



HUMAN
RIGHTS
WATCH

“No Money, No Care”

Obstetric Violence in Sierra Leone



“No Money, No Care”
Obstetric Violence in Sierra Leone

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Summary

The doctor said, “don't pay, it's all for free,” but you have to pay [the nurses] if you don't pay you will suffer and die, and they will just leave you to die.

—Former patient¹

She died at the hospital ... It was because of money, because of that, the nurses did not take prompt action.

—Traditional birth worker, speaking about a maternal death she witnessed²

The baby was not breathing; that was all they told me. I did not feel like I could ask for more information.... Why? Because they had all the power, and I did not have power.

—Former patient whose baby died during birth when she was left unattended for a long period of time³

Obstetric violence is a very common and, so far, mostly invisible dimension of how girls and women are discriminated against and their autonomy and dignity undermined by individuals or systems. Obstetric violence, which takes place in health facilities providing reproductive and especially maternal health care, is a form of gender-based discrimination. It can take a wide range of forms such as health providers beating and hitting pregnant or birthing women, verbal and psychological abuse, the use of unnecessary medical interventions, delaying care, withholding pain relief, detaining women, and unnecessarily separating women and their newborns.

Obstetric violence includes severe abandonment and neglect, forms of abuse that this report examines especially closely in the case of Sierra Leone where devastating results include avoidable maternal and newborn deaths, injuries, and suffering. When a provider

¹ Human Rights Watch interview, name withheld, Kabala, December 10, 2024.

² Human Rights Watch interview, community member, Kabala, December 10, 2024.

³ Human Rights Watch interview, name withheld, Manonkoh Village, Bombali Sieray chiefdom, Bombali district, Freetown, December 11, 2024.

delays clinical support to a women giving birth in extreme duress because she has no money, it sends a clear message; she is powerless and unimportant.

This report, based on more than 130 interviews with patients, healthcare providers, government officials, and public health and policy experts in Sierra Leone, in 2024 and 2025, seeks to provide insights into obstetric violence in Sierra Leone by examining how women, especially indigent women, are at higher risk of obstetric violence if they cannot make informal cash payments to staff in government facilities for services, drugs, and other commodities, even if in an obstetric emergency.

Officially, according to government health policy, no woman or girl in Sierra Leone should be paying for maternal or newborn health care at government facilities. Despite being a post-conflict country and one of the most impoverished countries in the world, Sierra Leone made a major commitment to women’s rights, announcing the Free Health Care Initiative (FHCI) in 2010 to address what was among the globe’s highest rates of maternal and infant mortality at the time. This government policy guaranteed free-of-cost health care for pregnant and lactating women and children under five at public healthcare facilities.

The FHCI ostensibly removed cost as a major barrier to facility-based birth and has remained official policy since, although never written into law, and never adequately resourced by the government. Sierra Leone has seen dramatic improvements in official maternal death rates since 2010. In 2010, about 1 out of every 100 women died during childbirth in Sierra Leone, according to data from the World Health Organization. This meant that childbirth was 59 percent more dangerous in Sierra Leone than the average among African countries that year, and nearly 300 percent more dangerous than the global average. However, by 2023, the most recent year for which this data are available, Sierra Leone had reduced the likelihood of maternal mortality to nearly one-third of what it was in 2010. The FHCI is sometimes credited as having driven significant increases in women birthing in hospitals and clinics but localized bans and fines—many which are still in force—on traditional birth attendants supporting home deliveries were also put in place at the same time.

While maternal and newborn health care is meant to be free, in reality it is often not. All 50 Human Rights Watch interviewees who had recently given birth said that they had paid for

some element of their maternal health care. Most interviewees said they felt the quality of the care they received, including how quickly, how kindly or respectfully, and how effectively they were treated by providers was generally dependent on payment.

When unable to provide such payments, interviewees said they were treated brusquely by providers and ignored in hospital corridors or left waiting on benches for hours or even longer while their families struggled to pull together some cash. One interviewee described watching providers delay treatment for a woman who later died “because of money.” Another woman whose baby eventually died waited for days on a hospital’s grounds for medical attention at the end of her pregnancy, which she believes she would have received if she had been able to pay. All non-government experts and many government officials too, when speaking off record acknowledged that these individual experiences are part of a much broader problem for pregnant women. Postpartum women and experts used words such as “a ghost,” “a mirage,” or “a utopia,” to describe the FHCI, others simply stated “it’s not working.”

Inadequate public funding for health care, provided by what is likely a 50 percent unpaid volunteer workforce, has left Sierra Leone’s public healthcare system, as a whole, largely reliant on generating operating revenues from patients through “out of pocket” payments or “OOPs” and through both formal and informal means. OOPs are payments that people must make to receive a healthcare good or service when they require it, whether treatment in a hospital’s emergency department or medicine from a local pharmacy. In 2022, more than 50 cents out of every dollar spent on health care in the country came from OOPs, according to data from the World Health Organization. However, this data may not reflect all the costs of informal payments or bribes, which Human Rights Watch found to be common in the maternal health space.

All forms of OOPs can undermine the right to health and other economic, social, and cultural rights because they can make it too costly for people to access goods and services essential for rights. Such cost-based barriers are harmful in countries, like Sierra Leone, where a large share of the population experiences poverty. But they are especially pernicious in the context of pregnancy, birthing, and post-partum care, where these cost-based barriers can lead to acute and even life-threatening harm that can constitute obstetric violence, which the African Commission of Human and Peoples’ Rights recognized, in March 2025, as a form of gender-based violence and discrimination that violates human rights, including the right

to dignity, the right to freedom from torture, the right to health, and the right to life. While state failures to adequately resource and manage maternal and newborn health care systems are not obstetric violence per se, obstetric violence can, as shown in the case of Sierra Leone in this report, be a devastating result.

In Sierra Leone, the heavy reliance on OOPs to fund health care also creates additional risks that can negatively impact the right to health and contribute to obstetric violence. Because OOPs for health care are so often levied through informal means throughout the country, with providers directly soliciting patients for money without regularized or more transparent forms of billing, it is often difficult if not impossible for patients to determine whether they are being asked to pay for a good or service, such as medicine they require (and if so, whether at a reasonable or extortive cost), or a bribe. These levies are toxic to patient-provider relationships and corrode trust, communication, and respect. Costs can be exorbitant for patients, and providers may bully or withhold care for patients until they have paid. Especially in the case of complex emergencies or hospital births, women and cash-strapped families have no idea how much they might end up paying.

The official government position is that providers are banned from asking for money for goods or services, but government system failures that Human Rights Watch believes are responsible for the patterns of obstetric violence documented in this report mean that providers must often do so to keep working. Roughly half of the government health care workers in Sierra Leone are unpaid, working as volunteers in the hope of eventually getting paid work. These providers still need money for the years it often takes to be put on government payrolls. High work stress levels in facilities with empty medicine stores, no lifesaving blood, and no or low salaries for staff, are also increasingly exacerbated by extreme heat in overfull, uncooled facilities.

This report finds informal payments that girls and women must make to access maternal care undermine the right to health by creating barriers to accessing health care based on one's ability to pay. As well as documenting healthcare providers who withhold or delay the provision of medicines and services when women and their families could not pay, Human Rights Watch also documented cases where people experiencing poverty were forced to forego care. One postpartum woman, for example, did not get a needed blood transfusion because she had already spent all her cash paying for birth-related commodities and services.

Longer-term harms result from costs and poor treatment in facilities. These interconnected factors are making women delay going to facilities for births, or sometimes even decide against it. Such cost-based barriers to accessing health care also intersect with other forms of gender-based discrimination, other ways girls and women are silenced and positioned without autonomy. Because men often control household finances in Sierra Leone, women are often forced to ask permission from male relatives to pay for required care, including in situations of extreme duress. Provider curtness and demonstrations of medical superiority worsen tensions and dramatically reduce trust and information sharing between the patient and provider, including the willingness and ability of women and girls to articulate their concerns, needs, and wishes, thereby silencing them. It also creates a setting in which patients can feel constantly under threat of abandonment or delay by providers. Anti-poor and misogynistic discrimination are complex forces in any society and hard to quantify or pin down in interviews. But everywhere, in assumptions voiced and in how blame was placed, this report found evidence that normalized discrimination against poor women and girls, often with low literacy, plays a role in obstetric violence in the country.

The Sierra Leone government has taken important steps, including the recognition that addressing disrespectful maternity care is a public health priority, and since 2020 has made specific efforts to address this as part of broader quality of care improvements. But more action is required of the government, a party to multiple international treaties protecting women’s rights including the Maputo Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, which provides protection from “harmful practices or all other forms of violence, abuse and intolerance.”

The government should publicly recognize that the public healthcare system is failing to respect, protect, and fulfill the human rights, including agency, of all girls and women, and that maternal and newborn health care is very often not, in fact, currently, cost-free. The government should also recognize that harms extend beyond public health, to extremely negative implications for patients’ right to life, and right to non-discrimination, sense of self-worth, health, and wellbeing, and girls’ and women’s status in society.

Sierra Leone should continue trainings and other efforts to address disrespect and abuse by providers directed at pregnant and birthing patients. Officials, nongovernmental organizations, and girls’ and women’s rights activists should consider augmenting this work with national information campaigns that center the experiences of birthing girls and

women, patients' rights, and human rights. Significant improvements are urgently needed to facilitate patients' ability to report mistreatment, access remediation, including real consequences for extortion, and see improvements in their local healthcare facilities. Any complaints mechanism, however, should be co-designed with patients and former patients and be easy to use by everyone, including women who cannot read and write.

Under international human rights law, Sierra Leone has obligations to respect, protect, and fulfill economic, social, and cultural rights, which includes the right to health. This includes the obligation to progressively realize these rights, and to dedicate the maximum of their available resources to reach the highest possible standards of these rights.

Sierra Leone is a very low-income country, but it can commit to doing more to meet these obligations. It should enact measures that will help it progressively raise additional public revenues in ways that are aligned with human rights, including through implementing progressive forms of tax and reducing tax abuses. It should also enact measures that will progressively increase public spending in ways that improve the enjoyment of economic, social, and cultural rights, including by increasing public funding for the healthcare system, and maternal care, in particular.

To better ensure the right to health of women and children and reduce the abuses documented in this report, the government of Sierra Leone should urgently apportion needed funds to pay for FHCI commodities now in extremely short supply and reduce their volunteer health workforce. The government should also make concrete commitments to reduce the healthcare system's reliance on regressive sources of financing like OOPs by increasing public funding for health care in line with international public healthcare spending benchmarks (some of which they have publicly committed to).

While the government can and should do more, the human rights harms documented in this report also reflect the policies and practices of other, wealthier governments, including Sierra Leone's creditors. Sierra Leone's creditors, including the International Monetary Fund, should assess the impacts of debt payments on the abilities of the government of Sierra Leone to meet its human rights obligations, and provide debt restructuring or relief where necessary to enable the adequate funding of health care and other rights-essential public services. These governments should also support rights-

aligned reforms to international tax rules that would help the government of Sierra Leone better prevent tax evasion and avoidance.

Donors also play an important role in ensuring the availability, accessibility, and quality of health care for women and children in Sierra Leone. Funds from foreign donors, whether grants from foreign governments or donations from private actors to nonprofit providers in Sierra Leone, accounted for about 28 percent of all healthcare spending in the country in 2022, according to data from the World Health Organization. Donors, whether governments or private institutions, should continue providing financial support for health initiatives that provide free-of-cost healthcare for women and children in Sierra Leone, which is vital to ensuring the right to health.

Human rights law also obligates governments to engage in “international cooperation and assistance” to support all states’ ability to progressively realize economic, social, and cultural rights. Such cooperation should extend to international tax rules that enable governments to fairly tax corporations with economic activities in their territory and adequately prevent tax abuse and illicit financial flows. According to the Atlas of Offshore Wealth, a database maintained by the EU Tax Observatory, an independent organization that advocates for tax justice, households in Sierra Leone held \$410 million in wealth in offshore tax havens, amounting to around 11 percent of GDP. Levying a tax on such wealth could generate enough revenues for Sierra Leone to significantly increase its public healthcare spending.

Creditors, both government and private, should ensure that debt servicing obligations do not come at the expense of rights. In November 2024, the International Monetary Fund approved a \$248.5 million program to Sierra Leone that noted the country was spending as much on debt servicing as it was raising in revenues, putting it at “high risk of distress.”

Governments should support Sierra Leone’s, and other countries’, ability to adequately fund healthcare, including, for example, by supporting ongoing negotiations for a UN convention on international tax cooperation that improves the ability of governments, particularly in the Global South, to raise tax revenues, including by preventing companies from shifting profit to tax havens and illicit financial flows. Actors in Sierra Leone, including United Nations agencies, nongovernmental organizations, and the government itself, should avoid obfuscating and sanitizing the realities of both constant payments by

women into a “free” maternal health system and the prevalence of abusive treatment directed at pregnant and birthing people.

The Sierra Leone government and the thousands of health care workers and other actors who provide care and other resources to pregnant and birthing girls and women in the country have made very significant improvements to maternal care and rights. If adequately resourced and managed, the Sierra Leone government’s free health care initiative, or another health system that ensures all women can access maternal and newborn care including in obstetric emergencies, can save lives and support girls’ and women’s rights.

Recommendations

To the Government of Sierra Leone:

- Publicly acknowledge the human rights harms, including obstetric violence, caused by the current maternal health system as a major obstacle to girls' and women's rights in the country.
- Take actions that explicitly improve women's rights in the maternal and newborn health sector, help address imbalances in power between patients and providers and increase awareness through public information efforts on patient rights and women's rights in healthcare, including in pregnancy and delivery.
 - Implement a country-wide and multimedia-based information campaign about the harms of obstetric violence, patients' rights, and girls' and women's rights, and the importance of ending disrespectful treatment of girls and women in health facilities.
 - Together with systems changes (see below), continue provider training and other quality of care improvement initiatives including ones that improve respectful maternity care.
 - Establish a patients' feedback and complaints system designed for low-literacy environments where clients feel disempowered and ensure that patients can easily provide information about their experiences of abuse and the services, drugs, and commodities they paid for without fear of recrimination, and ensure that facilities respond appropriately to complaints.
- Reduce reliance on informal payments and other out-of-pocket costs (OOPs) to fund healthcare facilities, goods, and services, and increase the availability of healthcare goods like essential medicines by increasing the allocation of domestically-sourced public funds to the provision of health care, and reproductive, maternal, newborn, and child health care in particular, including by:
 - Urgently insuring funding for urgently needed procurements of Free Health Care Initiative commodities and drugs.
 - Urgently fulfilling commitments to reduce the use of and reliance on the volunteer health workforce in a way that is fair to all health care workers.
 - Making public commitments to and publicly communicating specific measures that the government will enact to make progress towards meeting international public healthcare spending benchmarks associated with

greater healthcare access and outcomes, such as spending the equivalent of at least 5 to 6 percent of gross domestic product (GDP) or 15 percent of total government expenditures on health care.

- Reaffirming the government’s commitments to ensuring the rights of women and children under the age of 5 years to free-of-cost or, at a minimum, affordable health care and ensure that any planned social health care insurance or similar government schemes designed to improve access to health care does not exclude any indigent pregnant or postpartum girl or woman.
- Improve the regulation and oversight of public healthcare providers involved in the delivery of maternal and newborn health care. Urgent actions should include:
 - Publicly outline specific measures that the government will enact to make progress towards reducing the informality of healthcare financing and corresponding medical corruption, including by establishing a taskforce, led by civil society and that includes community-based women’s groups, which will make recommendations on reducing abuses, including obstetric violence, related to medical costs and debt.
 - Reduce the actual and perceived diversion of publicly procured healthcare resources, particularly essential medicines, by improving oversight systems for the procurement, distribution, storage, and dispensing of healthcare commodities.
 - Improve the collection of healthcare outcomes data, particularly regarding reporting on maternal deaths, medical complications arising during perinatal care including severe maternal morbidity, neonatal deaths in facilities, and still births. Efforts should include patient-centered and careful information provision to families.
- Increase the generation of domestically sourced public funds to allocate towards rights-essential public services such as health care, including by:
 - Increasing tax receipts from forms of taxation that equitably distribute the burdens of financing public services (e.g., progressive income taxes), with an aim to progressively increase the generation of these resources towards the average among low-income countries and then beyond, towards a level appropriate for the adequate and sustainable financing of health care.
- Ensure businesses making profits and especially those extracting resources from Sierra Leone are sharing the financial benefits of their businesses with

communities, including by directly or indirectly benefitting maternal and newborn health.

To Sierra Leone’s bilateral and multilateral creditors, including the International Monetary Fund:

- Sierra Leone’s creditors should assess the impacts of debt payments on the ability of the government of Sierra Leone to meet its human rights obligations and provide debt restructuring or relief where necessary to enable the adequate funding of health care and other rights-essential public services.
- The International Monetary Fund should ensure that the social spending floor included in its loan program with Sierra Leone is adequate to fund health care and other rights-essential services.
- These governments should also support rights-aligned reforms to international tax rules that would help the government of Sierra Leone better prevent tax evasion and avoidance, including the ongoing UN Tax Treaty negotiations.

To Governmental, Nongovernmental, and Multilateral Organizations That Support Maternal and Newborn Health and Rights in Sierra Leone:

- Governments that provide bilateral official development assistance (ODA) for public and private healthcare initiatives in Sierra Leone, and particularly programs that provide maternal and newborn health care, should continue to do so.
- Governments in the Development Assistance Community (DAC), in particular, should meet their commitments to spending the equivalent of at least 0.7 percent of gross national income on ODA, and should strive to address shortfalls in funding caused by the US’ recent withdrawal of aid and assistance in Sierra Leone.
- Financially support nationwide efforts by academics, journalists, and civil society to better understand and publicize the true scale of informal payments in maternal and newborn health and the impacts on individual women, newborns, and communities.
- Support programs that enhance knowledge of human rights, including women’s and girls’ rights to non-discrimination.

Methodology

This report was written and researched by Human Rights Watch. Human Rights Watch conducted this research as part of its global initiative to publicize and increase recognition of obstetric violence as a women’s rights issue and as a form of violence against women problem that has been largely neglected.

Human Rights Watch began its research with a scoping trip to Sierra Leone in 2023, followed by four other research and advocacy trips in 2024 and in February and July 2025. From 2024 through 2025, Human Rights Watch interviewed 50 women about their experiences recently giving birth. Most of these interviews were done individually, but some were in small groups. After initial research indicated that women in referral hospitals or with complicated births experience the most acute problems including gross neglect and abandonment, Human Rights Watch sought out women to interview who had experienced birth complications in addition to those who had not.

Most research took place in the capital, Freetown, and its surrounding areas, the most populated part of the country, and areas of increasing in-migration. To include the experiences of women in other parts of the country, Human Rights Watch also conducted research in Kabala town, Koinadugu district, and Makeni town, Bombali district, both in Sierra Leone’s Northern Province.

Human Rights Watch also interviewed 55 providers, who were mostly midwives and obstetricians but also nurses and community health officers. Most of these interviews were done individually, but two small groups were interviewed to save the providers’ time.

Alongside interviewing women who had recently given birth and providers, Human Rights Watch made on-site visits to primary health care units and hospitals, including hospitals in Freetown and Kabala. This report focuses on the Princess Christian Maternity Hospital (PCMH) in Freetown, which is the main referral hospital in the country and thus has an outsized impact on maternal and newborn health and is a site of some of the greatest strain for providers and patients.

In addition, Human Rights Watch interviewed 30 other experts in maternal and newborn health in Sierra Leone, including 12 government officials, among which were five senior Ministry of Health and Sanitation officials covering reproductive health; and United Nations, donors, and nongovernmental organization (NGO) representatives with deep knowledge of maternal and newborn health.

Interviews were mostly in English, but some were in Krio with interpretation support. Human Rights Watch obtained informed consent from all interviewees, who were clearly told that no benefit would accrue or be denied in connection with their decision to participate or not, and that Human Rights Watch does not and will not provide any health or other similar services or funding, and interviewees could choose not to answer any question and end the interview at any moment. Human Rights Watch did not provide compensation to interviewees, but it paid small fees to local organizations' members who helped identify interviewees and interpret. Human Rights Watch's interview process attempted to avoid re-traumatization and where relevant referrals to health services were made.

Except for some government officials who were able to speak on record, the names of all interviewees have been withheld to protect patients and providers who respectively gave or received informal payments. This report intentionally uses "informal payments," which is a softer term for what might technically be considered extortion, petty medical corruption, or illegitimate payments, because "informal payments" better decenters the official illegality or wrongdoing of individual providers who are operating under difficult, unpaid, or underpaid circumstances.

In June 2025, to clarify some facts, seek further information, and provide an opportunity for a right to reply so that our findings could be reflective of all relevant perspectives, Human Rights Watch sent letters with questions to the two different parts of the Ministry of Health and Sanitation, the main referral hospital for obstetrics (also managed by the Ministry of Health and Sanitation), and to the UK Foreign and Commonwealth Development Office (FCDO) in Sierra Leone. Human Rights Watch only received one letter in response in mid-October from the West Africa Team at the FCDO and information from that letter is reflected in this report. However, several senior government officials in the health ministry provided in-person or online interviews to Human Rights Watch after the letters were sent and answers to many questions (although not all). That information has been included in this report. Human Rights Watch also had an off-the-record meeting with the Chief

Superintendent and Head Matron of the Princess Christian Maternity Hospital during which the findings of this report were discussed.

Background

Defining Obstetric Violence

Human Rights Watch does not have a fixed definition of obstetric violence but considers the following elements of how women and girls are treated in reproductive and, especially, in maternal healthcare to be of particular importance: physical violence, physical restraint, verbal abuse, denial of autonomy and decision making, stigma and discrimination, and severe neglect.⁴

Like all forms of gender-based violence, obstetric violence is complex, consisting of both individual acts of abuse and patterns of gendered, racialized, and classed social hierarchies, expectations, and actions. Obstetric violence can consist of acts generally considered to be violent, such as hitting or yelling at a birthing woman or a newborn, and those that are not considered as such, such as performing cesarean sections (or C-sections) to financially or otherwise benefit the provider but not the patient, or touching a woman's genitals without asking permission. Obstetric violence can result in a range of harms; usually, it harms the victim unnecessarily and disregards or takes away their autonomy.⁵ According to the World Health Organization, “disrespectful and abusive treatment during childbirth in facilities” include:

outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health

⁴ Human Rights Watch, *Addressing Obstetric Violence in Africa, Abused in Health Care Systems Amounts to Violence Against Women*, November 13, 2024, <https://www.hrw.org/news/2024/11/13/addressing-obstetric-violence-africa>.

⁵ The International Confederation of Midwives provided a useful description: “Obstetric violence refers to the mistreatment of women during childbirth, which can manifest in various forms. It includes physical violence, loss of autonomy; being subjected to any clinical intervention without appropriate informed consent; being shouted at, scolded, humiliated, or threatened; and being ignored, refused, or receiving no response to requests for help. It may also include non-evidence-based practices, such as routine episiotomy and lack of access to physiological birth. Disrespect, mistreatment and obstetric violence has an impact on women, and has been associated with birth trauma, postpartum depression, post-traumatic stress disorder, negative implications on sexuality, exacerbated risks of complications during childbirth, and distrust in the health system resulting in unwillingness to seek medical care.” See International Confederation of Midwives statement, “Obstetric Violence and Mistreatment and Violence Against Women in Reproductive Health Services,” November 24, 2024, <https://internationalmidwives.org/resources/obstetric-violence-and-mistreatment-and-violence-against-women-in-reproductive-health-services/> (accessed May 2, 2025).

facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.⁶

These types of treatment can lead to obstetric violence. Obstetric violence can also be the result of a health system's actions that may ignore a specific woman's important personal choices, in ways that significantly humiliate or diminish her. For example, certain medicalized childbirth (or over-medicalized where interventions are used even when they are not needed), such as fetal monitoring or induction, when opposed by the pregnant person undercuts their autonomy.⁷

Obstetric violence is also a children's rights issue insofar as it affects pregnant and parenting girls and teenagers who are children under international human rights law, as well as the mother-baby dyad. For example, the state forcibly separating a newborn from their carer may have long-term impacts on the newborn's wellbeing and may constitute obstetric violence if not medically necessary.⁸ Increasingly, activists have pointed to the importance of the mother-baby dyad's interlinked rights to breastfeed, to be together, and to be treated with compassion.⁹

However, the term "obstetric violence" remains controversial among some health care professionals. Some public health and provider groups reject the term "obstetric violence"

⁶ World Health Organization, "The prevention and elimination of disrespect and abuse during facility-based childbirth", September 14, 2024, <https://www.who.int/publications/i/item/WHO-RHR-14.23> (accessed August 29, 2025).

⁷ Joanna N. Erdman, "Commentary: Bioethics, Human Rights and Childbirth", *Harvard University, Health and Human Rights*, June 11, 2015, <https://www.hhrjournal.org/2015/06/02/commentary-bioethics-human-rights-and-childbirth/> (accessed May 2, 2025). Erdman writes in support of a sociological approach to "defining" obstetric violence: "Rather than subsume individual experience under a human rights norm, [sociologists] to construct the content of that norm from the particulars of experience. A richer concept of autonomy in medicalized care is constructed from a fuller appreciation of different women's different needs in labor and delivery." A tension remains between ensuring a useful definition of the problem, but also that health and rights groups remain as open and inclusive as possible to a range of experiences. See also Pickles C. "Everything is Obstetric Violence Now': Identifying the Violence in 'Obstetric Violence' to Strengthen Socio-legal Reform Efforts", *Oxford Journal of Legal Studies*. 2024 May 4;44(3):616-644. doi: 10.1093/ojls/gqae016.

⁸ See for example, World Health Organization, "New research highlights risks of separating newborns from mothers during COVID-19 pandemic," March 16, 2021, <https://www.who.int/news/item/16-03-2021-new-research-highlights-risks-of-separating-newborns-from-mothers-during-covid-19-pandemic> (accessed May 7, 2025). A large body of research has examined the health and human rights harms of forcibly separating incarcerated women from newborns. See for example, Jennifer G. Clarke and Rachel E. Simon, "Shackling and Separation: Motherhood in Prison" *US American Medical Association Journal of Ethics*, September 2013, accessed August 29, 2025, doi: 10.1001/virtualmentor.2013.15.9.pfor2-1309.

⁹ See, for example Mary Kinney et al., "Born Too Soon: Progress and priorities for respectful and rights-based preterm birth care," *Reproductive Health* 22 (Suppl 2), 112 (2025), accessed August 29, 2025, doi.org/10.1186/s12978-025-02042-w.

in facility-based care because they believe the term unfairly suggests providers' intention to harm and is "an unjust and offensive term, generating a defensive and less collaborative mindset."¹⁰ The International Confederation of Midwives supported the term in a 2024 statement, reasoning that "[a]s with all forms of violence, the only way to end it is to name and define it" and "the term places the experiences, needs and wishes of women at the same level as those of health professionals."¹¹

Other important commentators have also said that ending the normalization of, and making more visible, oppression that supports patriarchal, anti-women, or anti-poor norms in clinical settings is crucial.¹² While state failures to adequately resource and manage maternal and newborn health care systems are not obstetric violence per se, obstetric violence can, as shown in the case of Sierra Leone described in this report, be a damning result.

Maternal Health in Sierra Leone

Sierra Leone has made important improvements in indicators of maternal and newborn health. However, the maternal mortality rate is still very high, most of these deaths are preventable, and the rate at which children under five die remains among the very highest in the world.¹³

¹⁰ Diogo Ayres-de-Campos et al., "European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA) Joint position statement: Substandard and disrespectful care in labour – because words matter," *European Journal of Obstetrics and Gynecology and Reproductive Biology*, Volume 296, 205 – 207, accessed August 25, 2025, doi: 10.1016/j.ejogrb.2024.02.048. For another rejection of the term "obstetric violence," see: Frank A Chervenak et al., "Obstetric violence is a misnomer," *American Journal of Obstetrics & Gynecology*, March 2024, accessed August 25, 2025, doi: 10.1016/j.ajog.2023.10.003. For more on the debate around terminology, see Patrizia Quattrochi, Clémence Schantz et al., "Obstetric violence: abuse during childbirth is widespread, but the first step to fighting it is naming it," *The Conversation*, October 2, 2024, <https://theconversation.com/obstetric-violence-abuse-during-childbirth-is-widespread-but-the-first-step-to-fighting-it-is-naming-it-235161> (accessed May 5, 2025).

¹¹ International Confederation of Midwives, "Obstetric Violence and Mistreatment and Violence Against Women in Reproductive Health Services," November 22, 2024, <https://internationalmidwives.org/resources/obstetric-violence-and-mistreatment-and-violence-against-women-in-reproductive-health-services/> (accessed May 2, 2025).

¹² For example, in her report, the former UN Special Rapporteur on violence against women and girls, Dubravka Simonovic, noted: "Similar to the #MeToo movement ... victims of obstetric violence are often silenced or afraid of speaking out because of a fear of taboos, stigma or a feeling that the violence they have experienced could constitute an isolated incident; testimonies from women have shown that mistreatment and violence during childbirth is widespread and engrained in the health system." UN Human Rights Council, "Report of the Special Rapporteur on Violence against Women and Girls, its Causes and Consequences, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence", A/74/137, July 11, 2019. https://digitallibrary.un.org/record/3823698?v=pdf&ln=zh_CN (accessed May 2, 2025), para. 16.

¹³ United Nations Children's Fund, "UNICEF in Sierra Leone Annual Report 2024," 2024, <https://www.unicef.org/sierraleone/media/2971/file/UNICEF%20Sierra%20Leone%202024%20Annual%20Report.pdf> (accessed July 28, 2025). The report states: "Of particular note is a 15 per cent decrease in the under-five mortality rate, from 109 per 1,000 live births in 2019 to 94 in 2023" but also acknowledges that roughly one in ten children dying before reaching

A 2009 Amnesty International report noted that Sierra Leone’s high number of maternal deaths—the highest in the world at that time—“could ultimately be traced to the high cost of care and the fear of such costs.”¹⁴ In 2010, because of activism by national organizations such as the Healthcare for All Coalition, Amnesty International Sierra Leone, and others, over the extremely high maternal mortality rate, Sierra Leone’s government announced the Free Health Care Initiative (FHCI) to provide pregnant and lactating women and girls, and children under five with free health care at government facilities.

The FHCI is often credited with being an important part of major improvements in maternal health and as a driver of large increases in the proportion of births taking place in facilities/with a skilled birth attendant. However, the FCHI is not a law, and the government has inconsistently and inadequately allocated public resources towards its realization.

The FHCI was also accompanied by government policies that encouraged local authorities to ban home births accompanied by traditional birth attendants (TBAs), experienced attendants without or with little clinical training, as another kind of incentive to get women to deliver in healthcare facilities. These bans and the fines that often accompanied them are implemented by chiefs and other local authorities across Sierra Leone.

Home births have declined since then (see table below). TBAs, which would have formerly assisted with such at-home births, now sometimes work as health workers linking pregnant women to healthcare facilities, sometimes receiving a fee or payment in kind from patients or NGOs for this work.¹⁵

five years of age is unacceptably high. On maternal deaths, see also UN Population Fund, “Sierra Leone, Maternal Mortality,” <https://sierraleone.unfpa.org/en/topics/maternal-health-10> (accessed August 25, 2025).

¹⁴ Amnesty International, “Out of Reach: The Cost of Maternal Health in Sierra Leone,” September 22, 2009, <https://www.amnesty.org/en/documents/afr51/005/2009/en/> (accessed May 7, 2025). The report describes how “[t]housands of women die each year from complications related to pregnancy and childbirth in Sierra Leone. Almost all of these deaths could have been prevented by accessible, affordable and timely medical care. The resources devoted to health care are totally inadequate. The discrimination women face in almost all aspects of their life in Sierra Leone is reflected in the lack of priority given to their health needs and undermines their right to health.”

¹⁵ Human Rights Watch interview with Tom Sesay, director of policy, planning and information, Ministry of Health and Sanitation, Freetown, July 16, 2025. This policy, which has never been formalized or made into law, is widely implemented by local chiefs and other local authorities, not by the central ministry. “The fines are different in different places not formalized, the communities come up with their own actions, come up with strategies impose a fine, in some places women are fined too, some places the fine is only on TBAs doing births, we’ve not stepped in to impose policies communities are encouraged to take action,” explained Mr. Sesay. This policy is controversial, some commentators see it as taking choice away from women and forcing women into facilities where they can face violence and costs, but others say that the poor practices by TBAs mean a ban is needed.

Even in its early years, the FHCI was plagued with oversight problems. A 2011 Amnesty International report found failures in monitoring and accountability, particularly regarding access to essential drugs for pregnancy and childbirth. It also found women and girls had no recourse to grievance or complaint mechanisms to report the many obstacles they faced in using the healthcare system, including informal payments and OOPs.¹⁶ All these problems remain today as later sections of this report will show. Still, a large study, the Sierra Leone Demographic Health Survey, in 2013, found significant improvements in the years following the FHCI.

The 2014 to 2016 Ebola epidemic in West Africa was especially devastating for birthing women, who, because the virus is spread by bodily fluids, were sometimes shunned from health facilities.¹⁷ But the outbreak also left the country traumatized, and its health system upended. Healthcare workers in Sierra Leone were traumatized and experienced burn out and have since continued to face extremely hard working conditions.¹⁸

Despite this, measures of maternal health outcomes have continued to improve since then. The Sierra Leone Demographic Health Survey in 2019, the most recent comprehensive household survey conducted by the government, found large improvements in the maternal mortality rates (MMR), the number of maternal deaths per 100,000 live births, as well as other important indicators of maternal and newborn health care outcomes (see table on the following page).

¹⁶ Amnesty International, "At a Crossroads, Sierra Leone's Free Health Care Policy," September 6, 2011, <https://www.amnesty.org/en/documents/AFR51/001/2011/en/> (accessed May 5, 2025).

¹⁷ Benjamin Black, *"Belly Woman, Birth, Blood and Ebola: the Untold Story,"* (Neem Tree Press, 2024).

¹⁸ Guy O. Taylor, "Perspectives of Sierra Leoneans Healthcare Workers' Mental Health During the Ebola Outbreak," *Walden Dissertations and Doctoral Studies*, 7086 (2019), <https://scholarworks.waldenu.edu/dissertations/7086> (accessed August 25, 2025).

Maternal Health Indicator	Sierra Leone Demographic Health Survey 2013	Sierra Leone Demographic Health Survey 2019	Percent change
MMR (deaths per 100,000 live births)	1,165	717	38 percent decrease
Women who delivered their last live birth in a health facility	54%	83%	54 percent increase
Births assisted by skilled birth attendants	60%	87%	45 percent increase
Early initiation of breastfeeding	54%	75%	39 percent increase
Teenagers who had given birth or were pregnant with their first child	28%	21%	25 percent decrease

Sierra Leone’s MMR, according to more recent UN sources, has continued to decline from 443 in 2020 to just 354 in 2023 — a roughly 70 percent decline from 2013 levels over a decade.¹⁹ The neonatal mortality rate, the number of deaths of infants under 28 days old per 1,000 live births, which is also closely related to maternal health, also decreased in recent years: from 36 in 2020 to 29.3 in 2023.²⁰

Data regarding the availability of healthcare personnel vital for maternal and child health have also shown improvement over the past decade. According to the UN Population Fund (UNFPA), the number of midwifery schools and trained midwives in Sierra Leone has grown from under 100 in 2010 to 1,579 in 2023.²¹ According to the government, the country needs

¹⁹ These numbers come from estimates based on smaller data sets than the Sierra Leone Demographic Health Survey data sets. World Health Organization, “Maternal mortality ratio (per 100 000 live births),” April 10, 2025, <https://data.who.int/indicators/i/Co71DCB/AC597B1?m49=694> (accessed May 6, 2025).

²⁰ United Nations Children’s Fund, “Neonatal mortality,” March 2025, <https://data.unicef.org/topic/child-survival/neonatal-mortality/> (accessed May 6 2025). Sierra Leone’s neonatal mortality rate is among the very worst in the world.

²¹ “UNFPA celebrates midwives for their roles in saving lives,” UN Population Fund Sierra Leone press release, May 8, 2023 <https://sierraleone.unfpa.org/en/news/unfpa-celebrates-midwives-their-roles-saving->

Obstetric Violence in Sierra Leone

All 50 Human Rights Watch interviewees who had recently given birth said that they had paid for some element of their maternal health care. Most interviewees said they felt the quality of the care they received, including how quickly, how kindly or respectfully, and how effectively they were treated by providers was generally dependent on payment.

Despite maternal health care being professedly free in Sierra Leone under the FHCI, Human Rights Watch documented 15 cases where women in obstetric emergency or facing other health complications during perinatal care were abandoned or neglected by medical providers at a public healthcare facility because of their inability to pay fees, a potentially life-threatening course of action that constitutes obstetric violence.

This chapter also describes other forms of poor treatment by providers against patients such as physical abuse, verbal abuse and especially shaming, failing to provide informed consent or crucial information to patients, and intimidation or silencing. Human Rights Watch research found that many of these abuses also took place alongside or directly in connection with overt or implied requests by providers for cash payments, whether OOPs related to the purchasing of healthcare goods and services or informal bribes solicited by healthcare workers. When profound, humiliation and verbal abuse are forms of obstetric violence.

These abuses undermine the right to health and dignity of individuals and reinforce misogynistic and discriminatory practices and perspectives that are a major obstacle to women's rights in Sierra Leone and across the planet.

Later chapters in the report provide important context for experiences of bullying, neglect, or extortion at sometimes the worst moment of interviewees' lives and place the blame for obstetric violence on failing government health systems rather than on individual providers. Because of under or unreformed systems, many health workers are volunteers, and facilities face drastic drug shortages. As a result, stress and payments are core experiences of maternal health in government facilities.

Delays, Abandonment, and Neglect During Births with Complications

Patients and providers interviewed by Human Rights Watch reported that they or their patients experienced life-threatening and frightening delays or denials of care if they were unable quickly to pay for drugs and services required to treat health complications that occurred during perinatal care.

All cases described below occurred in public referral hospitals, mostly in Princess Christian Maternity Hospital (PCMH) in Freetown. They reveal a pattern in which healthcare providers, particularly those with more regular interactions with patients, neglect patients and delay or withhold care from women in situations that do not ostensibly appear dangerous, but which often cause or contribute to serious threats to their health or even lives. These women endured obstetric violence in the form of prolonged delays before receiving care.

Nurses in PCMH stopped a woman, a mother of two who works to link pregnant women in her community to clinics, from being taken into surgery for a C-section in 2023 because she could not pay for a catheter, which drains urine from the bladder. “The doctor was in the theater shouting at [the nurses]: ‘you are holding that woman, if anything happens to that woman, you are to blame!’ He was pissed off.” Because she did not pay for the catheter, the nurses refused to change her urine bag, but the doctor changed it.²⁶

Another doctor working in a regional hospital said women in the community he served chose to delay or forego care because of costs at the hospital. Women and girls commonly experience delays in receiving required care at his hospital, the doctor said, whether because of inadequate staffing to meet demand or because patients and their families struggled to get enough money to pay for required commodities, drugs, and services. Such delays are even common during medical emergencies, as he described assisting a woman who had miscarried and had experienced delays because her family had a cash shortage:

I rushed to the hospital. The relatives were standing there, just waiting, the woman had just miscarried and was bleeding profusely.... After [the operation], they said, “Thank you for saving her life, we will get you the

²⁶ Human Rights Watch interview with a mother of two who works to link pregnant women in her community to clinics, name withheld, Freetown, February 10, 2024.

balance of the money that we owe you when we can.” The nurse had used my name to take the money.²⁷

Adverse Birth Outcomes

The common practice of withholding health care until women or their families pay providers, whether for fees legitimately related to their care or mere opportunistic exploitation, has contributed to the deaths of women and newborns and adverse birth outcomes.

Newborn Mortality

Emma (last name withheld) did not have money when she delivered her son at PCMH in late 2023, and “they only focused on the ones who had money and because I lacked money I had to suffer.” She said that because she could not buy soap or plastic sheeting for the birth, she was abandoned for two hours while in labor and alone while her husband tried to collect money from their community. Eventually during the final, active stage of labor, a midwife appeared. “I heard the baby, but then it died,” Emma said. She does not know why her baby died, but she blames the poor treatment she received at PCMH.²⁸

Another woman in the early stages of labor waited for almost three days on a bench at PCMH, sleeping on the ground before she was finally seen by providers because her partner made enough of a fuss. Her condition at that point was “very bad,” and a doctor urgently operated on her, but it was too late to save her baby. She said the doctor who did her C-section told her that the baby died because of the delay in her care which she attributes to her lack of cash. “He was so angry,” she told Human Rights Watch. “He said it was the fault of PCMH that my baby died.”²⁹

One 21-year-old woman said she arrived at Kabala Government Hospital in the Northern Province after going into labor but was completely neglected by staff because she had no money and could not pay the 200 Leones [equivalent to about US\$8.60] requested to secure a bed. She waited in the hospital without any care or monitoring from evening until mid-afternoon the next day, when the providers checked the baby and found it was in distress and she was rushed into the delivery room. The baby was dead upon delivery, and

²⁷ Human Rights Watch interview with a medical doctor, name withheld, Makeni, December 12, 2024.

²⁸ Human Rights Watch interview with “Emma” (full name withheld), Susan’s Bay community, Freetown, December 6, 2025.

²⁹ Human Rights Watch interview, name withheld, Kissy Street, Freetown, December 13, 2024.

her family had to take out a loan from relatives to pay for the care she received. “My sister spoke to the nurse and said that we have no money but that we would prepare to give it to them the next day,” she said. “They asked for 500 Leone [US\$21.50], and we were able to raise 400 Leone [US\$17.20], and they accepted that.”³⁰

Two women who had given birth at PCMH told Human Rights Watch that they had bought medicine for their deliveries from nurses at the facility, but that these drugs were subsequently stolen and they were then forced to buy more.³¹

“They only paid attention to me when my husband paid,” one of them said. “Then they gave me some attention, [and] when they saw that I was bleeding, they rushed for action.” After her drugs were stolen, she experienced a delay in her care until they bought more. Her baby was alive at delivery but died quickly after the traumatic birth. She and her family paid about 1,600 Leones in total, [equivalent to about US\$70], for the care that she received at PCMH, including the multiple medicines that they had to purchase.³²

Stillbirth rates at PCMH “remain high” according to the hospital’s most recent annual report, which also acknowledges that “delays in interventions” contribute to these high rates of stillbirth and that “[c]onsiderable efforts should be made to reduce the stillbirth [rates].” According to this report, stillbirth rates dropped from 9.3 percent in 2019 to 6.6 percent in 2021, before reversing course and rising again to 7 percent in 2023 and then 7.9 percent in 2024.³³

Women often arrive at referral hospitals in dangerously poor condition but delays at these facilities are also driving poor outcomes. A doctor in Makeni, Northern Province, attributed

³⁰ Her family ended up paying about 350 Leones (approximately US\$15). Human Rights Watch interview, name withheld, Kabala town, December 9, 2024.

³¹ Human Rights Watch interview, name withheld, December 11, 2024, Manonkoh Village, Bombali Sieray chiefdom, Bombali district, Freetown.

³² Ibid.

³³ University of Sierra Leone Teaching Hospital, University of Sierra Leone Teaching Hospitals Complex, Freetown, “Annual Report 2024, Princess Christian Maternity Hospital” (undated), on file with Human Rights Watch. Fresh still births, as opposed to macerated still births (which suggest the fetus has been dead for a while) make up about half the still births, but Human Rights Watch was unable to get an estimate from any hospital official of how many still births might be attributed to abusive neglect or unacceptably long delays at the hospital.

newborn mortality to delays: “We are seeing the fresh stillbirths in early neonatal births because of these [in-hospital] delays.”³⁴

A women’s rights expert who spoke with Human Rights Watch described her intense frustration and fear after rushing Zainab (last name withheld), a colleague who was in obstructed labor, in which the fetus is unable to descend through the birth canal, to PCMH only to face a long waiting time to receive care. When a doctor finally saw Zainab, the doctor told her she needed to be induced. Because the situation was so urgent and she felt so desperate after the delays, Zainab’s colleague felt forced to make a backroom deal for drugs:

I went into another room to get the needed drugs. The nurse said that the drugs were not available, but then she brought them out of her bag to sell them to me. I said, “I will report you,” but then she took away the drugs.... For the sake of Zainab, I bought the drugs. If you don’t give money, then they won’t give you treatment.³⁵

Although in this case, Zainab’s baby, sleeping deeply while Human Rights Watch conducted this interview a few months later, was born alive, she had to be immediately resuscitated and was then taken to an intensive care unit (incurring more costs). Delays leading to newborns in poor condition is a common problem. Six doctors interviewed at PCMH said that babies born in distress or with low Apgar scores, associated with higher infancy death and morbidity rates, were a common problem.³⁶ One said for example, “Babies are often dying because of delays.”³⁷ “There’s a high number of babies with low Apgar, I would say 20 - 35 percent, the delays in the C-section are a big part of this,” another doctor said. “We do not track the decisions to surgery time but know that it’s often too long—6 hours sometimes, sometimes days—especially if the relatives are not around (to push for care or pay for care).”³⁸

³⁴ Human Rights Watch interview with a medical doctor, name withheld, Makeni, December 12, 2024.

³⁵ Human Rights Watch interview, name withheld, Freetown, December 12, 2024.

³⁶ Human Rights Watch interviews, names withheld, Freetown, September and December 2024, and February 2025.

³⁷ Human Rights Watch interview with an obstetrician, name withheld, Freetown, September 20, 2024.

³⁸ Human Rights Watch interview, name withheld, Freetown, September and December 2025. The Apgar score is a standardized assessment of a neonate’s status immediately after birth and the response to resuscitation efforts.

Maternal Mortality

Human Rights Watch spoke to the family, including the husband, of a woman who died soon after giving birth in Kabala Government Hospital in 2024. According to her husband, she was neglected by hospital personnel when the couple arrived at the hospital while she was in labor. “The nurse knew she was bleeding but did not take action,” he said. “I had to push to get her treatment.” Another person who was present said, “Because of money, the nurses did not take prompt action,” despite signs of her serious condition, including incredibly low blood pressure.³⁹ The baby survived the delivery and was being cared for by a sister while Human Rights Watch did this interview in a small village just outside Kabala, but the husband of the deceased woman said he struggles to take care of the infant and the infant’s five siblings without his wife, their mother.⁴⁰

A doctor working at PCMH said he and other colleagues often found other hospital staff preventing patients from accessing free emergency care by keeping them in wards of the hospital where they were required to pay. “A lot of the delays here are because of money,” he said. “They are trying to stop the patients from [getting to me].”⁴¹ Another doctor there recalled many cases where “nurses selling drugs” created dangerous delays. She recounted one recent example of a patient with a retained placenta, who nearly died:

I reviewed the case, the surgical assistant was to get the patient ready. But then, one hour later, she still was not in surgery, and I asked relatives what was going on and they said they were asked for money and had to send someone off to get it. This was a bleeding case: you need to intervene within 30 minutes or else the hemoglobin will reduce to two and if you're at home, you will die.⁴²

Another doctor working at PCMH said he estimated that one or two women died in the hospital every month because of “waiting.”⁴³ He described how a lack of drugs and other

³⁹ Human Rights Watch interview with a birth worker, name withheld, Kabala, December 10, 2024.

⁴⁰ Human Rights Watch interview, name withheld, Kabala, December 9, 2024.

⁴¹ Human Rights Watch interview a doctor, name withheld, Freetown, February 4, 2025.

⁴² Human Rights Watch interview with a medical doctor, Freetown, December 14, 2024.

⁴³ Human Rights Watch interview with an obstetrician, name withheld, Freetown, September 20, 2024.

healthcare commodities and the frequent neglect of women and girls in labor often means no one is monitoring them and their fetuses until the last stage of labor:

We give a prescription to the relatives of the patient or to the patient; it takes time for them to raise the money.... No one really cares until they show up later with the items, no system in place to monitor, some of them deliver around the compound. Suddenly, the woman is pushing, and we take her to the operating room, but during all that time, the fetus is not being monitored.⁴⁴

Others healthcare personnel working in PCMH reported similar problems, and felt things were only growing worse in recent years as medical supplies at the hospital dwindled and price inflation throughout the nation rose. “Everyone knows that the place where you go to give birth is a place where you can die,” a member of a maternal and child health non-profit organization in Sierra Leone said. “At PCMH deaths happen often—and even once is not good—because women are waiting while their relatives find money to pay for surgeries and drugs and even when it’s a dire emergency.”⁴⁵

Maternal mortality rates at the hospital have risen since 2021. In 2024, 82 women died at PCMH, in 2023, 84, in 2022, 77, in 2021, 43 and in 2020, 94.⁴⁶ One expert pinned the increase on fewer FHCI drugs and blood in the hospital in the past two years.⁴⁷

Physical and Verbal Abuse, Shaming

Physical Abuse

Human Rights Watch found two cases of physical abuse of women and girls in perinatal care, both where women had their legs slapped by providers to “encourage” them to labor harder. A few providers who spoke with Human Rights Watch reported witnessing physical abuse of patients, mostly in the form of forcing women’s legs open or hitting their legs

⁴⁴ Ibid.

⁴⁵ Human Rights Watch interview with a senior international NGO official, name withheld, Freetown, July 16, 2025.

⁴⁶ Doctors and administrators at the hospital say that some deaths are because of unnecessary delays in the hospital but the PCMH also receives many patients who have faced long delays and inadequate treatment before reaching the hospital. Human Rights Watch was unable to ascertain how many deaths in any given year were because of abusive neglect or unacceptable delays at the hospital itself.

⁴⁷ Human Rights Watch interview with a public health worker at a NGO, name withheld, Freetown, February 13, 2025.

while birthing. Most of the providers who reported these practices also said that such physical abuse was less common now than in previous years in their opinion. Touching patients' genitalia without consent can be a form of physical abuse, discussed below.

Shaming and Blaming

Rude or verbally abusive treatment by providers was also widely reported by women who spoke with Human Rights Watch. Some people complained that healthcare providers participating in their perinatal care sometimes made comments that made them feel that it was their fault for experiencing health complications or even being pregnant. A woman told Human Rights Watch that providers in Makeni used discriminatory and ableist language against her sister, who is a person with dwarfism, laughing at her and making crude jokes about her looking like a pregnant child.⁴⁸

Shaming and blaming women in perinatal care settings was very commonly reported by women who spoke with Human Rights Watch, who also cited several common factors that contributed to their mistreatment, including the following:

For Delays in Seeking Facility-Based Care for Births with Complications

Women who arrive “late” to the hospital or are referred to the hospital by an outside provider and do not “register” with the hospitals’ antenatal care unit prior to labor, a process which generally involves informal payments, often reported facing blame and shame from providers.

A young woman in Kabala said she felt that providers involved in her delivery had blamed her for bleeding severely and that she believed that they abandoned her for hours during labor because she had not regularly received antenatal care at that hospital. “I feel that I was being punished that is why they left me [alone],” she said. Her newborn died soon after being born.⁴⁹

A traditional birth attendant in Koinadugu district told Human Rights Watch about a woman who first tried to deliver at home to save money, despite having had fistula in the

⁴⁸ Human Rights Watch interview, name withheld, Manankoh Village, Bombali Sieray chiefdom, Bombali district, Freetown, December 11, 2024.

⁴⁹ Human Rights Watch interview, name withheld, Kabala town, December 9, 2024.

past. When the woman finally went to a hospital after facing difficulty, its health workers blamed her, saying “you want to give us problems, you want to die?”⁵⁰ The birth attendant, who had advised the woman to go to the hospital, provided this story as an example of how successfully encouraging women to deliver in hospitals was made much harder because those who do go experience blame and other abuse as well as costs.

For Pain or For Needing Help

Echoing several other reports, a woman, speaking to Human Rights Watch from a small wooden home in a busy part of Freetown where she lived and also made and sold doughnuts, said providers told her when she cried out in agony during delivery: “You are not a child, we are not the ones that called you here (i.e., you are responsible for being here, not us).”⁵¹

Facilities are expected to investigate maternal deaths and record the cause of death.⁵² Perhaps because providers feel pressure to avoid blame for maternal deaths, laboring women sometimes received inappropriate and misplaced aggression. Several women reported being angrily instructed not to die or being blamed for nearly perishing. One woman said a nurse berated her for feeling fear and pain during a C-section:

I was in a lot of pain, the nurse said, “if you are afraid and die, they [the government] will blame us as if it’s us who killed you”.... I grabbed the hand of the doctor, I said that I am feeling pain, and the nurse said, “whatever we do for you, you are always complaining.”⁵³

Two other women also reported that when they complained or cried out in pain, they were shamed by providers who said that they should have considered the pain of birth when they sought pleasure through sex.

⁵⁰ Human Rights Watch interview with a traditional birth attendant, name withheld, Kabala, December 10, 2024.

⁵¹ Human Rights Watch interview, name withheld, Freetown, December 13, 2024.

⁵² Yasir Shafiq et al., “Causes of maternal deaths in Sierra Leone from 2016 to 2019: analysis of districts’ maternal death surveillance and response data,” *BMJ Open*, Jan 12;14(1):e076256. doi: 10.1136/bmjopen-2023-076256

⁵³ Human Rights Watch interview, name withheld, Kissy Street, Freetown, December 13, 2024.

For Being Pregnant, Including for Not Planning Pregnancy

Shame and blame and other forms of verbal hostility from providers undermines quality and accessibility of care, making patients, especially young women and girls, disinclined to seek care and speak frankly.⁵⁴ The blaming of pregnant women or girls for their health conditions is deeply ingrained and reflected in providers' responses to Human Rights Watch's questions. A midwife said: "[If] you want to give birth, you must plan it. You have to save money." She said women, especially teenagers, are "irresponsible" and bring pregnancy-related problems on themselves.⁵⁵

A midwife working in PCMH similarly accused women of not planning pregnancies or even valuing their own lives:

The women say, "I have no money" or that "my husband is out," but they need to plan.... They say, "I cannot take this contraception, this one does not fit me." They make so many excuses, but really it is just negligence. They do not care if they live: it is an "if I die, I die" attitude.⁵⁶

One woman had mixed experiences with nurses. "One nurse who was so nice, she comforted me," she said. "But the others, if you ask for help, they will say: 'we are not the ones who made you pregnant.'"⁵⁷

Several midwives who spoke with Human Rights Watch said they most often saw colleagues using blaming and shaming language towards teenagers and other young people. However, one midwife said training and awareness-building among providers, including herself, was making a positive difference in her hospital:

Teen girls feel shy even to come because we are not friendly to them. They are looking to where they can be accepted and advised. I used to see the

⁵⁴ World Health Organization, "Adolescent Friendly Services," undated, https://www.who.int/health-topics/adolescent-health/adolescent-friendly-health-services-what-health-workers-can-do#tab=tab_1 (accessed August 27, 2025).

⁵⁵ Human Rights Watch interview with a midwife, name withheld, Freetown, October 4, 2024.

⁵⁶ Human Rights Watch interview with a midwife, name withheld, Congotown area, Freetown, December 6, 2024.

⁵⁷ Human Rights Watch interview, name withheld, Freetown, December 13, 2024.

pregnant girls as my own children; I would say: “why are you pregnant?” I thought that was helpful, but this is not the lecture they needed.⁵⁸

Other providers and government officials who spoke with Human Rights Watch said women and girls needed to do more to plan for pregnancy given the difficulty of accessing quality health care in the country. One health ministry official, when asked about some of the problems with women’s struggles with providers extracting cash in government maternal health, said: “Our people do not want to take responsibility. They need to get on contraception; everyone needs to hold onto their own.”⁵⁹

Silencing of Women

Silencing of women in both private and public spaces reinforces gender inequality. Many women reported not being able to, or choosing not to, express their anger about poor treatment and extortion or other payments, or ask questions to the nurses, midwives, and doctors they encountered during their care because they feared recrimination or felt that it was pointless to complain.

Failing to Ensure Women Can Ask Questions

Most women patients interviewed by Human Rights Watch said they did not feel like they could ask questions or push back against medical providers mistreatment, let alone complain.

Most providers who spoke with Human Rights Watch, meanwhile, said their patients were usually passive and uncomplaining. “Generally, women do not ask questions [because in their lives], they have to do what they are told,” a private healthcare provider said.⁶⁰ Four midwives said that they wished patients voiced their questions and concerns, including for diagnostic reasons, and blamed a culture of female subservience for their not doing so.

⁵⁸ Human Rights Watch interview with a non-governmental organization midwife, name withheld, Freetown, September 25, 2024.

⁵⁹ Human Rights Watch interview with a senior official at Ministry of Health and Sanitation, name withheld, Freetown, February 12, 2025.

⁶⁰ Human Rights Watch interview with a private clinic administrator, name withheld, Waterloo, December 14, 2024.

Sierra Leonean feminists and experts in women’s rights or maternal health interviewed by Human Rights Watch agreed that broader patriarchal societal norms are among the reasons for patients’ compliance and silence. High rates of maternal mortality and morbidity are not the only challenges women face. Girls and women tend to have fewer years of education and less money.⁶¹ Girl child marriage and female genital mutilation are both common, and the Sierra Leone Demographic and Health Survey in 2019 health survey showed that domestic violence had increased since the 2013 survey.⁶² In addition, women have less control over family finances than men, which means they have to ask for cash for healthcare and are less able to save for it (see below for more on this). However, constant campaigning by women’s and girls’ rights groups has yielded some major successes. For example, in 2020, Sierra Leone lifted a ban on visibly pregnant girls attending school.⁶³

But experts who understood the experiences of women in health care said the context of patriarchal norms is only one reason women often feel they cannot speak up for what they want or need in facilities. Poor treatment and societal norms that give higher status to medical workers than to most pregnant women also play an important role in silencing women in facilities, including poor treatment connected to the levying of cash payments, whether OOPs or other informal and potentially illicit fees.

Information from patient interviews reflected this, revealing that patients often had a different explanation for their silence and disinclination to ask questions: the power dynamic between providers and patients, especially at hospitals.

Failing to Provide Informed Consent and Choice

Respectful maternal care requires that, wherever possible, patients: provide their consent to providers, including before being touched; receive timely and relevant information and

⁶¹ Sierra Leone Demographic and Health Survey 2019. From the survey: “Men are less likely than women to have no education (29% versus 46%) and more likely to have more than a secondary education (8% versus 4%),” and on literacy, “Literacy: 43% of women and 62% of men are literate.”

⁶² Sierra Leone Demographic and Health Survey 2019. According to the percentage of teenagers who have given birth or are pregnant with their first child has decreased since 2013, from 28% to 21%. Prevalence of female genital cutting: 83% of women age 15-49 are circumcised, a decrease from 2013 (90%). 71% of women aged 15-49 were circumcised before age 15. The percentage of women who have experienced physical violence since age 15 increased from 56% in 2013 to 61% in 2019. The percentage who experienced physical violence in the 12 months preceding the survey increased even more sharply over the same period, from 27% to 43%.

⁶³ “Sierra Leone: Schools Reopen for Pregnant Girls, Teen Moms,” Human Rights Watch news release, March 31, 2020. <https://www.hrw.org/news/2020/03/31/sierra-leone-schools-reopen-pregnant-girls-teen-moms>.

ideas about their health issues and their available medical choices; and are allowed to make such choices about their care.⁶⁴ These practices can improve the quality of clinical care and also better ensure respect for the autonomy of the pregnant or postpartum woman, centering their voice as determinative of what care they will receive and how.⁶⁵

Four women reported feeling pleased when providers asked for their consent and gave them information and options. They reflected positively on an experience involving their informed consent, even when other aspects of their care were problematic, like if they had to pay or were worried about birth complications. However, very often, patients said they were not asked for consent, and even in highly stressful circumstances, they were not provided with very much information or choice.

Not Providing Space for Reporting Poor Treatment, or Avenues for Complaints

The patients Human Rights Watch spoke to said they found it hard to report concerns about their care or treatment. For example, there is currently no working complaints system at PCMH, although patients and families can bring complaints to matrons.⁶⁶ No provider or patient interviewed by Human Rights Watch knew if the Makeni and Kabala referral hospitals had a complaints box either. Regarding complaints boxes as a way of providing feedback, while their presence messages that patients' opinions matter, might not be very effective for patients who do not trust opaque systems and have low literacy. Human Rights Watch found an example of a good practice at one NGO provider that experimented with a system where non-providers conduct exit interviews with all patients after the six-week post-birth visit. However, even when postpartum women were encouraged to speak freely, an official at that NGO said, "There was a lot of fear, a lot of them will never speak negatively, they're worried about recrimination, that in the future they won't have access to the health care."⁶⁷ Many other experts in both maternal health and in the broader girls' and women's rights movement concurred saying that much work remains to be done to

⁶⁴ World Health Organization, "WHO recommendations: Intrapartum care for a positive childbirth experience," 2018, <https://iris.who.int/bitstream/handle/10665/260178/9789241550215-eng.pdf?sequence=1> (accessed August 25, 2025).

⁶⁵ Klaartje M. Olde Loohuis et al., "Strategies to improve interpersonal communication along the continuum of maternal and newborn care: A scoping review and narrative synthesis," October 11, 2023, <https://doi.org/10.1371/journal.pgph.0002449>

⁶⁶ Human Rights Watch interviews with a senior NGO midwife and NGO obstetrician, senior official at PCMH, names withheld, Freetown, September 25, 2024, and July 14, 2025.

⁶⁷ Human Rights Watch interviews with a senior NGO midwife and NGO obstetrician, names withheld, Freetown, September 25, 2024.

educate girls and women on their rights and that they are equal rights holders with providers.

People told Human Rights Watch they feel they cannot complain because of the power imbalance between them and their providers. One young woman said she did not complain about the terrible treatment she received because she “[did] not have the power or the authority to make a complaint.”⁶⁸ Another woman who spent an hour in a wheelchair and was ignored by providers while she bled onto the floor similarly said she did not complain because of the power dynamic.⁶⁹ In addition to norms around medical superiority, patriarchal norms make women feel unable to push back or complain about poor maternal and newborn health services.

All patients and providers who had experienced paying for care that they knew should have been free said they felt sure nothing would change if they complained, so there was little reason to do so. “It’s a syndicate,” one NGO worker with good knowledge of PCMH said about how entrenched fee-demanding practices had become.⁷⁰ Colleagues complaining about other colleagues’ charging fees is hard because providing care is already stressful in low-resource settings, and because colleagues sympathize with volunteers’ need to earn money, or with colleagues who are underpaid (a problem described in more detail below). “The nurses do not earn enough, their income is all gone at the end of the month, how are they surviving?” one doctor said.⁷¹

All women Human Rights Watch interviewed indicated, and often in clear statements, that they were resigned to paying for maternal health care that is supposed to be free under the FCHI. Some responded with grim humor when asked if they knew the care was meant to be free, or with anger, especially when their lives or health had been leveraged for cash or when they were overcharged. Patients also often had low expectations about the quality of the care available in the country. As an example, although one woman’s baby was born in poor condition after the woman had to wait hours for an urgently needed C-section, she

⁶⁸ Human Rights Watch interview, name withheld, Kabala town, December 9, 2024.

⁶⁹ Human Rights Watch interview, name withheld, Waterloo community, Freetown, December 14, 2024.

⁷⁰ Human Rights Watch interview with a public health worker at a NGO, name withheld, Freetown, February 13, 2025.

⁷¹ Human Rights Watch interview, medical doctor in a referral hospital, name withheld, Freetown, December 14, 2024.

was “happy” with her care. “The birth was good because I am alive and the baby is alive,” she said.⁷²

Women had even lower expectations that anything useful would come out of reporting poor treatment or being required to pay for treatment. “Paying was stressful, I did not have a lot of money at that time [but] why complain about having to pay for what should be free?” wondered a woman who had a normal birth that still cost her SLE 200. “No one will hear it if we complain.”⁷³

Moreover, some interviewees said they faced a backlash for complaining. One interviewee took a colleague in obstructed labor to PCMH and desperate to get medical attention, advocated for her colleague. She said a doctor told her she was “causing a nuisance,” chiding her: “Are you really the only person here at this hospital? You have influence and you’re using it to put your own case first.”⁷⁴

Sometimes, including when in medical danger, women feel that not complaining or speaking up will better help them get care or survive. One woman described how simple inquiries about her treatment were met with providers’ refusal to continue providing care:

I tried to ask a [medical] question, they began quarreling with me. Then when I tried to ask about the medicine, when I asked, “Why did you sell the drugs to me?” they shouted at me, “Just get out!”⁷⁵

Five interviewees said some patients had more ability to speak up and ask questions than others. “They have all the power, if you have money, they will speak to you nicely,” one noted. “If not, you are not able to ask questions, you [will instead] get more problems and then they will leave you alone [abandon you].”⁷⁶

⁷² Human Rights Watch interview, name withheld, Kabala, December 9, 2024.

⁷³ Human Rights Watch interview, name withheld, Freetown, February 10, 2024.

⁷⁴ Human Rights Watch interview, name withheld, Freetown, December 12, 2024.

⁷⁵ Human Rights Watch interview, name withheld, York, Freetown, December 16, 2024.

⁷⁶ Human Rights Watch interview, name withheld, Kabala, December 10, 2024.

Providing Information

Human Rights Watch found a lack of information and support for women around stillbirths, newborn deaths, and maternal deaths. None of the 10 women interviewees whose fetuses or babies died during or soon after a facility-based birth were given a clear explanation for the death, and many were confused about what had happened to their babies. Some also reported being treated coldly by providers instead of with understanding.⁷⁷ A woman who lives with her husband and two children in a crowded area of Freetown said she and her husband struggled with grief after their baby died soon after delivery in the Bo Government Hospital. “I asked, but no one explained what happened to the baby,” she said.⁷⁸

Another woman’s baby was taken away soon after birth in Makeni Government Hospital to be resuscitated. She did not know if the baby had survived or not until the following morning because she was too frightened to ask providers for information and they told her nothing. “That the baby was not breathing, that was all they told me,” she said. “I did not feel like I can ask; they had all the power, and I did not have power.”⁷⁹ The baby died.

The lack of communication is apparent to doctors as well. A doctor working at PCMH was shocked to discover that a patient she had met on one of her rounds had not been told that her baby had died. “She was upset when she found out, [and] when I said I was surprised that she did not know, the midwife began yelling at her that she should be happy that *she* was alive,” the doctor said.⁸⁰

In addition, providers’ communication to families regarding maternal deaths that occur in their facilities, which should be documented and investigated as per the government’s maternal death surveillance and response system, was sometimes wholly inadequate.⁸¹

⁷⁷ Bereavement care is an essential dimension of maternal and newborn health care, in which there has been underinvestment around the world. World Health Organization, “Why we need to talk about losing a baby,” undated, <https://www.who.int/news-room/spotlight/why-we-need-to-talk-about-losing-a-baby> (accessed July 30, 2025).

⁷⁸ Human Rights Watch interview, name withheld, Freetown, December 6, 2024.

⁷⁹ Human Rights Watch interview, name withheld, Manankoh Village, Bombali Sieray chiefdom, Bombali district, Freetown, December 11, 2024.

⁸⁰ Human Rights Watch interview with a medical doctor, name withheld, LIA, Freetown, February 14, 2025.

⁸¹ Shafiq et al., “Causes of maternal deaths in Sierra Leone from 2016 to 2019: analysis of districts’ maternal death surveillance and response data.”

Two men whose wives died during childbirth at Kabala hospital said they had not received any explanation of why their wives had died.⁸²

Privacy, Birth Companions

Another important component of respectful maternal care is physical privacy, especially when patients are in the active stage of labor.⁸³ Human Rights Watch found that privacy during birth was not always available at the clinics and hospitals visited. However, some facilities were trying to address this, including by putting up new partitions and curtains.

Providers told us they were cognizant of privacy and other important aspects of respectful care, such as allowing a birth companion and allowing choice in delivery position. Generally, providers seemed to try to accommodate birthing women in having a person of their choice with them as best they could. However, providers said that the birthing space in some facilities does not have room for a companion. There may not even be a proper waiting area for a friend or family member in the hospital. For example, one woman's mother slept for three nights on flattened cardboard boxes on the PCMH grounds while her daughter faced pregnancy complications while giving birth to twins.⁸⁴

Those interviewed by Human Rights Watch described how birth companions, such as partners or female relatives, often played a crucial role in advocating on their behalf for medical attention, especially when they were too afraid or were struggling with the birth. However, advocating too much could backfire for relatives. One woman said that her chosen birth companion, a sibling, was kicked out of the ward for "complaining about money."⁸⁵

⁸² Human Rights Watch interview, name withheld, Kabala, December 9, 2024.

⁸³ For example, the WHO recommends "[p]rivacy measures such as private rooms or consistent use of curtains or partitions in shared areas." From, World Health Organization, "Promote respectful care for safe childbirth," undated, https://cdn.who.int/media/docs/default-source/mca-documents/nbh/enc-course/revised-resources/supplemental-materials/communication-and-respectful-care/respec-1.pdf?sfvrsn=7e1fa82a_3 (accessed August 25, 2025).

⁸⁴ Human Rights Watch interview, Waterloo community, Freetown, December 14, 2024.

⁸⁵ Human Rights Watch interview, name withheld, Kabala, December 10, 2024.

Longer-Term Impacts of Disrespectful Treatment and Informal Payments

Obstetric violence linked to informal payments undermines the rights and dignity of women and girls in specific instances in clinical settings. But other harms have also emerged because these problems are so widespread in Sierra Leone. These include women delaying and rationing medical care and losing trust in their providers. This impacts how women think about care and undermine accessible and quality health care, constituents of the right to health.

Some of the most harmful curtailments of women's rights globally take place within the home or private sphere. Patriarchal norms are enacted and reinforced when women and girls in Sierra Leone must ask husbands or male relatives for permission to spend money on health care. During health crises, perceptions of women's lower value can result in real consequences.

Fear of Costs and Obstetric Violence Cause Deadly Delays and Rationing of Medical Care

Sierra Leone's improvement in maternal mortality rates between 2000 and 2020 happened at the same time that an increasing proportion of births began taking place in facilities (*see Background section*). But fear of costs that women and their families would incur in those facilities, especially of unknown and possibly high ones at PCMH or other referral hospitals, cause some pregnant women to delay seeking medical care, even when they face dangerous and potentially life-threatening health complications.

Around 20 interviewees described how they or one of their patients had delayed seeking medical treatment at the hospital due to fear of costs, abusive treatment by providers, or some combination of both.

One doctor in the Makeni area said he had seen women die when they delayed coming to the hospital because they “fear having to pay, [and] by the time they make the call that

they have to come, it's too late.”⁸⁶ A trainee midwife said she referred patients with complications, such as high blood pressure, severe anemia, and placenta previa (when the placenta covers the cervix, so the baby cannot be born without assistance), to PCMH, but they sometimes refused to go because of cost. She gave an example of one woman with eclampsia who did not “register” (go to antenatal care) at PCMH as she had been told and who almost died towards the end of her pregnancy. The doctor who saw her berated her too. The midwife said:

The doctor said to her: “You don't want your life because you are trying to deliver at home,” but it was because of the money. Her husband is a fisherman, and he told her to “wait until I get some fish, and then you can go to the hospital.”⁸⁷

Reports of poor treatment by providers, long waits, and slow service, including delays related to the payment of OOPs and other informal fees, discussed above, also contribute to making pregnant and birthing women more hesitant to go to the hospital, contributing further to delays. One provider working in a community clinic south of Freetown said, “There is a lot of resistance to going to PCMH,” for example, because “the cost is too much” and “the care there is bad.”⁸⁸

Three interviewees who delivered without complications at home rather than at PCMH, their nearest healthcare facility, said that their decision to do so was partly because they had heard about significant delays and inadequate care at PCMH. “Women complain about the delays at PCMH, that they don't get much attention,” one said. “Even when there are emergency cases, the intervention only happens slowly.”⁸⁹ Another woman echoed others' fears of PCMH: “if you are referred to cottage [PCMH], you cry, things get worse there, for the baby or the pregnant woman, that's the last station.”⁹⁰

⁸⁶ Human Rights Watch interview with a medical doctor, name withheld, Makeni, December 12, 2024.

⁸⁷ Human Rights Watch interview with four midwives in training, names withheld, Makeni, December 12, 2024.

⁸⁸ Human Rights Watch interview, midwife, name withheld, York, December 16, 2024.

⁸⁹ Human Rights Watch interview, name withheld, Susan's Bay community, Freetown, December 6, 2025.

⁹⁰ Human Rights Watch interview, name withheld, Freetown, February 10, 2024.

Broken Trust Between Providers and Patients

Human Rights Watch found that pregnant and birthing women in Sierra Leone often mistrusted their healthcare providers, because they perceived that good treatment was variable and more available to those who can pay, and because they felt they needed to hold a defensive position to reduce how much cash was extracted from them.

Trust between a healthcare provider and a patient is vitally important to quality maternal health care as it helps ensure that their interactions are respectful, that patients share health information essential for accurate diagnosis and treatment, and that patients seek out medical advice and treatment in a timely manner.

One doctor working in central Sierra Leone spoke passionately about how the dissonance between the promise of free health care and the reality, where communities know that patients must often make payments at many points of care, was detrimental to trust even before and long after births. “They think that it is a broken system from the very beginning and so they don’t trust it,” he said. “If the patient doesn’t feel confident, that can lead to misdiagnosis.”⁹¹

Reinforcing Patriarchal Systems: Male Relatives’ Control Over Money

Patriarchal practices common in Sierra Leone, including men tending to handle the finances and financial decisions of households, intersect with the healthcare system’s heavy reliance on OOPs and the related levying of other informal fees in ways that have highly gendered impacts on the enjoyment of the right to health. This is especially harmful in cases where pregnant and birthing women experience dangerous health complications, the treatment of which requires the expenditure of household resources over which many women have little control, putting their pregnancies, births, and lives in the hands of their male relatives. This both endangers women and newborns and undermines women’s power and value.⁹²

⁹¹ Human Rights Watch interview with a medical doctor, name withheld, Makeni, December 12, 2024.

⁹² This problem may be getting worse. In 2010, 68 percent of currently married employed women with cash earnings participated in decisions about the use of their earnings alone or jointly with their husband, less than in 2013 (73 percent). The percentage of women who had experienced physical violence since age 15 increased from 56 percent in 2013 to 61 percent in 2019. The percentage who had experienced physical violence in the 12 months preceding the survey increased even more sharply over the same period, from 27 percent to 43 percent. Sierra Leone Demographic and Health Survey 2019.

Human Rights Watch heard multiple accounts of how husbands' or male relatives' control over money led to delays, even deaths. Several PCMH doctors and midwives reported desperately calling male relatives because women would not consent to C-sections or other lifesaving interventions without the permission of their male relatives because of the costs of these procedures. "Some women may refuse to do a procedure not for any good reason medically, but because they are afraid [of costs] and want a husband or a senior family member to make the decision," one obstetrician at PCMH said. "It's about money, they think that they will owe you."⁹³

A community health worker in a private clinic in the Waterloo, Western District area, about 20 miles east of Freetown, told Human Rights Watch about a patient she referred to PCMH because of her extremely high blood pressure. Her husband was out of town, so the patient could not ask permission to go and thus stayed home, where she died. "I knew that if she was not admitted, she would die, but she was more worried about angering her husband," the health worker said.⁹⁴

A midwife in a training program in Makeni remembered that in 2024, a woman named Marianne needed to be transferred to PCMH because she had a medical condition that stopped her blood from clotting, which the Makeni hospital could not handle. Her father refused to let her move even after a group of friends pooled their cash so she could afford to go to PCMH. "We were all angry, but the father said 'I do not have the money to bring a corpse from Freetown back here to the village. If she is going to die, let her die here,'" the midwife said. Although Marianne's baby died soon after birth, Marianne survived; "only by the grace of God, she did not bleed, because if she had bled, she would have died."⁹⁵

⁹³ Human Rights Watch interview with a medical doctor, name withheld, Freetown, December 14, 2024.

⁹⁴ Human Rights Watch interview with a private clinic administrator, name withheld, Waterloo, December 14, 2024.

⁹⁵ Human Rights Watch interview with three midwives in training, names withheld, Makeni, December 12, 2024.

Government Efforts to Improve Respectful Maternity Care

The Sierra Leone government has recognized that optimizing health outcomes necessitates improving not only the number of staff and facilities, but also the quality of care, including respectful care in maternal, newborn, child, and adolescent health.⁹⁶ “We have realized that the attitude of service providers is very important, that this is something that needs to change,” one senior government official remarked.⁹⁷

The implementation of the health ministry’s quality-of-care roadmap has prompted important changes in at least some providers and facilities, which several experts and providers noted would need repeat trainings to maintain. However, as the report mentions throughout, informal payments, obstetric violence, and the links between these two major characteristics of maternal and newborn care in Sierra Leone has undermined these important efforts.

Many providers interviewed reported a shift in their own and other providers’ perceptions about the importance of respect in the past two years, including because of training. In fact, several respondents said that consequently, they and their colleagues had been more consciously implementing respectful maternity care practices.

One midwife trainer noted what she called the “big shift in approach”:

Respectful maternity care has really been a focus of the past three or four years. It was always there, but it was not structured, not as much importance was given to it. The focus was always on the clinical details. Consent, for example, was often forgotten, but all practicals [practical teaching] now begin with consent.⁹⁸

⁹⁶ Sierra Leone Ministry of Health and Sanitation, “Quality of Care Strategic Road Map, Reproductive, Maternal, Newborn, Child and Adolescent Health, 2020 – 2025,” undated, <https://mohs.gov.sl/download/50/policy-documents/17900/sierra-leone-qoc-strategic-road-map.pdf> (accessed August 29, 2025).

⁹⁷ Human Rights Watch interview with Michael Amara, team lead, Sierra Leone Social Health Insurance (SLeSHI), Freetown, July 18, 2025.

⁹⁸ Human Rights Watch interview with a midwifery trainer, name withheld, Makeni, December 12, 2024.

A small group of midwives in a training agreed that respectful maternity care was “more common” now. “We now offer birth companionship and choice in delivery position,” one of them said. “We spread something clean on the floor for the baby if that is how she wants to deliver.”⁹⁹

A nurse interviewed in Kabala hospital said she and her colleagues were trying harder to provide respectful maternity care. While before, she had “yelled” at patients, now she makes a conscious effort to “ask consent and get informed consent,” even when relatives shout at her and her colleagues or when women patients are “arrogant or uncooperative.” In her view, there has been an “80 percent” improvement.¹⁰⁰ Another midwife said she and her colleagues used to regularly hit women “hard” on the legs “for the woman to cooperate.” According to her, some used to do episiotomies without asking permission and would just tell women their babies had “bitten them” when they made the cut.¹⁰¹ But she said these practices had declined or even stopped now and that providers better understood the importance of consent, choice in birth position, and women being able to have a companion of choice in the birthing room.¹⁰²

Human Rights Watch made repeated efforts, including via phone, WhatsApp, email, and visits to the manager of the quality of care program, to access more information about the government’s ongoing quality of care improvement efforts, but was unsuccessful.

The Safe Motherhood Bill

Women’s rights groups in Sierra Leone were hopeful that parliament would pass the activist-driven Safe Motherhood and Reproductive Healthcare Bill. But because of protests “especially (from) the Inter-Religious Council of Sierra Leone, which has emerged as a

⁹⁹ Human Rights Watch interview with four midwives in training, names withheld, Makeni, December 12, 2024.

¹⁰⁰ Human Rights Watch interview with a midwife, name withheld, Kabala, December 9, 2024.

¹⁰¹ An episiotomy is a surgical incision of the perineum, the area between the vagina and anus, during childbirth. Sometimes these cuts are necessary but “routine or liberal use of episiotomy for women undergoing spontaneous vaginal birth” is not recommended by the World Health Organization. Overuse of episiotomy has been used as an example of obstetric violence by some experts. See World Health Organization, “WHO Recommendations: Intrapartum Care for ‘A Positive Childbirth Experience,’” undated, https://www.who.int/docs/default-source/reproductive-health/maternal-health/ipc.pdf?sfvrsn=dc3ofcoo_8 (accessed August 28, 2025).

¹⁰² Human Rights Watch interview with a midwife, name withheld, Kabala, December 9, 2024.

powerful voice against certain aspects of the bill, especially those related to reproductive rights,” in June 2025, further consideration of the bill was postponed.¹⁰³

The bill states that a “person shall, in the access of safe motherhood and reproductive health care services, be (a) treated with dignity and respect; (b) accorded respect of privacy and confidentiality; (c) treated with dignity and respect; (d) protected from harm, ill-treatment and all forms of violence including physical, verbal and psychological; and (e) protected from economic and sexual exploitation.” Importantly the bill would protect access to safe abortion care, as well as other crucial elements of sexual and reproductive care, including quality maternal health care.

The bill also includes a provision that would fine or imprison providers who do not comply with the provisions above, or other provisions that call for non-discrimination and “safe motherhood and reproductive health information, education and counselling.”¹⁰⁴ While Human Rights Watch strongly concurs with the importance of safe abortion care access, and respectful maternity care, it does not support the use of criminal law as a method of addressing systemic change to health care systems. The government’s responsibility is to reduce and prevent obstetric violence primarily through education, training, data collection, and administrative responsibility from hospital directors, among other measures. The criminal law should only be applied in egregious cases to hold individuals accountable, for example, where treatment amounts to assault, and the perpetrator has the requisite criminal intent to harm the victim, or in some cases of medical malpractice.

¹⁰³ Augustus Osbourne et al., “Sierra Leone’s safe motherhood bill: balancing public health, religious values, and cultural traditions,” *Reproductive Health* 22, 125 (2025), doi: 10.1186/s12978-025-02051-9. Opposition to the bill by some religious groups focuses on provisions that would allow access to safe abortion care before 14 weeks of pregnancy or where continuation of the pregnancy would endanger the physical or mental health or the social wellbeing of the pregnant person, or where the pregnancy is the result of rape or incest, and other provisions (abortion is a major contributor to maternal deaths in Sierra Leone), but also reflects broader antipathy to girls’ and women’s autonomy in their own reproductive health. “Religious opponents argue that certain provisions of the bill, particularly those related to comprehensive sexual education and reproductive rights, could undermine traditional family structures and encourage promiscuity among young people. They express concern that the bill’s emphasis on individual reproductive rights might conflict with communal and family-based decision-making processes that are central to many religious communities’ understanding of healthcare choices.”

¹⁰⁴ The Safe Motherhood and Reproductive Health Care Bill 2024, Part III, Right of Access to Safe Motherhood and Reproductive Health Care.

Disrespectful Care May Be Worsened by Extreme Heat

Poor working conditions, including stress and low morale, are drivers of disrespectful care including that which escalates to obstetric violence.¹⁰⁵ Providers in government facilities in Sierra Leone must struggle with intensely stressful shortages of the commodities and a higher demand for services than they and their colleagues can manage. Human Rights Watch also found that extreme heat was an additional source of stress for providers that adversely impacted treatment and patient-provider relationships.

Sierra Leone has seen an increase in the number of hot weather days and days with dangerously high temperatures in recent years.¹⁰⁶ Officials have said Freetown has already seen worrisome increases in temperatures.¹⁰⁷ These high temperatures are not only dangerous for pregnancy but also negatively impact healthcare providers who already work under difficult conditions.

Midwives, nurses, and doctors interviewed said extreme heat made their work of serving pregnant or birthing women with few resources even harder. “When it is so hot, the work is so stressful,” a senior midwife in a Freetown government hospital said. “It changes the mood when the place is so hot and the level of energy gets so low.”¹⁰⁸ Another midwife, also in Freetown, said: “This year was so bad, we had serious heat, even at times it was too hot for you to think, you get confused.”¹⁰⁹ She found the heat during the day harder to work in because she and colleagues did not sleep well at night when the nights were also very hot. Another provider said the heat was exacerbated by hot aprons and other protective clothing for assisting women during birth. More than once, she had to leave the intensely hot ward to go outside and try to recover, even though it was still hot outside.¹¹⁰ Two doctors separately reported seeing their own sweat drop into a C-section incision.

¹⁰⁵ Emma D. Collins et al., “Maternity Care Providers Perspectives and Experiences of Obstetric Violence in Low-, Middle-, and High-Income Countries: An Integrative Review,” *Journal of Advanced Nursing*, July 5 2025, doi.org/10.1111/jan.70055.

¹⁰⁶ International Monetary Fund “High-Level Summary Technical Assistance Report: Sierra Leone – Climate Policy Diagnostic” December 19, 2024, <https://www.imf.org/en/Publications/high-level-summary-technical-assistance-reports/Issues/2024/12/19/Sierra-Leone-Climate-Policy-Diagnostic-559726> (accessed August 30, 2025).

¹⁰⁷ Freetown City Council, “African Urban Heat Summit,” undated, <https://fcc.gov.sl/urban-heat-summit/> (accessed August 30, 2025).

¹⁰⁸ Human Rights Watch interview with a midwife and NGO worker name withheld, Freetown, July 20, 2024.

¹⁰⁹ Human Rights Watch interview with a senior midwife, NGO clinic, Freetown, September 25, 2024.

¹¹⁰ Human Rights Watch interview with a senior midwife, government clinic, Freetown, September 30, 2024.

One doctor said about the heat: “There are more mistakes and there is more aggression, not happy to get to work, and the healthcare worker gets angry and transfers that anger to relatives and patients.”¹¹¹ According to a midwife from the Waterloo area:

Heat changes your mood and how you treat patients. You are exhausted and hot, you are asking the patient to do something again and again, eventually you get irritable and shout at them. You feel bad afterwards, but in the moment, you are so fed up. For some patients, even if you apologize, some will never tell you their problem after that.¹¹²

Clinics are often crowded and hot, but they are unbearably hot in the warmest months of the year. Several providers said they had seen pregnant patients faint while waiting for services such as antenatal care.¹¹³ Providers also reported increased rates of rashes on babies, which they believed were linked to hot weather. Furthermore, both previous maternal care patients and providers reported that bed net use—crucial for preventing malaria, which is especially deadly for pregnant people—decreases when nights are hot.

¹¹¹ Human Rights Watch interview, medical doctor, name withheld, Makeni, December 12, 2024.

¹¹² Human Rights Watch interview, group of providers, names withheld, Waterloo, December 14, 2024.

¹¹³ Human Rights Watch interview, group of providers, names withheld, Waterloo, December 14, 2024.

Sierra Leone’s Low Public Funding for Health Care System Contributes to Obstetric Violence and Inadequate Maternal and Newborn Health

By failing to end the widespread use of unpaid volunteer workers, address the shortage of medical supplies and other serious systems problems, Sierra Leone’s government has undermined the right to health and exposed women and girls to discrimination, abandonment, and bullying by medical providers seeking cash in order to continue to provide services. Sometimes this abuse amounts to obstetric violence.

Sierra Leone’s Low Public Healthcare Spending

Global research has found that government underspending on health is often a driver of obstetric violence.¹¹⁴ Healthcare providers’ poor working conditions, poor pay, low-quality training, and lack of resources can also hamper their capacity to deliver quality care, increase their stress, and contribute to worsening relationships between providers and patients.¹¹⁵

In addition to its obligations to dedicate the maximum of its available resources towards the progressive realization of all economic, social, and cultural rights, including the right to health, Sierra Leone’s government has also signed up to commitments to realize Universal Health Coverage, a framework developed by the UN to measure access to health care, an important element of the right to health.¹¹⁶ A significant body of research analyzed by Human Rights Watch has found that meeting this commitment will generally require

¹¹⁴ United Nations Human Rights Council, “A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.” According to UN Special Rapporteur Dubravka Simonovic states “must devote the maximum available resources to sexual and reproductive health and adopt a human rights-based approach to identifying budgetary needs and allocations ... [but] many States have failed to prioritize women’s healthcare in their budgets ... and fail to ensure that health workers receive adequate training on medical ethics and patients’ human rights, including the obligation of providers to provide respectful, non-discriminatory care.” para. 39.

¹¹⁵ Ibid. para 40. See also Collins, Burns, et al., “Maternity Care Providers Perspectives and Experiences of Obstetric Violence in Low-, Middle-, and High-Income Countries: An Integrative Review.”

¹¹⁶ Sierra Leone Ministry of Health and Sanitation, “The Sierra Leone 2021–2025 National Health Sector Strategic Plan (NHSSP): Towards Universal Health Coverage and Health Security,” https://portal.mohs.gov.sl/download/33/publications/1579/nhssp-abridged-version_ns_16-11-21-dir-22-11-21.pdf (accessed August 25, 2025), p.2.

governments to allocate the equivalent of about 5 to 6 percent of gross domestic product (GDP) from public resources toward the health care system.¹¹⁷

However, in 2022, the most recent year for which data from the World Health Organization is available, the government of Sierra Leone spent only about 1.5 percent of GDP on health care through domestically generated public sources such as tax revenues or social health insurance contributions.¹¹⁸ While significantly below one international public healthcare spending benchmark of 5 percent of GDP, this level of spending was slightly above the average for low-income countries that year—1.2 percent of GDP—and represented a nearly 30 percent increase from what the government had been spending in 2019, prior to the Covid-19 pandemic.¹¹⁹

Although robust data is less available for recent years, Sierra Leone appears to have continued making significant progress towards increasing its public health care spending. In 2022, Sierra Leone healthcare spending accounted for only 5.2 percent of government expenditures, according to data from the World Health Organization.¹²⁰ According to an interview with an official from Sierra Leone’s Ministry of Health and Sanitation, 7.7 percent of the 2024 government budget was allocated to health. The following year, the share of public resources allocated to health care increased further to 9.2 percent of the government budget.¹²¹

While commendable, this level of public spending is still below a specific commitment to allocate 15 percent of public spending towards the improvement of health care that the

¹¹⁷ “Global Failures on Healthcare Funding, Pandemic Data Reveals Threats, Opportunities to Improve Systems,” Human Rights Watch news release, April 11, 2024, <https://www.hrw.org/news/2024/04/11/global-failures-healthcare-funding>; “New Data Exposes Global Healthcare Funding Inequalities,” Human Rights Watch news release, April 10, 2025, <https://www.hrw.org/news/2025/04/10/new-data-exposes-global-healthcare-funding-inequalities>; and “African Governments Falling Short on Healthcare Funding,” Human Rights Watch news release, April 26, 2024, <https://www.hrw.org/news/2024/04/26/african-governments-falling-short-healthcare-funding>.

¹¹⁸ “New Data Exposes Global Healthcare Funding Inequalities,” Human Rights Watch news release.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*; see, also World Health Organization, “Global Health Expenditure Database,” undated, <https://apps.who.int/nha/database> (accessed July 29, 2025).

¹²¹ Human Rights Watch online interview with Abdul Jibril Njai, senior health financing specialist at Sierra Leone Ministry of Health and Sanitation, July 24, 2025. Dr. Njai said that this figure does not include overseas development assistance to health.

government of Sierra Leone and other African Union governments made when they adopted the 2001 Abuja Declaration.¹²²

Increasing the allocation of public resources towards the health care system is key to improving the availability, accessibility, and quality of care that it provides. The more a country spends on health care through public sources like tax revenues or social health insurance contributions, the less reliant its healthcare system is on fees paid out of pocket by individuals and households.¹²³

Given Sierra Leone's very low levels of public spending on health care, the burden of financing care largely rests on those who require it, forcing many to pay out of pocket to access care that they or those in their circle of care require, even when they do not have the means to do so.

A World Bank Group 2021 assessment on health spending lays out spending for 2018 in detail, for example: "In 2018, the government's [spending] was about 10 percent (9.71 percent), which was small compared with other two sources ... Development partners support represented over a quarter (25.88 percent). Household out-of-pocket (OOP) payments made up nearly 45 percent (44.78 percent). ... About 10 percent of the population faces the risk of catastrophic spending on health ... Patients pay for virtually all the services delivered to them at public health facilities and the fees they pay vary from one facility to another even within the same district."¹²⁴

According to data from the WHO, more than 50 cents out of every dollar spent on health care in 2022 was paid out-of-pocket from an individual or their household. Such out-of-pocket costs worsen health care inequalities by creating barriers to accessing health care based on the ability to pay.

¹²² "African Governments Falling Short on Healthcare Funding," Human Rights Watch news release.

¹²³ "Global Failures in Healthcare Funding," Human Rights Watch news release.

¹²⁴ World Bank, "Sierra Leone Public Expenditure Review 2021: Improving Quality of Public Expenditure in Health," June 2021, <https://documents1.worldbank.org/curated/en/329991623665655127/pdf/Sierra-Leone-Public-Expenditure-Review-2021-Improving-Quality-of-Public-Expenditure-in-Health.pdf> (accessed July 29, 2025), p.22.

Low Taxes, High Debt, and Other Drivers of Low Public Health Spending

Health ministry officials interviewed by Human Rights Watch said that the major obstacle to increasing public healthcare spending is that the overall envelope of available money is too small.¹²⁵ More than half Sierra Leone’s already-small health budget is spent on salaries (about 55 percent) and the rest on keeping facilities operable, often minimally so, with very little left over. Non-salary spending on reproductive health, for example, accounted for about 0.4 percent of the health ministry’s budget in 2025.¹²⁶

Low Taxes

According to data from the Organization for Economic Cooperation and Development (OECD), Sierra Leone’s tax receipts, including all monies received from income, payroll, and consumption taxes, added up to only 11.4 percent of GDP in 2022, the most recent year for which such data is available.¹²⁷ This was below the average of 13.4 percent for other low-income countries that year, and well below 15 percent of GDP, which the World Bank has identified as a “tipping point” beyond which low-income countries are better able to graduate to middle-income status.

Sierra Leone’s ability to raise tax revenues is also hampered by international tax rules that enable, for example, companies to shift profits to tax havens, and wealthy households to similarly avoid taxes by hiding assets offshore. According to the Atlas of Offshore Wealth, a database maintained by the EU Tax Observatory, an independent organization that advocates for tax justice, households in Sierra Leone held \$410 million in wealth in offshore tax havens – amounting to around 11 percent of GDP.¹²⁸ According to Human Rights Watch calculations of data from the Atlas of the Offshore World, if Sierra Leone taxed the overseas financial wealth held by its nationals, it could significantly increase public healthcare spending.¹²⁹

¹²⁵ Human Rights Watch interviews with Abdul Jibril Njai, July 24, 2025, and Tom Sesay, July 16, 2025.

¹²⁶ Human Rights Watch interviews with Abdul Jibril Njai, July 24, 2025, and Tom Sesay, July 16, 2025.

¹²⁷ “New Data Exposes Global Healthcare Funding Inequalities,” Human Rights Watch news release. A World Bank assessment of the Sierra Leone health sector noted “low revenues have resulted in substantial fiscal deficits and rising public debt.” World Bank Group, “Sierra Leone Public Expenditure Review 2021: Improving Quality of Public Expenditure in Health,” p.6.

¹²⁸ Atlas of the Offshore World, “Sierra Leone,” undated, <https://atlas-offshore-world.org/country/SLE> (accessed August 25, 2025).

¹²⁹ Ibid. The Atlas of the Offshore World is an independent research organization that provides “a global data repository that sheds light on how multinational enterprises shift profits, the scope of hidden wealth in offshore destinations, and how capital and labor are taxed around the world.”

Human rights law also obligates governments to engage in “international cooperation and assistance” to support all governments’ ability to progressively realize economic, social and cultural rights. Such cooperation should extend to international tax rules that enable governments to fairly tax corporations with economic activities in their territory and adequately prevent tax abuse and illicit financial flows. UN member states are currently negotiating the first-ever UN tax convention on international tax negotiations that has the potential to greatly improve all governments’ ability to address these issues. The treaty process was initiated by African countries, which face particularly consequential losses under current tax rules, and a draft is expected to be submitted for adoption in 2027, during the UN General Assembly’s 87th session.¹³⁰

High Debt

But low tax revenues are not the only issue limiting the amount of public resources that can be allocated toward health care. In November 2024, the International Monetary Fund approved a \$248.5 million program to Sierra Leone that noted “total debt-service-to-revenue ratio remains 100 percent until 2028,” putting it at “high risk of distress.”¹³¹ Creditors, both government and private, should ensure that debt servicing obligations do not come at the expense of rights.¹³²

Public debt is not inherently bad, but the costs of servicing Sierra Leone’s debt place significant constraints on the government’s ability to adequately fund health care. In 2022, the government of Sierra Leone spent about US\$7.4 per person on health care.¹³³ That same year, the government sent the equivalent of about \$8.1 per person to its creditors.¹³⁴ If the government of Sierra Leone were able to increase its tax receipts to 15 percent of

¹³⁰ “Negotiations for UN Tax Treaty Present Historic Opportunity for Rights,” Human Rights Watch news release, February 10, 2025, <https://www.hrw.org/news/2025/02/10/negotiations-un-tax-treaty-present-historic-opportunity-rights>.

¹³¹ International Monetary Fund, “Sierra Leone: 2024 Article IV Consultation and Request for a 38-Month Arrangement Under the Extended Credit Facility-Press Release; Staff Report; Staff Statement; and Statement by the Executive Director for Sierra Leone”, November 22, 2024, <https://www.imf.org/en/Publications/CR/Issues/2024/11/22/Sierra-Leone-2024-Article-IV-Consultation-and-Request-for-a-38-Month-Arrangement-Under-the-558772> (accessed August 25, 2025), p.20.

¹³² A 2021 World Bank Group assessment of the health sector noted “low revenues have resulted in substantial fiscal deficits and rising public debt.” See: World Bank Group, “Sierra Leone Public Expenditure Review 2021: Improving Quality of Public Expenditure in Health.” See also: *Ibid.*, p. 6. “External shocks and suboptimal domestic policies contributed to stagnating income levels and rising poverty over the past decade. Despite Sierra Leone’s abundant natural resources, its young population, and favorable geography, the years since the Ebola outbreak did not deliver critically needed improvements in standards of living. A series of shocks, paired with suboptimal policies and weak governance, contributed to low growth, high inflation, a high risk of debt distress, and low reserves.”

¹³³ “New Data Exposes Global Healthcare Funding Inequalities,” Human Rights Watch news release.

¹³⁴ *Ibid.*

GDP, it would be able to generate an additional US\$17 per capita, more than enough to both service its debt and double its public healthcare spending, if allocated towards those purposes.¹³⁵

Human rights activists have called on Sierra Leone’s creditors, including the International Monetary Fund, to assess the impacts of debt payments on the ability of the government of Sierra Leone to meet its human rights obligations, including the right to health, and to provide debt restructuring or relief where necessary to enable the adequate funding of health care and other rights-essential public services.¹³⁶

Increasing such public revenues is critical, but it should be done through progressive measures, where the taxes paid as a percentage of income or assets increase with earnings or wealth, such as taxes on high personal income and wealth, as well as corporate profits. As recently recognized in a statement by the UN Committee on Economic, Social and Cultural Rights, regressive taxes, which disproportionately fall on people with lower incomes, can undermine rights. Value-added taxes (VAT) tend to be regressive because everyone pays the same rate regardless of income and wealth, and they generally consume a higher share of income the less one earns. According to data from the OECD, VAT accounted for 22 percent of Sierra Leone’s tax receipts in 2022.¹³⁷

The country’s modern problems exacerbate the harmful economic legacy of the transatlantic slave trade and British colonization for Sierra Leone.¹³⁸ Meanwhile, both systems have benefited the US and the UK and contributed to their global economic governance.¹³⁹ These governments and other governments should also support rights-aligned reforms to international tax rules that would help the government of Sierra Leone better prevent tax evasion and avoidance.

¹³⁵ Ibid.

¹³⁶ See for example, Budget Advocacy Network, Christian Aid, Action Aid, and Oxfam, “Sierra Leone Debt Situation 2020: A Call for Debt Relief, Transparency and Accountability,” October 2021, <https://sierra-leone.actionaid.org/sites/sierra-leone/files/publications/SIERRA%20LEONE%20DEBT%20SITUATION%20REPORT.pdf> (accessed August 26, 2025).

¹³⁷ Organization for Cooperation and Economic Development, “Revenue Statistics in Africa 2024 – Sierra Leone,” undated, <https://www.oecd.org/content/dam/oecd/en/topics/policy-sub-issues/global-tax-revenues/revenue-statistics-africa-sierra-leone.pdf> (accessed June 9, 2025).

¹³⁸ For example, see Mickey Butts, “How the slave trade’s financial legacy harms Africans today,” February 28, 2020, <https://newsroom.haas.berkeley.edu/how-the-slave-trades-financial-legacy-harms-africans-today/> (accessed September 30, 2025).

¹³⁹ Joshua Nevett, “UK’s £18tn slavery debt is an underestimation, UN judge says,” *BBC Politics*, August 23, 2023, <https://www.bbc.com/news/uk-politics-66596790> (accessed September 30, 2025).

Donor Dependence

In recent years, international donor countries and institutions—such as the United States Agency for International Development (USAID), the United Kingdom’s Foreign and Commonwealth Office (FCDO), and the World Bank—have together spent more on health in Sierra Leone than the government itself.¹⁴⁰ Sierra Leone’s donor-dependence in health care is often criticized, especially given donor “boom and bust” patterns that mean the availability of other countries’ and institutions’ resources can be hard to predict and uneven over time, and may be earmarked toward issues that may be more important to donors than domestic decision-makers, contributing to imbalances in public spending.¹⁴¹

A dramatic example occurred in early 2025, when the US halted all work done or funded by United States Agency for International Development (USAID), a major donor in Sierra Leone. The full impact of this withdrawal is still unclear at time of writing, but a \$45million health project in five districts that had a focus on maternal, child, and adolescent health has been cancelled according to an interview with an official from the Ministry of Health and Sanitation who spoke with Human Rights Watch.¹⁴²

The UK’s Foreign, Commonwealth and Development Office (FCDO), historically the main donor to Sierra Leone’s Free Health Care Initiative (FHCI), has also planned to greatly roll back development assistance funding by 2027.¹⁴³

The UK’s Foreign, Commonwealth and Development Office (FCDO), has historically played a crucial role in the Free Health Care Initiative as the largest and at times only purchaser of the FHCI medicines the system relies on (see below for more on this).¹⁴⁴ However, as stated in a letter to Human Rights Watch, FCDO will “from the end of this financial year ... no longer directly procure or distribute FHCI medicines.” The letter added “[w]e have

¹⁴⁰ World Bank, “Sierra Leone Public Expenditure Review 2021: Improving Quality of Public Expenditure in Health,” (accessed July 29, 2025), p. 22.

¹⁴¹ Mara Kardas-Nelson, “Boom and Bust: How Sierra Leone lost faith in foreign aid,” *The Dial*, April 28, 2025, <https://www.thedial.world/articles/news/issue-27/usaaid-ebola-sierra-leone> (accessed May 7, 2025).

¹⁴² Human Rights Watch online interview with Abdul Jibril Njai, July 24, 2025.

¹⁴³ Philip Loft and Philip Brien, “UK to reduce aid to 0.3% of gross national income from 2027,” *UK Parliament House of Commons Library*, February 28, 2025, <https://commonslibrary.parliament.uk/uk-to-reduce-aid-to-0-3-of-gross-national-income-from-2027/>.

¹⁴⁴ Letter from West Africa Team, Foreign, Commonwealth and Development Office to Human Rights Watch, October 16, 2025. On file with Human Rights Watch.

communicated this change to the Government of Sierra Leone in time for this to be factored into the national budgeting process, which began in September.”¹⁴⁵

Sudden and harmful withdrawals, such as the USAID freeze, undercut recipient countries’ capacities to progressively realize rights such as the right to health as required under international human rights law, and run counter to the human rights principles and goals inherent in the responsibility to provide international cooperation and assistance.

Low Public Healthcare Spending Harms Maternal and Newborn Health

Human Rights Watch found that the chronic under-resourcing of public healthcare facilities in Sierra Leone undermines the right to health of women and girls by undermining access to quality antenatal and birth care.

Volunteer and Underpaid Staff

Women and girls are often tended to by healthcare workers who are working without pay, whether voluntarily or involuntarily, or who do not receive a living wage for their labor. Human Rights Watch found that the maternal and newborn healthcare system’s reliance on un- and underpaid staff contributes to obstetric violence by pushing workers to find ways to extract money, including abandonment or the threat of abandonment.

The government pays salaries for “PIN-coded” or official health care workers. About 55 percent of the health budget is spent on staff salaries.¹⁴⁶ About 50 percent of Sierra Leone’s government health workers are volunteers and almost 40 percent of these individuals work in hospitals.¹⁴⁷ These workers volunteer with the understanding that they will eventually get “PIN-coded” and receive a government salary (one expert said that for many, volunteering is the only path to a salaried job and it is normal to expect to have to work for free for at least two years at first).¹⁴⁸ Using volunteers, especially at this scale,

¹⁴⁵ Ibid.

¹⁴⁶ Human Rights Watch interviews with Abdul Jibril Njai, July 24, 2025, and Tom Sesay, July 16, 2025.

¹⁴⁷ Sierra Leone Ministry of Health and Sanitation, “Human Resources for Health Country Profile: Sierra Leone Country Profile,” December 2016,” <https://www.afro.who.int/sites/default/files/2017-05/hrhprofile16.pdf> (accessed July 29, 2025). PowerPoint presentation by Pieterella Pieterse, February 6, 2025, on file with Human Rights Watch.

¹⁴⁸ Sierra Leone Ministry of Health and Sanitation, “The Sierra Leone 2021–2025 National Health Sector Strategic Plan (NHSSP).” Pieterse and Saracini, *International Journal for Equity in Health* (2023). The authors of this paper provide a useful explainer in their abstract: “The World Health Organisation (WHO) estimates a 10 million health worker shortage by 2030. Despite this shortage, some low-income African countries paradoxically struggle with health worker surpluses. Technically,

invites corruption as volunteers need money to travel to work and cover other life costs and “undermines the equitable delivery of healthcare.”¹⁴⁹ A 2023 academic literature review found “a high incidence of charging for care ... by salaried and unsalaried staff” as a coping mechanism. Staff also charged fees so they could provide patients with drugs and tests they needed.¹⁵⁰

Although volunteers are officially part of the workforce, not being paid and thus sometimes not having the money for transportation, for example, can make it hard for them to “show up,” both literally and metaphorically.¹⁵¹ One midwife observed that sometimes volunteers in the hospital where she worked were absent. And if they were present, they tended to slack off, even when they were needed. “But if you are paid, it is your duty,” she compared.¹⁵² A government plan to cut back on the use of volunteer healthcare workers in Sierra Leone has not been implemented.¹⁵³ Human Rights Watch was told that funds for an additional 3,000 health care workers have been budgeted for and volunteer workers may then get these salaried jobs. But even if this is implemented, this initiative does not end the bigger problem, an expert in volunteer health care workers in Sierra Leone said. “We estimate that by 2029 Sierra Leone will add another 2,500 nurses per annum to job seekers. Technically this means Sierra Leone will come closer to the 44.5 Skilled-Health Workers per 10,000 population WHO goal, but if these are unemployed, that doesn’t count,” health staffing researcher Pieternella Pieterse told Human Rights Watch.¹⁵⁴

But even salaried providers receive low salaries, which contributes to them seeking payments from patients and other measures to make money, such as selling drugs. One midwife said she bought and sold drugs both to have the materials she needed to work on

these health workers are needed to meet the minimum health worker-population ratio, but insufficient job opportunities in the public and private sector leaves available health workers unemployed. This results in emigration and un- or underemployment, as few countries have policies or plans in place to absorb this excess capacity. Sierra Leone, Liberia and Guinea have taken a different approach; health authorities and/or public hospitals ‘recruit’ medical and nursing graduates on an unsalaried basis, promising eventual paid public employment.” Human Rights Watch online interview with Pieternella Pieterse, July 28, 2025. PowerPoint presentation by Pieternella Pieterse, February 6, 2025, on file with Human Rights Watch.

¹⁴⁹ Pieterse and Saracini, *International Journal for Equity in Health* (2023).

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² Human Rights Watch interview with a midwife, name withheld, Congotown area, Freetown, December 6, 2024.

¹⁵³ Government of Sierra Leone Ministry of Health and Sanitation, “Human Resources for Health Strategy 2017–2021;” see also: Pieterse and Saracini *International Journal for Equity in Health* (2023).

¹⁵⁴ Human Rights Watch online interview with Pieternella Pieterse, July 28, 2025. The research conducted by Pieterse and her colleagues suggests that the quality of the teaching may also be very low, with underqualified instructors in some training sites, and little student time in wards.

hand and to survive. “I have transport costs, the salary is so small—I get only \$100 a month—by the end of the month it is all gone,” she said. “How can you expect me to survive on this?”¹⁵⁵ Two medical doctors—one in PCMH and one in Makeni hospital—said they thought the country’s big economic problems might be contributing to what they believed were worsening levels of medical corruption.¹⁵⁶ Small or no salaries are a known contributor to poor health worker morale, which has been linked to providers’ poor treatment of patients, including in Sierra Leone.¹⁵⁷

Out-of-Pocket Costs and Barriers to Antenatal Care

Interviewees across the interview sites described paying a small fee or making a small “donation” every time they visited clinics or hospitals during their antenatal care, called “greeting the table” or “appreciation.” According to patient interviewees and community members, antenatal care staff at the clinics at Graybush, Kroo Bay, and PCMH, all in Freetown, all expect “donations” of 20, 30, or 40 leones at least (approximately US\$0.82 – US\$1.70), but patient interviewees all agreed when asked that staff could be flexible and accept less from indigent women. “At Mercy Ship healthcare is free, but at Graybush the staff ask for tokens, 20 or 30 Leone (approximately US\$0.82- \$1.30), they said this is to ‘greet the table,’” one woman who had used both a non-governmental and a government clinic during her pregnancy said.¹⁵⁸ “[At Kroobay clinic] You have to greet the table every time, 10, 15, 30 (up to approximately US\$1.30ea) Leones every time you go, you give what you can,” said another Freetown resident who lives in a crowded area downtown above the ocean.¹⁵⁹

Another woman who used the antenatal clinic at PCMH, said:

There is a slogan at cottage: “make appreciation” and then you get treatment. It means “give us something and then we will treat you nicely.”

¹⁵⁵ Human Rights Watch interview with a midwife, name withheld, Congotown area, Freetown, December 6, 2024.

¹⁵⁶ Human Rights Watch interviews, names withheld, Makeni and Freetown, December 12, 2024, and February 2, 2025, respectively.

¹⁵⁷ Chris Willott et al., “Staff recognition and its importance for surgical service delivery: a qualitative study in Freetown, Sierra Leone,” *Oxford Journals, Health Policy and Planning*, 2021, 36(1):93–100, doi: 10.1093/heapol/czaa131.

¹⁵⁸ Human Rights Watch interview, name withheld, Freetown, February 10, 2024.

¹⁵⁹ Human Rights Watch interview, name withheld, Freetown, October 1, 2024.

There is not a specific amount, but it should be at least 40 Leones (around US\$1.70).¹⁶⁰

As well as “greeting the table” during ANC visits, interviewees often described paying for prenatal supplements and deworming or antimalarial drugs, sometimes at the clinic or sometimes at nearby pharmacies. Sometimes patients said they got some supplements or anti-malarial drugs for free at their clinics.

Antenatal care is crucial to healthy pregnancy including to catch complications that can lead to maternal mortality, injury, or poor health. When asked about drivers of poor maternal health in the communities they serve, providers interviewed by Human Rights Watch talked most often about high rates of anemia (which can make pregnant women very sick and weak during and after their pregnancy and increase the chance of maternal hemorrhage, the main cause of maternal deaths in Sierra Leone), high rates of high blood pressure including pre-eclampsia and eclampsia both very dangerous conditions, high rates of psychosocial stress and anxiety, and overall poor nutrition. Providers may be able to address these concerns during antenatal care visits, including by providing drugs, iron, and supplements for good nutrition. Providers can also offer important health advice about anti-malarials and avoiding malaria, as well as tailored advice for women with specific concerns, such as a history of multiple pregnancies or issues around maternal age.

Low attendance across the course of pregnancy is a known problem in Sierra Leone and although rates of adequate ANC rose dramatically after the FHCI was introduced they have subsequently declined.¹⁶¹ Women often attend one or two appointments but attendance for further appointments often drops. This may be linked to cost. One academic study that looked at patterns of ANC between 2008 and 2019 found that wealthier women tended to

¹⁶⁰ Human Rights Watch interview, name withheld, Susan's Bay community, Freetown, December 6, 2025.

¹⁶¹ Augustus Osborne et al., “Trends and inequalities in adequate antenatal care coverage among women in Sierra Leone, 2008–2019,” *Archives of Public Health* 82, 208 (2024), doi.org/10.1186/s13690-024-01430-1. “Notably, the proportion of women receiving adequate antenatal care (ANC) coverage rose markedly from 15.2% in 2008 to 36.5% in 2013 before declining to 22.1% in 2019. This trend could be due to government policies providing free maternal care to women and the Free Health Care Initiative in 2010. However, these fluctuations suggest that while initial efforts to improve ANC were successful, sustaining these gains proved challenging.” The World Health Organization recommended that the number of ANC visits is at least eight, with the first taking place in the first trimester.

access more appointments, suggesting that “[t]his economic inequality indicates that financial barriers impede access to antenatal care for poorer women.”¹⁶²

Out-of-Pocket Costs and Barriers to Quality Healthcare During Labor

They spoke to me nicely and quietly [but] if you want the nurse to come, you have to pay money. If you fail to pay them, then you wait to get any drug[s] from them. They will not serve you and you will be ignored.¹⁶³

Human Rights Watch heard numerous testimonies from patients, providers, and other community members, of how patients are regularly paying for commodities, drugs, and services during normal births. Patients very often need to provide gloves, plastic sheeting, cleaning supplies, and in some facilities even bring water to a facility to give birth there. At PCMH, women are told during their antenatal care what they will need to purchase to deliver. One woman, who washes clothes for a living in Susan’s Bay in downtown Freetown, described that antenatal care was also when patients are “orientated” about what they will need to pay:

While you are getting ANC, they let you know that you will have to buy [commodities]. They expect you to buy [products] at the premises. If you go with a small bottle of Dettol, they will reject it and say, no you need to buy this bigger one from us, if you bring your own bleach they will say, no not this one, you need to buy this one with another label.¹⁶⁴

Other interviewees who gave birth at PCMH also said the system seems to be the same for drugs, if providers have a particular drug available, the expectation is that the patient and her family will purchase the drugs from that provider. “We bought some drugs from the nurses and some from the pharmacy. If they had that drug, we had to buy [it] from them,” a hairdresser and mother of five including twins, said.¹⁶⁵ Women told Human Rights Watch that they were asked to pay for many different items at the hospital, and that costs could

¹⁶² Osbourne et al., “Trends and inequalities in adequate antenatal care coverage among women in Sierra Leone, 2008–2019.”

¹⁶³ Human Rights Watch interview, name withheld, Kabala town, December 9, 2024.

¹⁶⁴ Human Rights Watch interview, name withheld, Susan’s Bay community, Freetown, December 6, 2025.

¹⁶⁵ Human Rights Watch interview, name withheld, Waterloo community, Freetown, December 14, 2024.

add up quickly and begin to cause financial strain. The hairdresser added, “You have to have money to survive in the hospital, a flask of water is 5 Leone (US\$0.22), to have your wound cleaned is 50 Leone (US\$2), to change the bandage is another 50 Leone.”

One woman from a coastal fishing community described how she spent all the cash she had at the hospital. “They also asked me for the delivery, the washing of the hands, all in all they wanted 160 Leone (US\$6.5), one asked for 100 (US\$4.30) and then another one asked for 60 Leone (US\$2.50).” She said by the time she was discharged she did not have enough cash for a bus ride home and had to call a relative to meet her and loan her some money.¹⁶⁶

Human Rights Watch often heard the phrase “handwashing fee” to describe money given to a provider after the delivery for the service provided. Different facilities can have different “normal” amounts, a group of Kroo Bay clinic patients Human Rights Watch interviewed, for example, said that the norm was to pay 200 Leone for a girl (US\$8.60) and 250 Leone (US\$10.75) for a boy.

Many interviews said that paying is a “choice,” that is not really a choice. “You don't have to pay money but if you want to get attention then you need to make sure you pay,” a market seller said.¹⁶⁷ “They prepare you during the birth time that you should give them something for the birth, and when you give birth if you don't have the money that's when you have the embarrassment (shame), they will grumble at you,” another woman said.¹⁶⁸

In some cases, women were so stripped of cash after a birth they were unable to access important health care they needed afterwards. One woman said she paid 150 Leones (US\$6.45) for stitches; after she tore one while using the toilet at the hospital, she had to pay another 150 Leones for the repairs. Since she had already paid for plastic sheeting, soap, water for washing, face masks, and gloves, she ran out of money. Consequently, she could not afford to get a postpartum blood transfusion even though a doctor said she was anemic and needed it.¹⁶⁹

¹⁶⁶ Human Rights Watch interview, name withheld, York, Freetown, December 16, 2024.

¹⁶⁷ Human Rights Watch interview, name withheld, Forbay road, Freetown, December 6, 2025.

¹⁶⁸ Human Rights Watch interview, name withheld, Susan's Bay community, Freetown, December 6, 2025.

¹⁶⁹ Human Rights Watch interview, name withheld, Forbay road, Freetown, December 6, 2025. Anemia is a serious condition in pregnancy, linked with both higher maternal mortality and worse fetal outcomes, but after pregnancy it can “also cause fatigue, poor work capacity, impaired immune function, increased risk of cardiac diseases, and mortality.” Robert E.

Another Freetown resident had intense foot pain after giving birth, although she does not know if this pain was linked to her birth. However, after paying for plastic sheeting, soap, gloves, and other items necessary for the birth, for painkillers sold “one by one” by nurses, and for the “handwashing” fee, she could not afford to address her foot problem. “I had no money left, so I came home,” she said. “The doctor did not touch me because I had no money left.”¹⁷⁰

Shortages of Medicines and Other Healthcare Commodities

When medicines, bandages, plastic sheeting, sutures, and other essential supplies are missing, women and families must purchase them or else risk delays or poor treatment. Shortages are also stressful for providers, undermining respectful care, and have created opportunities for black markets to flourish in hospitals. Shortages, Human Rights Watch found, are a result of both underspending and poor systems management.

All providers in the government hospitals and clinics Human Rights Watch visited complained of extreme shortages of maternal and newborn health supplies needed for facility births, including basic drugs to manage very common complications and commodities, such as gloves, cleaning supplies, and a clean surface to birth on (plastic sheeting). Although different drugs and medical supplies were missing or in worryingly short supply in different facilities, providers consistently identified shortages as their key obstacle to providing quality maternal care.

One midwife in a government clinic in York said she had no IV fluids, iron supplements, or magnesium sulphate, an important drug for managing pregnancy hypertension. “Our supplies are meant to be quarterly, but it has become only two times a year and also the amount is not enough for the community,” she noted.¹⁷¹ At the time of our visit, a small government clinic in the Waterloo area only had children’s cannulas (a thin tube inserted into the body used to administer medicine or drain fluids). It had no IV fluids or drugs left except oxytocin, a drug used to stop hemorrhage.¹⁷²

Black et al., “Maternal and child undernutrition and overweight in low-income and middle-income countries,” *The Lancet*, Volume 382, Issue 9890, August 2013, 427 – 451, doi: 10.1016/S0140-6736(13)60937-X.

¹⁷⁰ Human Rights Watch interview, name withheld, Freetown, December 6, 2024.

¹⁷¹ Human Rights Watch interview with a primary health care unit midwife, name withheld, York, December 16, 2024.

¹⁷² Human Rights Watch interview with a community health worker, name withheld, Waterloo area, December 14, 2024.

As another example, Kabala’s main referral hospital’s stores that had been last supplied in August were basically bare by December 2024. The stores only had some gloves, children’s cannulas, and two boxes of ibuprofen. Missing items included antenatal care (ANC) cards, IV fluids, birthing sets, iron, folic acid, plastic sheeting, forceps, scissors, and misoprostol and oxytocin (two crucial uterotonics used to prevent maternal hemorrhage).¹⁷³

Doctors and midwives at PCMH said they bring their own gloves. Three PCMH doctors told Human Rights Watch they always made sure they had sets of sutures on them in case of a shortage at the hospital or if a patient could not pay. One doctor recounted how the delivery of birth kits from a US donor brought some immediate relief, although he had to use their contents sparingly to make the donation last as long as possible. A senior hospital official showed Human Rights Watch a pile of sutures and other commodities he had in his office to give to women that were waiting so long for interventions he feared they could die.¹⁷⁴ An obstetrician noted how lacking sutures impacted providers’ ability to do their work:

If there is an emergency like a ruptured uterus, there is no time to send the patient or family out to go and buy sutures, or it’s 3 a.m. and you are running helter skelter with different competing cases, and there’s an acute bleed, if you don’t have sutures there is nothing you can do.¹⁷⁵

But sutures were only one of this doctor’s problems. PCMH had only 1 of 10 antenatal blood and urine tests because it was out of reagents, she added.¹⁷⁶

Shortages of Blood Products

The availability of blood products, including whole blood for transfusion, is a major problem in Sierra Leone, including for birthing women who are at high risk of anemia and hemorrhage.¹⁷⁷ In cases of post-partum hemorrhage, the biggest driver of maternal death

¹⁷³ Human Rights Watch interview with a store manager, name withheld, Kabala town, December 12, 2024.

¹⁷⁴ Human Rights Watch interview with a senior medical official, name withheld, Freetown, July 17, 2025.

¹⁷⁵ Human Rights Watch interview with a medical doctor in a referral hospital, name withheld, Freetown, December 14, 2024.

¹⁷⁶ Human Rights Watch interview with a medical doctor in a referral hospital, name withheld, Freetown, December 14, 2024.

¹⁷⁷ Yassir Shafiq et al., “Causes of maternal deaths in Sierra Leone from 2016 to 2019: analysis of districts’ maternal death surveillance and response data.” “Overall, obstetric haemorrhage was the leading cause of maternal death (39.4%), followed by hypertensive disorders (15.8%) and pregnancy-related infections (10.1%). Within obstetric haemorrhage, postpartum haemorrhage was the leading cause in each district. The burden of death due to obstetric haemorrhage slightly

in the country, women must be transfused quickly, but hospitals often do not have a ready supply on hand. Instead, the burden is on women and families to provide the necessary blood. Women are advised to prepare to supply blood before birth, and especially before cesarean sections which are often delayed while families try to access blood, and even when the need for surgery is pressing. Providers often complained that relatives are unwilling to donate blood, and facilities rely on paid blood donors, often young men, who provide their telephone numbers and blood type to hospitals in case a family needs it and is ready to pay for a match.

Providers are not always involved in negotiations over payments for blood, and problems with blood availability are systemic, but the additional cost in time and money can be terrible for birthing women and their families. Human Rights Watch documented four cases where women died apparently because of a lack of blood. For example, a group of midwives at a training center for refresher training told Human Rights Watch about a colleague midwife who had died in January 2024 in childbirth. “They wanted to do a cesarean section, there was a need for prompt action, but they were delaying looking for her blood match,” one of the midwife interviewees said. “She and the baby both died.”¹⁷⁸

Human Rights Watch found that these shortages are driven by low government spending, but also weak supplies management.

A group of Sierra Leonean government officials and UN partners have joined together to plan for and purchase UN-sourced maternal and child health supplies to support the FHCI, including essential medicines and supplies. However, Sierra Leone has not paid for commodities for the FHCI through this process, except for in one year, 2022, when the government paid for about 10 percent of that year’s procurement, even though the UK’s Foreign, Commonwealth and Development Office (FCDO) had reduced funding over the years, as planned.¹⁷⁹

increased over the study period, while hypertensive disorders showed a slightly decreasing trend.” According to the 2019 Sierra Leone Demographic and Health Survey, the prevalence of anemia among women age 15-49 increased from 45 percent in 2008 and 2013 to 47 percent in 2019.

¹⁷⁸ Human Rights Watch interview with three midwives in training, names withheld, Makeni, December 12, 2024.

¹⁷⁹ Human Rights Watch interviews with a United Nations agency staff member and Sierra Leone government official, Freetown, February 11 and 13, 2025. This FHCI fund has had various donors that have provided both cash and in-kind support to the initiative, but the UK government has been the most significant donor.

In 2024, the government-UN group calculated they would need US\$45 million to purchase enough UN-sourced drugs to meet part of the FHCI demands for 2025-26.¹⁸⁰ However, while they received \$9.2 million from FCDO and nothing from the Sierra Leone government, and could only buy 47 key drugs and commodities out of the list of 200 essential drugs and commodities and in much smaller quantities than needed. Shortages in 2024 were made more acute by a temporary pause in distributions while an investigation initiated by the UK's Foreign, Commonwealth and Development Office (FCDO) regarding a warehouse fire that destroyed commodities was underway.¹⁸¹ At the time of writing, there are no funds available to procure medicines and medical supplies for 2026.¹⁸²

The government promised in 2025 to contribute to funding free health care drugs in 2025 (as noted above, FCDO will no longer be providing FHCI medicines).¹⁸³ At time of writing, however, it has yet to disperse money for these essential commodities, a worrying sign as the government has in recent years repeatedly promised to pay for commodities and has budgeted for it formally, but has not released the funds.¹⁸⁴

Gaps in supplies create strong incentives for providers to fill them, both to have drugs and commodities immediately available, including in emergencies, and to make money. These gaps provide an excuse and cover for providers to sell drugs even though this is not allowed. "We do not charge, it is free," a midwife in a densely populated neighborhood of Freetown said. "But to be honest, if I buy many drugs so at night there are drugs after the pharmacy closes, I will charge you for those."¹⁸⁵ To reduce corruption and protect patient-provider trust, government staff are meant to send patients to private pharmacies if they do not have the necessary drugs. This happens sometimes, and women patients reported

¹⁸⁰ Human Rights Watch interviews with a United Nations agency staff member and Sierra Leone government official, Freetown, February 11 and 13, 2025.

¹⁸¹ Human Rights Watch interviews with a United Nations agency staff member and Sierra Leone government official, Freetown, February 11 and 13, 2025; and Letter from West Africa Team, Foreign, Commonwealth and Development Office to Human Rights Watch, October 16, 2025, on file with Human Rights Watch.

¹⁸² *Ibid.*

¹⁸³ Eric George, "Govt. Allocates NLe 1.5 Billion to Health Sector in 2025 Budget," *Awoko News*, November 19, 2024, <https://awokonewspapersl.com/govt-allocates-nle-1-5-billion-to-health-sector-in-2025-budget/#:~:text=Fantamadi%20Bangura%20has%20outlined%20the,expenditures%20for%20the%20coming%20year> (accessed May 6, 2025).

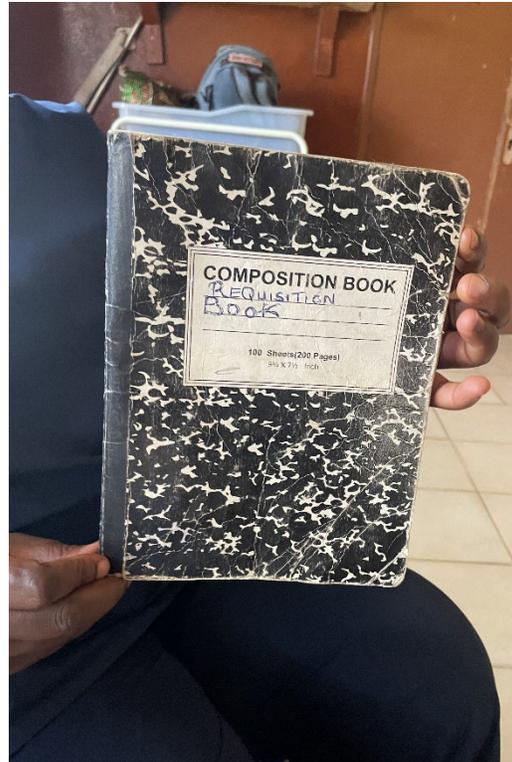
¹⁸⁴ Human Rights Watch interviews with government and non-government officials, names withheld, Freetown, July 17 and July 18, 2025.

¹⁸⁵ Human Rights Watch interview with a midwife, name withheld, Congotown area, Freetown, December 6, 2024.

being sent to pharmacies to buy drugs or prenatal vitamins, especially if providers did not have any to sell or give to them.

The lack of an effective supply chain to ensure the timely delivery of medicines is a major impediment. One UN document, for example, notes: “in addition to closing the funding gap and timely release of funds for procurement of commodities, comprehensively strengthening the supply chain system is *equally* critical.”¹⁸⁶

Although foreign governments and other donors often pay for the procurement and delivery of medicines and other healthcare commodities to government-controlled facilities in Sierra Leone, the government is responsible for the “final mile,” that is, the transportation of these rights-essential commodities from regional hubs to local clinics and hospitals. However, because of a lack of cars, fuel, and sufficient coordination, as well as infrastructure problems such as flooded roads, the government is often unable to dispense these medicines and other commodities in a timely manner.¹⁸⁷ To help address this problem, USAID was providing financial support for the development of a new drug distribution management system called “m-Supply,” but this process ground to a halt after the US government froze and then withdrew most of its development funding, including to Sierra Leone.¹⁸⁸



A midwife shows a notebook used to record drug use for a major regional hospital. Paper-based systems are inadequate to manage drug and other commodity supply systems, according to government officials. © 2025 Skye Wheeler/Human Rights Watch

¹⁸⁶ On file with Human Rights Watch, our italics.

¹⁸⁷ Human Rights Watch interviews with a United Nations agency staff member and Sierra Leone government official, Freetown, February 11 and 13, 2025.

¹⁸⁸ Human Rights Watch interviews with a United Nations agency staff member and Sierra Leone government official, Freetown, February 11 and 13, 2025.



Drugs in unlocked cupboards in a major referral hospital. Systems that are poorly managed make it easy for drugs to be stolen and difficult to know when supplies need to be refilled to meet needs. © 2025 Skye Wheeler/Human Rights Watch

The lack of consistent and comprehensive inventory monitoring practices at public healthcare facilities also contributes to acute shortages of essential medicines, as hospitals do not have systems to effectively monitor the receipt, withdrawal, and use of hospital inventory, including medicines. “The weak record systems lead to corruption vulnerabilities,” Rashid Turray, director of prevention in the Anti-Corruption Commission of Sierra Leone, said in an interview with Human Rights Watch. “Most of the records are not there.”¹⁸⁹

The Anti-Corruption Commission told Human Rights Watch that it has conducted numerous sting operations in facilities across Sierra Leone, including in 2024 and 2025. In 2022, officials said the commission executed a large-scale operation to root out abuses linked to FHCI drugs.¹⁹⁰ Some of the sting operations have resulted in court cases against health workers. At least two cases, both in the Bo area in the country’s center, are currently being

¹⁸⁹ Human Rights Watch online interview with Rashid Turray, director of prevention, Anti-Corruption Commission of Sierra Leone, April 22, 2025.

¹⁹⁰ Human Rights Watch online interview with Evelyn Kuyateh and Francis Ben Kaifala, Sierra Leone Anti-Corruption Commission, April 22, 2025.



One of the posters in the PCMH hospital seen by Human Rights Watch in 2024 and 2025. © 2025 Skye Wheeler/Human Rights Watch

prosecuted.¹⁹¹ In others, health workers were officially reprimanded and warned they would face prosecution if they re-offended, transferred, or embarrassed in front of their colleagues about their conduct.¹⁹²

Drugs and money were recovered in some cases. For example, in April 2025, the commission retrieved significant amounts of FHCI drugs in Freetown, and in 2022, it retrieved and reported to the government FHCI drugs found in a residence in Kabala. In some cases, money was also recovered from staff who took double salaries or continued to receive a salary after leaving the country.¹⁹³

Because of the commission's actions, the person in charge of PCMH's pharmacy was transferred in 2023 over corruption charges.¹⁹⁴ Anti-Corruption Commission

officers interviewed also said their office has taken action to educate hospital staff, and patients, about the importance of following ethical rules and developed service charters in PCMH and in Makeni and Kabala hospitals. The commission said the government consistently provided promised funds to the body to do its work and had increased funding for public education and awareness efforts and other prevention activities in recent years.¹⁹⁵ During its visit to PCMH, Human Rights Watch saw four or five A4 posters in the hospital reminding providers not to sell drugs. One commentator, an international health worker with many years working in maternal health in Sierra Leone (but not in PCMH) noted however that government officials blaming providers for "extortion," when the government doesn't provide them with the drugs, IV needles, sutures, running water,

¹⁹¹ Ibid.

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

or salaries so they need to provide care is best understood as government shifting the blame, rather than taking responsibility for the problems.¹⁹⁶

However, a range of experts in the maternal and newborn health system agreed that not enough was happening to address medical corruption. Some nurses, midwives, and doctors could remember one or two cases where a colleague was transferred for medical corruption, but no one could recall any instances when an individual was prosecuted or transparently fired for taking money. In addition, no one remembered any systematic or significant efforts by their facility administration or the health ministry to address the problem. “They do not fire nurses and midwives for bad behavior,” one exasperated midwife said. “They are suspended, or they send them to do different things.”¹⁹⁷ An obstetrician said one doctor was scolded for negligence and taking money for an operation but later returned to work.¹⁹⁸ “Some health workers are not feeling that they are accountable for what they are doing,” another doctor concluded.¹⁹⁹ A senior official at PCMH said that she did not know of any dismissals of providers for taking money, but, echoing other senior officials, noted that only the central government can fire government health workers, making it harder for the hospital to take action.²⁰⁰

None of the four national government officials whom Human Rights Watch interviewed could think of any major effort to crack down on providers selling commodities, drugs, or services.

However, while egregious cases of abuse and extortion should be addressed, experts, from both within the government and outside, agreed that a bigger problem is the government’s failure to engage with the drivers behind systemic and long-standing problems, including those described earlier in this chapter. Multiple interviewees argue that the government does not want to end the FHCI or admit that it does not provide free health care as envisaged but also is not willing to address its failures.

¹⁹⁶ Human Rights Watch online interview with an official from an international non-governmental organization, name withheld, August 15, 2025. Human Rights Watch interview with the head of an international non-governmental health organization, name withheld, Freetown, July 17, 2025.

¹⁹⁷ Human Rights Watch interview with a midwife, name withheld, Congotown area, Freetown, December 6, 2024.

¹⁹⁸ Human Rights Watch interview with an obstetrician, name withheld, Freetown, February 22, 2025.

¹⁹⁹ Human Rights Watch interview with a medical doctor, name withheld, Freetown, February 2, 2025.

²⁰⁰ Human Rights Watch interview with Christiana Squire, head matron at PCMH, Freetown, July 17, 2025.

Human Rights Watch reviewed 20 key government, UN, health NGO, and donor reports concerning health generally or maternal and newborn health more specifically. These reports openly discussed some serious public healthcare problems, such as health financing and poor-quality systems, but they did not explicitly raise widespread informal payments or medical corruption except occasionally in passing and with sanitized language. The government and its partners' failure to acknowledge the problem is an obstacle to addressing it.

A Way Forward? The Sierra Leone Social Health Insurance Scheme

The Sierra Leone health ministry has designed a health insurance scheme that, when rolled out, officials hope will provide an alternative to the Free Health Care Initiative, which is, as one official noted, “always in a crisis of supply and drugs” and which also only (primarily) caters to pregnant and lactating women, and children under five.²⁰¹

Ministry officials hope that the proposed Sierra Leone Social Health Insurance Scheme, “SLeSHI,” will eventually provide health insurance coverage for all residents, but it will start with one region and aim to cover 30 percent of the population in its first stage. Civil servants and people who work in private business will pay part of their salaries into SLeSHI, and the health ministry plans to tax other goods and services, as well as from vehicles and on overseas remittances, to support the scheme. The health ministry is still deciding on how to ensure the poorest Sierra Leoneans are not excluded from the scheme, which patients will have to buy into before using government services, including indigent pregnant women who are in particular need of health care during this period of their life.²⁰²

²⁰¹ Human Rights Watch online interview Abdul Jibril Njai, July 24, 2025.

²⁰² Human Rights Watch interview, Michael Amara, team lead, Sierra Leone Social Health Insurance (SLeSHI), Freetown, July 18, 2025.

International Human Rights Law and Obstetric Violence

The Sierra Leone government has obligations under international human rights law to ensure that all human rights are respected, protected, and fulfilled, including, relevant to this report, the rights to health, to life, to a remedy, to be free from cruel and inhuman and degrading treatment, and to nondiscrimination.

The Right to Health Including Maternal Health

The International Covenant on Civil and Political Rights (ICCPR) sets out that the inherent right to life should be protected by law.²⁰³ Positive measures should be taken by a state to protect people living under its control from being deprived of life.²⁰⁴ States should develop strategic plans “designed to reduce maternal and infant mortality” and if maternal mortality is high, “[ensure] the accessibility of health services including emergency obstetric care ...[and] ensure that its health workers receive adequate training.”²⁰⁵

The International Covenant on Economic, Social and Cultural Rights (ICESCR), to which Sierra Leone is also a party, enshrines the right to the highest attainable standard of physical and mental health. The “provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child” is specifically mentioned in the ICESCR.²⁰⁶ The ICESCR emphasizes the need for special protection for mothers before and after childbirth.²⁰⁷ The Convention on the Elimination of All Forms of Discrimination

²⁰³ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, acceded to by Sierra Leone on August 23, 1996, art. 6.

²⁰⁴ ICCPR General Comment 6, The right to life (Article 6), International Human Rights Instruments, 16th Session, UN Doc HRI/GEN/1/Rev. 1 (1994), para. 5.

²⁰⁵ ICCPR General Comment 36, The right to life (Article 6), UN Doc CCPR/C/GC/36, September 3, 2019, para.26; and Concluding Observations of the Human Rights Committee: Mali, 04/16/2003, CCPR/CO/77/MLI, para. 14. ACHPR/Res.135 (XXXIII).08, http://www.achpr.org/english/resolutions/resolution135_en.htm.

²⁰⁶ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, acceded to by Sierra Leone on August 23, 1996, art. 12.2(a).

²⁰⁷ *Ibid.*, art. 10(2).

against Women (CEDAW) provides that governments “shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period.”²⁰⁸

The African Charter on Human and Peoples’ Rights (African Charter) protects the right to life, the right to health, and says that states “shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.”²⁰⁹ The African Commission on Human and Peoples’ Rights also characterizes preventable maternal mortality as a violation of women’s right to life.²¹⁰

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol) specifically calls on states to “establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.”²¹¹

Obstetric Violence in International Human Rights Law

Human rights law that protects women from violence, from ill-treatment linked to gender or sex, or from discrimination imposes obligations on states to act and prevent behavior which constitutes obstetric violence. Article 3 of the Maputo Protocol requires states to ensure the dignity of women, who “have the right to respect as a person and to the free development of her personality.”²¹² In addition, the Maputo Protocol demands states act, including through legislation and other methods, to ensure “protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.”²¹³

²⁰⁸ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, ratified by Sierra Leone on November 11, 1988, art. 12(2).

²⁰⁹ African [Banjul] Charter on Human and Peoples’ Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986, art 18.

²¹⁰ African Commission on Human and Peoples Rights, Resolution on Maternal Mortality in Africa - ACHPR/Res.135(XXXIV)08, November 24, 2008, <https://achpr.au.int/en/adopted-resolutions/135-resolution-maternal-mortality-africa-achprres135xxxiv08#:~:text=Convinced%20that%20preventable%20maternal%20mortality,1>.

²¹¹ Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, September 13, 2000, CAB/LEG/66.6, entered into force November 25, 2005, art 14.2(b).

²¹² *Ibid.*, art. 3.

²¹³ *Ibid.*, art. 5.

Women’s rights and reproductive justice organizations and activists, especially in Mexico, Central America, and South America, have interrogated the physical violence, bullying, interventions without consent, abandonment, and neglect, among other horrors, against pregnant and birthing women in facilities as dimensions of violence against women. South American activist efforts resulted in a major ruling by the Inter-American Court of Human Rights that defined obstetric violence as a human rights violation.²⁴⁴ In March 2025, the African Commission of Human Rights recognized obstetric violence as a form of gender-based violence and discrimination that violates human rights, including the right to dignity, the right to freedom from torture, the right to health, and the right to life.²⁴⁵

Various experts have analyzed how obstetric violence violates several internationally protected human rights. The UN Special Rapporteur on the right to health said these include women’s and girls’ right to life; the right to the best attainable state of physical and mental health; the right to freedom from discrimination; the right to privacy; and the right to integrity and security of the person.²⁴⁶ It also violates women and girls’ right to information and adolescent girls’ right to be heard, such as when forced or medically unnecessary procedures are carried out on women without their free and informed consent.²⁴⁷

²⁴⁴ Center for Reproductive Rights, “In Ruling by Inter-American Court of Human Rights, New Legal Protections for Pregnant Women,” February 2, 2023, <https://reproductiverights.org/inter-american-court-human-rights-protections-pregnant-women-latin-america/> (accessed May 7, 2025). The court’s defined obstetric violence as: “a form of gender-based violence (...), exercised by health care providers against pregnant women, during access to health services that take place during pregnancy, childbirth and postpartum, which is expressed mostly, but not exclusively, in a dehumanizing, disrespectful, abusive or negligent treatment of pregnant women; in the denial of treatment and full information on the state of health and applicable treatments; in forced or coerced medical interventions; and in the tendency to pathologize natural reproductive processes, among other threatening manifestations in the context of health care during pregnancy, childbirth and postpartum.” Argentina (2009), Mexico (2014), Panama (2013), Suriname (2014) and Venezuela (Bolivarian Republic of) (2007) have passed laws criminalizing obstetric violence. For more, see: C.R. Williams et al., “Obstetric violence: a Latin American legal response to mistreatment during childbirth,” *BJOG, An International Journal of Obstetrics and Gynaecology*, 2018, doi: 10.1111/1471-0528.15270.

²⁴⁵ African Commission Resolution on the need to Develop Guidelines on the Elimination of Obstetric Violence and Promotion of Maternal Healthcare in Africa - ACHPR/Res.625 (LXXXII) 2025, March 14, 2025, <https://achpr.au.int/index.php/en/adopted-resolutions/625-achpres625-lxxxii-2025> (accessed June 17, 2025).

²⁴⁶ UN General Assembly, Report of the Special Rapporteur on the right to health: A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence, Dubravka Šimonović, A/74/137, July 11, 2019, <https://digitallibrary.un.org/record/3823693> (accessed November 11, 2024), para. 8.

²⁴⁷ *Ibid.*, paras. 21-25 and 38; and African Committee of Experts on the Rights and Welfare of the Child (ACERWC), “Teenage Pregnancy In Africa: Status, Progress and Challenges,” 2022, https://www.google.com/search?q=acerwc&rlz=1C1GCEA_enUS1033US1033&oq=acerwc&gs_lcrp=EgZjaHJvbWUyCQgAEEUYORiABDIHCAEQABiABDIHCAIQABiABDIHCAMQABiABDIHCAQQABiABDIHCAUQABiABDIGCAYQRRg8MgYIBxBFGDzSAQgxMzAoajBqN6gCALACAA&sourceid=chrome&ie=UTF-8 (accessed November 11, 2024), pp. 57-59.

Acts of obstetric violence may also amount to torture or other cruel, inhuman or degrading treatment. The UN Special Rapporteur on Torture’s 2013 report on torture and ill-treatment in healthcare settings analyzed the mistreatment of women seeking reproductive health care.²¹⁸ It noted how abuse can be hidden behind medical superiority and defenses of “medical necessity” or efficiency. The World Health Organization (WHO) made a statement in 2014 condemning disrespectful treatment in childbirth that undermined maternal and newborn health and the rights to “life, health, bodily integrity and freedom from discrimination.”²¹⁹

The White Ribbon Alliance, a global network of maternal health advocates, activists, and providers created the “Respectful Maternity Care: The Universal Rights of Childbearing Women” charter in 2011. The charter argues that dignity, respect, noncoercion, and nondiscrimination were barriers to decreasing rates of maternal and newborn injury and death and achieving core women’s rights goals.²²⁰

²¹⁸ “Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez,” U.N. Doc. A/HRC/22/53 , February 1, 2023, https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed May 5, 2025).

²¹⁹ World Health Organization, “The prevention and elimination of disrespect and abuse during facility-based childbirth,” WHO/RHR/14.23, September 14, 2014, <https://www.who.int/publications/i/item/WHO-RHR-14.23>. One commentator called the statement, also signed by many civil society organizations, as “a turn from the public health world of systems and resources in preventing mortality to the intimate clinical setting of patient and provider in ensuring respectful care.” Joanna N. Erdman, “Commentary: Bioethics, Human Rights and Childbirth, Harvard University, Health and Human Rights,” <https://www.hhrjournal.org/2015/06/02/commentary-bioethics-human-rights-and-childbirth/> (accessed May 2, 2025).

²²⁰ White Ribbon Alliance, “Respectful Maternity Care: The Universal Rights of Childbearing Women,” <https://newborntoolkit.org/fr/reading/respectful-maternity-care-the-universal-rights-of-childbearing-women> (accessed May 5, 2025).

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“No Money, No Care” Obstetric Violence in Sierra Leone

This report, *“No Money, No Care”: Obstetric Violence in Sierra Leone*, documents healthcare providers’ abuse, neglect, and abandonment of pregnant and birthing women in Sierra Leone, including cases of obstetric violence. It describes how many of these abuses which are demeaning and dangerous for women and newborns are often driven by informal fees levied by healthcare providers, which create cost-based barriers to health care.

Obstetric violence is a globally under-addressed form of gender-based violence. As elsewhere, obstetric violence in Sierra Leone undermines girls’ and women’s bodily autonomy, agency as well as their right to health.

Sierra Leone has made some improvements in its healthcare system in recent years, significantly reducing the maternal mortality rate over the past decades and improving training on respectful maternal healthcare for providers. This report, based on about 125 interviews with patients, healthcare providers, and policy experts, documents how the promise of Sierra Leone’s “Free Health Care Initiative” — which declared that no pregnant or lactating women or children under 5 should have to pay for health care — is, in practice, unfulfilled by the realities of the underfunded public healthcare system heavily reliant on unpaid healthcare providers exacting out-of-pocket costs from patients to function, and stymied by chronic shortages of essential medicines and other healthcare commodities.

Addressing these drivers of obstetric violence is urgently needed to continue the improvement of maternal health care in Sierra Leone, and to ensure women and girls are free from violence and discrimination based on their gender in healthcare settings.

(above) Patients wait for their turn to be served at the pharmacy of the Princess Christian Maternity Hospital in Freetown, Sierra Leone, on April 25, 2016. © 2016 MARCO LONGARI/AFP via Getty Images

(cover) Pregnant women sit in the waiting area at the pre-natal clinic of the Princess Christian Maternity Hospital in Freetown, Sierra Leone, on April 25, 2016. © 2016 MARCO LONGARI/AFP via Getty Images