MEDECINS SANS FRONTIERES

LESSONS FROM PAIN

Treating Sierra Leone's endless health emergency

EXECUTIVE SUMMARY

As it slowly emerges from a decade of civil war, Sierra Leone is struggling to repair its ruined economy, the basic infrastructure and the state's provision of essential services. Despite the relative political stability, the population's health status has not improved from the disastrous levels of five years ago. Mortality and morbidity numbers remain incredibly high. The healthcare system barely functions and there are huge deficits of staff and skills. MSF, which has been working in the country since 1994, is trying to fill some of these gaping holes.

This report documents MSF's experience in three critical areas of healthcare: malaria treatment, mother and child health, and the impact of user fees. It sets out the problems as recorded by our medical statistics and it contains substantial patient testimonies, which speak of the suffering regularly endured by people who have very limited access to what is normally inadequate care. Those personal histories also point to the difference that can be made by some relatively simple changes, which are already being implemented in MSF's projects.

In malaria treatment, the vital, missing component is Artemisine-based Combination Therapy (ACT). The Sierra Leone government agreed in July 2004 that it should become the new first-line treatment for uncomplicated malaria. MSF has been using it successfully in the country for two years. Despite public commitments and international funding the drugs have yet to reach patients in Ministry of Health facilities. Instead, chloroquine, to which the malaria parasite is widely resistant, is still being prescribed. A mother, whose son has just been successfully treated by MSF with ACT, describes how she had lost a daughter to what she believes was the same fever when she was given different pills at an MoH clinic that did not work.

In maternal and child health, the innovation that MSF is proposing is the provision of maternity "waiting houses" attached to district hospitals, where pregnant women can spend the last few weeks before delivering. One of the cruelest and most common causes of death amongst new born babies and their mothers is the difficulty of getting to a place where trained care can be given. The case histories record what a difference in life chances can be made by coming early to a "waiting house". MSF's own medical records suggest that despite the fact that many pregnant mothers are referred to the houses because they have high risk factors, mortality figures amongst women and children are much better than at hospitals which do not have them. They are also cheap and easy to run.

The cost of medical care and the impact this has on the ability of people to access that care is also a theme running through the patient stories. In late 2005 MSF conducted a survey in four rural districts of Sierra Leone[1] to look at the effect of various levels of charges and at the socio-economic condition of the population.

The study showed that there is a significant under use of health services in the formal system in Sierra Leone. Only one out of three households declared using the nearest health centre during their last episode of illness. The present healthcare payments are a substantial burden on households, they discourage them from seeking care and they create real risk of further impoverishment. Although in theory sick people who are unable to pay should be protected by an exemption system, the system is not working and poorest face exclusion. MSF's attempts to use a low, flat rate system of charges, rather than the tariff method applied in many MoH facilities, made some difference. However, the clearest evidence of the connection

1 See: *Access to healthcare in post-war Sierra Leone; A summary of a 2005 survey in four districts: Kambia, Tonkolili, Bombali, Bo* – Médecins Sans Frontières, January 2006.

between charges and health seeking behaviour came when MSF removed charges in some of its clinics and saw a doubling of patient numbers. The elderly man who tells his story of a long term struggle with disabling pain would not have been able to afford in an MoH hospital the treatment he received free from MSF. He probably would have died as a result.

MSF is aware of the complex deficits in the country's health sector, which will take decades to reform. However the three recommendations covered by this report show that reducing malaria deaths, as well as those among mothers and babies, and increasing people's access to medical care can already be achieved with relatively simple changes. The Sierra Leonean people should not have to wait for all of the structural reforms to make the final difference; things can be done to cut those unnecessary deaths rates now.

INTRODUCTION

Some five years after one of Africa's most devastating civil wars, Sierra Leone's health conditions are still at disaster levels. The slaughter once delivered by machetes and automatic weapons is now more stealthy and routine. People have always died here in huge numbers from malaria, from TB, from just giving birth or being born. That is the emergency the world has never noticed.
International health statistics put the country at or near the bottom of so many tables of suffering that it seems only to be expected when lives are drastically shortened and when pain is part of the landscape of poverty. Médecins Sans Frontières (MSF) has been working in the country for 12 years now and yet we were still shocked when our own mortality survey1 last year showed that the crude mortality rate averaged at 1.8 deaths per 10,000 people per day, while that for children under 5 was between 2.7 and 3.5. Both of these figures are well above internationally recognised thresholds indicating a health emergency.

The health system has been devastated and with only US$34 spent per person each year[2] its recovery is problematic. At the same time, the shortage of medical professionals is if anything growing. The "brain drain" combined with limited training facilities mean that the public sector at the last count[3] had one surgeon for every one million people and one midwife for every 26,000. Grinding poverty, minimal infrastructure and a perception of corruption at all levels completes the picture of the wider economy and society.
These are huge development challenges, progress on all of which has been disconcertingly slow since the end of the war. But Sierra Leonean people cannot wait for all of these issues to be solved. Something has to be done to cut those death rates and the torment that surrounds them. MSF has itself been struggling to respond in its specific commitment to health facilities in 3 of the 13 districts (Kambia, Tonkolili and Bo). We have had many of our own failures and frustrations. Even so, our experience in providing that direct medical care has documented that there are very substantial gains to be had from relatively simple changes that could be made to the rest of the health care system. This report describes three of them: Artemisine-based Combination Therapy (ACT) for malaria, waiting houses for near-term expectant mothers and free medical care at the point of delivery for the population as a whole.
There is compelling evidence from MSF's work that each of these changes can make a significant difference to lives and life expectancy in the country. Testimony from individual patients illustrates how the lack of these critical elements has proved disastrous for families. But then the stories also point to the dramatic change that can be achieved when these things are in place. Our medical data clearly support that anecdotal picture.

We are not pretending that these changes by themselves will answer the massive problems of access to effective medical care. We believe they are very necessary first steps while the big structural issues are being wrestled with. The government itself is pledged to implement ACT – but it has not yet done so. Mother and child health measures are so clearly a priority for the country's progress. While on the issue of funding the health system, we believe that the international donors need to reconsider their support for a charging regime that excludes so many vulnerable people. It is true that the health system cannot function on the funding currently available. Extorting cash from subsistence farmers and the mass of unemployed when they become sick is a desperate choice for public policy. All the testimonies here speak of the suffering it causes.

MALARIA: TREATMENT FAILURE

The burden of malaria on Sierra Leoneans is so constant and oppressive that in one MSF survey we found that between 25% and 39% of all deaths were caused by the disease, including up to 63% of deaths in children under five[1]. The country's climate and geography mean that the malaria season lasts from April to January every year. 95% of the parasite species are the most dangerous *Plasmodium Falciparum.*

For years the first line treatment for "uncomplicated" malaria has been the cheap and widely available chloroquine. Resistance levels inevitable grew and by the time MSF, along with the National Malaria Control Programme, conducted and presented a resistance study[4] in October 2003, the picture was bleak. The research showed that resistance to chloroquine was between 39.5% and 78.8%. MSF recommended that the national treatment protocol should be changed as quickly as possible to an effective ACT using Artesunate/Amodiaquine. That was finally approved by the Ministry of Health in July 2004 and at the same time funding for the new drugs was agreed by the Global Fund to fight AIDS, Tuberculosis and Malaria. MSF began using ACT in September 2004. More than two years later, the Ministry of Health (MoH) clinics across the country have still not received their ACT supplies, so patients have continued to get ineffective drugs for what is the most dangerous disease in the country.

The story that follows is one mother's experience of the difference that can make. Her son, Chernor, survived malaria, while her daughter did not.

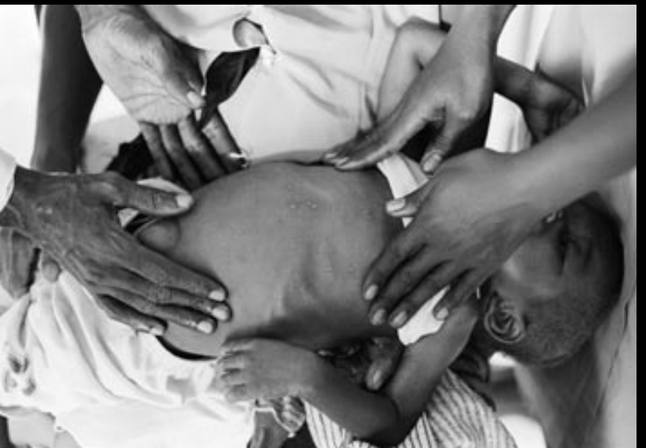
Chernor Kanu

Chernor arrived with his mother, Adamu, at the MSF paediatric ward in Kambia hospital in western Sierra Leone on the 27th July. He had a fever and was suffering from malnutrition, often a fatal combination for a child of two years two months old. A rapid test established that he had malaria and he was given an Artemeter injection and then a three-day course of ACT. The malnutrition, which so often accompanies malaria in young children in Sierra Leone, was treated with de-worming pills, amoxyciline for any infections, multi-vitamins, folic acid and concentrated milk intake. As Adamu explains, Chernor's story ended very differently from that of her only daughter, just over a year earlier.

When my daughter got sick last year she had a fever, a continuous fever. I tried to give her native herbs that you can get from the traditional healer in the village. They are secret remedies and I tried them for four days. Then I took her to the other (MoH) hospital. They gave me some pills and told me that I had to give them to her every day.

The charge for the pills was US$10 but I begged that I could only afford $5 and they accepted. But it was also another $6.50 to pay for the transport to the hospital and home. I had to borrow all that money. My husband works on a farm and we grow cassava to sell in the market. It took two weeks to pay back just the $5 and then they had to wait again for the rest.

So I went home with the pills and the baby was a bit better. But after the pills finished the baby got sick again straight away. She was shaking with



cold and I had to put her in front of the fire. This was more fever than before. I did not have any money to go back to the hospital and I was trying to get more. But the day after that the baby died. I was very sad because this was my favourite, it was my daughter and I loved her very much. A daughter will be a companion for a mother, she will look after you when you are old. I only had three other boys.

Now one of my sons, Chernor here, got sick with the same fever. I tried to give the native herbs but he was very hot and he was swelling all over his body. We believe that this comes from a sore in the stomach. So we need the native herbs to help to pass stool frequently and clear the stomach and the fever. My husband wanted him to go to the hospital at Kambia and I said, "How can we afford the hospital when we have no money?" But the people in the village told us that the people at the hospital there do not charge any money. It is for free. And I was very afraid that Chernor was going to die like before. Many people died in the village from the same fever.

The first thing that I did was to take him to the clinic at Mambolo, which is connected to the Kambia hospital. He was sweating all over and the clinic said he must go to the big hospital because his condition was so bad that they could not deal with it there. So when I came to Kambia they made lots of tests on my baby. They did not tell me what the problem was but they gave him some medicine. This time the nurses gave the medicine, not me.

After four days he was getting better. He was noticing me and was not so hot and was starting to want to eat. After six days he is much better and smiling and laughing. I am very happy that he will not die.
When I go home I will tell all the people that they should go to the Kambia hospital because they have the right medicine for the fever. They should go because everything is free. The medicine is free, even the food. And the medicine here is stronger than the other one. Maybe the other one was expired. When you spend the money in the other hospital and the medicine does not work…… Here they treat the child and it works.

The difference in the effect of medicines given to Chernor and his sister is unlikely to be to do with expiry dates. The MoH clinic that Adamu went to in 2005 in Port Loko district would have been using chloroquine as the standard treatment for malaria. ACT use had been agreed but not implemented and because chloroquine had been widely used and abused across West Africa, parasite resistance levels in the little girl were probably very high. Chernor was very fortunate to have been brought to one of the very few centres in the country where ACT is being offered. His mother brought him to avoid the charges at the other clinic but her initiative may have saved his life, as well as her limited finances.

Children under five are so vulnerable to malaria that in one district surveyed by MSF, 2.2 deaths per 10,000 per day were reported. This is well above the emergency threshold for mortality – and that is counting only the malaria deaths.

The continuing lack of ACT drugs in MoH health facilities is a scandal. There appears to be no satisfactory explanation for the cumulative delays in purchasing, shipping, distributing and training. As this report is being written, stocks have been arriving in the country but the record so far does not give confidence that the necessary arrangements have been made for the full and effective use of the supplies across the country. The scientific data, MSF's clinical experience and the government's own policy demand that this basic reform be instituted with maximum speed.

WAITING FOR SAFER BIRTHS

One of the clearest symptoms of Sierra Leone's disastrous health condition is the alarming risk of maternal and infant mortality. Put most simply, one in six women will die from having babies during their lifetime and one in six babies will die at birth[5]. These figures, generally recognised as among the worst in the world, are driven by a fatal mix of poverty, ignorance and poor health provision. But one of the most deadly elements is that of delay in getting to any health service that would stand a chance of improving the life expectancy of the mother and child. MSF has put a substantial effort over a number of years into trying to improve the chances for these patients. Our experience has led us to invest in maternity "waiting houses" located near the district hospitals in Kambia and Magburaka. They are designed to minimise the time between the onset of labour and contact with qualified help. They are open to any pregnant woman who wants to spend the last few weeks close to the hospital. But in practice they are most heavily used by expectant mothers who are referred by the MSF primary health care clinics as displaying particular risk factors in their current or previous pregnancies. The "waiting houses" are a simple and inexpensive answer to one of the greatest hazards about giving birth and being born in Sierra Leone.

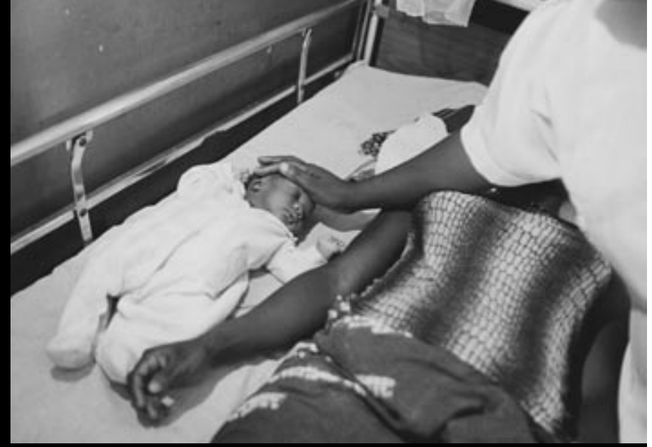
Kandeh Jalloh

Kandeh is about 25 years old and has just given birth to a healthy baby girl in the MSF maternity ward of Magburaka hospital. But she lives in Kendeya, which is some eight hours away on difficult roads towards the Guinea border. She arrived at the hospital on Jul 4th, stayed in the maternal "waiting house" and gave birth on the 23rd July. This is her story…

"I was born in Kendeya and my husband is a farmer. We rent a small piece of land and pay for it with part of the harvest. When I was going to have my first baby I was very happy. But then I was very sad because the baby was dead. It happened like this. Everything seemed to be normal when I was feeling the pains. The traditional helper from the village was with me. She said it was all right. Then the baby seemed to get stuck. I was pushing but the baby would not come out. I tried a lot and pushed a lot but when it came out it was a dead baby."

"The problem with the traditional helper is that I did not want them to push on my stomach. That is the thing that they do all the time because they think that it will help to make the baby come out quicker. They squeeze on the big belly very hard. But I know that this is not a good thing to do, so I told the lady not to press. She just sat there when I was trying to get the baby out."

"It was three years more before I got the second pregnancy. I was trying but it would not happen before. Then the same thing happened with the baby. It got stuck and it died before I could get it out. And it happened two more times, so four babies I lost in my own house because they would not come out."



"Every time I went to the same two ladies in the village who know the traditional ways. They were with me each time in my house but they did not have any new thing to tell me about how to have my babies alive. Every time the same thing happened. The baby came with its head first, which is the right thing. But then it would not come out all the way."

"I thought about the hospital that was closer than here. But it was two days walking from my house. There is no road that a car could go on. And when you get there they would make you pay money. We are poor and we have no money. So I had to stay at home. And the babies would not stay alive. Every time I was worried because of what happened before. But I had nothing else I could do. The distance was too far and we had no money."

"In my village there are different beliefs and traditions that explain what was the problem with me and the babies. I had dreams about chickens and in the dreams I killed them. This means that I had an evil spirit in me. Because I got pregnant at the time of this dream the people believe that it was the problem with the babies. I had to go through lots of ceremonies to try to get rid of the spirit and the dream with the chickens."

"I know that our parents thought that this was the reason but I was worried that it happened four times, so when I was pregnant again I wanted to try to get to a hospital. I did not want to sit there and depend on the traditional helpers again. And now there is a road for some of the way. I was asking my husband all the time and worrying him about how we should go to the big hospital, we must go to the big hospital. Then one day he finally said, "If you want to go there, now you can go". So I decided on my own that I should come."
"When I left home I was not in labour. I tried to save money by walking all the way to another village that is on the new road. That took one whole day. So that is why I started walking before I was having the birth pains. The transport on the road to here cost a lot of money, $6.50. It all had to come from selling what we grow on our farm."
"I came to the hospital because a relative of mine called Mabinti met me in the village. She told me to come here and helped me to come here. But after I got to the clinic and the waiting house I could not find my friend. So I went out to a village where some people sent for my husband to come down and bring me some more money."

"When I came back to the hospital I started to have some pains in my stomach that meant the baby was coming."

Kandeh went into labour and things progressed normally until the cervix was dilated to about 7cms. The midwife had been monitoring the foetal heartbeat and there were suddenly signs of distress. Kandeh was moved into the operating theatre, where it was decided that she should have a Caesarian section. The baby girl was delivered in good health.

"My husband is very pleased. The hospital has done the best for me. I have had all the traditions in the village but I never had a child. Now I am here and I have a live baby. The next time I will come here again and I will come early because that is a help."

Only that last part of Kandeh's story is unusual. Her ability to have her baby monitored and for a Caesarian to be performed quickly is very rare in Sierra Leone. Most mothers have to take their chances of giving birth at home with only the traditional herbs and birth attendants as support. Unfortunately, these are often more of a hazard than a benefit. Whatever positive effect the native remedies

might have is usually obliterated by over dosing. One mixture, which stimulates contractions, is frequently the cause of ruptured uteruses. There are deeply held beliefs about the causes and treatments of all kinds of medical conditions in Sierra Leone and they are particularly powerful at significant moments like birth. MSF and other agencies have struggled to convince communities that science-based medicine has something to offer. One of the greatest challenges has been in overcoming the perception that when patients get to hospital they sometimes die. They die because they often arrive very late in the development of the condition. Often they have tried everything else first, it hasn't worked and they then have to overcome the enormous difficulties of travel and cost to get the hospital. That is exactly the syndrome that the "waiting house" attempts to overcome by providing shelter and basic food for women in their last days of pregnancy. If the mothers can be attracted or referred by the antenatal clinics to go there – and the MSF experience suggests that the power of example is very persuasive – the late, crisis-laden arrivals are reduced.

The physical conditions that increase the risk of infant deaths are often those which threaten the mother as well. Babies have been saved by their mothers being in the "waiting house" when they have high blood pressure or when there is slow or obstructed delivery. This often arises from the narrow pelvises of very young mothers or the complications ensuing from female circumcision, which is almost universal in Sierra Leone. Mothers' lives are also at risk from these obstructed deliveries or from poor presentation of the baby's head. Pre-eclampsia is certainly a condition that can kill within hours and where the "waiting house" mother stands a much better chance of survival. Post-partum haemorrhage, as we shall hear, is an extremely dangerous event for home-birthing mothers.
Because the issue of timing can be so crucial, MSF clinics are referring mothers to the "waiting houses" when they have a range of risk factors, such as indications of large babies or multiple births, high blood pressure, anaemia, first pregnancy, fifth or more pregnancy, or previous Caesarean or complications. Although it is a very inexact science and not all problems can be predicted in this way, risk referrals do maximise the impact of the "waiting house".

The record of the relatively limited number of mothers passing through these houses in the last one and a half years suggests a substantial impact on mortality. A vital point here is that the houses would need to be backed by trained staff in the hospital, which is not always a given. But despite selecting for those most at risk pregnancies, the latest figures for women using the "waiting house" suggest that they are seven times less likely to die in childbirth as the average for district hospital intakes. For infant mortality, the figures are nearly twice as good as the average.

The other reason to recommend them is that they are simple to construct, do not require any special equipment or trained staff and are cheap to run. On hospital land a structure could be built for 30 beds at US$2,000, with another $2,500 a year on the three staff to run and guard it. MSF's houses are supported with food deliveries by the World Food Programme, which regards this as an effective way to reach a vulnerable group.

The "waiting house" in Kambia was donated by the local community and for women like Wara Kamara it changed their lives.

Wara Kamara

Wara lives in a village called Royark, several hours journey away from the maternity ward and its obstetric care in Kambia hospital. She gave birth after spending three weeks in the "Waiting House", having been referred there by the MSF clinic nearest to her home. Her story is not typical of most mothers in Sierra Leone who have life threatening complications. She survived.

"I had one child already, a boy, who is four years old. He was born in my house but at that time I was living in a different place. When I was pregnant I got swollen and went to the clinic. By boat and road that is about five hours away. They told me to eat less salt. At the time of delivery I had problems and felt very sick and it took me two weeks to be able to walk and do things in the house.

When I was pregnant again this time I was here in Royark. And I was worried all the time that I might have the same problems in delivering this baby. My grandmother too was worried and she took me to a clinic near to here, where they gave me some medicine. That was when I was about four months pregnant and I was having a headache a lot of the time. This stayed the same and I went at six months to the clinic at Gabongomaria. They gave me a bed net for mosquitoes and what they called a mother's kit for delivery. But still I was not feeling good and so when I was at eight months I went back again. This time they told me that the baby is not lying in the right position. They said that I should go to Kambia hospital and gave me a referral paper.

When I got my things from the house I travelled first by boat to Rokupr and then by car. It took me about seven hours to get to Kambia. The paddling boat was not fast and it took most of the time. It cost me $8 for the journey. In Kambia I went to the vaccination centre to ask how to get to the hospital and they told me how to find it. The nurse when I got there put me on a bed and asked me what was the problem with the first delivery. Then the midwife came and looked at my belly. She said that the baby was now lying in a normal position. She gave me some tablets and took me to the "Waiting House". They told me that the house was for the pregnant women, so that if any of them were having a problem they would come and stay there.

The idea was about having a safe delivery. Some women are swollen up or have other problems but if they are in this house they will get care. If you are at home and you have the same problems maybe it will lead to your death. When I was here and I started to have labour pains they took me quickly to the hospital. So that is much better than being at home many hours away.

For me, I know that if I was at home I would have the same problems that I had with my first pregnancy; bleeding and dizziness. But now I was in the labour ward and at six in the evening I gave birth. I was crying because there was too much pain. I could not get up until the next morning and I was not feeling good. The problem was that I was bleeding after the birth. They had to put a bag with a drip because I was not in a good condition. They also gave me an injection and I was in the hospital ward for two days afterwards. But the bleeding stopped soon."

Wara had post partum haemorrhage, which causes around a quarter of deaths in maternity cases in Sierra Leone. Because she was in hospital she was given an oxytocin drip and an injection of ergometrine to shrink the uterus and stop the bleeding.

"I want to have more babies but I know now that I must go to Kambia early. I have to go before delivery so that I can be always under nt and for it to be in time."

Wara's story was unusual in that she managed to get to a hospital well before she went into labour and developed complications. But in other respects it is a very familiar tale. Like most Sierra Leoneans, she and her family are poor and find it very difficult to afford the charges made at hospitals and clinics. After her first delivery she went to a Ministry of Health clinic for treatment and had to pay for everything she got there. On top of that are the travel costs, which are always a burden in a country with such a poor transport infrastructure.

"I am living with my father now and he cannot work so I have to borrow money to pay for long journeys and the health charges. So my father has to go and sit all day to catch fish at the edge of the water. Then he has to sell them to help repay the money. It cost $8 to go to Kambia. And sometimes if he is not lucky there will only be enough to eat not to sell any.

When I had my first baby and I was living with my husband in the south at Yelboa. I went to the hospital there afterwards for help and I was charged $13. My husband helps the owner of a fishing boat and that man gives him fish, which he can sell. My husband cannot do any real work for himself, only to help other people, because he is sick. He was hurt in an accident when a house fell on him. So when I had to pay the hospital his brothers and his family collected the money to help us."

Once again, that part of the history shows how hard it is for people in Sierra Leone to afford the cost of the medical care they need. After many years of observing and debating the consequences of these charging systems, MSF is convinced that in Sierra Leone they very clearly harm the ability of people to get care.

CHARGED TO DEATH

Sierra Leone is one of the poorest countries in the world, which creates enormous problems for the public finances as well for individuals. The health system, devastated by the civil war, is in a state of destitution. It had staggered through on the basis of a de facto system of charging. That process has recently been regularised through a formal system of cost recovery. The major justification was the chronic under-funding from the restricted state budget and insufficient support from international donors. But user fees are also seen by their supporters as benefiting health systems by instituting a form of rationing, which discourages frivolous visits and probably also helps reduce demand on the very limited human skills available.

As a partner with the MoH, MSF has itself charged for services in those facilities that it supports. However, there were so many instances where the system seemed to produce unfairness or to discourage people from coming at all, that we conducted a thorough study of the impact of these charges. The figures quoted here are from that survey of access to healthcare, conducted in four districts in April and June 2005. The study exposed a pervasive trend of people avoiding the formal healthcare system where charges were made. The source of comparison was with free care being offered by MSF in Bo district and a low, flat fee charged in other MSF facilities. Around 50% of households with a medical problem used the free or flat fee centres, while only 35% went to the MoH cost recovery centres. Amongst the poorest segment of the population, people were only half as willing to go to the cost recovery clinics.

This study was focussed mainly on the primary health care sector, where the vast majority of health-seeking – or avoiding – behaviour takes place. It found that only one third of households said they used the nearest health centre during their last episode of illness, when the centre used the cost recovery system. We are talking about only very small charges, which make a huge difference to people's probability of getting medical care. In the survey, 97% of the population lived under the threshold of extreme poverty with less than US$1 a day. An average household of 7.4 people lives on around $10 a week. So paying over $3 in the cost recovery centres as the average charge represents at least 3 days of income for the whole family.

As we have heard already from our previous patients, sums beyond that scale are much more difficult. More than 6 out of 10 households in the study admitted that they had to use risky survival strategies to get the money. They either went into debt or pawned possessions. Imagine then the position of someone needing even minor surgery.

Momoh Turay

Momoh is a sixty-year-old man who was admitted to MSF's emergency surgery ward at Magburaka hospital on the 22nd July. He was crying with pain because he had been unable to pass urine for days. It was a chronic complaint complicated by a hernia but he now needed rapid draining. However the catheter would not pass through his urethra and a surgeon had to put it through his abdominal wall directly into the bladder. The treatment was free. Momoh's story is about why that matters:

"I am a farmer from Makurrgbeh village which has about one hundred houses in it. I have two wives, three sons and four daughters. The problem

that I have now started about five years ago when I had diarrhoea. Because I was straining all the time I started a hernia. There were people in the village who knew what to take for that and I sent my children into the bush to get the bitter herbs for me to chew so that they would relieve the pain. It would go away a bit for a time and then come back."

"From that time I hardly urinated properly. I tried more native herbs but they did not do any good. There is a health centre in the village and I went to see the nurse. She told me that she could not tackle the problem I had and that I should go to a hospital to have it treated. But I did not go. The problem is that when I have been to the health centre for other things, for pains in my stomach, they tell me that I have to pay money.

I am a farmer who grows to eat. I have a small farm that I sow with two or three bushels of seed (probably around two or three acres). It is my own inherited land from my forefathers. I grow rice, cassava, pepper, corn, millet and sorghum all on the same land at different times of the year. But is not enough for us to eat. Often I do not have any spare rice to sell. Sometimes it is only a quarter of what we need to eat, so it is difficult to sell any to buy other things.

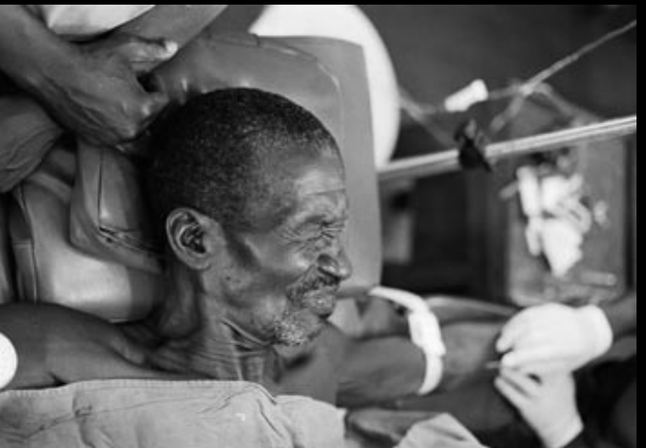
"My children now are full grown and they have families themselves. So my daughters have married and left my home. But I have my sons' wives and some grandchildren with us. That is now 14 people on the farm. It means that if I fall sick I have to depend on friends and supporters in the village to give me money. Or my family would have to borrow money. If you do that then for a subsistence farmer it takes a long time to pay back – maybe one, two, three years. You have to offer to pay what you can because you still have to eat, even if that is not enough."
"There was a big problem with my eldest son. He was sick and went to a hospital. But he had no money and he stayed there for ten days in the hospital without treatment because we did not have the money. He died. That was five years ago. But even today it would still be difficult to raise the money. If MSF was not here most of the people in the villages would be dead because they cannot afford treatment."

I have many relatives who have died. They do not go to the health centres in time. They try to buy drugs from the "pepe doctors" who sell drugs in the villages. By the time that they come to the hospital it is too late and that is why some of them die. Maybe it is only 50 cents for the pills but they do not do any good."

"This is all the problem of poverty. If you have a limited amount of money and you fall sick, then the poverty will not allow you to go and pay to go to the hospital. Because if you do then all of that money will go and you will have nothing left at all. So I prefer – if I have $3.50 – to remove 50 cents and go to the pepe doctor and keep the $3. But it only works if you have a small problem. If it is a serious problem is doesn't work. It works for a short time. If you take the drugs then the pain goes and it comes back after a short time."

If Momoh was not getting free care from MSF he would have to pay a range of charges in the public hospital system. On arrival and registration it would be 60 cents. Then to see the doctor would be another $1.70 for consultation. Then a "bed fee" to stay in the ward would be between $3.50 and $5.00. The catheter itself would be $1.70 and then there is the surgeon's fee. It depends on the area but it would be between $20 and $35. On top of that are the charges, as cost recovery, for any drugs. In this case it would be more than $5.

"For me, when I had this pain and the swelling my family had to borrow the money to pay for the transport for me to get here rather than to die in the village. The extended family will make small gifts so that we can repay the loan.



If Momoh had not been able to get free care and could not afford the charges for his operation he would have had a very painful death, eventually from renal failure.

Government policy on user fees does grant exemptions where sick people are unable to pay. But there are several problems with this. Whatever the theory, MSF's survey shows that of the exempt categories (children under five, breastfeeding mothers and elderly people) no more than 3.5% of patients actually received an exemption. That kind of practice must contribute towards the pattern whereby the population do not even go to a health centre to be considered for an exemption. What often happens is that the MoH tariff of charges is added to by desperate or greedy health workers, who charge what they think they can get away with. Even the official "list prices" are highly negotiable and vary a lot across the country.

MSF believes that providing care free of charge at the point of delivery is clearly the better alternative to the failures of the cost recovery system. That system does not contribute substantially to the running costs of the health service but it does act as a major barrier to people using it. MSF has stopped charging at all in its facilities and believes that the MoH, with the support of international donors, should do the same. It is a necessary first step towards improving the dire state of Sierra Leoneans' health and life chances.

BEGINNINGS

It can be argued that the complex and interrelated deficits in the health picture will take decades to reform and turn around. The appalling shortages of trained medical staff, the lack of emergency transport and decent roads to health facilities, the very low levels of public consciousness about basic health information, all these certainly hold the country back and cost many lives. The three recommendations here and the testimonies that accompany them are intended to support that long struggle with some early and uncomplicated victories.

Reducing the toll of malaria, cutting deaths among mothers and babies and increasing everyone's access to medical care must be immediate priorities that will create clear and overdue signs of progress in public health provision.

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MSF IN SIERRA LEONE

MSF has had a permanent presence in the country from 1994 and during much of that time the organisation has been involved with trying to meet some of the medical needs of the large numbers of people driven from their homes by the conflict within the country and in the wider region. As those concentrations of displaced people have decreased, MSF has focussed on filling some of the huge gaps in the healthcare system and on the needs of particularly vulnerable groups like children and pregnant women. Currently there are 390 national and 35 international staff working on our projects.

In the northwestern Kambia district, MSF is providing primary and basic secondary care. There are five health clinics in the rural areas, which give consultations, supply medication and refer more serious cases to the District Hospital. In its wards MSF works on maternal health and paediatric care, and has been involved in integrating HIV and tuberculosis treatment.

In Tonkolili district there is another range of rural clinics and a similar involvement in secondary care at Magburaka Hospital, where there is also a more substantial surgical component.

MSF also works in Bo, where it provides primary health care in the 5 clinics it supports, seeing approximately 20,000 patients a month, 10,000 of them being treated for malaria. Gondama Referral Centre, outside the large city of Bo, admits more than 500 patients a month. The facility offers inpatient care, an intensive care unit, a burns unit and a therapeutic feeding centre for malnourished children.

Colophon
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Graphic design: Ideart / Karin Hackfoort