LÄNDERANALYSE

Sierra Leone: Finanzierung von Gesundheitskosten

Auskunft der SFH-Länderanalyse

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Dieser Bericht basiert auf Auskünften von Expert*innen und auf eigenen Recherchen. Entsprechend den COI-Standards verwendet die SFH öffentlich zugängliche Quellen. Lassen sich im zeitlich begrenzten Rahmen der Recherche keine Informationen finden, werden Expert*innen beigezogen. Die SFH dokumentiert ihre Quellen transparent und nachvollziehbar. Aus Gründen des Quellenschutzes können Kontaktpersonen anonymisiert werden.

1 HAUPTAUSSAGEN

Das Gesundheitssystem Sierra Leones **ist stark unterfinanziert** und weist erhebliche **strukturelle Defizite** auf. Der Bürgerkrieg, die Ebola- Epidemie und die COVID-19-Pandemie sowie zuletzt zahlreiche Fälle von Mpox, die Kush-Krise und die Einstellung von USAID-Programmen haben das bereits geschwächte System zusätzlich belastet.

Die öffentlichen Gesundheitsausgaben sind gering und Sierra Leone ist **stark von internationalen Geldgebern abhängig**, welche rund 75 Prozent Gesundheitsversorgung finanzieren. Diese Abhängigkeit beeinträchtigt die Planbarkeit und Kontinuität der Gesundheitsversorgung. **Krankenkassen sind kaum verbreitet** und decken gerade mal 1 Prozent der Bevölkerung ab. Patient*innen sind mit **hohen Eigenkosten für Gesundheitsdienstleistungen** konfrontiert und sind dabei auf die Unterstützung aus informellen familiären und gemeinschaftlichen Netzwerken angewiesen.

Die «Free Health Care Initiative» (FHCI) sieht kostenlose Behandlungen für Schwangere, stillende Mütter, Kinder unter fünf Jahren, Personen mit Behinderung und Ebola-Überlebenden vor. In Praxis funktioniert dieses System jedoch nicht und Anspruchsberechtigte müssen häufig **Medikamente, Leistungen oder informelle Gebühren bezahlen** – ansonsten droht Verweigerung oder Verzögerung der Behandlung. Auch chirurgische Behandlungen können hohe Eigenzahlungen verursachen und Haushalte in finanzielle Not oder Armut bringen

2 EINLEITUNG

Einer Anfrage an die SFH-Länderanalyse sind die folgenden Fragen entnommen:

1. Gibt es Informationen zur Deckung von Gesundheitskosten bei fehlenden finanziellen Mitteln von Patient*innen in Sierra Leone?

Die Schweizerische Flüchtlingshilfe (SFH) beobachtet die Entwicklungen in Sierra Leone seit mehreren Jahren.[1] Aufgrund von Auskünften von Expert*innen und eigenen Recherchen nimmt die SFH zu den Fragen wie folgt Stellung:

[1] http://www.fluechtlingshilfe.ch/publikationen/herkunftslaenderberichte

3 GESUNDHEITSSYSTEM

Indikatoren weisen auf schwaches Gesundheitssystem hin. Diverse Quellen weisen darauf hin, dass das sierra-leonische Gesundheitssystem unterfinanziert und mangelhaft ist. Die Lebenserwartung bei Geburt liegt laut dem Jahresbericht 2023 der *Weltgesundheitsorganisation* (WHO) bei 54,3 Jahren, 31 von 1000 Kinder sterben bei der Geburt, 122 von 1000 Kinder sterben vor dem fünften Lebensjahr und auf 1000 Personen kommen gerade mal 0,34 Arzt*innen, Krankenpflegende oder Hebammen (WHO, 2024). *Amnesty International* (AI) schreibt in seinem Jahresbericht zur Menschenrechtssituation, dass Sierra Leone eine der höchsten Müttersterblichkeitsraten weltweit verzeichnet – und dies, obwohl sie im Jahr 2025 verglichen mit den Vorjahren zurückging (AI, April 2026).

Schwaches Gesundheitssystem wird durch verschiedene Krisen zusätzlich belastet. Gemäss *Forikolo*, einer Nichtregierungsorganisation, die im Gesundheitssektor aktiv ist, hat das sierra-leonischen Gesundheitssystem nach dem jahrelangen Bürgerkrieg, der Ebola-Epidemie und der COVID-19-Pandemie mit strukturellen Defiziten zu kämpfen (Forikolo, April 2025). Auch die *sierra-leonische Regierung* gibt an, dass der Bürgerkrieg das Land vor erhebliche Herausforderungen gestellt hat und Ebola sowie COVID-19 das ohnehin schon angeschlagene Gesundheitssystem stark belastet haben (Republic of Sierra Leone, Oktober 2025). AI berichtet, dass die Einstellung der US-amerikanischen Entwicklungsagentur USAID zur Schliessung von Kliniken, zu Personalabbau und zur Einstellung grundlegender Dienstleistungen wie HIV-Tests, Behandlung und Betreuung führte und gerade die Gesundheitsversorgung für Mütter ernsthaft beeinträchtigt. Zusätzlich habe das Gesundheitssystem im Jahr 2025 auch an der Viruserkrankung Mpox erkrankte Personen und Konsument*innen des Rauschmittels Kush auffangen müssen (AI, April 2026).

Geringe Gesundheitsausgaben der Regierung und grosse Abhängigkeit von ausländischen Geldgebern gefährdet Kohärenz und Kontinuität der Gesundheitsdienstleistungen. Gemäss einem im November 2025 von *Human Rights Watch* (HRW) veröffentlichten Bericht betrugen die Gesundheitsausgaben der Regierung im Jahr 2022 gerade mal 1,5 Prozent des Bruttoinlandprodukts (empfohlen wären 5 bis 6 Prozent), respektive 9,2 Prozent des Staatsbudgets im Jahr 2025 (empfohlen sind mindestens 15 Prozent laut Abuja Deklaration). Internationale Geldgeber wie USAID**,** the United Kingdom's Foreign and Commonwealth Office (FCDO) und die Weltbank hätten zusammen mehr für das Gesundheitswesen ausgegeben als die Regierung selbst. Dies verdeutlicht laut HRW die enorme Abhängigkeit des sierra-leonischen Gesundheitssystems von ausländischen Geldgebern. In diesem Kontext sei die Schliessung der amerikanischen Entwicklungsbehörde USAID «dramatisch», auch wenn die Auswirkungen dieses Rückzuges zurzeit noch nicht vollständig abgeschätzt werden könnten. Unter Berufung auf eine für das Gesundheitsministerium tätige Person berichtet HRW aber, dass mit der Einstellung von USAID ein Gesundheitsprojekt mit einem Budget von 45 Millionen Dollar gestrichen wurde, das mit einem Schwerpunkt auf der Gesundheit von Müttern, Kindern und Jugendlichen in fünf Distrikten geplant war. HRW unterstreicht, dass die krasse Abhängigkeit von internationalen Geldgebern oft kritisiert werde, da sie einem «Boom-and-Bust»-Muster («Auf- und Abschwung»-Muster) unterliege, welches dazu führe, dass die Verfügbarkeit von Ressourcen schwer vorhersehbar und im Zeitverlauf ungleichmässig sei (HRW, November 2025). Weil 75 Prozent der Gesundheitsfinanzierung von Geberbeiträgen abhängen, sieht auch die WHO die Kohärenz der Gesundheitsdienstleistungen in Sierra Leone als gefährdet an (WHO, 2025).

4 GESUNDHEITSKOSTEN

Probleme bei der Gesundheitsfinanzierung, Eigenanteile überdurchschnittlich hoch. Angesichts dieser äusserst geringen öffentlichen Ausgaben für das Gesundheitswesen lastet die Finanzierungslast laut HRW weitgehend auf denjenigen, die medizinische Versorgung benötigen. Dies zwinge viele dazu, die Kosten für medizinische Versorgung, die sie selbst oder ihre Angehörigen benötigen, aus eigener Tasche zu bezahlen, selbst wenn sie dazu nicht über die nötigen Mittel verfügten (HRW, November 2025). So machen laut WHO die Zahlungen aus der eigenen Tasche («out-of-pocket-payment») 56 Prozent der gesamten Gesundheitsausgaben aus und liegen damit deutlich über dem Durchschnitt von 30 Prozent in Subsahara-Afrika. Dadurch seien viele Menschen katastrophalen Gesundheitsausgaben ausgesetzt und Haushalte würden weiter in die Armut getrieben (WHO, 2025).

Krankenkassen kaum verbreitet, Unterstützung ist informell organisiert. Private Krankenversicherungen decken laut der *Internationalen Organisation für Migration* (IOM) weniger als 1 Prozent der Bevölkerung Sierra Leones ab (IOM, 2024). Laut WHO sind weniger als 1 Prozent durch Systeme der sozialen Gesundheitssicherung abgedeckt. Die *Bertelsmann Stiftung* (BTI) schreibt in diesem Zusammenhang, dass Unterstützungsnetzwerke – wie die Wirtschaft an und für sich – informell organisiert sind und dass die meisten Menschen in Sierra Leone auf Familie, Sippe, Gemeinschaft oder Selbsthilfestrukturen als soziale Überlebensgrundlage angewiesen sind (BTI, 2026).

Kostenlose Gesundheitsversorgung nur für bestimmte Gruppen, in Realität müssen auch sie informelle Zahlungen tätigen. Gemäss Angaben der sierra-leonischen Regierung deckt die «Free Health Care Initiative» (FHCI) Schwangere, stillende Mütter und Kinder unter fünf Jahren und Personen mit Behinderung ab. Seit der Ebola-Epidemie sind auch Ebola-Überlebende in die FHCI eingeschlossen (Republic of Sierra Leone, Oktober 2025). Mehreren Quellen zufolge müssen FHCI-berechtigte Gruppen in Sierra Leone trotz formellem Anspruch auf kostenlose Versorgung weiterhin direkte oder informelle Zahlungen leisten: *Pieterse and Lodge* schrieben bereits im Jahr 2015 über die von Korruptionsskandalen gebeutelte FHCI und berichteten, dass vom Personal erhobene Gebühren für Leistungen, die eigentlich kostenlos sein sollten, eine fortgesetzte Praxis sind; genauso wie das Umleiten von Medikamenten an private Apotheken oder in Nachbarländer (Pieterse and Lodge, November 2015). *Das UN-Kinderhilfswerk UNICEF* analysiert die FHCI in einem 2024 veröffentlichten Bericht und bemerkt dabei, dass die Verfügbarkeit von Medikamenten nach wie vor uneinheitlich sei, was dazu führe, dass Patient*innen diese selbst bezahlen müssen, was wiederum die Qualität der Versorgung sowie das Vertrauen in das Gesundheitssystem untergrabe (UNICEF, März 2024). Eine 2023 veröffentlichte Review im Gesundheitsfachmagazin *International Journal of Equity Health* hält fest, dass in Sierra Leone sowohl unbezahltes als auch bezahltes Gesundheitspersonal Gebühren für Gesundheitsdienstleistungen erhebe, die eigentlich kostenlos sein sollten. Die Review erwähnt eine 2016 durchgeführte Studie, wonach bis zu 96 Prozent der Haushalte angaben, sie hätten für vermeintliche kostenlose Leistungen bezahlt (Pieterse and Saracini, Dezember 2023). In einem umfassenden Bericht zu geburtshilflicher Versorgung in Sierra Leone zeigt HRW im November 2025 auf, dass schwangere Frauen, die offiziell Anrecht auf kostenlose Behandlung haben, häufig direkte oder indirekte Zahlungen tätigen müssen, um Zugang zu Geburtshilfe zu bekommen. So berichteten 50 von HRW interviewte Frauen, die kürzlich entbunden hatten, dass sie für mindestens einen Teil der geburtshilflichen Versorgung bezahlen mussten. Viele Interviewte gaben an, dass die Geschwindigkeit und Qualität der Behandlung sowie ein respektvoller Umgang davon abhingen, ob sie entsprechende Zahlungen leisten konnten. Frauen, denen dies nicht möglich war, berichteten von Verzögerungen, Vernachlässigung, Demütigungen, fehlender Aufklärung und Einschüchterungen. In

einzelnen Fällen bestand zudem der Verdacht, dass ausbleibende Zahlungen zu einer unzureichenden oder verspäteten Versorgung beigetragen haben könnten, die für das Neugeborene oder die gebärende Frau tödlich endete. Frauen nach der Entbindung und Expert*innen verwendeten HRW gegenüber Begriffe wie «ein Geist», «eine Fata Morgana», oder «eine Utopie», um die FHCI zu beschreiben. Andere hätten schlicht und einfach festgestellt: «Es funktioniert nicht» (HRW, November 2025).

Chirurgische Versorgung birgt Risiko für «katastrophale Gesundheitsausgaben» und Verarmung. Die Studie von *Phull et al*. zeigt auf, dass chirurgische Versorgung in Sierra Leone für viele Patient*innen mit hohen direkten Eigenzahlungen verbunden ist und dadurch ein erhebliches Risiko für «katastrophale Gesundheitsausgaben»[2] und Verarmung entsteht. Besonders belastend seien Kosten für Operationen, Medikamente, medizinisches Material, Laboruntersuchungen sowie nicht-medizinische Kosten wie Transport, Verpflegung und Einkommensverluste. Die Autor*innen der Studie stellen fest, dass fast ein Fünftel der Haushalte durch tertiäre chirurgische Versorgung «katastrophale Ausgaben» hatte und rund die Hälfte der betroffenen Haushalte weiter in Armut gedrängt wurde. Informelle Zahlungen, teils direkt an das Personal, kamen häufig vor und weisen laut den Autor*innen der Studie auf Probleme bei der finanziellen Governance, das heisst der finanziellen Steuerung und Kontrolle im Gesundheitswesen hin. Gleichzeitig deutet die Studie darauf hin, dass chirurgische Versorgung die ärmsten Personen möglicherweise gar nicht erst erreicht, da die für die Studie untersuchten Patient*innen eher aus urbanen Gebieten kamen und im Vergleich zur Gesamtbevölkerung über mehr Vermögenswerte verfügten (Phull et al. 2021).

5 QUELLEN

AI, April 2026:

> *«Right to health*
> ***According to development and humanitarian organizations, drastic cuts in USAID funding in March resulted in the closure of clinics, staff retrenchments and the suspension of essential services such as HIV testing, treatment and care, and threatened to seriously affect maternal health services. Maternal mortality rates in Sierra Leone were among the highest in the world, although government initiatives in recent years led to a decline in 2025 compared to previous years.***
> ***By May, more than half of Africa's confirmed Mpox cases were in Sierra Leone.*** *Over 61,000 doses of the Mpox vaccine were distributed and more than 24,000 people vaccinated, with healthcare workers and high-risk groups prioritized.*
> ***Also in May, the Ministry of Health, supported by the WHO, convened a high-level policy dialogue on a draft bill to establish the Sierra Leone Agency for Universal Health Coverage.***

[2] «Katastrophale Ausgaben», deutsch für «catastrophic expenditure» (CE) werden definiert als die Gesamtsumme der Gesundheitsausgaben aus eigener Tasche, also «out- of- pocket» (OOP), die einen festgelegten Schwellenwert des Jahreseinkommens oder der Jahresausgaben des Haushalts aufgrund fehlender finanzieller Risikosicherung überschreiten (Phull et al. 2021, S.1).

In July, President Bio launched the Water Security and Hygiene Program. It aimed to reach 4 million people by 2035 to improve access to clean water and promote hygiene in schools and health facilities, among other things.
According to Freetown City Council, between January and October it collected the bodies of 220 people who had died on the capital's streets as a result of kush consumption (a cheap synthetic drug). Measures were taken to fight substance abuse, particularly kush, in response to the national emergency declared by President Bio in April 2024. *Strategies included treatment and support for addicts, and strengthening law enforcement measures to dismantle drug trafficking networks and hold traffickers accountable.»* Quelle: Amnesty International, The State of the World's Human Rights; Sierra Leone 2025, 21 April 2026: Amnesty International, The State of the World's Human Rights; Sierra Leone 2025, 21. April 2026.

BTI, 2026:

«10 | Welfare Regime
Stately safety nets that compensate for the social risks of the capitalist economic system are negligible; most of the population lives in poverty. Just as the overall economy is largely informal, social safety nets are informal as well. Public expenditure on health care amounted to 1.9% of GDP in 2021, according to World Bank data. Most people depend on family, clan, community or self-help structures as the social basis of survival. *»* Quelle: Bertelsmann Stiftung, BTI 2026 Country Report - Sierra Leone, 2026, S.21.

HRW, November 2025:

« ***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."***
[…]
Sierra Leone's Low Public Healthcare Spending
[…] ***A significant body of research analyzed by Human Rights Watch has found that meeting this commitment will generally require 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 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.

[…]

Donor Dependance

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» Quelle: Human Rights Watch (HRW), "No Money, No Care" Obestric Violence in Sierra Leone, 3. November 2025: https://www.ecoi.net/en/file/local/2132667/sierraleone_wrd1125 web.pdf, S. 48-50, 54.

IOM, Juli 2024:

«Der Fortschrittsbericht 2021 über die Gesundheitsfinanzierung in Sierra Leone Verfügbarkeit und Kosten von Medikamenten nennt neun Finanzierungssysteme für das Gesundheitswesen, darunter das staatliche Gesundheitsbudget, die Initiative für kostenlose Gesundheitsversorgung und krankheitsspezifische Programme (Malaria, HIV/AIDS, Tuberkulose). 4 ***Private Krankenversicherungen decken weniger als 1 % der Bevölkerung ab****.»* Quelle: International Organization for Migration (IOM), Sierra Leone: Länderinformationsblatt 2024, Juli 2024.

Forikolo, April 2025:

«Sierra Leone, ein kleines Land an der Westküste Afrikas, steht vor enormen Herausforderungen in der Gesundheitsversorgung seiner Bevölkerung. ***Das Gesundheitssystem Sierra Leones ist nach Jahren des Bürgerkriegs, der Ebola-Epidemie und der COVID-19-Pandemie stark belastet und kämpft bis heute mit strukturellen Defiziten.*** *Besonders in ländlichen Gebieten ist der Zugang zu Gesundheitsdiensten und sauberem Wasser stark eingeschränkt.*
Gleichzeitig sind die Folgen dieser Situation gravierend: Krankheiten wie Malaria, Cholera, Tuberkulose oder akute Durchfallerkrankungen sind weit verbreitet – obwohl sie mit einfachen Maßnahmen vermeidbar wären. Viele Menschen sterben an Erkrankungen, die andernorts als harmlos gelten würden. *Genau deshalb sind neben modernen Gesundheitseinrichtungen auch präventive Maßnahmen zur Krankheitsvermeidung notwendig, wie beispielsweise der WASH-Ansatz: Water, Sanitation and Hygiene – Wasser, Sanitärversorgung und Hygiene.»* Quelle: Forikolo, Gesundheitswesen in Sierra Leone: WASH als Fundament für eine gesunde Zukunft, 15. April 2025.

Phull et al., 2021:

«Worldwide modelled data on CE and impoverishing expenditure (IE; defined as being pushed into or further into poverty) related to surgical care reveals that those most affected are individuals in low- income and middle- income countries (LMICs).1 2 6 ***Modelling studies from Sierra Leone, classed as 'least developed' by the UN and with a population of 7 million, reflect these findings; between 84.7% and 49.9% of the population in Sierra Leone is estimated to be at risk of CE if they require surgery. Estimated average OOP costs for major surgery in the country were US$117.60, which put 59.2% to 73.3% of the population at risk of impoverishment.5 7 However, there are no empirical data to validate these estimates. The estimated unmet surgical burden of disease in Sierra Leone is huge, at 92%, as a result of the historical neglect of surgical care both nationally and globally****.8–10 To enable effective planning of surgical services in future, an accurate*

understanding of the financial implications of accessing surgical services is required. ***In Sierra Leone, as in many LMICs, payments for health care are upfront, complex and not immediately apparent from hospital- listed service charges. In addition, hospital- listed charges—where they exist—may not reflect the total facility- incurred costs that patients pay during their hospitalisation. These include direct medical costs that are charges for the payment of medical care and direct non- medical costs that include items such as transport to the hospital and food. In addition, substantial costs of care may be incurred prior to the hospitalisation episode. For example, there may be direct medical costs at other healthcare facilities visited prior to the definitive admission. Finally, there are indirect costs (eg, loss of wages while receiving care) that patients, and in some cases their caregivers, experience in their illness, which also impact on ability to access care. Two ways of capturing these costs is the measurement of IE or CE. The two most widely used thresholds for CE are an expense of >10% of total annual expenditure or >40% of non- subsistence expenditure (ie, household expenditure net of subsistence costs, as a means of capturing the ability to pay).***

[…]

Discussion

In this study, we found that accessing and receiving tertiary- level surgical care in Sierra Leone requires large upfront OOP payments that have a substantial impact on individual and households' economic situations. These equate to a catastrophic expense in nearly a fifth of households and are impoverishing half of the households that receive care. We found poverty, as assessed by house hold expenditure, was high, indicating a limited financial buffer to accommodate costs of care. This is despite most people who access surgical care owning a higher level of assets than the general population. The majority of the OOP payments were incurred in- hospital and as a result of direct medical costs. Payment for the operation itself and medications, medical supplies and investigations (including laboratory tests) were the biggest contribution to these costs. A small percentage of costs were categorised as unofficial, such as for 'nursing care' and 'tips', although these were given by a majority of people who received care. In addition, almost half of these were being paid through unofficial payment channels and made directly to staff. We do not know whether these payments were later transferred to the hospital bank; however, these informal routes are common and indicate poor financial governance that urgently needs to be addressed. The majority of payments were met using savings, followed by raising money from family or borrowing money. In addition, a large number of participants lost wages during the sickness episode and a proportion lost their jobs. In a country where informal work predominates and earnings can be unpredictable, this may impact on household financial security and influence future health seeking behaviour, both of the individuals affected and their immediate family and communities. *The majority of patients accessing surgical care were young males; whether this male predominance is a true reflection of surgical disease burden, beyond obstetrics and gynaecological care, in Sierra Leone or reveals a hidden gender bias in care- seeking behaviour is beyond the remit of this study. Nevertheless, males who sought care in our study are traditionally the main breadwinners and the most economically active population group in Sierra Leone. This loss of wages and livelihood could have implications on the wider socioeconomic determinants of health and the well- being of the household. The additional burden to the patients and their households as a result of the indirect costs supports the macroeconomic argument for investing in surgical care put forward by Grimes et al, who demonstrated the opportunity to avert 36 487 Disability Adjusted Life Years*

(DALYs) by investing in surgical care at hospital level in Sierra Leone.23 24 ***Some specialties, such as general surgery and urology, incurred much higher overall costs for the surgical episode, and this may be because operative intervention (with blood transfusion and a longer length of stay) is usually required. This contrasts, for example, with trauma care that was often managed non- operatively. Such non- operative treatment for trauma may be partly as a result of local surgical practice, often driven by lack of resources such as the unavailability of internal fixation wires and orthopaedic implants, and partly because some common orthopaedic problems are managed non- operatively. In addition, we found that age and length of hospital stay were associated with significantly higher costs. This may be due to the fact that those under the age of 5 years were eligible for free healthcare in Sierra Leone and that a longer stay in hospital was associated with higher direct non- medical and indirect costs such as payment for food and lost wages.*** *There are a limited number of studies to draw a direct comparison with as only a few used a similar methodology (direct interview) as opposed to modelled data or the use of caesarean section costs as a proxy measure to extrapolate costs, CE and impoverishment.2 16 25–30 There are even fewer studies that report on the financial implications of all or most types of surgical care.* ***The majority report on single surgical subspecialties such as obstetric care, paediatric surgery or trauma care****. Nevertheless, there have been three recent studies from Uganda reporting CE rates of 31% and 55% and IE of 47%.16 31 32 A study in Malawi interviewing patients undergoing hernia operations reported CE rates as high as 90% using a threshold of 10% of yearly income.28 Various studies looking at injury and trauma care costs in Vietnam, India and Nigeria have reported CE rates of 60%, 30% and 86%, respectively,25 and a study in Morocco looking at obstetric surgical care alone estimated CE rates of 88%,33 while an emergency obstetric care study in Indonesia estimated CE at 68%.34 The intercountry variability makes it difficult to draw comparative conclusions. This highlights the need for a standardised way of assessing and measuring the financial implications of surgical care to allow accurate collection and reporting of these global surgery metrics on financial risk protection. In keeping with other studies, we noted lower rates of CE and IE in comparison with the modelled and extrapolated estimates for Sierra Leone. This is probably because the modelled studies are based on the whole population that may require surgery and not on those that have successfully accessed surgical care.* ***The lower rates of IE and CE seen may therefore be explained by a lack of access by the poorest. This is supported by data from Sierra Leone that estimates that up to 25% of deaths in 2011 could have been averted through access to safe, timely and affordable surgical care and that Sierra Leone has an unmet surgical burden of disease of 92%,10 with approximately 70% of Sierra Leoneans stating that the financial burden of OOP payments for healthcare was the biggest barrier to accessing care.****35 36* ***In addition, we found that those accessing tertiary-level surgical care came from predominantly urban areas of Sierra Leone and, when compared with the wider Sierra Leone population, had significantly higher asset ownership. It may be therefore that the poorest and those at the highest risk of financial catastrophe are not accessing care when needed. This may also reflect other known barriers to seeking surgical care in LMICs that are often complex and multifactorial such as cultural beliefs, attitudes and fears towards surgical care and structural barriers such as geographical access, transport links and referral systems.****37 »* Quelle: Phull, Manraj et al., What is the financial burden to patients of accessing surgical care in Sierra Leone? A cross-sectional survey of catastrophic and impoverishing expenditure, BMJ Open 2021, S. 2, 6-7.

Pieterse and Saracini, Dezember 2023:

> *«Despite the greatly improved HRH system put in place in 2010, the practice of recruiting new 'volunteers' in the public health system on an unsalaried basis did not stop.* ***In 2016, a report titled Sierra Leone Human Resources for Health, Country Profile, published by the Ministry of Health and Sanitation (MoHS), revealed that only half of its health workforce is on the payroll and out of the 9,120 unsalaried health workers identified in the payroll audit, approximately 40% were health professionals providing patient services, primarily in the lower-skilled cadres [29].***
> *Sierra Leone's health systems currently consists of over 1,400 facilities, including several specialist and referral hospitals, district hospitals, and primary healthcare is provided through a network of Peripheral Health Units (PHUs) [47]. The private sector provision of healthcare is relatively small and private facilities are primarily found in the capital Freetown and several other cities [44]. Sierra Leone's health systems, including its human resource management, is highly centralised, due to the stalling of the implementation of the 2004 decentralisation legislation [48, 49]. District Health Management Teams (DHMTs) cannot hire staff, decide where to deploy health workers, or dismiss them even if they misconduct themselves or are absent [50, 51] which leaves them lacking "power, resources and institutional incentives to enforce formal rules" [52]. Despite significant post-Ebola health systems strengthening support from the donor and NGO community, Sierra Leone's health facilities remain under-resourced and underperforming.* ***Official user fee exemptions exist, but charging for healthcare has remained a problem, and those exempted often still pay [53, 54]. A study carried out in 2016 found that "as many as 96% of households responded they paid" for supposedly free services [50], suggesting that charging for care is widespread and seemingly practiced by salaried and unsalaried workers alike.*** *If Sierra Leone were to introduce greater monitoring and oversight of its health workers to curtail informal charging, the question remains; how can unsalaried workers cope without pay for prolonged periods of time?* ***Health service provision in remote and rural would likely be much reduced without the contribution of UHWs, however, their coping mechanism might also be one of the barriers to the implementation of Sierra Leone's free healthcare initiative*** *[54]. This study assesses the influence that a significant reliance on UHWs has on the delivery of healthcare in Sierra Leone by providing an overview of all available evidence in the literature that demonstrate positive and negative impacts.»* Quelle: Pieterse and Saracini, Unsalaried health workers in Sierra Leone: a scoping review of the literature to establish their impact on healthcare delivery, International Journal of Equity Health, Dezember 2023.

Pieterse and Lodge, November 2015:

> *«On introduction, the initiative proved a success: the number of children who received care at primary healthcare facilities increased 2.5-fold within the first year4 and child mortality rates dropped from 217 to 158 per 1000 live births between 2010–2013.5,6* ***However, the new system is not without serious shortcomings: Sierra Leone continues to have the highest infant and maternal mortality rates in the world.7 Corruption scandals have plagued the free healthcare initiative. Media reports on the continued charging by health workers for services that should be free, and the diversions of drugs to private pharmacies or neighbouring countries, are common****.8,9»* Quelle: Pieterse and Lodge, When free healthcare is not free. Corruption and mistrust in Sierra Leone's primary healthcare system immediately prior to the Ebola outbreak, International Health, November 2015, S. 400.

Republic of Sierra Leone, Oktober 2025:

> *«**The country has faced significant challenges due to its troubled history, including a devastating civil war from 1991 to 2002. More recently, the Ebola Virus Disease outbreak from 2014 to 2016 and the impacts of the COVID-19 pandemic have heavily strained the nation's already struggling healthcare system**.»* Quelle: Republic of Sierra Leone, Ministry of Health, National Surgical, Obstetric and Anaesthesia Plan (NSOAP) 2026-2030, S.2, 5.

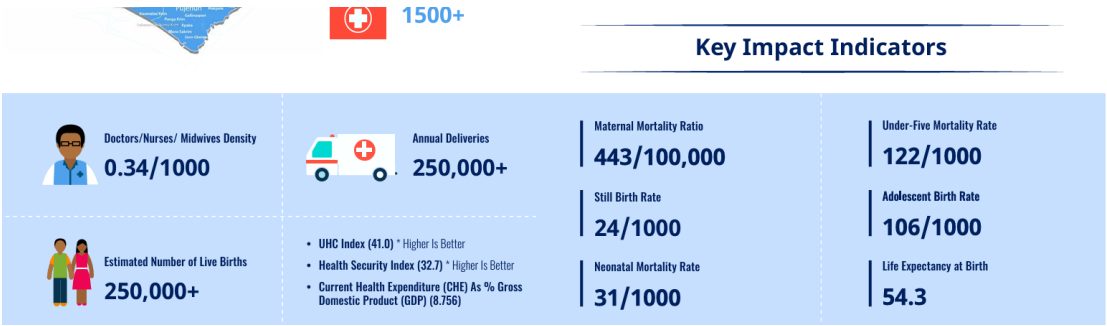
UNICEF, März 2024:

> *«The Free Health Care Initiative was enacted over a decade ago in 2010 to improve high rates of maternal and under-five mortality.* ***However, the availability of medicines remains inconsistent, resulting in patients paying for them, as well as undermining the quality of care and trust in the health-care system.*** *The gaps between services and medicines promised under the Free Health Care Initiative and actual resources delivered worsened during the 2013–2015 Ebola epidemic, which strained an already weak health-care system»* Quelle: UNICEF, Situation Analysis of Children and Adolescents in Sierra Leone, März 2024, S. 119.

WHO, Juli 2025:

> *«**The proposed SLAUHC Agency responds to longstanding structural challenges in the health financing landscape. Currently, out-of-pocket payments account for 56% of total health expenditure, well above the sub-Saharan Africa average of 30%. Less than 1% of Sierra Leone's population is covered by any social health protection scheme, exposing many to catastrophic health spending and pushing households further into poverty. Moreover, with 75% of health financing reliant on donor contributions, ensuring coherence with national priorities remains a pressing issue.** »* Quelle: World Health Organization (WHO), Sierra Leone moves closer to Universal Health Coverage with high-level engagement on draft SLAUHC Bill, 17. Juli 2025.

WHO, 2023:



Quelle: World Health Organization (WHO), 2023 Annual Report, 2024.

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