Secure Livelihoods Research Consortium

Mapping Sierra Leone's plural health system and how people navigate it

Key messages

- Sierra Leone is characterised by a plural health system, combining state and non-state health providers that people move between.
- Citizens navigate this plurality with reference to a number of factors, including proximity, cost, tradition, perceived effectiveness, experience of treatment and household power relations.
- The dominant paths of healthcare access vary across communities, so those seeking to improve healthcare must understand how the above factors play out in different contexts and tailor programmes accordingly.

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A traditional healer holds up the Koran and the herbs he uses to treat illness in Kambia, Sierra Leone

Gaining a better understanding of how to build state capacity to prevent malnutrition requires getting to grips with the nature of the health system itself, and how and why health seekers make decisions about which provider(s) to use. Sierra Leone is characterised by a plural health system: there is no one single provider, but rather diverse providers that cut across state and non-state provision. Understanding how and why people use the health services available to them is critical in developing appropriate interventions to address malnutrition.

Our research set out to make sense of people's relationships with the full range of health providers available to them, focusing on three communities at varying distances from state health facilities in Kambia District, northern Sierra Leone. This briefing sets out our findings. First, it maps the actors that constitute the plural health system and the relationships between them. Second, it examines the factors that influence health-seeking behaviour before setting out some recommendations on ways forward.

Cooperative plurality

Sierra Leone has a plural health system with multiple providers that users decide between. This plurality of health providers is, in part, a legacy of Sierra Leone's experience of civil war and the breakdown of state functions that accompanied the conflict (Scott et al. 2014).

Five providers were repeatedly mentioned in interviews and focus groups. From the most to least formalised, these include:

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1. **District hospitals** – located in district capitals. In Kambia, the district hospital has the only qualified practising doctor in the district.
2. **Peripheral Health Units (PHUs)** – government-run clinics providing everyday healthcare. In descending order of size, these include: Community Health Clinics (CHCs); Community Health Posts (CHPs); and Maternal and Child Health Posts (MCHPs). There are 1,228 PHUs across Sierra Leone.
3. **Community health workers (CHWs)** – community volunteers who have undergone training either by PHU or NGO staff in first aid and often child malnutrition screening.
4. **Traditional birth attendants (TBAs)** – women in the community who assist expectant mothers throughout pregnancy and delivery. Efforts have been made to sensitise TBAs to refer women to PHUs for delivery.
5. **Traditional healers** – including both herbalists, who treat illness using plants and animal products, and religious healers, who treat illness through spiritual means (Scott et al., 2014: 296).

The first three of these providers are part of the state-provided healthcare system – although community members did not view providers as a part of, or outside of, a particular 'system'. They were all referred to as options within the realm of healthcare, and connections were as strong between state and customary providers as they were between different levels of state provision.

In addition to these frequently mentioned health providers, two others deserve mention despite coming up less frequently during our research. The first, drug peddlers, are traders who sell medicines (often expired or counterfeit) without prescription or consultation. People often have to rely on them when faced by stock-outs in PHUs.

The second, not mentioned at all, are secret societies. Both male and female secret societies (*Poro* for men, and *Bondo* for women) are repositories of spiritual knowledge, with society elders believed to possess knowledge of spiritual treatments for illness. These societies are a particularly inscrutable health provider. No up-to-date data exists regarding membership, but it has been estimated that 91% of women in Sierra Leone have undergone clitoridectomy, a key part of society initiation for girls (Statistics Sierra Leone and ICF Macro, 2009: 13). It is likely that *Bondo* plays an important role in maternal health, as women's secret societies have traditionally been involved in practices surrounding childbirth (Fanthorpe, 2007).

The plural health system helps overcome the shortage of formal healthcare providers in the country. According to the WHO (2011), Sierra Leone has just 1.9 physicians, nurses and midwives for every 10,000 people, which falls far short of the recommended ratio of 23 providers per 10,000 people needed to deliver basic health services.

Our research found that these providers are largely cooperative rather than competitive, often referring cases between each other. We also found that it is common for people to use multiple providers at once to maximise chances of recovery, rather than moving through providers in a sequential manner (Scott et al., 2014: 298). These are important features to be considered when attempting to alter health-seeking behaviour and to minimise unintended consequences.

Factors influencing decisions about health care providers

Given this plural and largely cooperative health system, how do households navigate the options available and what factors influence decisions? We found that the path taken is influenced by proximity, associated costs, tradition, perceived effectiveness, and the way users are treated by providers. These factors are mediated by power relations within the household, which are fundamental to decision-making vis-à-vis health seeking behaviour.

Proximity

The most apparent obstacle to reaching health providers is the sheer distance that people have to travel. This is a binding constraint influencing decisions about where to seek healthcare. This was most apparent in research site 1, located six kilometres from the PHU. No one in the community possesses a vehicle and so travelling to the PHU means hiring a motorbike taxi or walking. No phone signal means people are reliant on motorbikes which come through the town four days a week on an ad hoc basis. Such challenges mean that many mothers only travel to the PHU for what they consider to be serious matters. Three mothers have delivered babies whilst walking to the PHU – and on one occasion the child died.

The Government of Sierra Leone has sought to overcome the challenges of geographical access by training CHWs, who can assist in monitoring illness at the community level and refer those requiring treatment to the PHUs. However, CHWs are not widely used in our research site and receive limited training.

Associated costs

The costs associated with healthcare providers come in three forms: (1) user fees, (2) travel costs and (3) lost time.

1 User fees

In 2010, Sierra Leone introduced the Free Health Care Initiative (FCHI) for pregnant and lactating women and children under five, formally abolishing user fees for a basic healthcare package (Donnelly, 2011). It was estimated that approximately 230,000 pregnant women and nearly one million infants would benefit from the free healthcare services in any given year (GoSL, 2009). Research suggests that the FCHI has led to greater uptake of government health services and between 40% and 52% of children with diarrhoea, fever or presumed pneumonia are brought for government healthcare (Diaz et al., 2013; Statistics Sierra Leone and Ministry of Health and Sanitation, 2010).

Despite this success, some PHUs continue to charge user fees. In two of our research sites, communities consistently reported having to pay PHUs for healthcare services and medicines. In some cases, these were services or medicines not covered by the FHCI and communities were simply unaware that these services were meant to be paid for. In other cases, PHU staff did appear to be charging for services or medicines that are meant to be free (reportedly between $0.23 and $1.59 per visit - in context where 50% of the population lives on less than

$1.25 per day (World Bank, 2011)). Thus, while the FHCI has had a transformational impact on health-seeking behaviour for many, cost remains an important barrier to access, particularly in remote communities.

Traditional healers and TBAs also charge fees for health services, but these were felt to be flexible, as they could be paid over time, or in kind. However, some community members noted that traditional healers can be more expensive than PHUs, depending on the treatment prescribed. For instance, if an animal has to be purchased as part of the treatment then traditional healers can become costly.

2 Travel costs

While user fees may be charged by traditional healers, TBAs and PHUs, if the PHU is not located within the community and requires travel it becomes much less affordable. In research site 1, the distance to the PHU, combined with a lack of vehicles within the community, meant that any trips required substantial walking or travel costs: a motorbike taxi takes 30 minutes and costs $1.14. In research site 2, while the presence of an MCHP alleviates travel costs in the first instance, community members reported taking those who remain ill to a larger PHU several kilometres away by car or boat.

3 Lost time

Costs should also be thought of in terms of time and lost earnings. The majority of people do not have access to cars and only some have access to motorbikes. This means that PHUs are often reached on foot, which can take hours – especially for pregnant women. After having travelled to the PHU very early to arrive by mid-morning, women often have to wait until the afternoon to see clinic staff. Travelling to a PHU takes substantial time away from other tasks such as farming, cooking, caring for children, market trading, etc.

Perceived effectiveness

The perceived effectiveness of health providers is a key factor when deciding where to seek help (Diaz et al., 2013). Unfortunately, other constraints can outweigh the perceived effectiveness of treatment, meaning people are forced to use services they do not deem to be the most effective.

The majority of community members in research site 2, and some in research site 1, felt that the PHU offered better care than alternative providers. Mothers generally said that PHU medicine worked more quickly than traditional medicine. In communities where access to PHUs was not a problem, households generally opted to take sick children to the PHU first. However, in site 1, even where some mothers felt PHU medicine was more effective, accessibility and affordability issues meant they often relied more on alternative providers.

Many community members claimed, however, that there are some illnesses more effectively dealt with by traditional medicine. This is primarily where illness is perceived to be caused by spiritual forces, rather than underlying biomedical problems, although malaria and typhoid were also mentioned in this regard. Some people reported pursuing both traditional and PHU medicine simultaneously when they were unsure of what caused an illness. Where people pursue both approaches in tandem, it is difficult for them to know which has been effective, and therefore which provider they would use the next time someone was ill.

Manner in which providers treat users

Decisions about where to seek healthcare are influenced by previous experience of treatment by providers, including the experience of others. In research sites 1 and 3 many community members reported poor treatment by PHU staff – including staff being rude, unhelpful and denying women water after their long walk to the clinic. Such experiences deterred not only the women directly affected, but also others within the community. Consequently, respondents spoke of often skipping the PHU and going directly from traditional healers to the district hospital.

'Tradition'

While alternative health providers, such as traditional healers and TBAs, are used in large part because they are closer and considered more affordable, they are also perceived to offer a unique form of treatment that other providers cannot deliver. Illness in Sierra Leone is often considered a manifestation of the spiritual world and traditional healers are seen to possess the ability to mediate with the spirits of ancestors who must be appeased for a sick person to recover (Ferme, 2001). Understanding these beliefs and how they relate to malnutrition is important to finding sustainable solutions to prevent it.

There is also a high level of respect accorded to elders and traditional knowledge in Sierra Leone. Because traditional healers are venerated in society, even individuals who do not actually believe in their treatments take them seriously. This is particularly the case where the traditional healer is a religious leader, as their treatments are bound up with social norms about good behaviour.

Role of household power relations

Mediating all of the above factors is the nature of household power relations which is critical in understanding health-seeking behaviour and decision-making.

In all our research sites, fathers dominate decision-making about where to take children when sick. In part, this is due to their control of household income – necessary to access most health providers. Even where women make their own income, this is almost always handed over to their husbands.

Decisions are also influenced by paternal grandmothers, who often live with their sons. It is often these women who encourage traditional remedies for illness that they used for their own children, when PHU facilities were more scarce and not free. However, our focus groups indicated grandmothers appear to welcome PHU healthcare (bearing in mind the limitations, discussed above) as much as others in the community.

Recommendations

Our research sheds light on an interactive network of health providers that Sierra Leoneans navigate on the basis of multiple factors.

For those seeking to strengthen Sierra Leone's health system, it is critical to understand its interactive nature and the multiple entry points that can be used to prevent malnutrition. Too often reforms focus on understanding delivery systems from a top-down perspective, capturing only formalised providers (Denney et al., 2014). What is missing is an understanding of the entire health system from the perspective of end-users (Luckham and Kirk, 2012). From this view, it is possible to capture the diverse range of providers – both formal and informal – and the ways they interact.

- **Recognise that the ways in which communities use health facilities varies from community-to-community and tailor interventions accordingly.** This includes understanding how communities access healthcare. Interventions that can adapt to these dynamics will prove more successful than those that overlook them.
- **Work more systematically through non-state actors.** In plural health systems people rarely use government providers exclusively. Efforts to prevent malnutrition and respond to illnesses that can exacerbate it must build on an understanding of how users actually navigate the health system, rather than on preconceived ideas about how a modern health system ought to work. This means greater work with traditional healers, TBAs, drug peddlers and secret societies – recognising that these are utilised health providers and that bringing them into the conversation about preventing malnutrition is more effective than sidelining them. One way to do this is through CHWs, who have an in-depth understanding of how things work in their communities (see Theobald et al., 2014).
- **Invest in CHWs and integrate them into the health system.** CHWs fill important gaps in Sierra Leone's health sector – yet our research found they are often underutilised, undertrained and unconnected to other health providers. However, CHWs are well-placed to assist in a number of areas – including providing important local context to those wanting to strengthen local health systems. CHWs need significantly more training and incentives so that they, and their communities, take the role seriously.
- **Build community trust in PHUs.** Negative community attitudes towards PHUs discourage attendance. This is problematic given that PHUs are one of the main channels through which health messages are disseminated. There are four ways in which trust in PHUs could be strengthened:

  1. Clarify what is and is not covered by the FHCI so that communities are aware of what they are entitled to and what they must pay for.
  2. Stamp out PHU staff illegally charging for items that are covered by the FHCI. Such practices are extremely damaging to the relationships between health-seekers and health providers. Part of this will involve ensuring that PHU staff are paid on time and that they are appropriately incentivised in their day-to-day work. It will also require strengthened monitoring.
  3. Ensure PHU staff receive training in patient care. Poor treatment by staff is a key factor deterring people from using PHUs. Technical training must be complemented by softer people skills necessary in providing healthcare, particularly to communities sceptical of modern medicine.
  4. Improve the efficiency of drug supply chains between Freetown and remote PHUs. People often have to travel significant distances to access a PHU, taking time away from productive activities. When drugs are not available, they are sent back home and told to return later. Not only does this undermine trust and confidence in the formal health service, it also encourages the use of unregulated drug peddlers.

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