot get a blood transfusion.

MAFEREH KAMARA,
aged 33, died in Kambia hospital on 20 November 2008.

By the time Mafereh reached Kambia hospital, she had already lost a lot of blood and from the account of the staff on duty, she was pale and weak. A caesarean section was performed that day and her dead, macerated baby was removed. Mafereh was catheterized with fluid, but what she really needed was a blood transfusion. According to hospital records, her haemoglobin count was just 6, indicating quite severe anaemia.

There was no blood of her type available in the hospital and none of the relatives in the hospital were a match. By noon that day, the family had sent for Mafereh's twin sister who lived in a nearby community, so that she could donate blood. However, by the time her sister arrived at the hospital, Mafereh was dead.

Ali Kari Bangora II, the bereaved husband of Mafereh Kamara who died for lack of a blood transfusion.

A survey conducted in 2007 on availability of essential drugs found that only 37 per cent of peripheral health units had all items in stock.[75] Staff buy supplies from private sources and sell them, sometimes at a higher price.

Some drugs, such as anti-malarial medicine, are donated free of charge by UNICEF and other donors and are supposed to be given free to patients. According to the 2008 Anti-Corruption Commission report, over 47 per cent of Sierra Leoneans complained that there were not enough of these drugs to treat their communities.[76]

All other drugs are supposed to be supplied on a cost recovery basis, under which 40 per cent of the proceeds from sale of drugs are used as a revolving fund to buy further drugs.[77]

Procurement of drugs for primary and secondary health services has been devolved to local councils. However, the cost recovery system has broken down in recent years, largely because of poor control of drug distribution between the central medical stores and the districts.[78] The Anti-Corruption Commission also found that health care staff working within the system were misappropriating drugs.

The Anti-Corruption Commission found in general that there was an inadequate number of drugs and supplies, that drugs were illegally sold and administered in hospitals and that no information was available on procurement and supply of drugs by councils or the Ministry of Health.[79] It also documented several concerns around the storage of drugs and medical equipment.[80] It noted that drugs with a short shelf-life were not being properly stored and used. It also found that record keeping was in a "scandalous state" and that most procurement committees lacked the technical expertise to determine the type of drugs to be procured.[81]

Yerie Marah's home village, Sokralla, near Kabala, Koinadugu district.

Princess Christian Maternal Hospital staff told Amnesty International that even where drugs and supplies like blood bags are donated so that they should be available free of charge, they are still not readily available most of the time. Health care staff complained that shipments are not made on time and rarely do they receive all the supplies that they request.

Although Yerie Marah was pregnant, she did not receive an insecticide-treated bed net, even though they were supposed to be distributed free of charge to pregnant women as part of a government programme to prevent malaria, financed through the Global Fund to Fight AIDS, Tuberculosis and Malaria. Amnesty International was informed by a local NGO that clinics in the area (near Kabala, Koinadugu district) had not had bed nets for several months, but that they had been available for purchase in stores.

With no bed net, Yerie Marah contracted malaria. This is believed to be a contributing factor to her death after severe blood loss in November 2008.

INEFFECTIVE REFERRAL SYSTEM

"There is a breakdown of linkages between tiers of the primary health care system because of the lack of communication and ambulances for referrals. Essentially, each health facility functions as an island."

Needs assessment survey, p.79

Once a patient makes contact with the health service at any level, a continuum of care should be guaranteed, up to a tertiary level facility if need be. Continuity of care requires health facilities to be able to communicate with each other, and is the backbone of the primary health care system.

The patchy and inequitable distribution of health care facilities in Sierra Leone makes life-saving services inaccessible to many women. These problems are compounded by the distance between facilities, the poor conditions of roads outside Freetown and the lack of public transport. In these circumstances an effective referral system is essential. However, in Sierra Leone, the lack of communications equipment and ambulances mean that the referral system is ineffective or non-existent, even in emergencies.

Dr Alikalie, District Medical Officer for Koinadugu district, the largest of Sierra Leone's 13 districts, told Amnesty International that the poor referral network is the main factor leading to maternal deaths in the district.

Few peripheral health units are equipped to transport people to hospitals and other health facilities. Although all hospitals are supposed to have at least one ambulance, fewer than

one in 10 does. Corruption is also widespread in relation to ambulances, with staff using them for personal travel, charging fees for their use and keeping the money, and claiming reimbursement for non-existent repairs.[82]

It is often impossible to communicate between different health facilities to request assistance or transport for patients because of the absence of radio sets, functioning telephone networks and other communications equipment.[83] None of the hospitals and peripheral health units (clinics and health posts) in Bonthe, Kailahun, Moyamba and Pujehun had communications facilities in 2008.[84] Anne Marie, a maternal and child health aide from Koinadugu, told Amnesty International, "We don't have a radio at my health post and the telephone network doesn't always work. So if I have cases that I need to refer for emergency it is left to the will of God. We use our own mobile phones but these cannot be used in areas that are without coverage."

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A broken ambulance – women needing to reach a hospital will have to find another means of transport.

HAWA DABOR

died on 19 March 2008 while giving birth to twins at the Lengekoro maternal and child health post, in Koinadugu district.

It was Hawa's sixth pregnancy. During her fourth pregnancy, she had had to have a caesarean section but her fifth pregnancy was normal and she gave birth in a health post without any problems. However, during her sixth pregnancy, a series of mishaps led to her death. Hawa started to go into labour on the evening of 18 March 2008. When she arrived at the health post after several hours of labour, the maternal and child health aide quickly advised that Hawa go straight to Kabala hospital to deliver. The family immediately began collecting money to pay her way there. However, as it was evening, there were few cars on the roads. Frantically, the family searched for a way to get Hawa to the hospital, but with no radio at the health post, no phone coverage and no other means of communication, all the aide could do was give her an intravenous drip and hope that a vehicle passed by. No vehicle came and Hawa died at 2.30am with the twins stillborn.

INADEQUATE STAFF TRAINING AND SUPERVISION

Most peripheral health units are run by maternal and child health aides (MCH aides), who have two years' training, are trained to carry out normal deliveries, and are considered by the government to be skilled birth attendants.[85] MCH aides perform a key role in deliveries in hospitals and conduct all deliveries at the village level in MCH posts.

The husband and son of Hawa Dabor, who died in March 2008 before she could be taken to hospital.

During the course of Amnesty International's research, it became apparent that some MCH aides did not have the skills to read charts or monitor heart rates. Amnesty International was also told repeatedly that MCH aides sometimes misuse drugs, such as using oxytocin to accelerate labour, which can lead to a ruptured uterus.[86] Their limited training, the high level of responsibility they are given, and the overall lack of supervision combine to produce a high rate of misdiagnosis and poor clinical management.

LACK OF SKILLED ATTENDANCE AT BIRTHS

Medical staff at the maternity hospital in Freetown identified a large number of maternal deaths as directly linked to complications that arise when people without sufficient training or expertise assist in childbirth without supervision.

At least 80 per cent of births take place in women's homes and are often managed by traditional birth attendants (TBAs) with little or no training, according to the needs assessment survey.[87] The government provided short-term training for traditional birth attendants in the 1970s and has continued to support training in some areas. Some international NGOs are also continuing to train traditional birth attendants as part of their maternal health programmes.

According to both international standards and guidelines set by WHO and by the Ministry of Health, however, traditional birth attendants cannot be considered skilled attendants, even if they have received some training.

Some health care professionals argue that traditional birth attendants should be excluded from the child-bearing process, but pregnant women routinely seek their services. As well as cultural factors which mean many women are more comfortable with a traditional birth attendant, cost is also important – their fees are low, may often be paid in kind, and can be deferred. A traditional birth attendant will assist a woman before being paid, while health facilities generally demand payment before treatment. In Kambia, if the traditional birth attendant is the first wife, she will not charge anything, while in and around Freetown the cost is generally Le60,000 (US$20).

Kadi Kamara, a traditional birth attendant in Kapairo, Kambia district.

Amnesty International was told by maternal and child health aides in Crossing, near Freetown, of another case involving a TBA: "In February [2009] there was a case of a woman, Adele Sesay, who was forced to go into labour prematurely by the TBA which resulted in a complication that the TBA could not handle. The TBA abandoned her and the woman bled to death. The TBA knew she would be in trouble if she referred the case. Instead she abandoned the woman and left her to bleed to death. I wrote a letter and reported her to my bosses. I only hope they take action soon." Amnesty International asked health officials for information on their response to this case. They said that they were acutely aware of the problem overall, although not of this specific case, and were in the process of formulating their policy. They admitted that they were not in a position to follow up on each individual case. Amnesty International returned to the health post in Crossing in April 2009 to find out if any action had been taken with regard to the TBA. The maternal and child health aides said that to their knowledge nothing had changed so far and they were aware of the fact that she was still working as a TBA.

In some areas, village by-laws have been passed banning home births, although it is unclear whether and how they are enforced. Amnesty International was told of several cases where alleged home births were reported to the police and both the family and the TBA were fined. Criminalizing women for not giving birth in specific locations can never be justified. In the current environment, where many women do not have money to pay for health care in designated facilities, punishing them – and those that assist them, such as TBAs – for giving birth at home, violates human rights and is counter-productive in terms of enhancing access to the right to health.

Binta Barrie, who nearly died in childbirth, and her baby.

BINTA BARRIE

nearly died in childbirth in January 2009. Only the intervention of a "good Samaritan" who paid for taxis and hospital fees saved her life.

Binta Barrie gave birth on 6 January 2009 in an area near Freetown known as Crossing. She told Amnesty International, "I planned to give birth in the clinic but when my labour started I called the TBA [traditional birth attendant] because it was late at night and she came to my house. I was in a lot of pain. The TBA came and she told me to push. I ended up delivering the baby after the TBA told me to push. After the baby came out I wasn't feeling right. I was bleeding a lot. The TBA did not know what to do so my family rushed me to the clinic. It was from there that I was rushed to the hospital."

Janet, the maternal and child heath aide who oversaw her case at the hospital, said, "This is what some TBAs are doing. They are not skilled and they force the girls to push and it is dangerous because it results in the girls ending up with a retained placenta. This was Binta's problem. When the girl started bleeding the lady left the house. The family panicked and ran to us here at the clinic. I gave them a stretcher and told them to bring her here. In the meantime I called the district health sister and was told to refer the patient. The family told me they did not have any money. I told the family that they needed to try; otherwise, she would die. By 6:30 pm she was in the Princess Christian Maternity Hospital. She was first taken to Waterloo and then switched to another car and went from Waterloo to the Princess Christian Maternity Hospital. Normally it costs Le15,000 (US$5) to go to Waterloo and then Le30,000 (US$10) to the hospital for a charter. But there was a good Samaritan who paid for everything. By 7:30 pm fees were paid to the doctor so when she arrived she immediately went to the operating theatre. The retained placenta was removed. She stayed the night and left the next day."

LACK OF INFORMATION

The systems for recording and monitoring maternal deaths in Sierra Leone are extremely weak and no systematic analysis is undertaken of maternal deaths in hospitals or health centres. An assessment of the Health Information System in 2006 found that Sierra Leone did not have reliable means to estimate the levels of maternal mortality.[88] It also noted that registration of deaths is very low – only an estimated 1 to 2 per cent of deaths may be reported by the Vital Statistics Office.[89]

The needs assessment survey found that there was "poor record-keeping especially for complications of pregnancy and maternal death. Maternal death audits are done in many of the health facilities visited but the records of such exercises are not obtainable."[90] It recommended strengthening the health information management system for routine collection of data on monitoring of maternal complications, deaths and the availability of signal functions.

It also recommended that maternal death audits be institutionalized in all health facilities, both public and private.[91]

In the health facilities that Amnesty International visited, data on women who died, including name, address, age, date of entry into the hospital, and cause of death, was collected and sent to the Ministry of Health on a monthly basis. The accuracy of these records is sometimes questionable, with staff collecting the data having little training and the cause of death often being recorded simply as "other". Family members rarely make efforts to find out the cause of death, and autopsies are rare, for both financial and cultural reasons.

For women who die outside a hospital or clinic, information about their deaths is even more scarce. The national and district death and birth registration sheets that Amnesty International was shown have no space to show women who die in childbirth – there is only a column for haemorrhage. None of the deaths of women investigated by Amnesty International who died at home had been officially recorded.

These are the records of the women who died in 2008 in the main government maternal hospital in the capital, Freetown.

Lack of information casts doubt on the maternal mortality ratio cited by the authorities. Sierra Leone's most recent Demographic Health Survey (DHS) gives the maternal mortality ratio as 857 maternal deaths for every 100,000 births. A 2005 survey gives an estimated ratio of 1,300 per 100,000,[92] and other relatively recent estimates are as high as 2,100 per 100,000.

4/COST AS A BARRIER TO HEALTH CARE

Many women in Sierra Leone do not seek or obtain health care when they need it because they know or fear that the cost will be more than they can afford. Given the persistent discrimination they face, and the resulting undervaluing of their health needs, the need to pay for health care for women is often not given a high priority when decisions are made about the allocation of scarce resources within the family.

The government of Sierra Leone has a duty under international law to prioritize the provision of affordable maternal health care, and to ensure that costs do not present an insurmountable barrier preventing impoverished women from accessing the treatment they need.

A survey carried out by the international humanitarian organization Médecins Sans Frontières (MSF) in 2006 found that 67 per cent of those surveyed (both men and women) said that cost was the main reason that they did not seek health services. It showed that even if people were sick, they would not seek access to health care services because of the cost.[93]

Sierra Leoneans pay the highest out-of-pocket expenditure in sub-Saharan Africa for health care, according to UNICEF. Individual patients pay the bulk of the costs of the health care system – out of pocket payments by individual patients account for more than two thirds of the cost of health care in Sierra Leone, mostly spent on medicine.[94] The National Health Accounts[95] estimate that private spending on health care in 2007 (by individuals in the household) came to US$45 per capita per year and public spending (by the government and donors) was US$16 per capita.[96]

As the majority of the population lives below the poverty line on less than US$1 a day, the only way that most people can pay for services and drugs is through borrowing money from friends and relatives or, if available, from community savings and loan schemes.

FREE CARE: THE GAP BETWEEN POLICY AND PRACTICE

A Presidential Decree issued in 2002 exempted vulnerable groups from paying fees for basic health services in the public sector. The groups identified included pregnant women and lactating mothers for up to 12 months after birth.[97]

The government itself has acknowledged that the "exemption mechanism is not well implemented and there are also under-the-table payments".[98] There also appears to be a lack

THE RIGHT TO HEALTH AND FINANCIAL BARRIERS

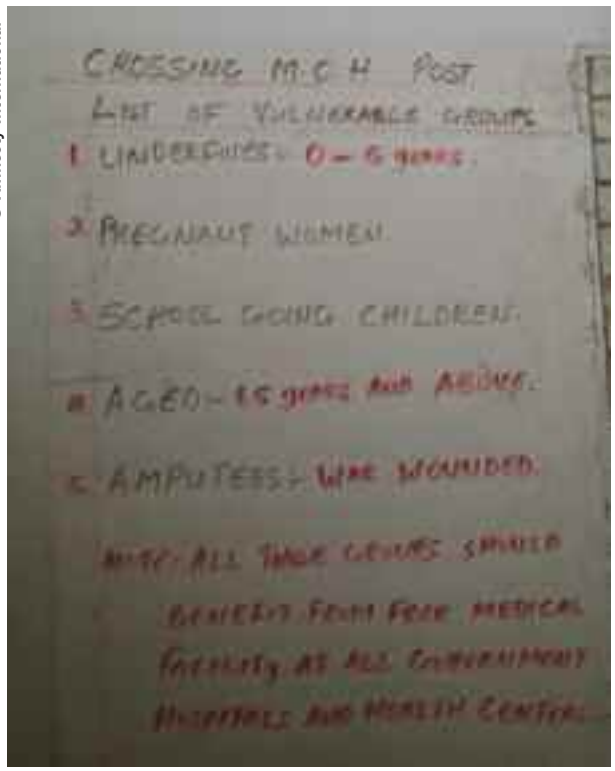
One of the crucial components of the right to health is economic accessibility or affordability. The UN Committee on Economic, Social and Cultural Rights has emphasized that under Article 12 of the International Covenant on Economic, Social and Cultural Rights, "health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."[99] The Committee has also interpreted the obligation to ensure reproductive, maternal (prenatal as well as postnatal) and child health care to be of comparable priority to a core obligation,[100] which states are under an immediate duty to prioritize. The government is also under a duty to prioritize the most vulnerable and marginalized groups, who face the greatest barriers realizing their rights, when allocating resources.

Sierra Leone, as a state party to the UNConvention on the Elimination of All Forms of Discrimination against Women (CEDAW), is under an obligation to take all appropriate measures "to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services" and "to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Article 12). The UN Committee on the Elimination of Discrimination against Women has interpreted Article 12 of CEDAW to include a requirement on states to eliminate barriers to accessing health services (such as "high fees... distance from health facilities and absence of convenient and affordable public transport") and to take measures to ensure women timely and affordable access to health services.[101] The Committee has emphasized that it is the duty of states to ensure women's right to safe motherhood and emergency obstetric services and that they should allocate to these services the maximum extent of available resources.[102]

of clarity among government officials on the scope of the decree. Some government representatives told Amnesty International that the free care policy applies only to supplies and drugs and is silent on the issue of service charges.[103]

The 2008 needs assessment survey found that two thirds of hospitals and clinics require patients to pay a fee when they arrive, before treatment, although almost all said that they would suspend the fee in an emergency. It also found that fees for maternity services varied widely between health facilities and that the costs of maternity services beyond a normal delivery are exorbitant.[104] The survey found that people's concerns centred on the costs of services and the fact that they have to pay numerous different fees before being treated, including administrative fees, consultation fees, fees for drugs from pharmacies, and the high cost of transport to health facilities.

Amnesty International found that free care was available in just a few hospitals across the country. According to representatives of international organizations involved in the 2008 budget and programme planning process at the district level, no effort was made to budget for implementation of the exemption policy in the districts. One of the recommendations of the needs assessment survey is an evaluation of the cost recovery system and fee waiver (exemptions) scheme.[105]



A notice stating who is exempt from charges is posted on the wall of the clinic in Crossing, a suburb 15 miles from Freetown.

There are major difficulties in implementing a free care policy for the defined vulnerable groups. Pregnant and lactating women, children, the disabled and the elderly account for at least 70 per cent of people using primary health care facilities. If charges for their visits were waived, revenue under the cost recovery system would be enormously reduced. In the prevailing conditions, the exemptions and the cost recovery system cannot work together.

In addition, appropriate drugs are often not available in health facilities so that the patient has no alternative but to pay for them. A maternal and child health aide, Fatmata, told Amnesty International, "We don't always get what we request and then we have to go and ask money from the patient to go buy the drugs in a private pharmacy."

In one clinic in Kambia district, Amnesty International was told that fees were set at the district level and at the end of the working day these fees were collected and distributed to all the health care staff working in the clinic. However, in most areas where Amnesty International carried out research, anyone working in the clinic, whether paid or unpaid, would unilaterally and illegally charge fees and keep the money. In the clinic, near Freetown, one maternal and child health aide is paid Le140,000 (US$47) per month but the other, who has been working since 2006 as a qualified maternal and child health aide, is not yet on the payroll. Her income comes from charging patients. According to her, "We charge between Le2,000 (US$0.67) and Le5,000 (US$1.66) [for each visit]. Sometimes we don't charge anything; it just depends if people can pay."

Fees can be exorbitant. For example, the price for an emergency caesarean section, as quoted to Amnesty International, ranged from zero to Le200,000 (US$67) to Le950,000 (US$316) in government hospitals across Sierra Leone. At Kabala hospital, Dr Alikalie told Amnesty International that a caesarean section cost Le150-200,000 (US$50-67). It is apparent that the system of fees for service in Sierra Leone lends itself to corruption.

In Kambia, the District Medical Officer told Amnesty International about a nurse who overcharged a patient. He did not raise the issue with her, as he knew that if he did she would leave. He needed her there more than he needed to address the issue of corruption on her part. The Chief Medical Officer of the Princess Christian Maternity Hospital raised similar concerns about trying to discipline staff stating, "The staff that we do have, we cannot put under strict control because we cannot satisfy them, both with regard to salaries and working conditions."

The Anti-Corruption Commission in its 2008 report recognized that conditions of service are poor and need to be improved but also found that staff at all levels were unilaterally charging revenue and not reporting it. It recommended that revenue collection in all government hospitals should be centralized and all revenue collected should be deposited to the finance units of hospitals on a daily basis.[106]

ADAMA KAMARA

was 25 when she died at home on 27 December 2008 in the village of Kapairo, Kambia district. Her husband felt unable to pay for the drugs she needed.

It was Adama's fifth pregnancy. She had had one stillbirth, and had delivered three live children – three of the 10 living children of Pa Abu Kamara, her husband, who has two other wives.

On 24 December 2008 Adama was approximately six months pregnant and went into premature labour. By the next day it became clear that she was suffering prolonged labour.

The family observed her at home for one day to see if her condition would improve before transporting her to Kambia government hospital in a car that evening. Transporting her to the hospital cost Le40,000 (US$13), which her husband borrowed from his neighbours.

When they arrived at the hospital, Pa Abu Kamara had to pay Le2,000 (US$0.67) for registration and Le10,000 (US$3.30) for a hospital bed, in addition to charges for medicines.

At the hospital, Adama was given an intravenous drip as well as several injections by the nurses on duty. She spent that day and the next in the hospital, and no doctor was present during that time. Pa Abu Kamara came home on the second day and when he returned to the hospital after several hours, he found that Adama had delivered the baby, but it had not survived.

Adama was bleeding heavily. Despite the fact that this was an emergency situation and despite the government's free care policy, there was no free medication. The nurse in charge at Kambia hospital told Pa Abu Kamara that he had to pay for medicines for Adama or "she will die".

Pa Abu Kamara told Amnesty International, "I didn't have any more money. I just took Adama out of the hospital and took her home. She did not look good and also I did not want to pay the hospital charge for her body which is at least Le60,000 (US$20)." Adama was delirious by this point and unable to speak for herself, even if she had been given the chance.

Pa Abu Kamara hired a taxi to take Adama from the hospital and she died at home the next day. Adama's body was taken to her parents' home and she was buried in her birth village.

Pa Abu Kamara told Amnesty International he felt sad about Adama's death, "especially for her children". He then said, "I am still struggling to pay off the debt I incurred taking Adama to the hospital and paying for medicines."

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Pa Abu Kamara, who said he took his wife Adama home from hospital because he had no more money to pay for her treatment or the hospital charge for her body. She died the next day, in December 2008, in Kapairo, Kambia district.

THE FEAR FACTOR: UNCERTAINTY OVER COSTS AND QUALITY

A large number of maternal deaths in Sierra Leone are due to interrelated delays, which can ultimately be traced to the high costs of care and the fear of such costs: the delay in making the decision to seek care, the delay in reaching the health facility and the delay in receiving treatment at the health facility.

The delays caused by the fear of cost are multi-faceted. Amnesty International found that the delay in making the decision to seek care was not only linked to the inability to afford

Neinie Mansaray, who said she was charged Le995,000 (US$330) for a caesarean section that has left her with an umbilical hernia. She needs another operation but cannot find the money for it.

NEINIE MANSARAY,
aged 28, from Kamanso in Koinadugu district, needs an operation that she cannot afford.

Neinie is married to a subsistence farmer, has one surviving child, and has suffered three difficult pregnancies. During her second pregnancy she was referred to Kabala Hospital. It took her five hours to get there being carried in a hammock. At Kabala hospital, she was told that she had a fistula, an abnormal opening between the vagina and the rectum (or, in some cases, the bladder) usually caused by trauma resulting from prolonged and difficult labour. Neinie told Amnesty International, "I had to go to Freetown to have a fistula repair operation. They also told me that if I got pregnant again, I would need to have a caesarean section."

Her third child had been born in Kabala hospital 16 months before Amnesty International met her. Neinie told Amnesty International, "The doctor on call performed a caesarean section and charged me Le995,000 (US$330). We could not pay for the operation all at once so I am still paying it off today." The amount that Neinie paid for her caesarean section is far higher than other public health centres and hospitals cited to Amnesty International.

In Neinie's case, the caesarean section was not adequately performed and she was left with an umbilical hernia. Neinie told Amnesty International, "It is difficult for me to work now. I need to have a hernia operation, but I am still paying off the money I owe for my caesarean section so have no money to pay for the hernia operation."

care but also doubts about the quality of care and uncertainty about what the price of care would be.

The main reason why patients are uncertain about the prices they have to pay for health care is that there is no standardization or transparency about health care fees. Because the system is decentralized, prices are determined locally. This means that they vary substantially between one health care centre or hospital and another. Price lists are also not readily available throughout the country.[107] Since June 2009, however, the Princess Christian Maternity Hospital has posted a list of prices for services rendered – it cites, for example, a charge of Le150,000 (US$50) for a caesarean section. These charges are clearly inconsistent with the government's policy of fee exemptions for pregnant women.

In addition, the low salaries paid to health workers and the number of people working within the health system without receiving any salary at all lead to individual health care staff charging patients for services directly. Fees are unregulated as receipts are rarely given and the transaction takes place directly between the patient and the health care staff. Patients have no way of knowing whether charges are official or unofficial.

With no certainty of what costs will be, it is difficult to plan and gather the money that is needed. As part of its obligation to ensure the accessibility of health facilities, goods, and services, the Ministry of Health should ensure that there is transparency and consistency in relation to charges and that any payments for health care services do not create barriers to women's access to health services, are based on the principle of equity and do not disproportionately burden poorer households.

ABIBATU COLE

died on 24 July 2008 at the Princess Christian Maternity Hospital. She gave birth to a girl before she died. She was survived by her husband James, a security guard.

James and Abibatu had planned to go to the Soroti clinic, a private clinic in Freetown where she had received antenatal care, for the delivery of their baby. However, when Abibatu went into labour her sister made the decision to take her to the Princess Christian Maternity Hospital. James told Amnesty International, "We had discussed going to Soroti clinic because they knew Abibatu there and if anything went wrong they would refer her to proper care. I did not want to go to the Princess Christian Maternity Hospital because of the high cost and because I don't really think they take good care of patients there."

When Abibatu arrived at the hospital on 21 July 2008 she was told she would need an emergency caesarean section. James told Amnesty International, "I met with the doctor in charge and he told me I should pay Le700,000 (US$233) for the service. I told him I did not have that kind of money. He then told me to pay Le400,000 (US$133) instead."

While the family was securing the money for the caesarean section, Abibatu gave birth to a baby girl. James said, "I was surprised she gave birth naturally. The nurses then demanded that I pay Le200,000 (US$67) for the delivery fee. I paid the fee to the nurses. Abibatu then had to stay in the hospital for several more days after the baby was born because Abibatu's condition seemed to be getting worse."

On 24 July the nurses called James to the hospital because Abibatu urgently needed blood. James told Amnesty International, "I rushed to the hospital and her brother who had the same blood type as her donated blood. While she was receiving the blood by transfusion she looked up at me and said she did not like how it was feeling. She asked the nurses to remove the needle. It was just after that that she gave up and died right there." Later, Amnesty International was told that the cause of death written on her file was anaemia. "They never told me what the reason for her death was. I know that I have to take care of my baby daughter."

Repeatedly Amnesty International was told that people do not trust the quality of care and therefore do not feel it is worth what they might have to pay for it. A community member in Kambia district told Amnesty International in March 2008, "When MSF was based in Kambia, health care was affordable, accessible, and provided a high quality of service. After the departure of MSF, health care became unaffordable, the quality deteriorated, and it was unreliable."

In focus group discussions in several districts, community members told Amnesty International they expected better quality care than they were receiving and would pay for it if it were available. In Rokupur, for example, members of the community health team said that they were more likely to go to a private clinic, despite the extra cost, than their own hospitals and health care centres, because of concerns about the quality of care.

TRANSPORT COSTS

The high cost of transport makes it difficult to reach emergency care quickly. If a complication arises and a woman is giving birth at home, her family has to find and pay for

Simethy Sesay, whose emergency hospital treatment cost more than Le1,200,000 (US$400).

transport to either the peripheral health unit or hospital. If a woman is at a peripheral health unit and is referred to a hospital, her family has to organize and pay for transport to the hospital. In most areas outside Freetown there is no communication between peripheral health units and hospitals. Transport can be very expensive and arduous, given the high cost of motor fuel, poorly maintained roads and long distances.

When Simethy Sesay developed severe complications during her labour in March 2007, a community health worker referred her to Kabala government hospital, approximately seven miles away. Neither Simethy's husband, Satanay, nor the community health worker had a mobile phone, and they were unable to communicate with the hospital to call an ambulance. Instead, Satanay borrowed money to charter a taxi to take Simethy to the hospital. When they arrived, the only doctor in the hospital was performing surgery. Another woman with an obstetric emergency arrived at the hospital at almost the same time as Simethy. Both had to wait. Six hours later, the doctor met the women and told them that he was too exhausted to operate after working for three days without rest and that Simethy and the other woman would need to be transferred to another hospital. Both Simethy and the other woman were required to pay Le180,000 (US$60) for fuel for the ambulance before undertaking a four-hour journey to Magburaka hospital. Simethy had an assisted vaginal delivery and gave birth to a stillborn child. She was hospitalized for a week, which cost her husband Le1,055,000 (US$352).

COSTS HIGHER AT NIGHT

Reaching and obtaining care is more expensive at night. Not only is it harder to find transport, especially in rural areas, but the prices can be three times as high. Also, if women arrive in the hospital at night, fewer staff are on duty and if there is someone available, they usually charge higher fees.

Community members in Susan's Bay, a slum close to the Princess Christian Maternity Hospital in the eastern part of Freetown, told Amnesty International that despite their close proximity to the referral hospital, a woman giving birth at night would never go there because the cost of even a normal delivery would be too high.

Immediately after giving birth at home with a traditional birth attendant, Princess Kallon of Calabala town (a suburb of Freetown) started bleeding and later died at home. Her husband Philip Kallon told Amnesty International, "It was late at night and we live up the hill and there was no money and no transportation to get her to the hospital. She died right at home." Philip later added, "Nothing goes for nothing in Sierra Leone."

ADAMA TURAY,
aged 33, died on 4 December 2008 in a taxi in a parking lot several hours after delivering her child.

On 3 December 2008, at about 11pm, Adama's contractions started. She was taken to a traditional birth attendant in Kroo Bay in Freetown near her home and at 5am on 4 December she delivered a baby girl. Immediately after giving birth she started vomiting and complained of being cold. She then started to bleed, and the family began looking for money to get her to the hospital. Although only a few miles away, the hospital is in the middle of Freetown, which has heavy traffic at all times.

Her sister Sarah told Amnesty International, "After several hours of looking for money we managed to get Le200,000 (US$67) together. At first the taxi was charging Le70,000 (US$23) but we got him down to Le40,000 (US$13). We planned to use the rest of the money at the hospital – Marie Stopes in Aberdeen, a neighbourhood in Freetown."

Both Hassan, her husband, and Sarah accompanied Adama on the 40-minute ride in the taxi to the hospital. She died in the parking lot of the hospital. It was about 8am, just three hours after she had delivered. They had to pay the taxi Le40,000 (US$13) to take the body to the mortuary.

Sarah told Amnesty International, "I think she died because we did not have money and therefore did not go to the hospital on time. We took her to the traditional birth attendant to deliver because her husband did not have any money to take her to the hospital."

Sarah went on to say, "We knew that if we took her to Marie Stopes they would charge us but we also knew that we could pay back later. But we simply did not even have the money to get her to the hospital." (Marie Stopes' policy is to provide free emergency obstetric care for women that need it, but Adama's family were unaware of this policy.)

Although the Princess Christian Maternity Hospital, the main maternity hospital in Freetown, is closer to their home, the family did not consider going there. At the Princess Christian Maternity Hospital, money is demanded immediately, and the family knew that they would be unable to pay.

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Sarah Kabbia with her two-month-old niece Maya at their home in Kroo bay in Freetown. Adama Turay, Sarah's younger sister, died while giving birth. Sarah, now solely responsible, says it is a struggle to pay for food for the baby each day.

ANTENATAL CARE

Good quality antenatal care is essential to raise awareness of possible danger signs and for the early detection of complications. During pregnancy, tetanus immunization, the prevention and treatment of malaria, management of anaemia and treatment of sexually transmitted infections can significantly improve maternal health and the prospects for the baby. Adverse outcomes such as low birth weight can be reduced through a combination of interventions to improve women's nutritional status and prevent infections during pregnancy. According to the needs

assessment survey, only 14 per cent of health care staff surveyed knew all the components of good quality antenatal care.[108]

Amnesty International found that the costs of antenatal care varied from one village to another. The needs assessment survey reported that 81 per cent of women had had at least one antenatal check during their last pregnancy.[109] However, UN-agreed standards stipulate that women should have at least four antenatal visits in each pregnancy.

INITIATIVES TO OVERCOME THE COST BARRIER

In some areas donors and international NGOs are supporting programmes to provide free care for pregnant women. Examples of such programmes running in early 2009 included: Gondema Hospital in Bo district, support provided by MSF; Makeni government hospital in Bombali district, support provided by UNFPA; and St John of God Hospital in Lunsar in Port Loko district, with Spanish government support (due to end in April 2009). UNFPA, through Japanese funding, was supporting the Princess Christian Maternity Hospital with drugs and supplies such as maternity kits.

The potential for improving outcomes by reducing costs for patients was observed by Amnesty International when it visited Makeni government hospital, Bombali district, in February 2009. The labour ward was full (unlike those seen in many other hospitals visited) and women on the ward said that they had not been charged for care. According to the needs assessment survey, of the 239 obstetric complications treated, there were nine maternal deaths, a lower fatality rate than in many other hospitals.[110]

Makeni hospital, a regional referral hospital for the entire north, has received funding from UNFPA to ensure that all contraceptive services and obstetric drugs are provided free, as well as fuel for the ambulance and funding for topping up health workers' salaries. The hospital is equipped to deal with emergencies, with trained personnel and the capacity to carry out caesarean sections and assisted vaginal deliveries.

Enhancing staff salaries is key to the success of the programme. Dr Ibrahim Bundu, director of the hospital and the regional surgery specialist, told Amnesty International, "Here at the hospital a midwife earns approximately US$100 per month and a doctor earns US$300 a month. This is far higher than in other places and it means that they don't have to charge." By contrast, the midwife in Kambia government hospital was earning Le254,000 (US$85) per month for a six-day working week and a doctor just over Le360,000 (US$120).

Community-based savings and loan schemes have been set up to provide funding for emergencies, including pregnancy-related emergencies, in Koinadugu district. In Koinadugu, CARE has helped set up several such schemes, including the scheme in Dogoloya, Saffiatu Jalloh's village. Community members contribute small amounts throughout the year – for example Le500 (US$0.16) a week – and the fund is then available for the members to draw on for emergencies. Approximately three quarters of the residents of Dogoloya are members of the scheme. The funds in the scheme are used only for problems in the community and if funds are not used they are shared out between the members at the end of each year.

Such schemes are also being promoted in other parts of the country by other organizations, including the national NGO Medical Research Council (MRC) in Tonkolili and Bo, and Health

SAFFIATU JALLOH

developed severe complications during her pregnancy in September 2008, but was able to borrow money from her village savings and loan scheme to pay for emergency treatment.

Saffiatu Jalloh and her baby, northern Sierra Leone. In October 2008, her family was able to borrow Le600,000 (US$200) from the village savings and loan scheme – a community self-help project. She needed the money for transport and urgent hospital treatment. "If I didn't have this money perhaps I would have died," she said.

After a visit to the antenatal clinic in September 2008, Saffiatu was told her baby was in the wrong position and was referred to Kabala government hospital. Instead of going there, where Saffiatu thought she would not get good quality care, she and her husband decided to go to the St John of God Catholic Hospital in Lunsar, in the neighbouring district of Bombali. The decision had major financial implications, given that Lunsar is at least an additional three or four hours away from the village by car, on the main road between Makeni and Freetown. They paid Le50,000 (US$17) for transport.

Once Saffiatu arrived she stayed for several days and then gave birth. She was discharged the next day. At St John of God Hospital, Saffiatu was charged Le5,000 (US$1.67) as a registration fee, Le10,000 (US$3.30) as a "filing fee", Le15,000 (US$5) in administrative fees, Le25,000 (US$8.30) for the vaginal delivery, and Le60,000 (US$20) for drugs. The family reports that they were charged an additional amount for the room, adding up to Le300,000 (US$100).

Saffiatu and her husband ended up borrowing Le600,000 (US$200) from the village savings and loan scheme to pay for the emergency care. They pay back some of the loan each month. When asked what would have happened to her without the village savings and loan scheme, Saffiatu pauses and says "If I didn't have this money, perhaps I would have died."

Unlimited in Bombali. The WISH Initiative, a project supported by Sierra Leone's First Lady, is also trying to set up similar schemes in various communities across the country.[111]

Recognizing the need for significantly more attention to be paid to the issue of cost as a barrier to essential services for pregnant women, in early February 2009, MSF and Save the Children-UK (SCF-UK) held a round-table meeting in Sierra Leone with key stakeholders including members of the government, donors, UN agencies, international NGOs and members of civil society.[112]

It was agreed by donors that support for free health care (including drugs, fees for service, and supplies), particularly for pregnant women and children under five, should be a priority. All participants at the meeting agreed to support the Sierra Leone government in implementing its policy of free care for pregnant women.[113]

Above: **Volunteers who carry women in labour, and others needing transport, to the nearest health facility in a hammock, Koinadugu, February 2009.**
Right: **Villagers contributing to the savings and loan scheme in Dogoloya, Koinadugu, February 2009.**

Since that meeting, the Minister of Health has been replaced and as of July 2009 the health financing system was still under review. In August 2009 the Ministry of Health announced plans for providing free care for pregnant women and children, established an advisory committee of international NGOs and donor agencies, and put an implementation plan together which was submitted to donors for funding in August.

The goal of supporting free health care is explicitly endorsed by many donors. A 2006 DFID White Paper states that the UK is committed to, "Help countries abolish user fees for basic health services, and help them tackle other barriers to access including discrimination against women." The abolition of user fees is also supported by WHO, UNFPA, UNICEF and many international NGOs.

INITIATIVES TO SUPPORT WOMEN IN PREGNANCY AND CHILDBIRTH

Support groups, called "belly women support" groups, encourage pregnant and lactating women to meet on a weekly basis to sing, cook and eat together. Health information talks and the distribution of insecticide-treated bed nets are also part of the programme. It is a place where women come together and give themselves a brief respite from the demands of cooking, farming, cleaning and caring for their families.

In Koinadugu, CARE is working with the Ministry of Health and the local government to organize such support groups. Similar initiatives are underway elsewhere, such as groups run by Save the Children in Kailihun district.

Maternal waiting houses, where women can stay in the run-up to delivery, ensure that when women go into labour they are close to a skilled birth attendant who can refer them on if necessary, and are not at the mercy of an unreliable and expensive transport system. Such waiting houses can serve as a bridge between the community and the health service in providing care for pregnant women. Currently maternal waiting houses are uncommon, except in Koinadugu district, where they have been set up because of the difficult terrain.

5/MISMANAGEMENT AND CORRUPTION

"These [health care] institutions have been overwhelmed by corrupt practices at both management and junior levels causing serious debilitating conditions in delivering health care services to the people."

Anti-Corruption Commission [114]

There are serious deficiencies in systems for monitoring and accountability across critical areas of the health system. In some areas, monitoring systems need to be set up or strengthened, in others existing systems and procedures are not being utilized. Mechanisms for accountability such as hospital boards do not function in practice, and data collection, on which monitoring and evaluation depend, is at best patchy, at worst non-existent.

In 2001, the Anti-Corruption Commission found that although considerable resources had been devoted to rejuvenating the health system by both the government and donors, "[a]pparently , a large amount of these resources have not been judiciously utilised because of years of endemic corruption".[115] In 2004, therefore, it created the Best Practice Guide on Financial Practices and Procedures for the Health Delivery System. Its 2008 review pointed to the fact that many of these practices and recommendations were still not being implemented.

The Best Practice Guide recommended the creation of a centralized revenue system with designated revenue collectors who would be expected to maintain cashbooks and issue receipts for all monies charged.[116] It also identified various officials, such as Finance Officers and Hospital Secretaries who would be responsible for monitoring the system of revenue collection and recommended that the Ministry of Health and Hospital Boards[117] carry out periodic monitoring.[118]

In 2008, the Anti-Corruption Commission produced another report, which it turned over to the Ministry of Health.[119] The Ministry of Health accepted it and is working with the Anti-Corruption Commission to implement the recommendations. The Ministry of Health promised to send quarterly reports on progress in implementing the recommendations.

The 2008 Anti-Corruption Commission report found that most hospitals did not follow the recommended centralized revenue collection system and that various hospital staff were involved in collecting revenue, at varying rates, without accounting to the finance office.[120] It

also found that the Ministry of Health did not carry out internal audits frequently and that hospital boards "have almost been relegated to moribund status".[121]

The Anti-Corruption Commission repeated its recommendation that revenue collection in all government hospitals should be centralized and deposited daily. It has also recommended that charges for various services should be publicized and that arrangements for the use of ambulances should be regularized.[122] Amnesty International was repeatedly told by women and their families that they had paid medical staff directly before receiving treatment, that they had had to negotiate the costs with the medical staff, and that they had not received a receipt, although they had carefully kept all the documents they had been given.

There are also serious problems in relation to availability of essential drugs and medical supplies and to mismanagement and corruption in the distribution of drugs. Poor inventory control management, together with poor accountability and mismanagement of drugs and supplies, have been identified as problems.[123]

Even where drugs and supplies such as blood bags are donated, they are still not readily available most of the time. Amnesty International was informed of drugs and supplies donated by the Global Fund, UNICEF and UNFPA to hospitals and health care centres being sold in pharmacies and markets.

In October 2008, UNFPA discovered that approximately US$60,000 worth of drugs donated to the Princess Christian Maternity Hospital had been siphoned off. An investigation identified staff within hospital who were involved, and although the main person responsible was removed from his post in May 2009, it was not clear if any other penalties would be imposed.

The Best Practice Guide suggests measures to improve record keeping of drugs and supplies, together with periodic stocktaking and verification.[124] The Anti-Corruption Commission has suggested that "severe punitive administrative measures must be imposed by Hospital Management teams on officers who illegally possess, sell or administer drugs".[125]

In April 2009 UNICEF announced plans to take over responsibility for drug procurement. Ministry of Health staff are to be trained simultaneously in order to be ready to resume this responsibility in 2011.[126]

The government of Sierra Leone has also itself acknowledged in its 2005 MDG report that "Medical, Nursing and Pharmaceutical Regulatory Boards and Councils, and other professional associations, are weak, and there are few enforceable rules and regulations."[127] The government has established a Medical and Dental Council to register and licence health care facilities and to monitor and periodically inspect them. However, the Anti-Corruption Commission has pointed out that this body must be given sufficient resources to carry out these tasks.[128]

DELIVERY AND CO-ORDINATION OF FUNDS

Greater efforts need to be made by the government not only to increase the allocation to the 15 per cent of national budget agreed as a minimum by African governments when they signed the Abuja Declaration in 2001, but also to deliver the amount promised in the budget. Amnesty International was repeatedly told by staff within the health system, at both national and district levels, that the sums promised were not actually received. The Anti-Corruption

Commission report also found that undue delays in receiving funds have caused extreme financial difficulties for departments and agencies.[129]

Dr Kargbo, Coordinator of the Reproductive and Child Health Directorate within the Ministry of Health, confirmed that the Ministry of Health normally receives less than 50 per cent of the amount promised by the government.[130] An international NGO representative told Amnesty International that district representatives complained that they were not receiving all the funds in their budget, making it difficult for districts to implement their plans.

Discussions with Ministry of Health staff and members of civil society revealed that they feel that there is no functioning mechanism in place to track how and whether government money is actually spent.[131]

Given the dependence of the health sector on donors for funding, there is also a need to develop system-wide competencies in the Ministry of Health, enabling it to drive forward health improvement according to agreed priorities, rather than through the piecemeal and uneven spread of donor funding.[132]

FEW, IF ANY, AVENUES OF REDRESS

The UN Committee on Economic, Social and Cultural Rights has stated that anyone who is a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. "All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition." It has also stated that "National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health."[133]

Women and their families who are victims of violations of the right to health have extremely limited access to avenues to make complaints and seek redress, either through the courts or by other means in Sierra Leone.

The 1991 Constitution does not recognize economic, social and cultural rights (as defined in the International Covenant on Economic, Social and Cultural Rights) among the fundamental rights it protects. It only acknowledges some aspects of these rights within the section devoted to Fundamental Principles of State Policy. According to Section 8 (3) of the Constitution, the "State shall direct its policy towards ensuring that… there are adequate medical and health facilities for all persons, having due regard to the resources of the State". However, unlike the fundamental rights set out in Part III of the Constitution, this provision does not confer "legal rights" which are enforceable in a court of law.[134] Failure to respect the right to health impacts on other rights such as the right to life, a right guaranteed by the Constitution.

There are few other ways in which people can complain and seek remedies. The mandate of the Human Rights Commission of Sierra Leone extends to rights embodied in the international treaties which Sierra Leone has ratified in addition to those rights that are explicitly protected under the Constitution.[135] The Commission has the mandate to investigate complaints made by any person alleging a human rights violation and to monitor and document human rights violations in Sierra Leone. However, Amnesty International is unaware of any cases related to maternal mortality taken up by the Commission.

MONITORING INITIATIVES

The role of civil society groups in monitoring the health care system and the government's use of funds is increasingly being seen as an important step in helping to reduce maternal mortality. Donors and UN agencies, including DFID, Irish Aid and UNICEF, have all made funds available to civil society groups to monitor the activities of the Ministry of Health at the local and national levels.

The Health Coalition of Sierra Leone, an umbrella organization of civil society groups from all over the country, monitors and reports on the level of care and access to services being provided in secondary and tertiary institutions. When members of a local civil society group in Kambia discovered that not all the drugs intended for the hospital actually reached it, they raised their concerns with the Ministry of Health at the national level. The Ministry of Health responded by carrying out an investigation into the diversion of drugs.

6/INTERNATIONAL AND REGIONAL HUMAN RIGHTS OBLIGATIONS

When women die in pregnancy or childbirth because the government fails to address preventable causes of maternal death, the government violates women's right to life.[136] Preventable maternal deaths and injuries also reflect violations of the rights to the highest attainable standard of physical and mental health,[137] equality and non-discrimination.[138] All of these are human rights and are protected in international and regional human rights treaties which Sierra Leone has agreed to be bound by.

THE RIGHT TO LIFE

The International Covenant on Civil and Political Rights, which Sierra Leone has ratified, guarantees that "Every human being has the inherent right to life".[139] The right to life is also guaranteed under the African Charter on Human and Peoples' Rights, to which Sierra Leone is a party.[140]

The UN Human Rights Committee has emphasized that the "inherent right to life" should not be understood in a restrictive manner and requires states to take positive measures to ensure protection of this right.[141] It has highlighted the obligation of state parties to take all possible measures to increase life expectancy.[142]

In its concluding observations and recommendations, while monitoring states' implementation of the International Covenant on Civil and Political Rights and obligations in relation to the right to life, the Human Rights Committee has consistently expressed concern over high maternal mortality rates.[143] It has recommended "So as to guarantee the right to life, the State party should strengthen its efforts in that regard, in particular in ensuring the accessibility of health services, including emergency obstetric care. The State party should ensure that its health workers receive adequate training. It should help women avoid unwanted pregnancies, including by strengthening its family planning and sex education programmes, and ensure that they are not forced to undergo clandestine abortions, which endanger their lives."[144]

THE RIGHT TO HEALTH

Everyone has "the right … to the enjoyment of the highest attainable standard of physical and mental health" including "access to medical service and medical attention in the event of sickness."

International Covenant on Economic, Social and Cultural Rights, Article 12

"[T]he right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."

UN Committee on Economic, Social and Cultural Rights[145]

The right to health is protected under a number of international and regional human rights treaties to which Sierra Leone is a state party, including the International Covenant on Economic, Social and Cultural Rights (Article 12), the Convention on the Elimination of All Forms of Discrimination against Women (Article 12), the Convention on the Rights of the Child (Article 24), and the African Charter on Human and Peoples' Rights (Article 16). The International Convention on the Elimination of All Forms of Racial Discrimination (Article 5 (e) (iv) also requires states parties to prohibit and eliminate racial discrimination and to ensure equality before the law in the enjoyment of, among other rights, the right to public health and medical care.

The Committee on Economic, Social and Cultural Rights has stated that the right to health should be understood as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health.[146] These include access to safe and drinkable water and adequate sanitation, an adequate supply of safe food and nutrition, safe and healthy working conditions and a healthy environment.[147] The Committee has clarified that the right to health also includes the right to access to information and education about health matters, including on sexual and reproductive health, and the right to participate in health-related decision-making at the community, national and international level.[148]

The Committee on Economic, Social and Cultural Rights has stated that the right to health requires that health and health care facilities, goods and services be available, accessible, acceptable and of good quality.[149] This means that:

- A sufficient quantity of health facilities, trained professionals and essential medicines must be available.

- Health facilities, goods, services and information on health must be physically and economically accessible (within easy reach and affordable) to everyone without discrimination.

- Health facilities, goods, services and information must be acceptable, that is respect medical ethics, be culturally appropriate and sensitive to gender requirements.

- Health facilities, goods, services and information must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment and adequate sanitation.

Under Article 2 of the International Covenant on Economic, Social, and Cultural Rights, the full realization of the rights recognized in the Covenant, including the right to health, should be achieved progressively, by all appropriate means, through the adoption of measures, whether individually or through economic assistance and co-operation, to the maximum of each of the states parties' resources. However, the Committee on Economic, Social and Cultural Rights has clarified a number of core obligations of states parties to ensure that at least the essential levels of each right under the Covenant are met without delay.[150] These core obligations include: ensuring the equitable distribution of all health facilities, goods and services, as well as providing essential drugs, as defined in the World Health Organization Action Programme

on Essential Drugs; and adopting and implementing a national strategy and plan of action to address the health concerns of the whole population. The Committee has stated that the obligation to ensure reproductive and maternal (prenatal as well as postnatal) health care is of comparable priority to a core obligation. This also extends to the obligation to provide appropriate training for health personnel, including education on health and human rights.

The Committee on Economic, Social and Cultural Rights has stated that, "A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12 [the right to health]. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above".[151] The Committee has emphasized that even in times of severe restraints in resources, the most vulnerable members of society can and must be protected by the adoption of relatively low cost programmes.[152]

THE RIGHT TO MATERNAL, SEXUAL AND REPRODUCTIVE HEALTH

Both the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women have clarified that the realization of women's right to health requires the removal of all barriers interfering with "access to health services, education and information, including in the area of sexual and reproductive health."[153] The Committee on the Elimination of Discrimination against Women has stated that "Barriers include requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport."[154]

The Committee on the Elimination of Discrimination against Women has also affirmed that "access to health care, including reproductive health is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women".[155] The Committee also said that Article 12 "requires States to eliminate discrimination against women in their access to health care services, throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period[156]… Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women".[157]

As discussed earlier, the Committee on Economic, Social and Cultural Rights has stated that the obligation to ensure reproductive and maternal (prenatal as well as postnatal) health care is of comparable priority to a core obligation. It has also emphasized that governments are required to "improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."[158]

Under a number of international treaties to which Sierra Leone has voluntarily bound itself, women are entitled to a range of health services which play an important role in improving maternal health, including:

- primary health care services throughout a woman's life;[159]

- education and information on sexual and reproductive health;[160]
- sexual and reproductive health care services, such as family planning services;[161]
- prenatal health services;[162]
- skilled medical personnel to attend the birth;[163]
- emergency obstetric care;[164] and
- postnatal health services.[165]

The Convention on the Elimination of All Forms of Discrimination against Women guarantees the right of women, on the basis of equality with men, to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.[166] The Committee on the Elimination of Discrimination against Women has stated that "Studies such as those which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care."[167] It has emphasized the obligation of states to "prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance."[168]

The UN Special Rapporteur on the right to the highest attainable standard of health has also clarified that "The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements." The Special Rapporteur continued, "In the context of sexual and reproductive health, freedoms include a right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (such as forced sterilization and forced abortion), female genital mutilation/cutting and forced marriage, all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health."[169] An example of an entitlement is "women should have equal access, in law and fact, to information on sexual and reproductive health issues".[170]

The Special Rapporteur has also stated that "Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible. In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed."[171]

According to the Beijing Declaration and Platform for Action: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."[172]

The Committee on the Elimination of Discrimination against Women has also stressed the obligations of states parties to address gender-based violence, which it considers to be a critical health issue for women, including by taking action to prevent and punish violations of rights by private individuals and organizations, enactment and effective enforcement of laws, and gender-sensitive training of health workers.[173] The obligations extend to the enactment and effective enforcement of laws to prohibit female genital mutilation, forced marriages and marriages of girl children.[174]

Sierra Leone has not yet ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.[175] However, this Protocol – the result of the work of African human rights and women's rights organizations – provides an important reference to guide the government of Sierra Leone on what women's human rights require in the context of maternal health.

The Protocol sets out the positive steps governments must take to ensure that women's rights to sexual and reproductive health are respected and promoted. Women must live free of gender-based violence and enjoy respect for their lives; for the integrity and security of their person; for their right to decide whether to have children, and if so, the number of children and the spacing of children; and for their right to the information and care they need during pregnancy, childbirth and motherhood. This includes the provision of adequate, affordable and accessible health services. It also includes information, education and communication programmes to women, especially those in rural areas, and the establishment and strengthening of existing prenatal, delivery and postnatal health and nutritional services for women during pregnancy and while they are breastfeeding. The Protocol also requires states to prevent maternal deaths by "authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[176]

In November 2008 the African Commission on Human and Peoples' Rights adopted a resolution to address maternal mortality in Africa. The resolution acknowledged that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality, a right enshrined in the African Charter on Human and Peoples' Rights and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. It calls on African governments to individually and collectively address the issue of maternal mortality.[177]

The UN Human Rights Council also adopted a resolution on maternal mortality and morbidity in June 2009, in which it recognized that most instances of maternal mortality and morbidity are preventable and "requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health".[178]

THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

The International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and the African Charter on Human and Peoples' Rights prohibit discrimination on the grounds of sex in relation to all the rights contained in these

treaties.[179] Under the International Covenant on Civil and Political Rights, there is also a self-standing right to equality and non-discrimination.[180] The Convention on the Elimination of All Forms of Discrimination against Women requires state parties to eliminate discrimination against women in all its forms.[181] As noted earlier, the Committee on the Elimination of Discrimination against Women has stated that "Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women."[182]

The government of Sierra Leone is therefore required to respect, protect and fulfill the right to non-discrimination, by ensuring that its laws and practices are not discriminatory, by protecting individuals from discrimination by third parties and by taking necessary legislative, administrative, budgetary, judicial and promotional measures to ensure the full realization of the right to non-discrimination. Its obligation to eliminate discrimination against women requires it:

- to incorporate the principle of equality of men and women in the legal system and adopt legislative and other measures prohibiting discrimination against women;[183]

- to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;[184]

- to establish tribunals and other public institutions to ensure the effective protection of women against discrimination;[185] and

- to ensure elimination of all acts of discrimination against women by individuals, organizations or enterprises.[186]

7/CONCLUSIONS AND RECOMMENDATIONS

Yerie Marah should still be alive today. Like so many other women in Sierra Leone, she died needlessly from a treatable complication of childbirth.

She needed access to good quality antenatal care. She needed prompt access to quality emergency obstetric care when complications arose. She needed to hear from the state that lack of money would not prevent her getting the life-saving treatment she needed. For its part, the government needed to fulfil its obligation to ensure that quality care was available and accessible.

But for Yerie, like the majority of Sierra Leonean women, none of this was within her reach.

The number of maternal deaths in Sierra Leone is a reflection of the many barriers faced by women in accessing maternal health care services. These barriers include the unavailability and inequitable distribution of health services, including skilled health personnel and emergency obstetric services; insufficient drugs, medical equipment and supplies; a poorly equipped and inadequate referral system; lack of adequate training and supervision of medical personnel; the lack of skilled attendance at births; the lack of transport to reach health facilities; and the cost of health care.

The husband and surviving daughter of Yerie Marah, February 2009.

Even though the government adopted a policy in 2002 exempting pregnant women and other vulnerable groups from paying fees for basic health services, financial barriers continue to block many women's access to life-saving health care. The government has failed to put systems and resources in place to implement its exemptions policy – it has not budgeted for it, has not publicized it and does not monitor its implementation. Women and their families are therefore charged for essential drugs, medical supplies and services which the government has stated should be free.

The failure to regularize the status of many health workers who work in the system without being paid salaries, or to improve the working conditions of health workers, has resulted in widespread corruption and arbitrary charges. This has untold impact on the quality and availability of health care. The fear of costs, and the refusal of some health workers to treat women without payment even in an emergency, leads to deadly delays in the decision to seek or receive care.

The discrimination experienced by women across many areas of their lives and their generally low social status lessen their ability to determine the number and timing of their pregnancies, and contribute to a situation where they may be sidelined in decisions about accessing health services. Practices such as early and forced marriage and female genital mutilation increase the risks women face in pregnancy and childbirth.

The decentralization of health services needs more work to clarify accountability, roles and responsibilities and to ensure effective management and distribution of budgets and other resources needed for the health system to function effectively. The government has failed to put in place adequate measures to prevent corruption and mismanagement and has not implemented crucial recommendations of the Anti-Corruption Commission. If women suffer violations of their rights within the health system, they and their families have limited or no avenues to make complaints and seek redress.

The government has taken some positive steps. It has developed a comprehensive Reproductive and Child Health Strategic Plan, which aims to address many of the barriers to maternal health care which this report has documented. It has created a Reproductive and Child Health Unit within the Ministry of Health and staffed it appropriately. Seeking technical assistance from UN agencies and donors, it has undertaken numerous assessments of the health system, including the Nationwide Needs Assessment for Emergency Obstetric and Newborn Care Services in Sierra Leone. Based on these findings and in consultation with key partners, UNFPA is working closely with the Ministry of Health, with funding from donors including DFID, the World Bank and the African Development Bank, to provide comprehensive emergency services in seven districts.

Donors are committed to ensuring that the Reproductive and Child Health Strategic Plan, estimated to cost approximately US$282 million from 2008 to 2010, is implemented. DFID has also committed to supporting the government of Sierra Leone by providing technical assistance aimed at helping the Ministry of Health to be in a better position to implement the Plan and deliver its objectives.

These are welcome steps, and the government must move quickly to implement them. In the meantime, women in Sierra Leone like Yerie Marah continue to be denied their right to life-saving reproductive and maternal health care.

In order to reduce the number of women dying from treatable complications of pregnancy and childbirth, the government of Sierra Leone must ensure women's access to good quality and affordable health care; take steps to challenge cultural beliefs and social practices that threaten women's lives; and create a situation where women can make autonomous decisions concerning their fertility and reproductive lives.

Donors also have an important role to play in assisting the government of Sierra Leone to fulfil its obligations in relation to the right to health. The Committee on Economic, Social and Cultural Rights has stated that, "Depending on the availability of resources, States should

facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required".[187]

RECOMMENDATIONS

Any plan to address maternal mortality in Sierra Leone must, at a minimum, include the following components:

1. ENSURE THAT COSTS ARE NOT A BARRIER TO ESSENTIAL HEALTH SERVICES, INCLUDING EMERGENCY OBSTETRIC CARE AND OTHER REPRODUCTIVE HEALTH SERVICES

Costs are a principal barrier to women's access to reproductive health services, including emergency obstetric care. Life-saving treatment, including drugs, should be provided free of charge for pregnant women.

- The Ministry of Health should ensure that the policy exempting vulnerable groups, including pregnant and lactating women, from payment of fees for essential drugs and services, including emergency obstetric services, is implemented across all health facilities. The government should take immediate measures to publicize the policy.

- The government should implement the recommendations of the Anti-Corruption Commission in relation to centralized revenue collection, displaying and announcing any charges that can be levied for health services and creating robust monitoring and accountability systems.

- The Reproductive and Child Health Strategic Plan should specify how its implementation will support the policy exempting vulnerable groups, including pregnant and lactating women, from payment of fees for services and drugs.

2. INCREASE THE AVAILABILITY AND ACCESSIBILITY OF SKILLED ATTENDANTS IN CHILDBIRTH

More than 80 per cent of women give birth at home without a skilled birth attendant, and have no access to appropriate care when a complication arises. The Ministry of Health should:

- increase the number of skilled birth attendants through training more midwives, maternal and child health aides and other relevant staff and upgrading the training of existing staff;

- provide incentives to promote an equitable distribution of skilled medical personnel throughout the country.

3. IMPROVE THE AVAILABILITY AND ACCESSIBILITY OF ESSENTIAL HEALTH SERVICES, INCLUDING EMERGENCY OBSTETRIC CARE

Even if women reach health care facilities, needed services may not be available. Most facilities, especially in rural areas, lack sufficiently qualified staff, supplies, blood services

and drugs. Six of 13 health districts have no emergency obstetric services. In line with its commitments under the Abuja agreement and under the Reproductive and Child Health Strategic Plan, the government of Sierra Leone should allocate 15 per cent of its national budget to health each year and ensure that the full amount is disbursed in a timely manner.

- The government should allocate sufficient financial and technical resources to implement the Reproductive and Child Health Strategic Plan commitment that by 2010, all districts will implement a basic package of essential health care services.

- The Ministry of Health should implement the recommendations of the Nationwide Needs Assessment for Emergency Obstetric and Newborn Care Services in Sierra Leone to ensure that every district has at least one hospital providing comprehensive emergency obstetric care, and that 70 peripheral health units are providing basic emergency obstetric care.

- The Ministry of Health should take immediate steps to ensure that health care staff currently working in the health care system without salaries are regularized as part of the civil service and receive adequate remuneration, in line with staffing requirements for specific health facilities.

- The Ministry of Health should increase the recruitment, retention, morale and training of staff, including improving the retention of health care workers in rural areas. It should take all possible measures to improve the working conditions and salaries of health care workers.

- The Ministry of Health should give staff adequate training and support, and ensure that their activities are supervised by more senior staff.

- The Ministry of Health should ensure the equitable distribution of blood, drugs, and other supplies throughout the country.

4. IMPROVE REFERRAL NETWORKS

Lack of communications between health facilities, lack of transport to carry patients, and the high costs of being referred combine to render the referral system largely dysfunctional.

- The Ministry of Health and district health authorities should strengthen linkages between all tiers of the health service by providing communications and transport equipment.

5. ENHANCE MONITORING AND ENSURE ACCOUNTABILITY

It is the responsibility of the government to address corruption and mismanagement within the health care system by establishing functioning, accountable institutions and systems. Civil society needs to play an active role in monitoring the health care system.

- The government must ensure that the national budget allocated to health is actually received by the Ministry of Health and by the district authorities, and that an appropriate proportion is devoted to reproductive health care services, including emergency obstetric care.

- Periodic assessments of progress on the UN process indicators set out in the Nationwide Needs Assessment for Emergency Obstetric and Newborn Care Services in Sierra Leone should be conducted at least once a year. The results should be widely disseminated to health care providers and the public.

- The collection of information on the number and causes of maternal deaths should be improved, including through maternal death audits. Relevant health care staff should be trained in data collection and there should be a system of accountability set up to make sure data are accurately and routinely gathered.

- The implementation of the Reproductive and Child Health Strategic Plan should be monitored by mechanisms which provide for the involvement and participation of women who use reproductive and maternal health services, other community members and civil society, in planning, monitoring and evaluation processes.

- The recommendations of the Anti-Corruption Commission should be implemented. Monitoring and accountability mechanisms should be strengthened, including through systems to reduce corruption and mismanagement in procurement, storage and distribution of drugs and supplies. Any complaint mechanisms should be readily accessible to people and well publicized.

- Medical regulatory bodies should be resourced to enable them to monitor, licence, register and regulate medical health facilities and professionals.

- The government should provide avenues for women and their families to seek redress, judicial and other remedies.

- The government should work closely with donors and international agencies to strengthen its systems so that they are accountable, transparent and viable. Key priorities include civil service reform, building the leadership and management capacity of the Ministry of Health at the central and district levels, assistance in putting effective drug procurement systems in place and, in the longer term, improved health information systems.

6. INFORM THE PEOPLE

The Ministry of Health should work with all stakeholders, including civil society, international and local NGOs, traditional leaders and community-based organizations, to increase transparency and to enhance health awareness. The government should:

- carry out a nationwide media and public education campaign to raise awareness among the population on:

    - the importance of family planning;

    - the need for urgent treatment of pregnancy-related complications;

    - the importance of skilled birth attendants during childbirth;

- the government's commitments and plans including the policy of free care for pregnant and breastfeeding women and the Reproductive and Child Health Strategic Plan;
- mechanisms for complaints and redress; and
- the right to health;

- launch a nationwide media campaign to publicize the policy exempting vulnerable groups, including pregnant and lactating women, from payment of fees for services and drugs;

- run education and awareness campaigns promoting the importance of skilled attendance in childbirth, but repeal village by-laws that make it illegal for women to give birth at home.

7. ADDRESS DISCRIMINATION AGAINST WOMEN AND HARMFUL PRACTICES

The government has an obligation to take all appropriate measures to end discrimination against women in all its forms, including the elimination of customary practices which are harmful to women, or which are based on stereotyped roles for men and women and reinforce the subordination of women. The government should:

- carry out a nationwide sensitization campaign to raise awareness of the Child Rights Act which prohibits early marriage and the 2007 gender laws on marriage, succession, inheritance, and sexual offences. The government should implement and enforce these laws;

- resolve the contradiction between provisions of the Child Rights Act that prohibit marriage under the age of 18 and Section 2 (2) of the Registration of Customary Marriage and Divorce Act that permits marriage under 18 years with parental consent;

- take steps to eradicate the practice of female genital mutilation by implementing the Child Rights Act 2007, section 33 (1), which makes the practice of child initiation an act punishable by law, by amending the law to prohibit the practice completely and by raising awareness of the inherent dangers of the practice.

8. ACCEPT AND HONOUR DOMESTIC AND INTERNATIONAL COMMITMENTS

Sierra Leone should recognize the right to health under domestic law, ensure that it is enforceable in courts of law and that effective remedies for victims of violations of this right are available.

- Sierra Leone should ratify the Protocol to the Africa Charter on Human and Peoples' Rights on the Rights of Women in Africa and once ratified should undertake measures to incorporate it into domestic law, including through amending internal laws to conform to the provisions of the Protocol.

- Sierra Leone should sign and ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, once it is open for signature, allowing the right of individual petition.

■ The government should encourage the Human Rights Commission of Sierra Leone and the National Ombudsman to address violations of the right to health as part of their work and ensure that systems to submit information about violations are accessible and well publicized.

9. DONOR GOVERNMENTS AND INTERNATIONAL AGENCIES SHOULD TREAT MATERNAL MORTALITY IN SIERRA LEONE AS AN URGENT HUMAN RIGHTS ISSUE

Amnesty International calls on donors, others governments and international agencies to:

■ continue to work with the government of Sierra Leone to put in place effective monitoring and accountability mechanisms in order to ensure that resources for health care, including those provided for through international assistance, are fully accounted for in a transparent manner, are distributed equitably and prioritize the most vulnerable and marginalized;

■ as a matter of urgency, ensure the effective co-ordination of efforts among donor agencies to work with the government of Sierra Leone to overcome barriers to the implementation of Sierra Leone's Reproductive and Child Health Strategic Plan;

■ ensure that financial and technical assistance to the government of Sierra Leone for health prioritizes support for efforts to remove financial and other barriers to women's access to health services;

■ support efforts to improve the training, recruitment, retention and working conditions of health workers, particularly in rural areas;

■ ensure that technical assistance is directed, among other priorities, to improving data collection in the health system, including through maternal death audits, in order to inform sexual and reproductive health planning, policy and practice;

■ provide international co-operation and assistance to the government of Sierra Leone to help fulfil the right to the highest attainable standard of health in Sierra Leone, through strengthening the health system and ensuring the prioritization of access to essential health care for the most marginalized and vulnerable.

APPENDIX 1/THE SIERRA LEONE HEALTH SYSTEM

The health care system in Sierra Leone has been undergoing a process of decentralization since 2004. The legal framework is provided by the Hospital Boards' Act of 2003 and the Local Government Act of 2004.

There are 19 Local Councils in Sierra Leone's 13 districts (12 district councils, 5 town councils, the Freetown City Council and the Western Area Rural Council) responsible for managing primary health care services. They cover the four administrative regions: Freetown and the Western area, Northern region (Bombali, Tonkolili, Kambia, Koinadugu, Port Loko), Southern region (Moyamba, Bo, Pujehun, and Bonthe) and Eastern region (Kono, Kailihun, and Kenema).

The 13 District Health Management Teams (DHMTs) are in charge of service delivery. They plan, organize, manage, implement, monitor and supervise health programmes in their districts. The DHMTs make yearly plans which they present to the Ministry of Health for funding. DHMTs are in charge of primary health care, and secondary health care is in the process of being devolved to the districts. A District Medical Officer (DMO) oversees health care delivery at the district level and heads the DHMT.

All Local Councils have a health committee and a Local Government Finance Department (LGFD). These are responsible for developing a health plan and budgets that are reviewed by the DHMTs, and then approved by both the Local Council and the Ministry of Health. The plans are submitted to the Ministry of Health and the Ministry of Finance and Economic Development (Ministry of Finance) for funds.

The Ministry of Health has an overall leadership and co-ordination role among donors and other key stakeholders. It is responsible for the formulation of health sector plans and policies, setting and monitoring sector performance standards and mobilization of resources. It is in direct charge of tertiary institutions. All aspects of the employment of health care workers are centrally controlled: recruitment is organized by the Ministry of Health, absorption into the civil service is controlled by the Establishment Secretary, and the payroll is administered by the Ministry of Finance. Under the Minister of Health are a Chief Medical Officer and various departments including the Reproductive and Child Health Directorate, a newly created department within the Ministry of Health to provide guidance on strategies and implementation of the Reproductive and Child Health Strategic Plan.

Within the districts, peripheral health units (PHUs) offer primary health care. These comprise Community Health Centres (CHCs), staffed by Community Health Officers (CHOs), Community Health Posts (CHPs), staffed by State Enrolled Community Health Nurses (SECHNs), and at the most basic level, Mother and Child Health Posts (MCHPs) staffed by maternal and child health aides (MCH aides). Each of the 13 districts has one government hospital. There are also a number of private hospitals and health care centres run by religious organizations and other national and international organizations.

Tertiary health care services have not yet been decentralized. The Princess Christian Maternal Hospital is the tertiary institution for maternal and child health.

As of 2007, there were approximately 97 NGOs registered within the health sector. It is estimated that the Ministry of Health provides 50 per cent of health care services. The rest is provided by NGOs and the private sector.[188] All private institutions, including local and national NGOs, religious organizations and donors, are required to register with the financial and planning departments within the Ministry of Health.[189]

APPENDIX 2/FINANCING THE HEALTH CARE SYSTEM

Health care in Sierra Leone has three main sources of finance: government, household out of pocket payments, and donors.

The National Health Accounts estimate that private spending on health care in 2007 (by individuals in the household) came to US$45 per capita per year and public spending (by the government and donors) was US$16 per capita.[190]

The health sector is substantially dependent on donors for funding. It is estimated that between 2004 and 2007, donors spent approximately Le128 billion (US$40 million), amounting to US$9 per capita.[191]

Public spending is financed partly from the consolidated fund[192] (22 per cent) and partly by external projects (78 per cent).[193] Donors, primarily DFID, the World Bank, the EU and the African Development Bank, provide about 20 per cent of the government's overall budget in terms of unearmarked support. It is unclear how much of this is allocated to the Ministry of Health.

Figures on government financing for the health system vary and are hard to compare. While the Ministry of Health stated in February 2008 that the government allocated 14.85 per cent of its 2007 recurrent budget to the health sector,[194] government representatives told Amnesty International that the total amount budgeted for health for 2008 was between 7.8 and 10 per cent of the national budget.[195] This amounted to approximately US$10 million, and did not include staff salaries paid by the Ministry of Finance.

DONOR FUNDING FOR THE REPRODUCTIVE AND CHILD HEALTH STRATEGIC PLAN

The overall cost of implementing the Reproductive and Child Health Strategic Plan between 2008 and 2010 is estimated at approximately US$282 million.[196] A high proportion of the estimated costs are allocated to direct expenditure in health facilities, including transportation, logistics, drugs, supplies and communications, and on human resources, including staff remuneration, health insurance, transport, housing allowances and training. Recognizing the need for salaries to be increased, the plan includes estimates for the cost of quadrupling salaries and of providing incentives for those working in high risk and rural postings.[197] One of its strategies is to "work with others on removing financial and other barriers to accessing health services".[198]

A major challenge to the programme is to develop system-wide competencies in the Ministry of Health, enabling it to drive forward health improvement according to agreed priorities, rather than through the piecemeal and uneven spread of donor funding.[199]

To date, the Reproductive and Child Health Strategic Plan has largely been funded by a group of donors. The World Bank through its Africa Catalytic Growth Fund has committed US$30 million in two phases. In 2008 the World Bank allocated approximately US$3 million for vehicles and computers. The World Bank mainly works through Local Councils.[200] Other donors such as Irish Aid have committed funds, largely through UN agencies. In 2008 Irish Aid provided funding for the nationwide needs assessment survey. In June 2009, UNICEF provided US$800,000 to districts for supervisory purposes, drugs and supplies, and for maternal death audits.

The Japanese aid agency JICA, the EU and international NGOs provide technical and financial resources to the health sector, as do UNICEF, WHO, UNFPA, WFP, UNAIDS and UNDP.[201]

DFID has committed to providing £50 million over 10 years for the Reproductive and Child Health Strategic Plan.[202] By February 2009, it had released approximately £0.5m (US$753,000), largely for technical support.

In April 2009 DFID announced £16 million (US$24 million) of support for the Reproductive and Child Health Strategic Plan to go to:[203]

- emergency obstetric care (including access to medical facilities, trained midwives and advice on family planning) as well as the promotion of immunization and of a feeding programme to tackle malnutrition;

- primary health clinics and district hospitals. DFID and the World Bank are due to create a pooled fund to provide health care facilities run by district councils with direct funding to deliver basic health services;

- effective resource management to ensure effective financial management and monitoring of how resources are spent;

- short-term funding provided to a group of NGOs to ensure the Reproductive and Child Health Strategic Plan is implemented as quickly as possible in five priority districts (Bo, Tonkolili, Bombali, Koinadugu, Kono). DFID also announced in April 2009 that it would support these districts in providing emergency obstetric care.[204]

Approximately one third of the funds are to go directly to the Reproductive and Child Health Directorate.[205]

Despite the importance of referral hospitals, there is little reference to tertiary institutions (the third level of health care) in the Reproductive and Child Health Strategic Plan. In discussions with donors, it seemed that tertiary institutions were not their priority and the focus of their funding was on secondary and primary care. However, UNFPA is currently donating drugs to the Princess Christian Maternity Hospital, the country's only tertiary level maternity hospital.

ENDNOTES

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2 Paul Hunt and Judith Bueno de Mesquito, *Reducing maternal mortality, The contribution of the right to the highest attainable standard of health*, UNFPA, p8.

3 UNICEF 2006 situational analysis.

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6 *Reproductive and Child Health Program, Ministry of Health and Sanitation, Nationwide Needs Assessment for Emergency Obstetrics and Newborn Care Services in Sierra Leone*, 2008, p1. (Hereafter, Nationwide EmONC Needs Assessment.)

7 Nationwide EmONC Needs Assessment, p1.

8 *The Sierra Leone Demographic Health Survey 2008, Preliminary Report* gives a figure of 5.1, but states that in rural areas it is higher. *The Nationwide Needs Assessment for Emergency Obstetrics and Newborn Care Services in Sierra Leone*, gives a figure of 6.1 (p1).

9 Nationwide EmONC Needs Assessment.

10 *Ministry of Health and Sanitation, Reproductive And Child Health Strategic Plan 2008-2010*, Volume III, Reproductive health programme norms and standards, 2008, p13.

11 In addition, although women make up 52 per cent of the population their participation in politics is limited: 14.5 per cent of members of parliament are women, and only three of 21 cabinet ministers. Just two of Sierra Leone's 22 ambassadors and two of its 19 magistrates are female.

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13 RCHSP p. 24.

14 All People's Congress, political party manifesto, 2007 p13.

15 Interview with Abdul Tejan Cole, head of the Anti-Corruption Commission, Freetown, April 2008. The mandate of the Anti-Corruption Commission is to examine the practices of public bodies in order to facilitate the discovery of corrupt practices or acts of corruption and to secure revision of those practices and procedures which in the opinion of the Commission may lead to or be conducive to corruption or corrupt practices.

16 Nationwide EmONC Needs Assessment.

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18 *Witness to Truth: Report of the Sierra Leone Truth and Reconciliation Commission Vol 3* A, p80.

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20 Figure for 2007, UN data, accessed July 2009, http://data.un.org/CountryProfile.aspx?crName=Sierraper cent20Leone.

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23 2004 Sierra Leone Poverty Reduction Strategy Paper.

24 CAFOD, *Local perspectives on Gender: Liberia and Sierra Leone*, July 2008, CAFOD and Christian Aid, p41.

25 UNICEF, http://www.unicef.org/infobycountry/sierraleone_statistics.html.

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prospective study in six African countries", WHO Journal paper, also published in *The Lancet* 2006;367:1835–1841.

33 Amnesty International, *Sierra Leone: Gender laws mean greater rights and protection for women*, Index: AFR 51/002/2007.

34 Child Rights Act 2007, sec. 35, p18.

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40 Sierra Leone Poverty Reduction Strategy Paper (SL-PRSP) p 29.

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43 As cited in RCHSP, p23.

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45 See RCHSP, p25.

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59 RCHSP, p25.

60 Nationwide EmONC Needs Assessment, p32.

61 http://hdr.undp.org/en/reports/nationalreports/africa/sierraleone/sierraleone_nhdr_20071.pdf

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71 CESCR General Comment 14, para 43 (e).

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73 While the UN guidelines require the fatality rate to be less than 1 per cent, the needs assessment survey found a case fatality rate of 7 per cent in Sierra Leone. The study qualifies this figure by stating that poor record-keeping for obstetric complications and even poorer maternal death records make it very difficult to rely on case fatality rates for Sierra Leone, p73.

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76 Anti-Corruption Commission, *Recommendations for Reform Towards a Better Health Care Delivery System*, 2008. (Hereafter Anti-Corruption Commission Report.)

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79 Anti-Corruption Commission Report, pp 25-26.

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81 Anti-Corruption Commission Report, pp 8, 14 and 18.

82 Anti-Corruption Commission Report, pp. 8, 23.

83 *Sierra Leone Demographic and Health Survey 2008, Preliminary Report*, Statistics Sierra Leone, Measure DHS, December 2008, p.79

84 Nationwide EmONC Needs Assessment, p79.

85 A skilled attendant is an accredited health professional who has been educated and trained to proficiency in the skills needed to manage uncomplicated pregnancies, childbirth, and the immediate postnatal period, and the identification, management, and referral of complications in women and newborns.

86 The 2008 needs assessment survey found that only 17 per cent of respondents involved in providing care in pregnancy and childbirth mentioned all the signs required for prompt diagnosis of post partum haemorrhage and only 20 per cent mentioned all the vital interventions required. There were similar findings for the other leading causes of death in pregnancy including retained placenta and post partum sepsis.

87 Nationwide EmONC Needs Assessment, 2008, p.1

88 Government of Sierra Leone, Ministry of Health and Sanitation, Report on an Assessment of the Sierra Leonean Health Information System, October, 2006, p. 27, available at: http://www.who.int/healthmetrics/library/countries/hmn_sle_his_2007_en.pdf

89 Government of Sierra Leone, Ministry of Health and Sanitation, Report on an Assessment of the Sierra Leonean Health Information System, October, 2006, p. 10

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96 Tim Ensor, Tomas Lievens, Mike Naylor, Oxford Policy Management, *Review of Financing of Health in Sierra Leone and the development policy options Final report*, 2008, p15.

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99 CESCR General Comment 14, para 12 (b).

100 CESCR General Comment 14, para 44 (a).

101 CESCR General Comment 14, para 21.

102 CEDAW, General Recommendation 24, para 27.

103 However, this interpretation is not based on any official document. Interview with Dr Kargbo, Coordinator, Reproductive and Child Health Directorate, Ministry of Health and Sanitation, Freetown, April 2009.

104 Nationwide EmONC Needs Assessment, p78.

105 Nationwide EmONC Needs Assessment, p81.

106 Anti-Corruption Commission Report, p12.

107 The Anti-Corruption Commission recognized this as a problem and recommended that price lists for services and drugs be made publicly available.

108 Nationwide EmONC Needs Assessment, p33.

109 Nationwide EmONC Needs Assessment, p1.

110 Nationwide EmONC Needs Assessment, p20.

111 A project of the Office of the First Lady, Women In Safer Health or WISH initiative, has been developed to reduce the level of maternal mortality through advocacy, training, development of women's groups and building and equipping birthing homes.

112 For more information, see Report of the Roundtable, "Suppression of patients' financial participation to care: New policies to increase the use of health services", Report by MSF and SCF-UK, 29 January 2009.

113 The meeting agreed a timeline and action plan that included the following components: the Minister of Health would call a co-ordination meeting by 17 February 2009 with the Health Financing Task Force; all health partners would meet to co-ordinate support for initiatives; free care for pregnant women would be considered an urgent short-term strategy while long-term health financing options such as social health insurance are developed; all stakeholders would support the government to ensure quality health systems that are managed, financed, supported and prioritized at national and district level; and mechanisms would be established to ensure that community voices are heard and acted upon. However, there was little clarity about precisely what was meant by "free care", either at the meeting or in subsequent discussions with members of SCF-UK in Sierra Leone.

114 Anti-Corruption Commission Report, p6.

115 Anti-Corruption Commission Report, p31.

116 Anti-Corruption Commission Report, pp32–33.

117 The Hospital Boards Act, 2003 provided for Hospital Boards to be created to maintain standards of medical care, training, management and administration and to recommend to the Ministry

the fees to be charged for the services rendered by the hospital.

118 Anti-Corruption Commission Report, pp32, 41.

119 Anti-Corruption Commission Report.

120 Anti-Corruption Commission Report, p7.

121 Anti-Corruption Commission Report, p9.

122 Anti-Corruption Commission Report, pp12-13.

123 Technical Group Appraisal of the RCH Document, May 2008, p18.

124 Technical Group Appraisal of the RCH Document, pp36-37.

125 Technical Group Appraisal of the RCH Document, p 14.

126 Meeting with Dr Kargbo, Coordinator, Reproductive and Child Health Directorate, April 2009.

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133 CESCR General Comment 14, para 59.

134 Section 14 of the Constitution provides that: "Notwithstanding the provisions of Section 4, the provisions contained in this Chapter shall not confer legal rights and shall not be enforceable in any court of law, but the principles contained therein shall nevertheless be fundamental in the governance of the State, and it shall be the duty of Parliament to apply these principles in making laws."

135 Human Rights Commission of Sierra Leone Act 2004, Section 1.

136 Article 6, ICCPR.

137 Article 12, ICESCR.

138 Article 12, CEDAW, Article 5 (e) (v) of the International Convention on the Elimination of All Forms of Racial Discrimination.

139 Article 6, ICCPR.

140 Article 4, African Charter on Human and Peoples' Rights.

141 Human Rights Committee General Comment 6, adopted 30 April 1982, available at: http://www2.ohchr.org/english/bodies/hrc/comments.htm, para 5.

142 Human Rights Committee General Comment 6, 1982, para 5.

143 See for example, Concluding Observations of the Human Rights Committee on Zambia, CCPR/C/ZMB/CO/3/CRP.1, 2007, para 18. For other examples see Centre for Reproductive Rights, *Bringing Rights to Bear: Preventing Maternal Mortality and Ensuring Safe Pregnancy*, October 2008, available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_Maternal%20Mortality_10.08.pdf, pp 9, 30.

144 Concluding Observations of the Human Rights Committee on Mali, CCPR/CO/77/MLI, 16 April 2003, para 14.

145 CESCR General Comment 14, para 9.

146 CESCR General Comment 14, para 11.

147 CESCR General Comment 14, paras 11 and 4.

148 CESCR General Comment 14, para 11.

149 CESCR General Comment 14, para 12.

150 CESCR General Comment 14, para 43.

151 CESCR General Comment 14, para 47.

152 Committee on Economic, Social and Cultural Rights, General Comment 3, HRI/GEN/1/Rev.7, para 12.

153 CESCR General Comment 14, para. 21; Committee on the Elimination of Discrimination Against Women, General Recommendation 24, available at http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24, para 31 (b). (Hereafter CEDAW Committee, General Recommendation 24).

154 CEDAW Committee, General Recommendation 24, para 21.

155 CEDAW Committee, General Recommendation 24, para 1.

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157 CEDAW Committee, General Recommendation 24, para 11.

158 CESCR General Comment 14, para. 14.

159 CESCR General Comment 14, para 21; CEDAW General Recommendation 24, para 8.

160 CESCR General Comment 14, para 11; CEDAW General Recommendation 24, para 18.

161 CEDAW Article 12; CESCR General Comment 14, para 14.

162 CESCR General Comment 14, para 14; CEDAW Article 12; CRC, Article 24.2b.

163 CESCR General Comment 14, para 12 (d) and para 36. These paragraphs refer to "skilled medical personnel" in a general sense (para 14) and then "sexual and reproductive health", among other things (in para 36).

164 CESCR General Comment 14, para 14.

165 CESCR General Comment 14, para 14; CEDAW Article 12; CRC, Article 24.2b.

166 Article 16 (1) (e).

167 CEDAW Committee, General Recommendation 24, para 17.

168 CEDAW Committee, General Recommendation 24, para 31 (c).

169 Report of The Special Rapporteur on the right of everyone to the

enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Commission on Human Rights, E/CN.4/2004/49, 16 February 2004, paras 24 and 25. (Hereafter Special Rapporteur's 2004 report on the right to health.)

170 Special Rapporteur's 2004 report on the right to health, para 28.

171 Special Rapporteur's 2004 report on the right to health, para 30.

172 Beijing Declaration and Platform for Action, para 96.

173 CEDAW Committee, General Recommendation 24, para 15.

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179 Article 2, ICCPR, Article 2, ICESCR, Article 2, ACHPR.

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182 CEDAW Committee, General Recommendation 24, para 11.

183 Article 2 (a) and (b), CEDAW, Article 26, ICCPR.

184 Article 2 (f), CEDAW.

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200 In early 2009 the World Bank was preparing a six-year Adaptable Program Loan to support service delivery in health, education and water and sanitation. It will channel funds directly to Local Councils (LCs). LCs will work directly with Ministry of Finance and Economic Development. A capacity building and technical assistance component will address local planning and management needs.

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204 According to the nationwide needs assessment survey, however, Bombali and Bo are already relatively well endowed with EmOC services.

205 In June 2009 DFID tendered for a company to provide technical expertise to strengthen systems and build capacity within the Ministry of Health to ensure an effective and accountable financial system, a sound human resource plan and a well managed and coordinated RCH Directorate.

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OUT OF REACH
THE COST OF MATERNAL HEALTH IN SIERRA LEONE

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