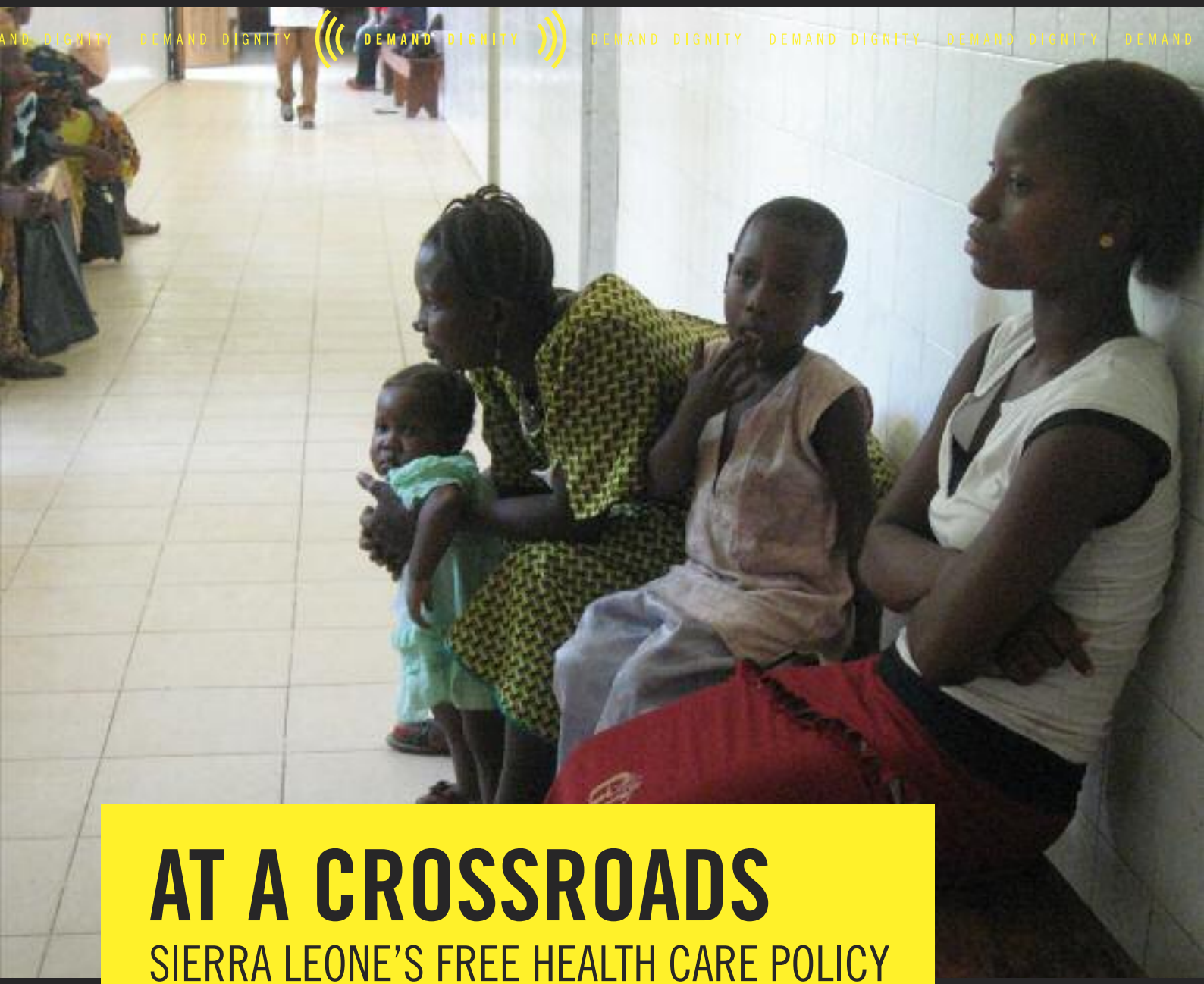

AT A CROSSROADS

SIERRA LEONE'S FREE HEALTH CARE POLICY

HEALTH IS A HUMAN RIGHT

AMNESTY INTERNATIONAL

Amnesty International is a global movement of more than 3 million supporters, members and activists in more than 150 countries and territories who campaign to end grave abuses of human rights.

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Cover photo: Under Sierra Leone's free health care policy, pregnant women, breastfeeding mothers and children under five should be given essential drugs and treatment free of charge. In practice, however, they still often have to pay. Sierra Leone, 2009.

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1. INTRODUCTION

"The nurses treat you badly. They talk bad. I tried to explain, I begged…Nurses said you are wasting my time, and kicked me out…I had to beg. But no money, no medicine…They say free care, but there's none here."[1]

Hawa, 28 year old pregnant woman

Pregnant women and girls in Sierra Leone continue to face serious challenges in accessing drugs and medical care that are crucial to ensure safe pregnancy and childbirth.

Over the last two years the Government of Sierra Leone has introduced various initiatives to address these challenges, including some welcome steps to increase women's access to health services and reform of the health workforce. In April 2010 the government launched a major initiative to provide free care to pregnant women and girls.[2]

However, much remains to be done. The healthcare system remains dysfunctional in many respects. Disparities persist between rural and urban maternal health services; the quality of care is frequently substandard, and many women continue to pay for essential drugs, despite the free care policy. As a result many women and girls living in poverty continue to have limited or no access to essential care in pregnancy and childbirth. Amnesty International has documented accounts of pregnant women and girls who were denied access to drugs that are meant to be provided for free under the new government initiative, because of their inability to pay.

A critical shortcoming within the healthcare system is the absence of any effective monitoring and accountability systems, without which reforms cannot succeed. According to a Gynaecologist in Freetown:

> *The thing [Free Health Care Initiative] is in chaos…We were told a team is coming around with monitors to all hospitals; they never came*

here… For complaints, I don't know what channel to use. I went down to complain to the clinic. I even went personally to meet the Chief Medical Officer. Nothing happened.[3]

Monitoring and accountability are central human rights principles which are integral to the realization of the right to health. An effective framework of monitoring and accountability serves as the basis for promoting systemic change that creates conditions under which women and girls can enjoy their right to maternal health.

This report briefly outlines the recent important reforms initiated by the government and examines how failures of monitoring and accountability are undermining these reforms, in particular access to essential drugs needed in pregnancy and childbirth. The report also examines the accountability gap, focusing in particular on complaint or grievance mechanisms, remedies and redress from the perspective of women and girls who use or try to use the healthcare system.

The challenges to addressing maternal mortality in Sierra Leone are enormous, given the country's inadequate infrastructure, high levels of poverty and the continuing impact of armed conflict that ended in 2002.[4] The government has taken some important steps to address these challenges, but deficiencies in the monitoring and accountability system allow poor practice and mismanagement to go unchallenged, and have provided some people with opportunities to exploit the system and plunder valuable medicines.

Amnesty International is calling on the Sierra Leone government to strengthen and establish systems of monitoring and accountability to ensure healthcare interventions are accessible to women and girls, and to guarantee their access to effective remedies for violations of their human rights.

ABOUT THE REPORT AND METHODOLOGY

This report is issued as part of Amnesty International's ongoing campaign to ensure that women and girls living in Sierra Leone are able to realize their maternal health and sexual and reproductive rights. This work is also part of Amnesty International's global Demand Dignity Campaign, launched in 2009. This Campaign aims to expose and combat the human rights violations that drive and deepen poverty. Through its work on this issue Amnesty International promotes the empowerment of women and girls and the removal of barriers to the realization of their sexual, reproductive and maternal health rights.

This report is based on research carried out by Amnesty International in two separate missions during 2010 (May and October) and subsequent desk research and interviews conducted in 2011. The research took as its point of

departure reports made by credible institutions and informants about the problems that pregnant and lactating women and girls continued to have in accessing health services and medicines after the introduction of the Free Health Care Initiative. In order to further investigate these reports Amnesty International undertook an iterative and qualitative research process, interviewing key informants within Sierra Leone's healthcare system, the donor community and civil society groups that specifically track relevant health issues in Sierra Leone. These key informant interviews – which provided a broad view of the problem and underlying issues – were supplemented with more detailed investigations in 15 Peripheral Health Unit (PHU) areas, which were randomly selected. These investigations included site visits to PHU, interviews with staff and with women and girls in the local communities.

Amnesty International representatives interviewed different stakeholders, including hospital staff, representatives of health professionals' associations, Pharmacy Board, Sierra Leone Medical and Dental Council, pharmacists, lawyers focusing on the right to health, current and former members of the Anti-Corruption Commission, non-governmental organizations (NGOs), United Nations (UN) officials, donor organizations, World Health Organization, United Nations Population Fund, United Nations Children's Fund, journalists, and traditional chiefs.

Amnesty International delegates also met with five senior Ministry of Health and Sanitation (MoHS) officials. They met representatives of the district health management teams (DHMTs) in several districts and other local government officials responsible for monitoring and accountability around maternal health issues.

Delegates visited 15 Peripheral Health Units (PHUs), clinics and hospitals in four of Sierra Leone's 14 districts: Western Area (Freetown, River Number 2, Yam's Farm), Moyamba, Bo, and Kenema to assess monitoring and accountability mechanisms in these facilities, particularly with respect to essential emergency obstetric care (EmOC) drugs. Sierra Leone has some 1,270 PHUs, and a full survey of PHUs would undoubtedly be valuable to enrich understanding of the monitoring and accountability challenges, and the potential solutions.

Amnesty International delegates conducted interviews with over 80 pregnant and lactating women individually and in groups. Separate questions were developed for interviews with the communities, key informants and for health facilities. At the facility level, questions ranged from basic information regarding the facility, capacity to deal with obstetric emergencies, communications, record keeping, costs and education and awareness. In the key informant interviews questions were asked regarding government interventions,

limitations/difficulties in the implementation of these interventions, technical competence of health professionals and mechanisms for monitoring and accountability in relation to government interventions and maternal mortality. Community interviews included a range of questions regarding the experience of the community in accessing services under the Free Health Care Initiative (FHCI), challenges, education and awareness about the FHCI and concerns regarding its implementation. The questions were administered in English and Krio (as relevant) with the help of a translator.

Further interviews and desk research was conducted in 2011 to follow-up on the information gathered during the research missions and to update on the recent developments in relation to the Free Health Care Initiative (FHCI).

An advance version of the report was shared with the Ministry of Health and Sanitation. Amnesty International welcomes the feedback received from the Ministry, which was taken into account in finalizing the report.

2. HUMAN RIGHTS FRAMEWORK

"Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."

UN, CESCR, General Comment 14, para 1

THE RIGHT TO HEALTH

The International Covenant on Economic, Social and Cultural Rights, to which Sierra Leone is a state party, requires states to take steps to provide for "the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child." The UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the compliance of state parties to this treaty, has stated that this treaty obligation must be: "understood as requiring measures 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".[5]

Further, the Convention on the Elimination of All Forms of Discrimination Against Women requires states parties 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 12.2).

Where resources are limited, states are expected to prioritize certain key interventions, including those that will help guarantee maternal health, and in particular emergency obstetric care.[6]

While the right to health is subjected to progressive realization and availability of resources, meaning that states are required to work progressively towards

the full realisation of the right to health based on the resources available to it, there are some obligations, for instance to ensure access to life saving maternal and newborn care, that are subject to neither resource constraints nor progressive realization, but are of immediate effect. The Government of Sierra Leone therefore has an immediate obligation to take steps to ensure access to life-saving maternal and newborn care for women and girls.

The International Covenant on Economic, Social and Cultural Rights requires state parties to ensure that health care services, goods and facilities connected to preventing maternal mortality must be available, accessible, acceptable and of good quality.[7]

Under a number of international treaties including 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, to which Sierra Leone is a state party, 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;[8]
- Education and information on sexual and reproductive health;[9]
- Sexual and reproductive health care services;[10]
- Prenatal health services;[11]
- Skilled medical personnel to attend the birth;[12]
- Emergency obstetric care;[13]
- Postnatal health services.[14]

Further, the right to health requires that there are effective, transparent and accessible monitoring, accountability and redress mechanisms, at the national and international levels.[15] Effective monitoring (e.g. by way of appropriate indicators) is a pre-condition of accountability. Monitoring and accountability are central human rights principles which are integral to the realization of the right to health. Accountability provides individuals and communities with an opportunity to understand how those with responsibilities have discharged their duties. Equally, it provides those with responsibilities the opportunity to explain what they have done and why.[16] Where mistakes have been made, effective accountability mechanisms enable corrective action and should ensure redress.[17] Accountability "allows us to look ahead" as well as back.[18] An effective framework of accountability serves as the basis for promoting systemic and institutional changes that create conditions under which women can enjoy their right to health.[19]

3. BACKGROUND AND UPDATE

Sierra Leone is an extremely poor country with a GDP per capita of only US$341,[20] an external debt of US$ 444 million and an economy that is highly dependent on donor funding.[21] The country is still recovering from a brutal 11-year armed conflict. Approximately 70 per cent of the population lives below the poverty line on less than US$1 per day, and the majority of people live in rural areas.[22]

While some progress has been made in recent years, Sierra Leone is currently off-track to meet most of its MDG commitments (see box 1).[23] Pregnancy and childbirth continue to be life threatening experiences for many women in Sierra Leone.[24] With much of the health and road infrastructure destroyed during the conflict, many people have to travel long distances to reach health facilities. When people reach health centres or hospitals the quality of treatment is often poor.

MILLENNIUM DEVELOPMENT GOALS (MDGS)

The Millennium Development Goals (MDGs) were adopted in 2000 by all UN member states. The MDGs are the most prominent global initiative to address poverty, and they focus on eight areas:

Goal 1 Eradicate extreme poverty and hunger
Goal 2 Achieve universal primary education
Goal 3 Promote gender equality and empower women
Goal 4 Reduce child mortality
Goal 5 Improve maternal health
Goal 6 Combat HIV/AIDS, malaria and other diseases
Goal 7 Ensure environmental sustainability
Goal 8 Develop a global partnership for development

The deadlilne by which most targets are to be achieved is 2015. Although there has been some progress in recent years in improving maternal health, the goal that is least likely to be achieved by 2015 is goal 5. At the September 2010 MDGs Summit in New York world leaders committed to take steps to realize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health.

Amnesty International's research confirms the need for governments to ensure monitoring and accountability in efforts to achieve MDGs.[25] Not only will these efforts contribute to achieving women's empowerment, they are likely to help remove some of the barriers to achieving MDG 5 on improving maternal health.

Sierra Leone's health system is characterized by a poor infrastructure, a lack of appropriately qualified health care workers, and insufficient supplies of drugs and equipment. Even the best government hospitals in Sierra Leone often lack running water, electricity, and other basic necessities.[26] These problems are exacerbated by poor co-ordination, management and oversight of the health system.

In 2009 Amnesty International published a report, *Out of Reach: The Cost of Maternal Health in Sierra Leone*, (AI Index: AFR 51/005/2009), that highlighted the range of barriers faced by pregnant women while trying to access emergency obstetric care services. Amnesty International called on the Government to remove financial barriers to accessing health care, and in particular emergency obstetric care, and to ensure that such care is available and equitably distributed throughout the country.[27]

Over the last two years several positive initiatives have been launched by the Government of Sierra Leone to address the situation. The Agenda for Change (Sierra Leone Poverty Reduction Strategy Paper II) identified as a priority the need to address high levels of child and maternal mortality and morbidity. This led to the development of the Health Sector Strategic Plan 2010-2015 which aims to ensure successful implementation of a Basic Package of Essential Health Services.[28] In an attempt to enhance accessibility of the Basic Package of Essential Health Services the government decided to remove user fees at the point of service delivery for some of the elements of the Basic Package. This was announced by the President at the UN General Assembly in September 2009 and subsequently launched in April 2010, as the "Free Health Care Initiative" for pregnant women, lactating mothers and children under five at all government-run facilities.[29]

In the first year of its implementation the Free Health Care Initiative was expected to cover 230,000 pregnant women and around one million children under five.[30] The scheme was supposed to guarantee that children and pregnant and lactating women would have access to a package of medical care that includes all treatment and medicines at no cost.[31]

In order to implement this Strategy the government identified a range of priority actions. These included: ensuring sufficient supply of drugs and equipment; ensuring sufficient numbers of adequately trained health workers were available and deployed; and strengthening of oversight, coordination and management.

The launch of the Free Health Care Initiative also galvanized broader reforms of the entire health sector. For example, payroll cleansing has helped to address

human resource irregularities – such as ghost employees. A pay increase for doctors and nurses was also implemented. Additional training for existing staff was also provided.

KEY ACHIEVEMENTS OF THE FREE HEALTH CARE INITIATIVE

According to government reports in the first year of implementation of the FHCI in relation to pregnant women:

- Higher number of women made at least one ANC visit as compared to the pre FHCI period;
- 39,100 more women delivered their babies in a health facility;
- 12,000 more maternity complications were dealt with in health facilities;
- Higher number of women sought post-natal care as compared to the pre FHCI period.

Source: MoHS FHCI Report: April 2010-March 2011; Volume 2, Number 3.

Despite progress on some of the reforms, several of the key actions identified by the government have only been partially implemented. Critically, shortages of appropriately qualified healthcare staff have created problems in terms of meeting the increased demand for services that resulted from the launch of the Free Health Care Initiative.[32] The availability of essential drugs and other medical equipment is also a significant problem; shortages and stockouts are widespread. Improvements made to the system to ensure supplies of drugs and equipment - including the installation of a computerized system - have failed to resolve fundamental problems with the availability of drugs.

The launch of the Free Health Care Initiative constituted a leap forward and inspired hope in people. However, the move from policy to tangible change for people using the health service has been difficult. While the government has tried to address some of the underlying and systemic problems, others remain un-examined and un-addressed. One of the central problems is the lack of effective systems of monitoring and accountability. This is the focus of this report which aims to highlight how strong and effective systems for monitoring the delivery of the Free Health Care Initiative are one of the keys to delivering the promised health impacts.

THE SIERRA LEONE HEALTH SYSTEM

The health system in Sierra Leone has been undergoing a process of decentralisation 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 responsible for managing primary health care services. They cover the four administrative regions: Freetown and the Western Area, Northern Region, Southern Region and Eastern Region.

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. Tertiary health care services have not yet been decentralized and are managed by the Ministry of Health and Sanitation. 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 Sanitation and the Ministry of Finance and Economic Development (Ministry of Finance) for funds.

The Ministry of Health and Sanitation 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.

There are several NGOs registered within the health sector. According to Ministry of Health and Sanitation estimates, 50 per cent of healthcare services are provided by the Ministry of Health and Sanitation the rest are provided by NGOs and the private sector.

4. MONITORING FAILURES AND MISSING DRUGS

The launch of the Free Health Care Initiative (FHCI) gave the promise of care and safe delivery to women and girls, and positive progress has been recorded. According to government reports institutional deliveries increased by 45 per cent - from 87,302 to 126,477 - in the last year.[33]

But for many women and girls the promise of the free health care has not been fulfilled. In interviews, women and girls who had tried to access the health care system after the launch of FHCI told Amnesty International that they were unable to access drugs or care.

Women and girls report two significant problems with the FHCI: either drugs and other essential medical supplies are simply not available at the health facilities, or they are charged for medicines and care that are supposed to be provided for free. Often, when essential drugs for women in pregnancy and childbirth are not available for free, they are available for a price – in the same facility - as "cost recovery" drugs.

Women described how they were sent to private pharmacies to buy drugs, and being told that drugs and consumables (such as needles, synergies, plasters) were available but only for sale. In cases where they were not able to pay the charges they were simply denied the care or the medicines.

19-year-old Umu, who was five months' pregnant, described her experience to Amnesty International:

> *The nurses shouted at me. They gave me no information. They asked me for 20,000 le [USD 5] for medicines. I had no money, they told me to go away. I will not deliver at the clinic.* [34]

Six months' pregnant Hajara, told Amnesty International:

> *I was feeling dizzy and vomited a lot. I went to the hospital, the doctor asked me to go for a scan. When I went for the scan, the nurse asked me for 35000 le {USD 8}. They did not do the scan. I had no money. I came back home. I am feeling ok now, but I am worried.*[35]

Many other women and girls interviewed by Amnesty International gave similar accounts of being denied drugs and health care when they were pregnant,

either because no drugs were available or they were physically available but unaffordable. These accounts were backed up by information provided by health care workers, donors and Sierra Leone's Anti Corruption Commission (ACC), which has examined some of the problems with delivery of the Free Health Care Initiative.

One doctor summed up the concerns around free health care:

> *I have problems. Drugs are often not available. I tried to get to the District Medical Officer (DMO) – you ask, they don't give you. EmOC [emergency obstetric care] drugs are not there. Consumables were not supplied. My worry is how sustainable this is going to be.*[36]

The reasons for these problems are generally known: firstly, it is clear that drugs and medical supplies leak out of the free health care system and are re-routed as drugs for sale; secondly, the system for procurement and management of drugs is complex and poorly managed. These two issues are interlinked: the weak drugs management system in Sierra Leone creates numerous opportunities for corruption, with women and girls ultimately paying the price.[37]

That price can be death or serious injury. In its 2009 report, *Out of Reach: The Cost of Maternal Health in Sierra Leone*, Amnesty International noted that a large number of maternal deaths in the country could ultimately be traced to the high costs of care and the fear of such costs. Women and girls die because they cannot afford vital medicines and care, or because concern about costs leads them to delay going to health facilities.

The FHCI is therefore a vitally important initiative; in order to ensure that it is translated into a reality for all women and girls in Sierra Leone, the government must address the problems referred to above, which are undermining the delivery of FHCI.

In examining why these problems persist it is clear that the lack of an effective system for monitoring and accountability are central challenges. While the problems are broadly known amongst health care workers and government officials, the lack of any effective monitoring system means that there is very little chance of specific instances being identified and addressed. Moreover, the scale and nature of the problem are not clear. Monitoring is needed to indentify the points of weakness in the system. The absence of functioning accountability mechanisms means that even if poor practice or corruption are detected, there is no effective deterrent.

These issues are examined in more detail below.

CORRUPTION AND FAILURES OF MONITORING

Sierra Leone is facing a public accountability test following concerns raised by UNICEF that large quantities of drugs intended for the FHCI may have gone missing since the initiative was launched.[38] Sierra Leone's Anti-Corruption Commission (ACC) has raised similar concerns and has stated that the ACC "has received numerous complaints with regards to the blatant and wilful misuse of the Free Health Care Policy" and that it will be conducting full scale investigations into it.[39]

Under the present system there are two types of drugs which are available, a) FHCI drugs for three priority groups (pregnant and lactating women, children under-five) and b) cost recovery drugs (for all other categories of patient). Patients are charged for cost recovery drugs and, in principle, 40 percent proceeds from the sale of these drugs goes back to the district stores to buy more drugs for the health unit, while 60 percent of the money stays in the health unit to cover those groups that are unable to pay.[40] Management of cost recovery drugs and FHCI drugs is done by the same pharmacist in the same store.

Amnesty International's research found that, in most cases, there was no way of distinguishing between the FHCI drugs and cost recovery drugs. Researchers found that often, when essential drugs are not available for free for women in pregnancy and childbirth, they are available for a price – in the same facility, as "cost recovery" drugs.

Poor record keeping is a key problem. At the Periphery Health Units (PHU) and hospital level no proper record-keeping is done and the overall management of drugs and supplies is extremely poor. For example, inventory management is weak or non-existent, there are no systems in place to properly record who dispensed drugs or which drugs were subject to charges.[41]

Monitors for an NGO called the Health for All Coalition Sierra Leone (HFAC-SL) told Amnesty International that FHCI drugs were found in private hospitals and pharmacies in Koinadugu and other districts.[42] According to the Coalition, in numerous facilities across Sierra Leone: "No distinction [was made] between FHCI drugs and Cost Recovery drugs in most facilities visited." In visits to PHUs, Amnesty International researchers also found that it was not possible to clearly identify cost recovery and FHCI drugs.

Officials at the Ministry of Health and Sanitation are aware of the problem. One senior representative described the situation:

The current system does not capture all drugs going in…Certain things

we cannot see. Are the drugs sent being used for the purpose they are designed for? We do send monitors to check records, but not often because of resources. Mostly they stay at the facilities, don't go to the communities, so they don't get the facts.[43]

In a few rare cases, efforts by civil society organisations to monitor FHCI drugs being sold as cost recovery drugs may be bearing fruit, but the problem remains widespread and requires more systematic monitoring.[44]

The government is reportedly planning to introduce a receipt system to record whether drugs are being sold as cost-recovery drugs or whether they are being provided under the FHCI. Such a process should facilitate better monitoring, particularly if communities are well informed about the process.[45]

In addition to the poor management of drug supplies, financial management systems at most health facilities are also weak. The Anti-Corruption Commission has noted that:

"*Officers in charge and their nurses randomly and indiscriminately collect monies for drugs and services without accounting for such funds….The concentration of efforts in all of these facilities is on private revenue collection rather than proper service delivery. Similarly stock keeping for drugs and medical supplies are in complete disarray."*[46]

The absence of proper record keeping and stores management procedures, combined with the lack of a robust financial accounting system, has created the permissive environment where staff within the health system can exploit the situation to their advantage with little possibility of being detected.

While the lack of monitoring and oversight within the system has created a context where corruption can flourish there is also a failure to monitor the experiences of women and girls, which could expose problems and empower women and girls as users of the health system.

In spite of some government initiatives to raise awareness about access to free health care drugs numerous pregnant and lactating women, especially those in the rural areas, interviewed by Amnesty International reported having paid for some or all drugs and consumables at the clinics. Women's descriptions of their experiences attempting to access the FHCI provide valuable insights into the problems.[47]

A 23-year-old pregnant woman told Amnesty International that she went to a government hospital because she was worried about her pregnancy but was charged in spite of the FHCI.

I went to the hospital. No tablets. No blood test. [They] wrote a paper

> *[prescription] and said go buy it. I was not happy because it is free care… I don't feel fine. I feel angry.*[48]

Another woman told Amnesty International:

> *I went to hospital. They say they have no medicine, come back on Friday. I went back, still no medicine. Go back a third time, still no medicine. I was angry because I go three times, they don't treat me fine, they say 'no treat.' I no go again.*[49]

In a hospital upcountry, in Kenema, when Amnesty International visited the maternity ward, it found that the majority of pregnant and lactating women there were being charged for all or some drugs and consumables they needed. Kadiatu a 27 year old woman, who had recently delivered told Amnesty International, that: "…*I was told I had to pay 25000 le (USD 5.5) for medicines. I told them it was free care but they shouted at me…There is no free care service in this* country*, I will not go again.*"[50]

Monitoring systems that capture the experiences of women and girls ensure that health care systems are responsive to their needs and concerns. Involving women and girls in monitoring not only makes health interventions more effective, it also leads to empowerment of women and girls as they are able to engage as active participants in decision making that impacts their lives rather than as passive recipients of services.

WEAK PROCUREMENT SYSTEMS

In addition to the widely-reported pilfering of medical supplies and corruption, problems in the procurement, supply and distribution systems often result in women and girls being denied access to life saving drugs during pregnancy and childbirth.

In a random survey[51] conducted by Amnesty International with Maternal Mortality Coalition partner organizations in Kenema, Bo, Makeni, Kabala and Kambia, severe shortages of essential EmOC drugs (in some cases complete stock-outs) and delays in supplies were reported in most of the facilities visited. There were insufficient needles, syringes, bandages and other consumables in almost all the PHUs visited.

A doctor at one of Sierra Leone's main hospitals elaborated on the problem:

> *The other problem is the supply of drugs… The importance of key tertiary drugs seems not to be known. We do not have what we need.*

> *We even complained to the President. We complained many times [to different people]. Many drugs that are needed are not available. For example a fine needle for an epidural is not available. To get that, I had to beg from other hospitals, and cry to UNFPA and others to get those.*[52]

A Community Health Officer in Bo District explained:

> *Free health care? There are so many constraints but nobody is listening to us. My problem is the irregular supply of drugs and material. The whole thing is working on a push system. We receive things that we didn't ask for. For example, some Periphery Health Units that are not meant to handle eclampsia receive magnesium sulfate. I received ketamine, used for anaesthesia, but I don't need it. Many times essential drugs are sent in small amounts… Things have started, but are not maintained. I have many recommendations but who can I tell them to?*[53]

There are two central problems with the supply of drugs: blockages, which lead to procurement requests not being addressed promptly, which results in delays; poor procurement practices which result in drugs not being available because they are not requested in a timely and appropriate manner. These problems are discussed below.

There are major concerns with respect to the present system of monitoring requisition and supply of drugs. Health workers are confronted with multiple official forms, which few understand or use effectively and the complexity of the new internet-based procurement system named CHANNEL, which very few understand how to use . As a result, at the facility level, there are regular stock-outs of essential drugs that are needed by pregnant and lactating women.

Some support has clearly been provided to assist health workers in managing drug procurement. For example, UNICEF assisted the Ministry of Health and Sanitation (MoHS) in providing inventory cards and requisition forms for drugs at the central, district and hospital stores but especially in PHUs. Despite this, in most PHUs visited by Amnesty International, health workers stated that because of lack of capacity they were not able to get the lists of drugs they needed to the District Medical Stores on a regular, reliable basis and as a result faced regular stock-outs for essential drugs.

A new web-based procurement system called CHANNEL was installed in 2010. However, there remain significant challenges with the use of CHANNEL. Although training was provided it is clear that many staff are not comfortable with the system. Additionally, the Internet is often unreliable in Sierra Leone, where electricity black-outs are commonplace, which reduces the functionality

of this new web-based system.

One doctor in Freetown described training and supervision gaps in the CHANNEL system, which is designed to monitor EmOC drug needs, procurement, and distribution:

> *We train people on the job. Even printers and equipment they needed. But they don't always understand [how to operate the equipment]. So they got the training, but didn't understand exactly how the procurement needed to work. That is why we have problems still. You need more training, and people need to be forced to use the system… The staff and human resources are not enough. The stock manager and pharmacists are alone. We need more numbers of people, and training, and the right supervision. If you can increase the number of staff who know how to use CHANNEL, it would help.*[54]

Another doctor explained:

> *Many staff struggle with filling in immense forms. You need a good procurement and requisition system if you want to monitor the drugs. Right now they have to tick a huge list. Most PHUs do not have the right forms. Moreover, the forms have the drug names and not the drug brand names, which is very confusing for a lot of people who do not have enough education. So they do not fill out the forms right.* [55]

In a recent pilot scheme, the government has recruited data clerks in six high-risk districts to provide additional data recording support in Periphery Health Units that suffer from acute human resource constraints. The results for this pilot are crucial in determining the effectiveness of this intervention to strengthen monitoring processes in Sierra Leone in relation to drugs procurement.[56]

Effective monitoring systems that seek to track the process of drug procurement and delivery and can identify gaps in staff capacity and knowledge are key to addressing these problems. For monitoring systems to be effective they must be capable of generating appropriate responses and remedial action where needed. This issue is taken up later in the report.

PROBLEMS AT FREETOWN PORT

Problems within the inadequate and ineffectual procurement system are compounded by corruption, in particular at Freetown Port, the point where

drugs enter Sierra Leone. Numerous health professionals and civil society actors told Amnesty International that corruption at the Port Authority has caused significant delays in drugs reaching their intended health clinics. According to these organizations port officials ask for money to clear shipments, expedite processing, or certify shipments.[57] There are clear concerns about corruption at the port.

One senior doctor described the situation:

> *The problem is in both directions: number one, the message going up through the procurement system gets lost. Number two, drugs coming back down accordingly can also go amiss. And here is another problem … At the quay, at the ports, they always ask for payments. It is corrupt. Things get delayed there, and they don't get to the medical stores… The individual contractors are no good… You know nowadays procurement is a way of making money, and it has spoiled the system.*[58]

The most high profile case involving the Port Authorities occurred in 2010 when they refused to clear drugs and consumables meant for the launch of FHCI. President Koroma and the Vice President had to personally intervene to ask the Port Authorities to release a major drug consignment of all the free care drugs for nationwide distribution. After a presidential visit to the port, the drugs were released. The fact that the Port Authorities were able to hold up a key drug consignment, and a presidential visit was needed to release the drugs, is clearly problematic.[59]

In an effort to address some of the challenges at Freetown Port, the Office of the President has reportedly put in place a "No Delay, No Demurrage" strategy, which is aimed at ensuring that drugs are cleared within a week of arrival at the port. The efficacy of this strategy has yet to be assessed.[60]

Moreover, it is clear that problems persist. In June 2011 civil society organizations in Sierra Leone reported that 43 containers of drugs are sitting at the ports awaiting clearance, some of which date back to 2010.[61]

The way in which port officials deal with such issues is not monitored by any single authority, but rather by a web of different actors, as highlighted by a senior UN Agency representative:

> *Each time we request drugs coming in, I have to send requests to the Ministry of Health to the Ministry of Foreign Affairs to the NRA [National Revenue Authority], who can make a huge bottleneck because lenders don't get signed [approved]. So at the port things are just stuck. The consignments stay there. Then the problems multiplied because you have to pay for demurrage fees, which can even exceed*

the customs fees. The president knows this.

In the past there have been efforts to monitor the port and address alleged corruption by port officials, but these efforts have had little success. An ACC staff member told Amnesty International that the ACC had repeatedly investigated and prosecuted the Port Authorities, and won cases against them. However, the convictions consisted of fines, described as "slap[s] on the wrist," and not jail time or a systemic overhaul of the problem of corruption at the port. "It is very frustrating," he added.[62] The Port Authorities refused to speak with Amnesty International to discuss these allegations.

Key stakeholders working with the MoHS recognized the challenges of monitoring EmOC drug distribution, and developed a joint proposal to revamp the Department of Planning in the MoHS "to restructure the Department of Planning and Information so that they can do better monitoring and accountability work."[63] The proposal to restructure monitoring for essential drugs, including at the port, has yet to be adopted and implemented.

THE MONITORING SYSTEM: MULTIPLE ACTORS, POOR COORDINATION, FLAWED METHODOLOGY

Many monitoring failures can be attributed to lack of capacity, resources, absence of clear methodology and the multitude of overlapping bodies responsible for monitoring maternal health at the local and national levels. The diversity of these authorities obscures responsibility for monitoring health and mismanagement of drugs, and makes it difficult to achieve clarity nationwide on where the problems are and how to fix them.

A donor representative told Amnesty International:

> *Monitoring and evaluation here is incredibly weak and there is no good data on uptake of drugs etc. Nobody knows who is doing what.*[64]

MULTIPLE ACTORS, LIMITED RESOURCES AND CAPACITY

At the national level, in Freetown, the MoHS Monitoring & Evaluation Unit has only three full-time staff working to cover monitoring and evaluation of all health issues in the entire country, including EmOC drugs.[65] With respect to monitoring, the MoHS is primarily responsible for monitoring policies and for setting standards for monitoring nationwide; monitoring the setting of salaries and pay scales; and for coordination of health services to facilitate nationwide harmonized monitoring.[66]

Beyond the MoHS monitoring team, there are a multitude of other actors also responsible for monitoring, without any clear responsibility. The Hospitals Boards were established with the Hospital Board Act of 2003 to "maintain the highest standards of medical care, training, management and administration of the hospitals."[67] The Hospital Boards are meant to monitor hospitals, although in the words of the Anti Corruption Commission (ACC), "Hospital Boards have almost been relegated to moribund status. They are not consulted when major decisions are taken." [68] In addition each District Hospital has a Hospital Management Committee, with the head of the Committee a member of the District Health Management Team. Nationwide these Committees fall far short of their mandate and have demonstrated little or no effective monitoring capacity.

In addition to the MoHS and Hospital Boards, the Ministry of Finance and Economic Development is responsible for monitoring the funding of the medicines budgets of the local councils. The government's auditor general audits the Local Councils. There are also local and traditional structures that play a role in monitoring: secret societies, Chiefs, and Paramount Chiefs monitor events and problems in their districts, with informal but powerful roles to play.

SOME OF THE KEY ACTORS INVOLVED IN MONITORING:

National Level
Ministry of Health and Sanitation
Ministry of Finance and Development
Ministry of Local Government and Community Development
Hospital Boards
District Level
District Health Management Teams
Hospital Management Committees
Local Councils Health Committees
Local and traditional structures
Other Actors
Anti Corruption Commission
Auditor General
Civil Society Organizations
Development Partners
National Human Rights Commission

Local councils also monitor health issues, often overlapping with DHMTs and Hospital Boards. According to the Local Government Act of 2004, local councils – not the MoHS – are responsible for health management, monitoring work plans, finance and implementation; monitoring the distribution of public

goods; monitoring staff performance;[69] registration of births and deaths; public health information and education; primary healthcare; maintenance of non-technical equipment; facilities management; and procurement of equipment and medicines.[70]

The first two service provision levels (PHUs and district hospitals) are part of the district health services, and are the responsibility of the DHMTs. They oversee planning, implementation, coordination, monitoring and evaluation of district health services and all primary health care, under the leadership of District Medical Officers.[71] Technical directors answer to the Chief Medical Officer (CMO), Administrative Directors answer to the Senior Permanent Secretary (SPS), with the CMO and SPS making decisions jointly.

In practice, decentralization has not ensured good monitoring. Within the multiplicity of central and district actors, messages get forgotten, information lost, and a blame-shifting exercise takes place where district level actors blame the central government and vice versa.[72]

Moreover, the capacity of the District Health Management Team is dependent on the Ministry of Health and Sanitation's financial, technical and strategic support. Amnesty International interviews with District Health Management Teams revealed that their feedback, including complaints and information about problems, goes to the MoHS at the national level, but nothing is done in most cases, and there is rarely even a response. Therefore, although the DHMT has monitoring powers, the lack of responsiveness from the Ministry severely undermines DHMTs' effectiveness.

WEAKNESSES IN METHODOLOGY

While the multiplicity of actors appears to have resulted in a lack of clear accountability for monitoring or for addressing issues, there are several other weaknesses in the system. These relate to *what* is monitored, the tools used and the frequency of monitoring.

There are critical gaps in terms of what is being monitored. In most cases monitoring is restricted to facility based reviews and, as noted above, does not capture the concerns of women and girls as end-users. Additionally, Amnesty International's research found that the limited monitoring that is done does not look specifically at drug procurement and distribution. Facility-based reviews appear to focus on a box ticking exercise which, for instance, checks the drugs requested against the delivery received. In most cases it does not capture the *met need* dimension, i.e. whether those who needed the drugs actually received them, or any other concerns that women and girls as end-users have.

Moreover, in looking specifically at the issue of access to maternal health care services Amnesty International found that the methodology and indicators used by the MoHS are often not adequate. Although the government of Sierra Leone used UN Process Indicators - which were specifically developed to monitor the availability, utilisation and quality of EmOC - when conducting a needs assessment exercise in 2008 to inform the development of the free health care policy, information is not being regularly collected on these indicators. The UN Process Indicators offer a systematic approach to assessing health care systems and planning sustainable maternal health interventions. While a variety of tools, service packages and policies have been developed by UN agencies and NGOs to monitor health services including maternal health, most do not adequately or systematically address women's access to EmOC. Systematic data collection on the UN Process Indicators would be invaluable to the government of Sierra Leone to capture a more complete picture of women's access to drugs.[73]

Secondly, monitoring undertaken by the Ministry of Health and Sanitation, and other relevant actors, is often infrequent. They are often constrained by lack of resources, transportation and appropriate tools, which results in infrequent monitoring visits by the authorities. As a result data collected is often based on unverified information provided by the staff at the facilities or collected from those facilities that are easier to access, resulting in incomplete information.[74]

In summary, monitoring systems are either poorly resourced or non-existent. What systems do exist are characterized by a multitude of actors without clear responsibility, poor management, planning, funding, and capacity. Such a system provides some people with the opportunity to exploit the deficiencies in the system and take unscrupulous advantages.[75]

5. NO ACCOUNTABILITY AND REMEDIES

"I went to the hospital. The nurse did not watch me at all, gave me no medicines. [They] shouted at me. I tried to complain. I did not complain to anyone because they do not care at all. I don't know where I will give birth. Husband wants me to go to the hospital, but the nurses do not care about us."[76]

Zulaikha, 22-year-old woman, seven months' pregnant

There are serious deficiencies in accountability across critical areas of the health system in Sierra Leone. Although in theory there are several avenues of accountability available to women and girls, in reality systems are often either non-existent or non-functioning. For example, the law provides for administrative and other procedures within the health system, which are often inadequate and largely unknown. Women and girls can also, theoretically, seek remedies through judicial and quasi-judicial mechanisms; however that has rarely happened and the system is confronted with challenges that hamper its effectiveness. This section examines some of the accountability gaps within both the health and the justice systems in Sierra Leone.

DEFUNCT ADMINISTRATIVE ACCOUNTABILITY MEASURES

Across the health services medical staff are rarely subject to checks and controls from senior or supervisory staff. Numerous key informants within the

health sector in Sierra Leone confirmed that very few health workers have been held responsible for misconduct, such as denying patients care.[77]

The MoHS has the power to mete out administrative sanctions, but this is hardly done in practice. The employment of staff is rarely terminated in cases of underperformance or misconduct. A senior MoHS staff member observed:

> *A problem is that the Resource Management Office (HRMO) has the authority [to fire people], not the Ministry of Finance or the Ministry of Health. To physically cut people out of the system. But they never do it because of the bureaucracy. There are not enough links or communication, so it's hard to hold people accountable if they are engaging in misdeeds… I never heard of someone being fired in the Ministry of Health.* [78]

Amnesty International's research also found that Hospital Boards were virtually defunct as accountability mechanisms and it was not possible to identify any cases of a hospital board sanctioning anyone. As explained by a Board member:

> *If you speak out you are the enemy. We complain all the time about things but no action is taken. Many people are corrupted, they're building mansion houses. I have never heard of a doctor or anyone in the hospital being sanctioned for a misdeed. It is difficult to sanction here…There is no confidentiality. If I write, the person in charge will show the letter I have written to the person I'm accusing. That accused person will suggest a bribe, he will say let me help you and we can take away this problem… I have never seen the disciplinary committee here.* [79]

The Sierra Leone Medical and Dental Council,[80] which is supposed to punish wrongdoing by medical personnel is also virtually defunct. Although there are disciplinary procedures provided by the Council, Amnesty International did not find evidence that medical personnel accused of inappropriate treatment of patients were ever punished or even that the disciplinary procedure was used at all.

However, the government has recently introduced some measures to increase the accountability of staff. In an effort to address absenteeism, staff who do not turn up to work will be frozen from the payroll. Additionally an incentive scheme for staff at PHU level was launched in 2011. Under the scheme the staff will be paid an incentive for performance against indicators, such as: number of pregnant women completing series of four antenatal consultations; number of pregnant women in labour attended by a health professional, at the facility.[81] Whether these measures have resulted in lowering absenteeism and

improving delivery of care is yet to be assessed.

LACK OF GRIEVANCE OR COMPLAINT MECHANISMS

A 23-year-old woman who had recently given birth told Amnesty International:

> *My baby was crying a lot, and had fever. Hospital had no drugs for him. Need to pay money. They chased me away. I don't know how to complain.*

Women and girls who are denied access to essential drugs in pregnancy and childbirth, who face corruption, have no effective means of complaint.

Amnesty International found no administrative procedures to check patients' satisfaction with the care they receive, nor, any mechanism to allow patients to register their complaints. Government officials told Amnesty International that it was possible for patients to seek remedies through different channels, either at the medical or the administrative level, but acknowledged that they did not know cases where it had ever been done.

In a sample survey conducted by Amnesty International with Maternal Mortality Coalition partners in Kenema, Bo, Makeni, Kabala and Kambia - most of the communities expressed anger because of lack of FHCI drugs and the often bad attitude of health workers but did not know what to do.

In reality few, if any, grievance mechanisms exist. Where they do exist they are highly inadequate and poorly resourced. Rural women interviewed expressed the view that they could not speak to the nurse in the PHU because they fear reprisals, such as not receiving any treatment from that nurse in the future, as punishment. Complaining directly to a doctor in a hospital is even more intimidating. Woman after woman told Amnesty International that they would never dream of criticizing a doctor, who holds a revered status in the community.

There are no procedures within the facilities to enable women and girls as end-users to raise concerns or grievances. Amnesty International did not see any complaint boxes in any hospital during its investigations, and was told that the complaint box at the largest obstetric hospital in Sierra Leone, Princess Christian Maternal Hospital (PCMH), had been taken down when the FHCI was launched in April 2010. A further problem with complaint boxes is that many Sierra Leonean women and girls are illiterate.

The Ministry of Health and Sanitation is reportedly collaborating with the National Telecommunications Commission and private mobile phone

companies to work towards establishing a toll-free hotline for people to complain if doctors try to levy charges where there otherwise should not be any, or try to charge men extra to make up for lost revenue from women, or if healthcare staff do not turn up for work.[82] There is, as yet, little clarity with respect to what happens if someone calls to register a complaint, in terms of follow-up. Further, the effectiveness of such a strategy in terms of its accessibility and acceptability to women and girls who are denied access to services is not clear.

QUASI-JUDICIAL MECHANISMS: THE HUMAN RIGHTS COMMISSION AND THE OFFICE OF THE OMBUDSMAN

The mandate of the Human Rights Commission of Sierra Leone extends to rights embodied in the international treaties that Sierra Leone has ratified.[83] According to Sonkita Conteh of Open Society Initiative, "the passage of the Human Rights Commission of Sierra Leone Act 2004 brought a different complexion to the rights landscape. Unlike the limited range of rights protected in the 1991 constitution, the Commission's function is to protect and promote human rights across the spectrum in Sierra Leone."[84] 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. The Commission has five commissioners and a secretariat in Freetown, as well as some staff based in Bo, Makeni and Kenema.[85] The Commission is meant to receive complaints from the public, monitor the actions of other state institutions, and call these institutions to account when they violate human rights and fail to provide redress. However, the Commission has serious capacity problems and lacks sufficient funding.[86] As far as Amnesty International could discover the Commission has not received any individual complaint about maternal health.

The office of the Ombudsman was established by an act of parliament in 1997 as an independent body to investigate, in relation to a government ministry, department or agency, any administrative act or omission against which a complaint is lodged by anyone claiming to have suffered an injustice. The office is located in the capital city. Complaints can be lodged in person, by telephone or by post. Currently, there are no offices at regional or district levels. The range of complaints the office has handled included non-payment of salaries and benefits, wrongful dismissal, biased and unfair treatment and harassment.[87]

LEGAL REMEDIES

Several laws regulate medical negligence, misconduct, systematic malpractice,

and prohibit demand of bribes. The Anti Corruption Act 2008 for instance contains a number of offences that a person who charges money for an otherwise free service could be charged with. These include abuse of position, abuse of office and obtaining an advantage. The punishment is a fine or imprisonment.[88]

Further, if an eligible patient - pregnant woman or lactating mother or child under five, is charged a fee or a health worker is caught stealing or selling drugs meant for free distribution, it can be treated as a criminal offence under the Larceny Act 1916 and will be investigated and dealt with accordingly by the police. Alternatively, a complaint of a less severe nature can be addressed to the Village Health Committee or the District Medical Officer.[89] In principle cases of medical negligence can be handled in the ordinary way as allowing for civil claims in the courts for damages, although such claims are rare.

Although there are legal provisions that help protect the rights of women and girls, aside from the pioneering work of the Anti Corruption Commission, the functionality of other processes is doubtful and there are no reported cases where individual women were granted remedies for the harm suffered in relation to maternal health.

There is no specific consumer protection law in Sierra Leone as such. The Law Reform Commission in 2004 produced a draft Consumer Protection bill which was submitted to the law officers department in the ministry of justice. This bill has still not been laid before parliament for enactment.

An added concern with regard to legal remedies is with respect to the dominance of customary law. According to studies, the vast majority of Sierra Leoneans fall under the jurisdiction of customary law.[90] For many Sierra Leoneans, especially women, traditional systems remain the primary avenue for redress of violations of rights or law.[91] However, the system is known to be discriminatory and often prevents Sierra Leonean women from accessing their rights. There is a clear recognition from the authorities in the Justice Sector Reform Strategy of these concerns and the need to strengthen the system.

Further, Sierra Leoneans attempting to access justice through the country's complex, dual legal system are presented with a number of barriers. They are faced with financial barriers (including costs of legal services, court fees, time taken from work to pursue a complaint, and the costs of transportation), and structural barriers (lack of court infrastructure and insufficiently skilled legal officials).[92]

In an apparent response to these concerns, the government has, this year, laid

before parliament a bill to amend the Local Courts Act, which seeks to overhaul the administration of justice at the local level.

The 2010 Legal Aid bill, is another key legislation that could also address some of these barriers. However, it is yet to be passed. The bill aims to provide accessible, affordable, credible and sustainable legal aid services to low-income persons in Sierra Leone. With the majority of the population, particularly those in rural areas, often resorting to customary institutions to solve a wide range of justice problems and a small cadre of lawyers operating almost exclusively in the capital, a multi-faceted approach is essential for the provision of accessible, low cost, high quality services. The bill forms an essential part of the Justice Reform Strategy and Investment Plan 2008-2010 to make justice accessible for all by recognizing the important roles that paralegals play in providing basic justice services. A final draft was recently approved by the cabinet and is now expected to be placed before parliament.

In a move that could strengthen accountability, President Koroma had promised to legislate a Freedom of Information bill (formerly knows as the Right to Access Information bill) when he was elected to office. The bill guarantees that "every person has the right to access information held by or is under the control to a public authority." The bill lays out a system for requesting this information from government information officers, the expected time it should take to receive a response and any charges associated with the request. The bill has been stuck in the parliament for sometime now.

Lack of legal recognition of the right to health as a legally enforceable human right under national law, further obstructs access to remedies for women and girls victims of violation of the right to heath.

JUSTICIABILITY OF THE RIGHT TO HEALTH

Justiciability refers to the ability to claim a remedy before an independent and impartial body when a violation of a right has occurred or is likely to occur. Justiciability implies access to mechanisms that guarantee recognized rights. Justiciable rights grant right holders a legal recourse to enforce their rights, whenever the duty-bearer does not comply with his/her duties.[93]

According to the 1991 Constitution of Sierra Leone, economic, social and cultural rights (as defined in the International Covenant on Economic, Social and Cultural Rights) are not justiciable. 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 human rights" set out in Part III of the Constitution, this provision does not confer "legal rights" which are enforceable in a court of law.

The lack of justiciability of the right to health, therefore further impedes access to remedies. When a pregnant woman at a PHU or hospital is denied access to drugs or services, (which should be free according to the FHCI), there are no remedies available – even when a pregnant woman is facing a life threatening emergency requiring urgent care. There are no procedures for individual redress such as an apology or some form of compensation in the event of maternal death or injury. A father of a five month old baby told Amnesty International:

> *My wife did not deliver at the hospital. She delivered at home because we were asked for 15000 le (USD 3.4) for medicines. We have no money. I want to complain, but do not know what to do.*[94]

According to the UN Committee on Economic, Social and Cultural Rights any 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.*[95]

It has also stated,

> *National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.*[96]

International law requires that states parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.[97] It also requires that judges and members of the legal profession should be encouraged by states parties to pay greater attention to violations of the right to health in the exercise of their functions.[98]

Without access to remedies, human rights mean very little. To be effective, all remedies must be accessible, affordable and timely. A remedy can be provided by a court or another institution that acts on complaints. International law also

entitles all victims of human rights violations access to reparations. Reparations require that, as far as possible, the consequences of the violation are corrected. The body providing a remedy should award the measures necessary to repair the specific harm suffered by victims, including some or all of the following: restitution, rehabilitation, compensation, satisfaction and guarantees of non-repetition.[99]

The continued lack of recognition of the right to health remains a major obstacle to women and girls accessing remedies. As explained by a representative of a civil society organization:

> *There is no culture of accountability. Health is not considered as a human right, most government officials think that it is a service they provide…But the problem is more complex in relation to maternal mortality, so many women die while giving birth, people don't think it is a violation of human rights. There is also an issue with the legal system, people do not trust it. The Legal Aid bill has been pending for years now.*[100]

The incorporation in Sierra Leone's domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures. Incorporation would enable the courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant. [101]

However, recognizing the right to health will not on its own guarantee effective remedy for violations when they occur. It is necessary for the courts to be independent from the government and to be able and willing to award effective remedies. The barriers preventing access to the courts must also be addressed.

6. CONCLUSION AND RECOMMENDATIONS

"The honeymoon period is over and our people must benefit from this programme."

President Koroma, July 5, 2011

Amnesty International campaigned for and welcomed the launch of the FHCI by the government of Sierra Leone. It represents important progress in lowering financial barriers to care for pregnant women. However, for this policy to be effectively translated into tangible outcomes in relation to maternal health, additional measures need to be undertaken. As the President highlighted, there is a need to identify "the weaknesses of the programme" so that corrective measures can be taken to address gaps "that have led to leakages."[102]

To ensure that the FHCI is effective and sustainable the Government must build on its existing initiatives and institute measures to strengthen the health system. As this report demonstrates there are clear gaps in the monitoring and accountability systems, which can undermine the progress made in other areas.

It is crucial that authorities are able to respond to lack of facilities, non-availability of drugs, systematic bad practices, corruption and other challenges. The government must ensure that women are informed of their right to redress and available complaint mechanisms and are able to participate in the monitoring and accountability processes. Monitoring and accountability bodies must have a strong mandate, be adequately resourced and be accessible, independent, and transparent and able to recommend remedies to improve delivery of health services. True deterrence – which is a principal goal of accountability - requires transforming the underlying, untenable situation that gives rise to widespread maternal mortality, not just restoring a prior equilibrium.[103]

Recommendations to the government of Sierra Leone:

The government must take effective and swift action to ensure pregnant women and girls have access to all essential EmOC drugs and to healthcare throughout their pregnancy. These steps should include immediate measures, such as a directive to all levels of the health services underlining the FHCI. Other measures to address the systemic problems described in this report may take longer to implement but urgent steps should be taken on the following:

1) Conduct a systematic assessment into the leakage and stock-out of essential drugs.

2) Reform and strengthen procurement, distribution and storage systems with respect to drugs.

3) Strengthen monitoring, evaluation and accountability mechanism to combat corruption and mismanagement in procurement, storage and distribution of drugs and supplies.

4) Ensure proposed systems to improve accountability and access to remedy, such as the proposed receipt system for drugs and the proposed hotline, are effectively tested before being rolled out. In particular the government should consider ways to involve healthcare users in the testing processes to ensure they are robust.

5) Conduct periodic assessments of progress based on the UN process indicators as set out in the Nationwide Needs Assessment for Emergency Obstetric and Newborn Care Services in Sierra Leone at least once a year.

6) Establish effective, accessible, participatory administrative mechanisms in the health sector to receive and investigate reports and complaints from users of health services about the violations of their rights. Any such mechanism should be developed and implemented with the participation of women and girls.

7) Carry out a nationwide public education campaign to raise awareness among the population, targeting specifically women and girls on:

    a. the government's commitments and plans including the FHCI;
    b. mechanisms for complaints and redress; and
    c. the right to health.

8) 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. To strengthen protection of the right to health, the government should also
    a. ratify the Protocol to the African 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 domestic laws to conform to the provisions of the Protocol;
    b. become party to the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, allowing the right of individual petition, and opting into the inquiry mechanism under that Protocol; and
    c. encourage the Human Rights Commission of Sierra Leone and the National Ombudsman to address violations of the right to health, ensure they have sufficient capacity to do so, ensure that systems to submit information about violations are accessible and well publicized.

ENDNOTES

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[6] CESCR General Comment 14, para 44.

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[10] Convention on the Elimination of All Forms of Discrimination Against Women, 1979, Article 12; CESCR General Comment 14, para 14.

[11] CESCR General Comment 14, para 14; CEDAW Article 12; Convention on the Rights of the Child, 1990, Article 24.2b.

[12] 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).

[13] CESCR General Comment 14, para 14.

[14] CESCR General Comment 14, para 14; CEDAW Article 12; CRC, Article 24 (2b).

[15] CESCR General Comment 14, para 59

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[42] Amnesty International interview with Health for All Coalition Sierra Leone (HFAC-SL), October 2010.

[43] Amnesty International interview with the MoHS, October 2010.

[44] Health for All Coalition Sierra Leone, *Report on Monitoring Activities*, p. 23.

[45] Based on feedback received from Ministry of Health and Sanitation, August 2011.

[46] Anti Corruption Commission, *Monitoring of the Health Review Recommendations*, 2010, p.9.

[47] Based on feedback received from Ministry of Health and Sanitation, August 2011.

[48] Amnesty International interview, Yam's Farm, October 2010.

[49] Amnesty International interview, Yam's Farm, October 2010.

[50] Amnesty International interview, Kanema, October 2010.

[51] For the purposes of this survey a questionnaire was prepared which was administered by a monitor. Questionnaires were administered both in English and Krio (as relevant). The monitors randomly selected the PHUs in their district and also conducted focused group interviews within the community. They also interviewed the members of the DHMT. Questions ranged from general information about the community: number of facilities, distance to the facility, number of pregnant or lactating women to access services since the FHCI, their experience, challenges if any that they faced and their experiences of seeking remedy if services were denied.

[52] Amnesty International focused group interview with doctors, Freetown, October 2010.

[53] Amnesty International interview, Bo, October 2010.

[54] Amnesty International interview, PCMH, Freetown, October 2010.

[55] Amnesty International interview, Freetown, October 2010.

[56] Based on feedback received from Ministry of Health and Sanitation, August 2011.

[57] Amnesty International interview, Mercy Ships, October 2010.

[58] Amnesty International interview PCMH, October 2010.

[59] Amnesty International interview, Ministry of Health and Sanitation, October 2010.

[60] Based on feedback received from Ministry of Health and Sanitation, August 2011.

[61] Save the Children and Health for All Coalition Sierra Leone, *Hurdles in Clearing Free Healthcare Drugs*, Concord Times, 1 July 2011.

[62] Amnesty International interview Anti Corruption Commission, October 2010.

[63] Amnesty International interview with UN agencies, October 2010.

[64] Amnesty International interview with donor organisation, May 2010.

[65] Amnesty International interview, October 2010.

[66] Shira Stanton, *The Health System in Sierra Leone – A Human Rights-Based Analysis for Medico del Mundo Espana*, September 2010; see also Ministry of Health and Sanitation, National Health Strategic Plan 2010-2015, page 8.

[67] Ministry of Health and Sanitation, "Operations Manual for the Reproductive and Child Health Programme 2008," page 14; see also the Hospital Boards Act 2003.

[68] Anti-corruption Commission, *Towards a Better Healthcare Delivery System,* 2009, page 10.

[69] Shira Stanton, *The Health System in Sierra Leone,* 2010; see also Katherine Whiteside Casey, "Decentralization in Practice," in Yongmei Zhou ed., *Decentralization, Democracy and Development: Recent Experience from Sierra Leone,* 2009, World Bank, page 60.

[70] GoSL, Local Government Act, 2004, section 20.

[71] MoHS, *Operations Manual for the Reproductive and Child Health Programme*, 2008, page 11 and 14.

[72] Shira Stanton, *The Health System in Sierra Leone*.

[73] UNICEF/WHO/UNFPA, *Guidelines for Monitoring Availability and Use of Obstetric Services*, 1997.

[74] Amnesty International interview at the MoHS and visits to the facilities, October 2010.

[75] Anti-corruption Commission, *Monitoring of the Health Review Recommendations*, 2010.

[76] Amnesty International interview, Yam's Farm, October 2010.

[77] Amnesty International interviews Freetown, October 2010.

[78] Amnesty International interview, October 2010.

[79] Amnesty International interview, PCMH, Freetown, October 2010.

[80] GoSL, Medical Practitioners and Dental Surgeons Act 1994 (as amended)

[81] MoHS, Designing of Sierra Leone's Simple Performance Based Financing Scheme, 2011.

[82] Based on feedback received from Ministry of Health and Sanitation, August 2011.

[83] GoSL, Human Rights Commission of Sierra Leone Act 2004, Section 1.

[84] Amnesty International interview, July 2011.

[85] Clare Castillejo, *Building Accountable Justice in Sierra Leone*, FRIDE Working paper 2009, p.16-17.

[86] Clare Castillejo, *Building Accountable Justice in Sierra Leone*, 2009.

[87] See press releases from the office of the ombudsman available at http://www.ombudsmansl.org/PressReleases

[88] GoSL, Anti-corruption Commission Act, 2008, sections 42-44.

[89] These are components of the institutional mechanism of the health and sanitation sector. The District Medical Officer leads a District Health Management team which is responsible for supervising healthcare workers at the district level and village health committees help resolve disputes between patients and service providers at the village level.

[90] The supremacy of local courts in civil cases was recognised in the 1963 Local Courts Act and the Local Court Rules PN No 8 of 1964.

[91] Pamela Dale, *Access to Justice in Sierra Leone*, 2008, p.1.

[92] Pamela Dale, *Access to Justice in Sierra Leone*, 2008, p.10.

[93] International Commission of Jurists, *Courts and Legal Enforcement of ESC Rights*, 2008, p.6.

[94] Amnesty International interview, Moa Warf, October 2010.

[95] CESCR General Comment 14, para 59.

[96] CESCR General Comment 14, para 59.

[97] CESCR General Comment 14 para 62.

[98] CESCR General Comment 14, para 61.

[99] CESCR General Comment 14, para. 59 and UN General Assembly, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, A/RES/60/147, 21 March 2006, para. 18.

[100] Amnesty International Interview, October 2010.

[101] CESCR General Comment 14, para 60.

[102] GoSL, Press Release, Freetown July 5.

[103] Alicia Ely Yamin, *Transformative Accountability*, 7 Sur 12 (2010), p.98.

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AT A CROSSROADS
SIERRA LEONE'S FREE HEALTH CARE POLICY

Pregnant women and girls in Sierra Leone face continuing challenges in gaining access to maternal health care services. Despite important reforms initiated over the last two years, including a free health care policy covering pregnancy and childbirth, the health care system is dysfunctional and much remains to be done.

Health facilities are often short of essential drugs and supplies. Disparities persist between rural and urban areas, the quality of care is frequently substandard, and overwhelmingly women still have to pay for essential drugs.

A critical shortcoming within the health care system is the absence of any effective monitoring and accountability mechanisms. The existing processes are poorly resourced and focus on reviews of individual facilities rather than on monitoring obstacles women face in accessing services. There are no effective complaint mechanisms available to women and girls when their human rights are denied.

In this report, Amnesty International examines how gaps in monitoring and accountability are undermining the success of the recent health care reforms, in particular free access to essential drugs in pregnancy and childbirth. Amnesty International calls on the government of Sierra Leone to strengthen and establish monitoring and accountability mechanisms so that health care is accessible to women and girls and effective remedies are available if their human rights are violated.

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