Structure

1. Health and policy context in Sierra Leone

2. Overview of SLURC urban health research portfolio

3. Findings from ongoing work

4. Policy implications and questions

Health system context

- Maternal and child mortality among highest in the world: maternal mortality 1,165/100,000[+]; under 5 mortality 156/1000[+] (DHS 2013)

- Per capita out of pocket expenditure on health care above SSA average - (MTNDP 2019-2023)

- Imbalance between government spending on prevention versus spending on curative services e.g. sanitation 0.2% of GDP versus health allocation 11.1% of GDP (MTNDP 2019-2023 & WHO)

- Donor spending on health significantly higher than on other sectors

Donor spend ($million)446.	2013	2014	2015	2016	2017
Health	93.43	172.12	130.34	116.05	153.29
WASH	35.88	35.38	30.50	27.65	38.55
Ag & Rural Dev	56.27	43.28	56.59	39.41	36.18
Roads	67.43	26.72	43.26	60.12	33.99
Ebola Response	-	446.60	373.89	54.65	29.72

Source: MTNDP 2019-2023

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Health and Policy context

Policy context

- 'Urban' not considered in National Health Sector Strategic Plan (2017-2021) or National Health Promotion Plan (2017-2021). Nothing on informal settlements.

- Numerous new plans (e.g. One Health Plan, Health Security Plan) but outdated regulatory instruments e.g.1960 Public Health Ordinance Act

New directions?

- Urban and informal settlements very prominent in National Development Plan 2019-2023 e.g. in land and housing, water and waste;

- Transform Freetown: ambitious targets for heath, water and sanitation and wide consultation including with informal settlements

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Urban health portfolio

1. **Future Health Systems (DFID):** 1) a scoping review to explore the state of knowledge on urban health; 2) empirical research to explore the relationship between living conditions in informal settlements and health problems

    -   1) literature review 2) FGDs in 4 communities, KIIs with health workers and policy makers

2. **Shock Tactics - Urban Health Futures in the Wake of Ebola (ESRC):** ethnographic research to understand disease control practices, collective action and governance in the post Ebola period

    -   Narrative life history interviews, governance diaries, participant observation and KIIs in 2 communities

3. **ARISE - Accountability and Responsiveness in Informal Settlements for Equity (GCRF):** explores inequalities in health and wellbeing and works with marginalised people to claim their right to health and other social services through building accountability with service providers; partners in Sierra Leone, Bangladesh, Kenya and India

    - Participatory and interdisciplinary action research

4. **Ebola project (IDRC):** exploring socio-cultural and environmental factors in improving Ebola disease response and resilience in partnership with York University; study is being conducted in selected areas which experienced high infection rates (Moyamba junction, Waterloo & Dwarzark)

    - FGDs & IDIs with Ebola responders, survivors, caregivers

FHS key findings – scoping review

Evidence gaps

- Knowledge base on urban health is limited

- No systematic study of health determinants and risks in informal settlements

- Absence of engagement with residents of informal settlements about their health-related priorities, beliefs and experiences

- *SLURC health research projects aim to fill these gaps*

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Care seeking behaviors

- Most people rely on self-administered treatments and later seek care from hospitals/health centres when conditions get worse or self-treatment fails

- High costs of care, distances, difficult terrain, poor roads, long wait times, past experiences, and perceptions about staff affect health seeking; also gender e.g. men more likely to use informal and private care

- Frequent drug stockouts affect the chances of people visiting PHCs; they are inclined to seek prescriptions and then purchase drugs elsewhere

- Private providers (e.g. Arab and Mercy Ship) are often preferred over public ones – perceived to be better value

Care seeking behaviours

- People rely on a range of informal care options which tend to be cheaper, nearer and (at times) preferred, including:

    - Pepe doctors/drug peddlers
    - Pharmacists
    - Providers known to the person e.g. a nurse living in community, or where there is a relationship; payment can be flexible

- Traditional healers consulted for conditions including convulsion, epilepsy, elephantiasis, witchcraft related conditions ("witch gun"/"fangay"), hernia, infertility, mental illness, ulcer, malaria, and blindness. (eg. Cockle Bay)

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ESRC initial findings

Long and costly care pathways:

"I have spent all my savings on maintaining my health. I have sought care from several health care services including the Chinese hospital, Kamakwe, Lunsar and Makeni hospitals without clear diagnosis…… The conditions I experience are very strange as my stomach protrudes and causes difficult breathing. I also experience eye problems, intermittent coughing, complete loss of appetite, very dark urine, limited sleep and loss of sexual urge".
(deceased male, Moyiba)

Self-treatment and rationing:

"I buy drugs sometimes at Le 10,000 for half of the dose, or 3 tablets if I can afford to pay Le 5,000 at the time of illness. I buy full dose if I have sufficient money, but I buy half or a quarter of the dose if I don't have enough money….. I am sometimes given discounts by the pharmacy attendants if my condition is severe to help me administer the full malaria dose, but if my condition is not severe, I take the first half dose and complete the second half when I have money". (elderly male, CKG)

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Health experiences

- Residents face a combination of health challenges relating to infectious disease, occupational injuries, environmental hazards, stress and hereditary causes, often at the same time

- Lives are occupied with making 'daily bread' and people are vulnerable to serious sickness or injury; health problems are compounded by social and economic e.g. loss of livelihoods

- Life histories show that there is limited social support and protection beyond close family; family support can be over-stretched

- People describe high levels of anxiety, fear, shame and indignity

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Collective action strategies for health

- Community-based action and social organisation
  - Youth groups, women's groups, FEDURP and savings groups, religious groups, neighbourhood committees (e.g. disaster, sanitation); political groups and campaigns, social clubs, organising online and offline (e.g. WhatsApp groups)
  - Also more traditional and hierarchical forms of authority e.g. chiefs, councillors, land owners and landlords
  - Governance diaries: who do people trust?
- Self-provision and co-production of health-related services
  - Organising own cleaning days, in addition to first Saturday
  - Digging own latrines
  - Local byelaws (and fines) to enforce health promoting behaviour e.g. no open defecation, build toilets
  - Establishing water connections (e.g. taps, or cutting pipes)
  - Supplying land, labour and materials for a new government health centre

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But…..

- Community based self-provision can be a burden and people are overwhelmed with competing priorities and initiatives

- Byelaws (incl. FCC and neighbourhood) tend to be ignored, and there is a risk that fines are predatory

- Community-wide initiatives rely on collective incentives but the collective (i.e. 'community') is not clear;

  - Differing priorities within settlements
  - How to deal with problems from 'outside' settlements e.g. waste
  - Health risks are not viewed as collective

- Complaints that 'public' assets and services get privatised & captured e.g. misuse of 'maintenance' fees for water access

- *Very limited accountability (within and beyond settlements)*

Accountability for health equity?

Can strengthened accountability mechanisms improve basic services and reduce inequalities?

- Accountability is more than dealing with grievances, but clarifying the rights and responsibilities between citizens and the institutions which effect their lives, and shifting the balance of power between them ('voice'; and 'teeth', horizontal and vertical)

- Current accountability models assume simplistic supply and demand relationship and are not applicable for informal urban settlements

- Urban accountability needs to work with fluid governance systems, plural health care systems, numerous actors and competing interests, multi-sectoral challenges

- Accountability at local level is limited by higher level factors e.g. the drug supply, land policy).

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Policy implications and questions

The characteristics of informal settlements need to be considered in health planning, and health should be part of spatial planning – and the health burdens are collective

How can informal settlements move towards sustained and scalable improvements in health?

- Can urban accountability mechanisms be developed for improved health? Who are the key stakeholders? What are their roles, responsibilities and priorities?

- How can local action be supported? Which groups and intermediaries can represent informal settlements and their diverse populations and needs?

- How can multi-sectoral planning for health be promoted? Can informal settlements and their health be integrated into non-health plans and policies i.e. National Spatial Development Plan, Freetown Structure Plan?

- How can lessons be shared across Freetown and urban settings in Sierra Leone?

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Any questions?

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