

The Effect of Free Health Care for Pregnant Women, Lactating Mothers and Under Five Children on Health Service Delivery in Moyamba District in Sierra Leone

Thesis

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By

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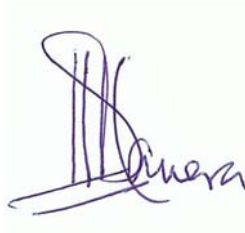
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Declaration and certification

I Ibrahim Kamara do solemnly declare that this piece of work was done by me out of the researches carried out through the utilization of triangulation techniques/method (Triangulation is simply using different methods to research the same issue with the unit of analysis. It is used to establish credibility of data gathered in qualitative ways) that involved the use of questionnaire and interviewing techniques, focus group discussions, interpersonal communications, observations, photographing and various references, books, reports, publications, journals and strong internet based research. Also this piece of work has never been presented to any institution for award of the degree in Doctor of Philosophy in Health Care Administration or the like.



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Executive Summary

The specific topic of this thesis is “The Effect of Free Health Care for Pregnant Women, Lactating Mothers and Under Five Children on Health Service Delivery in Moyamba District in Sierra Leone”. The thesis is organized in this order:

Acknowledgement, Declaration and Certification, Executive summary, Introduction, Statement of the Research Problem, Justification of the Report, Scope and Limitations, Literature Review, Research Methodology, Analysis and Findings, Anticipation of Objection, Conclusion and Summary, Bibliography and Annexes.

Sierra Leone before the introduction of the free health in the country had one of the world’s highest maternal and child mortality rates. The situation had been mainly due to the country’s weak health system with demoralized health personnel resulting from low salaries and working conditions especially in the rural areas where accommodations for staff and social amenities are lacking. Major among the issues that contributed to the challenges in accessing health service with subsequent high maternal and child mortality is cost of the health care services that were up to 68% paid by the users of the services.

It was as a result of this major challenge that the President of the Republic of Sierra Leone His Excellency Dr. Earnest Bai Koroma pledged his government’s commitment to provide free health care for the most vulnerable groups that were affected by the problem i.e. pregnant women, lactating mothers and children under five years of age at the United Nations (UN) General Assembly of 2009. After the pledge, the President officially introduced and launched the free health care initiative in Sierra Leone on April 27, 2010 as part of the 49th Independence Celebration for Sierra Leone. Two years after the introduction of the initiative in Sierra Leone it became interesting to know whether the initiative was effective or not. It was of interest to investigate the entire country implementation but that requires more resources, time and effort than just what one student can undertake. As such the investigation was necessary but required geographical focus which was placed on Moyamba District for this research. The problem statement in this thesis is therefore, “The Effect of Free Health Care for Pregnant Women, Lactating Mothers and Under Five Children on Health Service Delivery in Moyamba District in Sierra

Leone”. That has been determined by answering the following research questions in the findings, analysis of findings, conclusion and summary of this thesis:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?
- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

The researcher was assisted by colleagues in different health service providing non-governmental organizations in Sierra Leone but more so by colleagues in Plan Sierra Leone where the researcher works especially in the Plan Sierra Leone’s Moyamba Program Unit, colleagues from the Moyamba District Health Management Team (DHMT), Moyamba District Council (MDC). The researcher collected qualitative and quantitative data in the investigation of the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone. Photographing where necessary observations, focus group discussions and questionnaires were used to collect primary data while secondary data was collected through internet search, desktop analysis including use of the Moyamba District Health Information System (DHIS 2008 to 2012 i.e. two years before and two years after the introduction of the free health care initiative in Sierra Leone including Moyamba District).

Data was collected using triangulation technique. Triangulation is simply using different methods to research the same issue with the unit of analysis. It is used to establish credibility of data gathered in qualitative ways.

The researcher's position based on the findings of this study is that:

1. The introduction of the free health care initiative was aimed at removing the barriers to accessing health care services especially targeting the vulnerable groups of pregnant women, lactating mothers and under five children. The findings of this study according to tables and figures 20b and 40, free health care for pregnant women, lactating mothers and under five children has helped to improve maternal morbidity and mortality in Moyamba District in Sierra Leone with a reduction from 777/100,000 in 2008 to 201/100,000 in 2012 (two years before and two years after the introduction of the initiative). There was also a significantly higher reduction recorded in 2010 the year when the initiative was first launched.

2. Free health for pregnant women, lactating mothers and under five children has helped to improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone. According to views of respondents to questionnaires, participants of focus group discussions and those interacted with as someone said "the free health care has helped to improve maternal and child mortality". This view was expressed by majority of the people reached in this investigation by various means. Questionnaire specific responses according to tables and figures 15 and 16 show that under five child mortality reduced with the introduction of the free health care initiative in Moyamba District (two years before and two years after the introduction of the free health care). Table and figure 31 also supported this view because according data in table 31 and figure 31; 562 children under five years of age died in 2008; 634 in 2009; 171 in 2010; 654 in 2011 and 561 in 2012. The trend in absolute numbers showed that under five child death was high in 2008 and higher 2009 but dropped dramatically in 2010 the year the free health was introduced but rose to its highest in 2011 and then dropped in 2012 by a slight margin. The picture is slightly different in terms of proportion of under five child death per 1000 live births as shown and explained below for table 32 and figure 32. As stated in the data description for table 31 and figure 31, the trend of under five child deaths in absolute figures slightly differ from the figures in proportion per 1000 child deaths per year. According to table 32 and figure 32; 70 under five year old children per 1000 live births died in Moyamba District in 2008 while 66/1000 died in 2009. That trend dramatically

changed in 2010 (the year the free health was introduced) when the figure dropped to 17 under five child death per 1000. The death rate according to the available data increased again in 2011 to 64 deaths per 1000 but dropped to 51 per 1000 in 2012. This trend may not be unconnected with qualitative data gathered through this research which pointed out that the free health is working but not without challenges that affect the results such as staff motivation, availability of drugs and medical supplies and effective monitoring and supervision.

3. Free health care for pregnant women, lactating mothers and under five children that forms the bulk of the affected population that utilize health care services in Sierra Leone with Moyamba District inclusive, according to the findings of this research, has mixed effect on the health personnel in Moyamba District in Sierra Leone in that although they consider the initiative to be good in that it is making them reach more people, they also strongly feel that the free health care initiative has increased their workload and pressure from the beneficiaries to provide them the said free health care at all times and sometimes for categories of the population not targeted for the free health care. This sometimes results in misunderstanding and confrontation between health personnel and beneficiaries. For instance, according to the health workers from the questionnaire responses, focus group discussions, inter-personal interactions and observations, their workloads have increased with the introduction of the free health, their salaries and benefits or living conditions are not commensurate to their job and living environments especially in the remote communities with transportation and accommodation challenges in addition to other basic social amenities like communication. According to one health worker in the research location, “free health care initiative is good but it has increased our workload and does not leave any time for us for rest or even for preparation of meals and other personal business at the end of the day and the compensation does not match that much effort despite increase in salaries upon the introduction of the initiative.”

4. The effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone is positive because it has helped to improve the health service delivery system in terms of facilities, equipment, drugs/medicaments,

leadership and management in Moyamba District in Sierra Leone despite the challenges highlighted in the findings. This is supported by tables and figures 22 (under five year old children that sleep under long lasting insecticide treated nets (LLIN), 24 (appropriate treatment of children under five years of age with malaria treatment with 24 hours), 25 (diarrhoea case reported and treated) and 26 (cough or acute respiratory infection (ARI). The view of respondents to the various data collection approaches used (questionnaires, focus group discussions, personal interactions and observations) and the Moyamba District health data for 2008 to 2012, the initiative has improved facility service delivery, drugs/medicaments, and also it has helped to improve leadership and management but there is need for improvement. For instance, health workers think the workload is increased and that affects their personal lives and they need more compensation to match the increased workload; they also feel the required support in terms of drugs and medical supplies is not adequately and timely provided in a number of cases and that affects their work, relation with beneficiaries with consequent effect on the utilization of the provided health services and the resulting outcomes of health care services in the research location as well as other parts of the Sierra Leone. Considering table 26 and figure 26 that show the number of acute respiratory infections (ARI) cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age); 8,688 cases in 2008; 3,315 in 2009; 38,819 in 2010; 65,067 in 2011 and 66,450 cases were seen and treated in Moyamba District. The data showed that more people accessed health services and received treatment for acute respiratory infections or cough in Moyamba District after the launch of the free health care than they did before the launch which is one of the three leading killer diseases accounting for the high child mortality in the Sierra Leone (according to the Government of Sierra Leone's Free Health Care Position Paper of 2010). This dramatic increase in the number of reported and treated cases show that the need for supplies increased with the introduction of the free health care initiative. Thus overwhelming the existing system and hence the inadequate and often untimely supplies to the health facilities.

The research findings overall have provided positive answers to the research questions and supported the hypothesis that free health care is effective in Moyamba District in Sierra Leone. The said questions in the research that the findings have provided positive answers to are:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?
- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

Definitely, this been a study for just one of the 13 health districts in Sierra Leone, there is a need for further research into the topic area that can cover more or all of Sierra Leone for a complete picture on the free health care implementation to come out just in case there are slight geographical differences from district to district. One further research area within the same research location or elsewhere is research into the drugs and medical supply chain systems since the lack and or inadequacy of drugs and other medical supplies came out strongly from both the health workers and the beneficiaries or communities.

In summary, “The Effect of Free Health Care for Pregnant Women, Lactating Mothers and Under Five Children on Health Service Delivery in Moyamba District in Sierra Leone” is positive despite challenges faced in the implementation of the initiative. It is effective because it is relevant to the needs of the people of Moyamba District as it is in all other parts of Sierra Leone and it is achieving its set objectives and goals which determine the effectiveness and efficiency of a program in a development context. This is true because the research findings show that:

- Free health care for pregnant women, lactating mothers and under five children is improving maternal morbidity and mortality in Moyamba District in Sierra Leone.
- Free health care for pregnant women, lactating mothers and under five children is improving morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone.
- Free health care for pregnant women, lactating mothers and under five children has helped increased the salaries health personnel and their working environment which has in turn improved their commitment and service delivery as well as the quality of services delivered in Moyamba District in Sierra Leone.
- Free health care for pregnant women, lactating mothers and under five children has helped improved the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District.

A Sierra Leonean expressed true feelings about the free health care initiative that summarizes the effect as follow: “I'm delighted to say that the latest statistics have shown we are succeeding. The FHCI has had an incredible affect on the awful health indicators of just a few years ago”.

In addition, a World Health Organization (WHO) publication in expressing the positive effects of the free health care initiative within the first few years of implementation and the impressions created stated that:

“In the first year alone, there was a 214% increase in the number of children attending outpatient units. More women who needed care most were attending facilities, and we reduced - by an amazing 61% - the number of women dying from pregnancy complications at facilities. We are delighted, encouraged and proud of what has been achieved in so short a time” (WHO, 2014).

In concluding that the effect of the free health care initiative on the health service delivery system in Sierra Leone including Moyamba District (the research district) is positive, the views of the President of

the Republic of Sierra Leone in his own words summarizes everything as follow: “Two years on, we must sustain progress and I will do my best to ensure that the progress we have made is accelerated so that we can reach our common goals” (WHO, 2014).

Key to note from this research is that despite the positive effect of free health care in improving maternal and child health in Moyamba District as in other parts of Sierra Leone, the initiative is faced with some challenges that need to be addressed or at least looked into for possible solutions. For instance, lack of monitoring: according to focus group respondents “lack or inadequate monitoring of the overall free health care initiative is responsible for the charging of illegal costs for health service delivery in communities”.

The media made broadcasts that there are a lot of drugs supplied to the health facilities. This according to the discussions is an issue because in actual fact, drugs and other medical supplies provided for the free health care service delivery are at times not enough but it is communicated to the public that they are available. This situation leads to stock out, limited-functioning of some of the facilities at certain times and hence, the undesired consequences of increased health burden and mortality even amongst the free health care targets. It came out of the discussions that effective monitoring and supervision and community participation in their own health service delivery can help address this challenge.

Therefore an overall monitoring of the free health care implementation including the supply chain management is highly recommended for further study into that area as a way of enhancing informed review of the initiative and implementation process of the free health care in Moyamba District as well as in Sierra Leone as a whole.

The research has therefore over and above every other thing supported the hypothesis that:

“Free health care for pregnant women, lactating mothers and under five children improves health care service delivery”.

This research may vary from other studies but because there are some elements contained in all successful research reports, the general outline below was followed:

1. Introduction

Topic: The effect of free health care for pregnant women, lactating mothers and under five children on health service delivery in Moyamba District in Sierra Leone.

Hypothesis: Free health care for pregnant women, lactating mothers and under five children improves health care service delivery.

End user cost of health care service is a major challenge in Sierra Leone. This is because about 68% of end user cost is paid for by the users or individuals (according to the 2008 national health cost analysis carried out by the Ministry of Health and Sanitation - MOHS) amidst advert poverty with about 70% of the country's population living on less than two US Dollars a day according to the country's poverty reduction strategic papers one and two. As a result, Sierra Leone before the introduction of the country's Free Health Care system had one of the world's highest maternal and child mortality ratios and rates of about 1800/100,000 and 286/1000 respectively. In addressing the awful health situation, the government of Sierra Leone led by the President His Excellency Dr. Earnest Bai Koroma on the 27th of April 2010 (the 49th Independence anniversary of Sierra Leone) introduced Free Health Care for Pregnant women, lactating mothers and children under five years of age across the country. The aim of the scheme supported by various donor institutions including the World Bank is to enable the vulnerable groups (pregnant women, lactating mothers and under five children) freely access quality health care without cost been an impediment haven been identified as a major obstacle in health care delivery in the country. Moyamba District the study location is no exception to the entire country health situation described above and the district is therefore looked at in the study to investigate the effect of the free health care on pregnant women, lactating mothers and under five children.

2. Statement of the Research Problem.

This section provides a detailed explanation of what the thesis is about. It includes an explanation of the general problem area, the specific problem statement, and clearly identifies the research hypothesis and research questions. References from the literature were used to support the rationale for studying the topic.

Free health care in various parts of the world such as Scotland, the United States of America, South Africa and Burkina Faso in the West African Sub-region like Sierra Leone has been introduced and implemented in diverse ways but all aimed at improving the health service delivery and or increasing the health benefit to the populations targeted with different approaches used and different driving forces behind the initiatives. For instance in Scotland the Scottish Parliament is the major driving force; in America, President Obama is the major driving force, in South Africa, the government of the day and mainly the All African Congress is the driving force and in Burkina Faso and Sierra Leone, the governments and health implementing partners are the major driving forces.

In Sierra Leone, free health care initiative was launched by the President of the Republic of Sierra Leone, His Excellency Dr. Earnest Bai Koroma who is the major driving force behind the Sierra free health care initiative. The aim of the initiative is to improve the country's health care delivery system and consequently the high maternal and child mortality that was among the highest in the world before the introduction of the free health care initiative in Sierra Leone. This study is therefore about investigation of the effect of free health care for pregnant women, lactating mothers and under five children on health service delivery in Moyamba District in Sierra Leone. Moyamba is one of the 13 health district in Sierra Leone. The research therefore investigated the free health care for pregnant women, lactating mothers and under five children in relation to the health service delivery in Moyamba District in Sierra Leone. This was done by testing the study hypothesis i.e. "Free health care for pregnant women, lactating mothers and under five children improves health care service delivery." In Sierra Leone, before the introduction of the

free health care on April 27, 2010, child and maternal mortalities were among the highest in the world (GoSL, June 2010). The actual Sierra Leonean situation before the introduction of the free health care initiative is that Sierra Leone after 11 years of war for years remained close to the bottom of the United Nations Human Development Index (HDI) with some of the world's lowest health indicators. Weak salaries and incentives leading to poor service delivery have been part of the causes of the low health indicators. Service fees or drug cost are charged to users of health services part of which is used to meet some unpaid health workers' needs especially in public health facilities. In doing so even women and children that should be receiving free services by law or existing health policy are charged some informal user fees. To address the health needs of women and children under five years, His Excellency President Earnest Bai Koroma, President of the Republic of Sierra Leone in November 2009 announced at the UN General Assembly his country's plan to introduce a free healthcare initiative in Sierra Leone. The initiative was launched on April 27, 2010 for pregnant women, lactating mothers and children under five years of age throughout the country with support from World Bank and other donor agencies.

The research questions answered in addressing the study hypothesis are:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?
- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

3. Justification of the Report.

This section is telling why the topic is important and what use it may have to the reader or writer. It has provided enough references from the literature to adequately support the justification provided.

Investigating the effect of free health care for pregnant women, lactating mothers and under five children on health care service delivery in Moyamba District is very important since the high maternal and child mortality which the free health care initiative was introduced to address is highly important to all Sierra Leoneans. Since a small study research has some limitations for effectively investigating the entire country due to limited resources, this study focused on Moyamba District which is one of the 13 health districts in Sierra Leone. Although the results may not be completely reflective of the entire country, the findings of this research gives a picture of what the situation of the free health care looks like in Sierra Leone but more so in the research district of Moyamba. The findings of this research are important because they provide relevant information to and also portray the views of beneficiaries such as stakeholders involved in the free health care initiative implemented in Sierra Leone especially in Moyamba District. For instance the research findings show people's perception about the initiative, the utilization of the services provided, the quality of the services provided, the gaps between the expectations and the reality in terms of actual services provided and utilized. The information provided is important to the health workers, the government both local (at district level) and national and the donors to review and improve on the services delivered or information education communication exercises related to the implementation of the free health care initiative in the country but more so in Moyamba District. Availability of information on similar health care services or initiatives in other parts of the world helps in the review and improvement of strategies and services. For instance in Burkina Faso, evaluation of free health care services showed that community-based approach that involves the beneficiaries in decision making and the process helps the initiative than the use of a centralized approach. For instance details on the Burkina Faso free health care project initiatives, evaluation below show how findings from similar implementation can be useful for the improvement of similar initiatives.

Evaluation and Program Planning: Research on Implementing Evidence Based Practices in Community Based Addiction Treatment Programs: Policy and Program Implications, volume 34, Issue 4, November 2011, Pages 333-342 (Valery Ridde et al, 2011). In one health district in Burkina Faso, a state-led and two community-based (two action research/studies) free health care projects excluding the indigent from user fees payment at health facilities which are uncommon in Africa were undertaken in 2005 (state-led) and 2007 – 2010 (community-based) respectively. An evaluation of the projects using individual and group interviews with key stakeholders including health workers and community members looking at the strengths and weaknesses of key components of the interventions that included the relevance and uptake of the intervention, selection and information on worst-off beneficiaries, and financial arrangements within the implementation of the interventions. Effective mechanisms to exempt the indigent from user fees at health care facilities are rare in Africa. A State-led intervention (2004–2005) and two action research projects (2007–2010) were implemented in a health district in Burkina Faso to exempt the indigent from user fees. This article presents the results of the process evaluation of these three interventions.

This is what the findings from the evaluation showed: The evaluation findings brought out that there is room for improvement for the one state-led and two community-based interventions; stakeholders appreciated the community-based more than the state-led approach with regards to targeting of beneficiaries for the waiver of health care fees payment. This was because the community-based approach helped to clearly define the selection criteria, inform the waiver beneficiaries, use a participatory process and use indigenous funding. The downside, challenge or weakness of the community-based approach was that using indigenous funding led to restrictive selection by the community. The evaluation therefore showed that the community-based approach was the most effective of the tested inventions but it also required improvement to better inform scale up of the initiative.

It was therefore concluded from the findings that important to the effective functioning of the free health care especially the community-based approach are stakeholders' information and the funding for indigent coverage (Valery Ridde et al, 2011)

4. Scope and Limitations.

Every research study is limited in its scope and in the ability of the researcher to cover the topic completely. It was explained how the scope of the study is defined and what factors or situations limited the ability to fully explore the topic.

This research which investigated “The effect of free health care for pregnant women, lactating mothers and under five children, on health service delivery in Moyamba District in Sierra Leone” covered the period two years before and after the introduction of free health initiative in Sierra Leone on April 27, 2010. It is limited to that timeframe to allow the research to start and finish and therefore the research was unable to follow up the free health care implementation in Sierra Leone forever and ever. There must be a start and end to anything in life and that is exactly what the limitations included in this research. It should however be of interest to continue following up on the free health care implementation in Sierra Leone to see how it evolves over time especially when monitoring, supervision, evaluations and research finding and recommendations like the ones coming up from this research keep informing the further implementation of the initiative. In which case, improvement will be expected and such improvements can only be detected with further or continuous investigation into the process. The geographic factor which is the inability for the research to cover the entire country in itself is a limitation in the study. That is something that can generate further research interest that this research like any other research work did not and cannot fully accomplish for the free health care initiative in Sierra Leone. Building on the premise that free health care initiative is new to Sierra Leone including Moyamba District which is the research district, the start of the free health care implementation is bound to face challenges including acceptability on the sides of both the health workers and the beneficiaries; the pattern of donor support to Sierras Leone i.e. the provision of support mainly through non-governmental organizations versus provision of support

directly to government to support the free health care; the weak health system with huge human resource gap upon which the initiative was built upon and launched; the need for various stakeholders to adjust to the changes that come with the implementation of the free health care including restriction or removal of health workers' usual charging of fees for services rendered to pregnant women, lactating mothers and under five children although some had been illegal even before the introduction of the free health care initiative. The coming of global financial crisis at the time of the introduction of the free health in Sierra Leone is also a limitation in this research as that had effects on the donor response to country needs across the world including Sierra Leone and its free health care initiative despite the fact that it was attractive to the donor community including the UN from the time His Excellency Dr. Earnest Bai Koroma pronounce his government's intention to introduction free health care initiative in Sierra Leone from the 2009 UN General Assembly (GoSL, 2010)

5. Literature Review.

The literature review portion of the thesis is critical. This section contains a synopsis of what others have written concerning the topic i.e. free health care in and out of Sierra Leone, what research has been conducted on the topic, how that research was conducted, what such research discovered as well as what other researchers did not discover (Ideally, the study looked into an area which others have recommended for further study regarding free health care schemes). The literature review provides the foundation for the entire study, so it was very comprehensive. It establishes the current state of knowledge in the field, to which the research added incremental insights. This section excluded personal opinion and to the extent possible provided citations and one to two year old references for facts provided except for those of historical relevance such as the background and the situation leading to the introduction of the free health care initiative in Sierra Leone as well as the position papers.

Global perspective of health care and health care systems

Health terminologies, systems and other variables in the thesis relevant to health care service delivery:

Health is the physical and mental well-being individuals and not just the absence of infirmity.

According to Wikipedia, the free encyclopedia, health care is defined as the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Health care is delivered by practitioners in allied health, dentistry, midwifery obstetrics, medicine, nursing, optometry, pharmacy, psychology and other care providers. Health care according to the same source refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health (Health at a Glance 2013) and (Wikipedia, January 2014). Healthcare can be defined as either public or private.

Health care situation varies from one country or location to the other due to but not limited to varying factors ranging from epidemiological factors, disease or health burden, income levels, geography, politics, social environment, health work force, health infrastructure, health resources including budget, equipment and commodities, partners and donors. Likewise, access to health care varies across communities, countries or regions. Based on information available in Wikipedia (Wikipedia, January 2014), access to health care varies across countries, groups, and individuals, largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans in relation to the personal and population-based health care goals within their societies. Health care systems are organizations established to meet the health needs of target populations. Their exact

configuration varies between national and sub-national entities. In some countries and jurisdictions, health care planning is distributed among market participants, whereas in others, planning occurs more centrally among governments or other coordinating bodies. In all cases, according to the World Health Organization (WHO), a well-functioning health care system requires a robust financing mechanism; a well-trained and adequately-paid workforce; reliable information on which to base decisions and policies; and well maintained facilities and logistics to deliver quality medicines and technologies (WHO, 2013).

Like health situation, access to health care varies across countries or locations, groups and individuals, and this is a situation largely influenced by several conditions including social and economic conditions as well as the health policies or strategic directions in place. This is a situation that is caused by the fact that countries or geographic locations develop and use different policies and plans in relation to the personal and population-based health care goals within their societies for the benefit of their people (Health at a Glance 2013).

For the provision of health services, healthcare systems are set up by countries to meet the needs of their people with regards to health service delivery. Due to the various nature of country context, economy, socio-cultural environment and health pattern or epidemiology, health systems vary from country to country, sub-region to sub-region, and also from community to community especially in decentralized settings even within the same countries. Although health planning can be led by different governments or other structures or institutions, the process can equally take different forms including consultative, participatory, regional, central or national planning, and although health situations and systems in various places varies, a well functioning health care system according to the World Health Organization (WHO), requires a robust financing mechanism; a well-trained and adequately-paid workforce; reliable information on

which to base decisions and policies; and well maintained facilities and logistics to deliver quality medicines and technologies.

Health care systems are influenced by and thus contribute significantly to countries' economies. For instance according to web-based data sources (United Nations. *International Standard Industrial Classification of All Economic Activities, Rev.3*. New York) in 2011, the health care industry consumed an average of 9.3 percent of the GDP or US\$ 3,322 (PPP-adjusted) per capita across the 34 members of OECD countries. The USA (17.7%, or US\$ PPP 8,508), the Netherlands (11.9%, 5,099), France (11.6%, 4,118), Germany (11.3%, 4,495), Canada (11.2%, 5669), and Switzerland (11%, 5,634) were the top spenders, however life expectancy in total population at birth was highest in Switzerland (82.8 years), Japan and Italy (82.7), Spain and Iceland (82.4), France (82.2) and Australia (82.0), while OECD's average exceeds 80 years for the first time ever in 2011: 80.1 years, a gain of 10 years since 1970. The USA (78.7 years) ranges only on place 26 among the 34 OECD member countries, but has the highest costs by far. All OECD countries have achieved universal (or almost universal) health coverage, except Mexico and the USA. This is because conventionally, health care is considered as an integral part in the promotion of the general physical and mental health and well-being of people around the world. One clear global example of this was the worldwide eradication of smallpox in 1980—declared by the WHO as the first disease in human history to be completely eliminated by deliberate health care interventions (WHO, 2010).

In modern days, the success of health care service delivery depends on groups of trained professionals and paraprofessionals coming together as interdisciplinary teams (US Department of Labor, 2011). The list of professional or paraprofessional group of health workers

includes professionals in various areas such as medicine, nursing, dentistry, midwifery-obstetrics and allied health, plus many others such as public health practitioners, community health workers and assistive personnel, who systematically provide personal and population-based preventive, curative and rehabilitative care services. While the definitions of the various types of health care vary depending on the different cultural, political, organizational and disciplinary perspectives, there appears to be some consensus that primary care constitutes the first element of a continuing health care process, that may also include the provision of secondary and tertiary levels of care (Thomas-MacLean R et al, 2011).

A primary health care in different locations can take different forms and can involve different categories or cadres of health workers. In any cases, primary health care refers to the health care services or the work of health care professionals who act as frontline officers or first point of consultation for all patients within the health care system. Such professionals would usually be primary health care physicians, such as general practitioners or family physicians, licensed independent practitioners such as physiotherapists, or non-physicians primary health care providers or workers (mid-level providers or workers) such as physician assistants or nurse practitioners or community health workers or volunteers. The category or nomenclature largely depends on the locality, language, health system organization, and sometimes at the patient's discretion, they may see other health care professionals first, such as pharmacists, nurses (such as in the United Kingdom), clinic or community health facility officers (such as in parts of Africa), or Ayurvedic or other traditional medicine professionals (such as in parts of Asia). Most often all the steps taken by the patient or client depends on the nature of the health condition, patients may then be referred or the health workers will see the need for referral for secondary or tertiary care or a higher level health facility or professional series (WHO, 2011).

In some instances primary care is often used as the term for the health care services which play a role in the local community e.g. in Sierra Leone, it includes preventive and curative health care services provided at community level by community health volunteers like traditional birth attendants (TBAs) or community-based drug providers for neglected tropical diseases and malaria, the lowest to the highest level of peripheral health units (from Maternal and child Health Post – MCHP, through community health Posts – CHPs to community health centres – CHCs). The services (primary health care services) can be provided in different settings, such as Urgent care centres which provide services to patients same day with appointment (mainly for private practitioners) or walk-in bases (for community level primary health care services as seen in Sierra Leone including the free health care services for pregnant women, lactating mothers and under five year old children).

In general, primary health care involves the widest scope of health care and health care service provision in an inclusive manner that includes all boys, girls, men, women, young, youthful, old, whatever colour, whatever ethnicity, whatever location or geographic region, whatever physical or mental state and socio-economic background, primary health care covers all patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Therefore, primary care workers or practitioners wherever they may find themselves must be polyvalent in knowledge and skills by possessing a wide breadth of knowledge and skills in many areas or disciplines. Quality and continuity are key attributes of primary health service delivery because the clients or patients usually prefer to consult or visit the same practitioners or health workers for routine check-ups, curative and preventive care, health education or counseling, and each time they need an initial consultation or counseling about a new health problem, condition or

issue including those of community level health issues. There is a standard international tool for the classification of primary health care in a process called International Classification of Primary Care (ICPC) for understanding and analyzing information on interventions in primary health care based on the reason for the patient or client's visit (WHO, 2011).

There are instances when chronic cases or terminal conditionals are referred from higher level health facilities or levels to primary health levels for continuum of care and such common chronic illnesses usually treated in primary care may include but not limited to hypertension, diabetes, asthma, COPD, depression and anxiety, back pain, arthritis or thyroid dysfunction. Primary health care also includes many basic maternal and child health care services, such as family planning services and vaccinations. In the United States, the 2013 National Health Interview Survey found that skin disorders (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), disorders of lipid metabolism (22.4%), and upper respiratory tract disease (22.1%, excluding asthma) were the most common reasons for accessing a physician (Sauer JL, Warner DO, Yawn BP, et al, 2013) while in Africa and specifically in Sierra Leone including the research location (Moyamba District), the most common reason for outpatient consultation is malaria accounting on average for about 38% of all out patient consultations often presented as fever. According to Sierra Leone's 2010 multi indicator survey almost two in five children under five (37 percent) at the time of the survey were ill with fever in the two weeks prior to the survey in 2010 while fever prevalence peaked at 40 percent among children aged 13-48 months. According to the same survey fever or malaria is less common among children whose mothers have secondary or higher education than among children of less educated mothers. Fever prevalence from the survey is said to vary significantly across regions, from 26 percent in the south where Moyamba District the research location is found to 44

percent in the north. The same multi indicator survey showed that fever or malaria prevalence in Sierra Leone is somewhat lower among children living in households in the upper wealth quintile as compared to households in other quintiles (SSL, UNFPA & UNICEF, SL, 2010).

Globally, in some parts of the world especially in the developed countries, populations are aging, with increasing numbers of older adults at greater risk of chronic non-communicable diseases. Therefore, rapidly increasing demand for primary care services is expected around the world but more in those developed countries although non-communicable diseases or conditions are gradually becoming public health challenges in both developed and developing countries where communicable disease like malaria poses major health challenges for countries (WHO, 2011). Primary health care is important and that why the World Health Organization (WHO) attributes the provision of essential primary health care as an integral component of an inclusive primary health care strategy in globally (WHO, 2011).

Primary health care workers and personnel by design refer health issues, problems or conditions to secondary health care service delivery points or personnel often and normally at higher level health facilities. Secondary care therefore includes health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists or complicated common cases like malaria as seen in Sierra Leone. Often, secondary health care includes acute health care services such as necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. Secondary health care may also include skilled attendance during childbirth, intensive care, and medical imaging services as well as other medical investigations or diagnosis.

In most instances, the word or term "secondary health care" is sometimes used synonymously or to mean "hospital care" but it should be noted that many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists or physiotherapists (physiotherapists are also primary care providers and a referral is not required to see a physiotherapist), and some primary care services are delivered within hospitals especially in developed countries. Depending on the organization and policies of the national health system as it is the case in Sierra Leone under normal circumstances especially in the rural areas or at community levels, patients may be required to see a primary care provider for a referral before they can access secondary care. For example in other countries like the United Kingdom and Canada, patient self-referral to a medical specialist for secondary care is rare as prior referral from another physician (either a primary care physician or another specialist) is considered necessary, regardless of whether the funding is from private insurance schemes or national health insurance. On the other hand, in the United States, which operates under a mixed market health care system, some physicians might voluntarily limit their practice to secondary care by requiring patients to see a primary care provider first, or this restriction may be imposed under the terms of the payment agreements in private or group health insurance plans. In other cases medical specialists may see patients without a referral, and patients may decide whether self-referral is preferred. Allied health professionals, such as physical therapists, respiratory therapists, occupational therapists, speech therapists, and dietitians, also generally work in secondary care, accessed through either patient self-referral or through physician referral (St Sauver JL, Warner DO, Yawn BP, et al., 2013). However, the privilege of decisions on primary before secondary health care is often not available in developing countries like Sierra Leone including the research location in Moyamba District

where communities, patients or clients are remote from available secondary health care services or facilities and are therefore left with the one and only option of going through the nearest available primary health care services that are often and normally the community health workers or volunteers and community health professionals or peripheral health units that could be a maternal and child health post, community health post or community health centre.

By the nature of national health care system structures, tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital (Johns Hopkins Medicine, 2011). Some examples of tertiary health care services are those requiring specialist health care services like cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions (Emory University., 2011).

Hardly heard of is also the term quaternary care that is sometimes used as an extension of tertiary care in reference to advanced levels of medicine which are highly specialized and not widely accessed and they are mainly heard of in developed countries or in research health institutions. For instance it could be experimental medicine and some types of uncommon diagnostic or surgical procedures. These services are usually only offered in a limited number of regional or national health care centres as they are rare health care services. This uncommonly used term is mainly used in the United Kingdom and as much as it is used in the United States of America. What actually makes it different and not heard of in developed countries that are often low resourced and therefore have inadequately health facilities, is that a quaternary care hospital may have virtually any procedure available, whereas a tertiary care

facility may not offer a sub-specialist with that much provision (Christensen, L.R.; E. Grönvall 2011).

As a part of primary health care service delivery, home and or community health care service delivery that takes place outside health facilities are ways many types of health interventions are delivered. For instance home care for the aged mostly in developed or western countries aimed at helping seniors live full, independent lives in the comfort of their own homes and outreach or mobile health services or clinics that are common in developing countries like Sierra Leone is a strategy used to reach more people with health services such as food safety surveillance, distribution of condoms and needle-exchange programmes for the prevention of transmissible diseases such as malaria a leading public health challenge in Sierra Leone including the research district of Moyamba in Southern Sierra Leone. Home and community health care services also include the services of professionals in residential and community settings in support of self care, home care, long-term care, assisted living, treatment for substance use disorders and other types of health and social care services. Rehabilitation including physiotherapy can also be part of home or community health care. School health programmes can also be part of community health care, National Geographic magazine, June 2014)) and (Christensen, L.R.; E. Grönvall, 2011).

Different health promotion and demonstration through information, education and communication, and behavior change communication is part of home and community health care service delivery and can take diverse approached. For instance in Sierra Leone as part of the free health service delivery, sensitization sessions are held with pregnant women, lactating mothers and other community members on the essence of antenatal services, health facility delivery,

postnatal care, nutrition education and demonstrations either for addressing obesity in the west or developing countries or for addressing or preventing malnutrition common in developing or countries in the south.

Related to health care including free health care are some terminologies or areas of the health care systems that all contribute to the overall health care system and expected outcomes that are worth covering in this dissertation and they include but are not limited to health care system, health care industry, health care research, health care financing, health administration and regulations, and health care information technology:

A health or health care system is the organization of people, institutions, and resources to deliver health care services to meet the health needs of target populations.

Health care industry is an incorporation of several sectors that are dedicated to providing health care services and products. In further explaining this, the United Nations as a basic framework for defining the sector, through the International Standard Industrial Classification categorizes health care as generally consisting of hospital activities, medical and dental practice activities, and "other human health activities". According to that UN classification system (i.e. United Nations *International Standard Industrial Classification of All Economic Activities, Rev.3.*, New York), the last class involves activities of, or under the supervision of, nurses, midwives, physiotherapists, scientific or diagnostic laboratories, pathology clinics, residential health facilities, or other allied health professions, e.g. in the field of optometry, hydrotherapy, medical massage, yoga therapy, music therapy, occupational therapy, speech therapy, chiropody, homeopathy, chiropractics and even acupuncture.

Health care research often informs improvement plans for health care system including the introduction of free health care systems based on the identified health needs of populations. For

instance in Sierra Leone the response of the government to provide free health care for pregnant women, lactating mothers and under five children was based on data showing that Sierra Leone was having one of the world's highest maternal and child mortality rates. On the global stage for instance for pharmaceutical research and development spending, Europe spends a little less than the United States (€22.50bn compared to €27.05bn in 2006). The United States accounts for 80% of the world's research and development spending in biotechnology ("The Pharmaceutical Industry in Figures, 2010). Health care research is important because in addition to other benefits, the results of health services research can lead to greater efficiency and equitable delivery of health care interventions, as advanced through the social model of health and disability, which emphasizes the societal changes that can be made to make population healthier. Results from health services research often form the basis of evidence-based policy in health care systems including free health care initiatives. Health services research is also aided by initiatives in the field of AI for the development of systems of health assessment that are clinically useful, timely, sensitive to change, culturally sensitive, low burden, low cost, involving for the patient and built into standard procedures (Erik Cambria; Tim Benson, Chris Eckl and Amir Hussain, 2012).

Health care financing is the basis for the introduction of free health care systems of diverse natures in different parts of the world. Five health financing methods used in different countries, in different circumstances for different reasons include (WHO, 2006)

- general taxation to the state, county or municipality
- social health insurance for individuals, groups and institutions
- voluntary or private health insurance

- out-of-pocket payments by individuals, families, groups or institutions and
- donations to health charities often for organizations

The different health care financing ways are in most countries, mixed involving all the five models, but the exact distribution varies across countries and over time within countries. In all countries and jurisdictions, there are many topics in the politics and evidence that can influence the decision of a government, private sector business or other groups to adopt a specific health policy regarding the financing structure. Thus free health care initiative or social health insurance come in where a nation's entire population is eligible for health care coverage, and this coverage and the services provided are regulated. In almost every jurisdiction with a government-funded health care system, a parallel private, and usually for-profit, system is allowed to operate. This is sometimes referred to as two-tier health care or universal health care which is the same as the free health system operated in Sierra Leone including the Moyamba District that is the research location.

Health care administration and regulation regulated health care practice and methods or strategies used in populations or countries. Health care management and administration of health care is another sector vital to the delivery of health care services. In particular, the practice of health professionals and operation of health care institutions is typically regulated by national or state/provincial authorities through appropriate regulatory bodies for purposes of quality assurance.

Health information technology especially in modern world is very important considering the fact that health care is a dynamic system. Health information technology (HIT) is “the application of information processing involving both electronic computer hardware and software that deals

with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making”. However, a strict definition is elusive; "technology" can refer to material objects of use to humanity, such as machines, hardware or utensils, but can also encompass broader themes, including systems, methods of organization, and techniques. For HIT, technology represents computers and communications attributes that can be networked to build systems for moving health information. Informatics is yet another integral aspect of HIT. For instance in Sierra Leone in the implementation of the free health care system, CCTVs are used to track movement of drugs and medical supplies from central to regional locations within the country as a way of controlling leakages within the supply chain system. Likewise, mobile phones are used to collect data and transmit health data and they are especially useful for getting data from very remote locations with bad road systems. Health care technology is rapidly helping to improve health management information systems. For instance in Sierra Leone, all the 13 health districts can process their monthly health data and transmit to central level for planning and management information purposes using computer based data processing software. This in turn is helping improve health care system monitoring and evaluation (Tulenko et al., 2012).

Global perspective of free health care

Globally, there are several health care systems run by different countries and amongst those, different countries run universal health care systems that meet the cost of end user health care cost that target their people mainly through their public health sectors. Based on global data collected in 2010 by the ChartsBin statistics collector team looking at Universal Health Care around the world and viewed in June 2014, there is a list of countries below showing countries that were recognized as providing universal health care for their populations at the time of the data collection in

2010. The data provided in the table below showed that there are many countries providing universal health care (health coverage for all citizens of a nation) that were tracked as shown in the table below and it shows that there are still several other countries where the health care provided is not universal or health coverage for all citizens of those nations (Chartsbin, 2010).

Country name	Universal health care system	Start year of universal health care	Note
Afghanistan	NA		
Åland Islands	NA		
Albania	No		The health care system is heavily dependent on humanitarian aid and money sent home by emigrants, and the ongoing brain drain is depleting the country of its most valuable human resources. Yet despite the difficulties, the basic infrastructure for health care delivery is being maintained and rationalized. The success or failure of the reforms will

			depend on the country's continued stability and its economic recovery.
Algeria	Public universal health care through other means		
American Samoa	NA		
Andorra	Public universal health care through other means	1966	The Andorran health care system is based on a social insurance model. Citizens' health care rights are recognized by the constitution. Health care services are provided and financed by both private and public sectors. About 92% of the population is covered by the CASS (la Caixa Andorrana de Seguretat Social -the Andorran Office of the Social Security).
Angola	NA		
Anguilla	NA		
Antarctica	NA		
Antigua and Barbuda	NA		
Argentina	Public universal health care		Health care is provided through

	through other means		a combination of employer and labor union-sponsored plans (Obras Sociales), government insurance plans, public hospitals and clinics and through private health insurance plans.
Armenia	No		
Aruba	NA		
Australia	Two Tier	1975	Australia is committed to public financing and substantial public delivery in health care. The health system offers universal access to health care, regardless of ability to pay, through the government administers the compulsory national health insurance program, Medicare, which is financed through general taxation and a health tax levy. This provides the entire population with subsidized access to the doctor of their choice for out-of-hospital care,

			<p>free public hospital care and subsidized pharmaceuticals.</p> <p>Government provides a baseline of care, and in which a significant percentage of individuals purchase additional health insurance or premium direct health care.</p>
Austria	Public universal health care through other means	1978	<p>The Austrian health care system is characterized by the federalist structure of the country, the delegation of competencies to stakeholders in the social insurance system as well as by cross stakeholder structures at federal and Länder levels which possess competencies in cooperative planning, coordination and financing.</p> <p>There has traditionally been regulated competition between service providers for patients and contracts with the social</p>

			<p>insurance institutions, but not between the health insurance funds themselves. The sectors of the health care system have customarily been characterized by different stakeholders and regulation and financing mechanisms. However, in recent years there have been increased efforts to introduce decision-making and financing flows which are effective across all sectors.</p>
Azerbaijan	Public universal health care through other means	1991	<p>The current structure of the health care system was one of the least effective in the Soviet republics, and it deteriorated further after independence. As a result, the country experienced outbreaks of diseases that had once been controlled, and others, such as tuberculosis, began to increase; the health system faced</p>

			near complete collapse.
Bahamas, The	NA		
Bahrain	Single-payer	1957	
Bangladesh	NA		
Barbados	NA		
Belarus	Public universal health care through other means	1991	Belarus has managed to maintain a health care delivery system that provides a comprehensive package of care to the entire population, which is generally free at the point of delivery.
Belgium	Public universal health care through other means	1945	The Belgian health system is based on the principles of equal access and freedom of choice, with a Bismarckian-type of compulsory national health insurance, which covers the whole population and has a very broad benefits package.
Belize	NA		
Benin	NA		
Bermuda	NA		

Bhutan	Single-payer		The Royal Government of Bhutan maintains a policy of free and universal access to primary health care. As hospital facilities in the country are limited, patients with diseases that cannot be treated in Bhutan, such as cancer, are normally referred to hospitals in India for treatment. Such referral treatment is also carried out at the cost of the Royal Government.
Bolivia	NA		
Bosnia and Herzegovina	Public universal health care through other means		
Botswana	NA		
Bouvet Island	NA		
Brazil	Public universal health care through other means		The universal health care system was adopted in Brazil in 1988 after the end of the military regime's rule. However, free health care was available many

			years before, in some cities, once the #27 amend to the 1969 Constitution impose to the municipalities the duty of applying 6% of their income in healthcare.
British Indian Ocean Territory	NA		
British Virgin Islands	NA		
Brunei	Single-payer	1958	The people of Brunei Darussalam enjoy free medical and health care provided via government hospitals, health centres and health clinics.
Bulgaria	Public universal health care through other means		
Burkina Faso	NA		
Burma	NA		
Burundi	NA		
Cambodia	NA		
Cameroon	NA		
Canada	Single-payer	1966	In Canada, national health insurance (Medicare) is a public

			program administered by the provinces and overseen by the federal government. Medicare is funded by income taxes and sales tax revenues. All Canadian citizens have health care.
Cape Verde	NA		
Cayman Islands	NA		
Central African Republic	NA		
Chad	NA		
Chile	Public universal health care through other means		
China	Public universal health care through other means		The New Rural Co-operative Medical Care System (NRCMCS) is a 2005 initiative to overhaul the healthcare system, particularly intended to make it more affordable for the rural poor. While health insurance coverage is increasing, especially in rural areas, many people are underinsured and

			continue to face high out-of-pocket costs. While the health insurance schemes, particularly in rural areas, report high coverage, benefits are often limited to catastrophic illness; inpatient medical services frequently require pre-payment and reimbursement can be as low as 20%-30% of the total bill.
Christmas Island	NA		
Cocos (Keeling) Islands	NA		
Colombia	NA		
Comoros	NA		
Congo, Democratic Republic of the	NA		
Congo, Republic of the	NA		
Cook Islands	NA		
Costa Rica	Public universal health care through other means		

Côte d'Ivoire	NA		
Croatia	Public universal health care through other means		
Cuba	Single-payer	1959	Cuba has a national health service. Services are available without charge to everyone. They are provided by salaried personnel in facilities run by the government.
Cyprus	Single-payer	1980	
Czech Republic	Public universal health care through other means		
Denmark	Public universal health care through other means	1973	Denmark has a universal public health system paid largely from taxation with local municipalities delivering health care services in the same way as other Scandinavian countries.
Djibouti	NA		
Dominica	NA		
Dominican Republic	NA		
Ecuador	NA		
Egypt	Public universal health care		

	through other means		
El Salvador	NA		
Equatorial Guinea	NA		
Eritrea	NA		
Estonia	Public universal health care through other means		
Ethiopia	NA		
Falkland Islands (Islas Malvinas)	NA		
Faroe Islands	NA		
Fiji	NA		
Finland	Single-payer	1972	In Finland, Perceived imbalances between primary and specialized health care led to the Primary Health Care Act 1972, which introduced a network of primary health care centres, publicly owned and staffed, in charge of delivering integrated preventive and curative services.
France	Public universal health care through other means	1974	The health care system is regulated by two main players: the state – the National

			Assembly, the government and ministries – and the statutory health insurance funds. To a lesser extent, local communities play a role in regulating the system. The Juppé reform of 1996 clarified the roles of the state and insurance funds and reinforced the role of the regions.
French Guiana	NA		
French Polynesia	NA		
French Southern and Antarctic Lands	NA		
Gabon	NA		
Gambia, The	NA		
Georgia	Public universal health care through other means		
Germany	Public universal health care through other means	1941	Germany uses a social insurance model. All citizens must have health insurance, which they purchase from one of more than 200 private, nonprofit sickness

			funds.
Ghana	Public universal health care through other means		In Ghana, most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Some for-profit clinics exist, but they provide less than 2% of health services.
Gibraltar	NA		
Greece	Public universal health care through other means	1983	
Greenland	NA		
Grenada	NA		
Guadeloupe	NA		
Guam	NA		
Guatemala	NA		
Guernsey	NA		
Guinea	NA		
Guinea-Bissau	NA		
Guyana	NA		
Haiti	NA		
Heard Island and McDonald Islands	NA		

Holy See (Vatican City)	NA		
Honduras	NA		
Hong Kong	Public universal health care through other means	1993	
Hungary	Public universal health care through other means		
Iceland	Single-payer	1990	
India	Public universal health care through other means		India has a universal health care system run by the local (state or territorial), governments. The government hospitals, some of which are among the best hospitals in India, provide treatment at taxpayer expense. Most essential drugs are offered free of charge in these hospitals.
Indonesia	NA		
Iran	Public universal health care through other means		
Iraq	NA		
Ireland	Public universal health care through other means	1977	

Isle of Man	NA		
Israel	Public universal health care through other means	1995	In Israel, the National Health Insurance Law (or National Health Insurance Act) is the legal framework which enables and facilitates basic, compulsory universal health care.
Italy	Single-payer	1978	Italy has a public health care service for all the residents called "Servizio Sanitario Nazionale" or the National Health Service (NHS). It is publicly run and funded mostly from taxation: some services require small co-pays, while other services are completely free of charge.
Jamaica	NA		
Japan	Single-payer	1938	Japan uses a "social insurance" system in which all citizens are required to have health insurance, either through their work or purchased from a

			nonprofit, community-based plan. Those who can't afford the premiums receive public assistance. Most health insurance is private; doctors and almost all hospitals are in the private sector.
Jersey	NA		
Jordan	NA		
Kazakhstan	Public universal health care through other means		
Kenya	NA		
Kiribati	NA		
Korea, North	Public universal health care through other means		North Korea has a national medical service and health insurance system.
Korea, South	Public universal health care through other means	1988	
Kuwait	Single-payer	1950	
Kyrgyzstan	NA		
Laos	NA		
Latvia	Public universal health care through other means		

Lebanon	NA		
Lesotho	NA		
Liberia	NA		
Libya	Public universal health care through other means		
Liechtenstein	Public universal health care through other means		
Lithuania	Public universal health care through other means		
Luxembourg	Public universal health care through other means	1973	
Macau	Single-payer		
Macedonia [FYROM]	NA		
Madagascar	NA		
Malawi	NA		
Malaysia	Public universal health care through other means		
Maldives	NA		
Mali	NA		
Malta	Public universal health care through other means		
Marshall Islands	NA		

Martinique	NA		
Mauritania	NA		
Mauritius	NA		
Mayotte	NA		
Mexico	Public universal health care through other means		Public health care delivery is accomplished via an elaborate provisioning and delivery system instituted by the Mexican Federal Government.
Micronesia, Federated States of	NA		
Moldova	Public universal health care through other means		
Monaco	Public universal health care through other means		
Mongolia	Public universal health care through other means		
Montenegro	NA		
Montserrat	NA		
Morocco	Public universal health care through other means		
Mozambique	NA		
Namibia	NA		

Nauru	NA		
Nepal	NA		
Netherlands	Public universal health care through other means	1966	
Netherlands Antilles	NA		
New Caledonia	NA		
New Zealand	Two Tier	1938	Primary health care is provided by primary health organizations, which contract with District Health Boards for the bulk of their funding. New Zealand's healthcare system is funded through general taxation.
Nicaragua	NA		
Niger	NA		
Nigeria	NA		
Niue	NA		
Norfolk Island	NA		
Northern Mariana Islands	NA		
Norway	Single-payer	1912	The National Insurance Act guaranteed citizens universal access to all forms of medical

			care. Norway's health system is funded by progressive income tax, and from block grants from central government. Patients are free to choose their own physician and hospital, however, registration with local GP's who act as gatekeeper, will begin in 2001.
Oman	NA		
Pakistan	Public universal health care through other means		
Palau	NA		
Panama	Public universal health care through other means		
Papua New Guinea	NA		
Paraguay	NA		
Peru	Public universal health care through other means		
Philippines	NA		
Pitcairn Islands	NA		
Poland	Public universal health care through other means		

Portugal	Single-payer	1979	
Puerto Rico	NA		
Qatar	Public universal health care through other means		
Réunion	NA		
Romania	Public universal health care through other means		
Russia	Public universal health care through other means		
Rwanda	NA		
Saint Barthélemy	NA		
Saint Helena	NA		
Saint Kitts and Nevis	NA		
Saint Lucia	NA		
Saint Martin	NA		
Saint Pierre and Miquelon	NA		
Saint Vincent and the Grenadines	NA		
Samoa	NA		
San Marino	Public universal health care through other means		
Sao Tome and	NA		

Principe			
Saudi Arabia	Public universal health care through other means		
Senegal	NA		
Serbia	Public universal health care through other means		
Seychelles	Public universal health care through other means		
Sierra Leone	NA		
Singapore	Single-payer	1993	Singapore has a universal health care system where government ensures affordability, largely through compulsory savings and price controls, while the private sector provides most care.
Slovakia	Public universal health care through other means		
Slovenia	Public universal health care through other means		
Solomon Islands	NA		
Somalia	NA		
South Africa	Public universal health care through other means		South Africa's health system consists of a large, under-

			resourced public sector (serving 80 percent of population) and a small private sector for high income earners (20 percent of the population). Primary health care is free to everyone but highly specialized services are available in the private sector to those who can afford it.
South Georgia and the Islands	NA		
Spain	Single-payer	1986	The Spanish health care system is funded by payroll taxes through the National Institute of Health program (INSALUD)
Sri Lanka	Public universal health care through other means		
Sudan	NA		
Suriname	NA		
Svalbard	Single-payer		
Swaziland	NA		
Sweden	Single-payer	1955	The Swedish health care system is financed by both incomes tax

			and patient fees. County councils own and operate hospitals, employ physicians and run the majority of general practices and outpatient facilities. Other physicians work in private practice and are paid by the counties on a fee-for-service basis. Tuition for medical and nursing education is free.
Switzerland	Public universal health care through other means	1994	In Switzerland, compulsory health insurance covers the costs of medical treatment and hospitalization of the insured. The Swiss healthcare system is a combination of public, subsidized private and totally private healthcare providers, where the insured person has full freedom of choice among the providers in his region. Insurers are required to offer this

			basic insurance to everyone, regardless of age or medical condition. They may not make a profit off this basic insurance, but can on supplemental plans.
Syria	Public universal health care through other means		
Taiwan	Single-payer		The current health care system in Taiwan, known as National Health Insurance (NHI), was instituted in 1995. NHI is a single-payer compulsory social insurance plan which centralizes the disbursement of health care dollars. NHI is mainly financed through premiums, which are based on the payroll tax, and is supplemented with out-of-pocket payments and direct government funding. In the initial stage, fee-for-service predominated for both public and private providers.

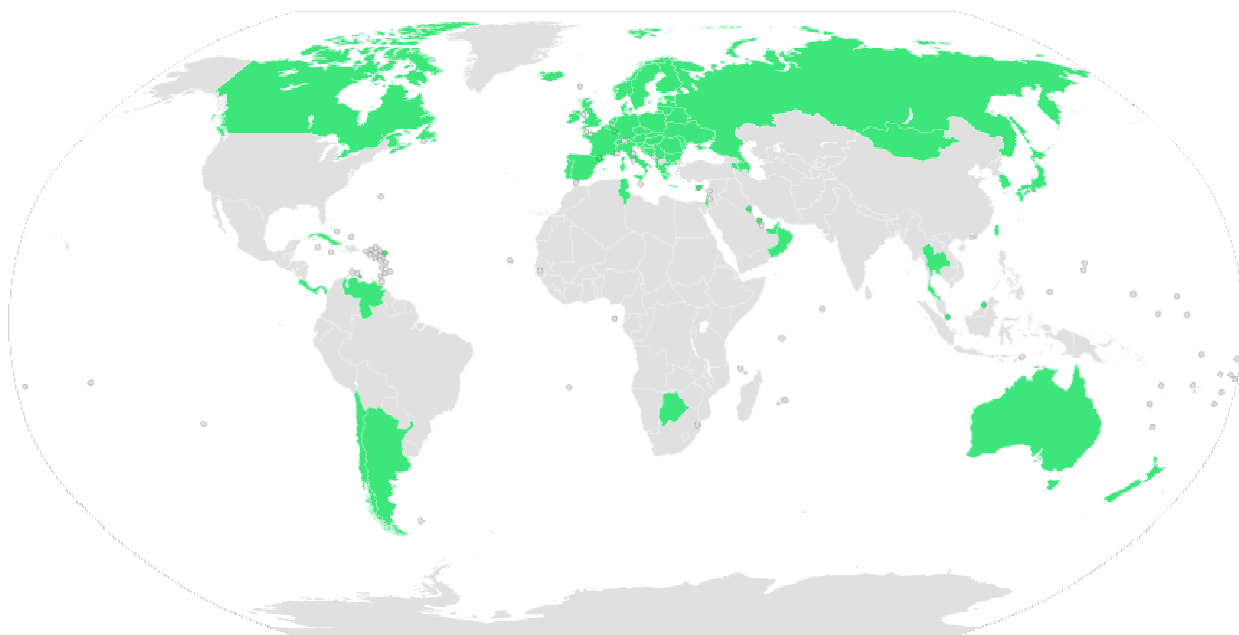
Tajikistan	Public universal health care through other means		
Tanzania	NA		
Thailand	Public universal health care through other means		
Timor-Leste	NA		
Togo	NA		
Tokelau	NA		
Tonga	NA		
Trinidad and Tobago	Public universal health care through other means		
Tunisia	Public universal health care through other means		
Turkey	Public universal health care through other means		
Turkmenistan	Public universal health care through other means		
Turks and Caicos Islands	NA		
Tuvalu	NA		
Uganda	NA		
Ukraine	Public universal health care through other means		

United Arab Emirates	Single-payer	1971	
United Kingdom	Single-payer	1948	United Kingdom has a National Health Service that provides public healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation.
United States	in transition	2014	2010 legislation has laid the ground for one to be fully functioning by 2014.
United States Minor Outlying Islands	NA		
Uruguay	Public universal health care through other means		
Uzbekistan	NA		
Vanuatu	NA		
Venezuela	Public universal health care through other means		
Vietnam	NA		
Virgin Islands	NA		
Wallis and Futuna	NA		
West Bank	NA		

Western Sahara	NA		
Yemen	NA		
Zambia	NA		
Zimbabwe	NA		

Source: *ChartsBin statistics collector team 2010, Universal Health Care around the World,*
(ChartsBin.com, viewed 21st June, 2014, <<http://chartsbin.com/view/z1a>>).

The map below show places in the world providing universal health care for all their citizens (mostly the wealthy nations)



Source: *ChartsBin statistics collector team 2010, Universal Health Care around the World,*
ChartsBin.com, viewed 21st June, 2014, <<http://chartsbin.com/view/z1a>>.

Health care around the world

There is abundance of information on the existence of health care all over the world and it shows that the provision of the services differs globally across countries. Based on available information, almost all wealthy nations provide universal health care (the US is an exception). This is mainly due to the fact that the health care provision is challenging because of the costs required as well as various social, cultural, political and economic conditions which vary from country to country around the world. The variation and the emergence of different health issues also lead to the use of varied health care options or systems in different parts of the world.

Health care poses challenges that some of them include getting adequate health care services for those that need the services most. The global institution responsible for looking at health care issues and systems across the world is the World Health Organization (WHO) which highlighted some contradictions in health care systems in some parts of the world. That is in some places or some countries what actually exists as the WHO puts it:

“Inverse care

People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor in high- and low-income countries alike.

Impoverishing care

Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care.

Fragmented and fragmenting care

The excessive specialization of health-care providers and the narrow focus of many disease control programs discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation.

Unsafe care

Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health.

Misdirected care

Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health” (Anup Shah, 2011).

This shows that the provision of health care services across the world is a complex situation. Therefore several countries around the globe spend considerable resources trying to provide that complex health care based on their situations and available resources. This is because health care is extremely important for any nation because health according to the United Nation, is a human right issue and also health or right to health is linked to several other rights such as the right to survival, development, protection, education, gender equality, the right for people with disability

and the realization of all of those rights accounts for a country's position on the international stage. That means the right to health is core to the realization of many other human rights (Anup Shah, 2011).

That is why the World Health Organization (WHO) and the Office of the United Nations High Commission for Human Rights (OHCHR) considered health as being relevant to all States and stated that:

“every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences” (Anup Shah, 2011).

The right to health is also related to the following as well:

“Inclusive rights, freedoms (from non-consensual medical treatment; from torture and other cruel or degrading treatments or punishments); entitlements (to prevention, treatment and control of diseases; access to essential medicines, maternal, child and reproductive health; health-related education; participation; timely services); non-discrimination and accessibility, acceptability and quality of services.” (Anup Shah, 2011).

These linkages between the right to health and other areas of life is important because there are a range of factors or determinants for living a healthy life and living a healthy life also enhances the realization of other rights of human beings and those include:

- “Safe drinking water and adequate sanitation
- Safe food
- Adequate nutrition and housing
- Healthy working and environmental conditions
- Health-related education and information
- Gender equality.” (Anup Shah, 2011).

Truly, there is a lot of overlap between the right to health and the right to other aspects of life and thus the promotion and protection of health and that of respecting, protecting and fulfilling human rights in general are strongly interrelated according to the World Health Organization (WHO).

The ways universal health care is funded in some countries, some people argue that it is an infringement on the very human rights the health care is aimed at promoting in that money is taken from those that have to support those that do not have.

Universal Health Care: Universal health care is health coverage for all citizens of a nation.

Some argue that a universal system requires some level of transfer of wealth from those who have to support those who do not have. Any such transfer infringes on the freedom of the individual being taxed.

Others argue that providing access to health enables one to enjoy freedom, and as a society it is a shared responsibility (much like sharing the burden of funding a military or providing education for all). As such, social equity and individual freedom do not necessarily have to be taken away

but it is that taking away of money often through taxation that some people consider as an infringement on their own rights while those or governments that institute universal health care aim having healthier societies by addressing inequalities in accessing health care services in their countries. Some of the ways in which universal health care is provided or supported include but not limited to:

- Having government funded national systems through payment of tax
- Having government funded through subsidization with users topping up cost at point of user of the services
- Having it done through health insurance system funded by government, individual citizens or a mix of the two.
- By having a decentralized, private systems that are run on profit or not for profit basis

Notwithstanding, in all of this, different countries in different parts of the world have used and will continue to use different means for health care and generally, it is known that poorer nations have struggled to provide adequate health care because health care provision is costly and is tied to available resources and support from donor communities or partners.

Best health care in the world

All countries have some form of health care system and the aim of every country is to provide its people quality health care but this determination is controlled to a large extent by the health issues and available resources to each country. Citizens can say whether they are satisfied with their countries' health care system or not but to determine countries providing exceptional health care in the world is the responsibility of the World Health Organization (WHO). The WHO

making that analysis is a complex work which the organization have actually stopped doing but based on the 2000 analysis carried out by the WHO, countries were ranked based on the quality of their health care systems. The WHO definition of health care system used for the analysis states that:

"A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behavior change programs; vector control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral actions by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health." (WHO, 2000).

According the WHO 2000 ranking of countries, France stood at the top of the list, in terms of its health care system. The French system according to WHO brings both the private and the public sectors together in providing the required health care cover for its citizens. This is because in France majority of the medical bills are paid by the government through the funds generated from income tax, whereas the remaining ones are paid by the individual's private insurers according to the WHO analysis. The analysis showed that the citizens enjoy many benefits of their country's health insurance scheme and most of the time their treatments are

almost free as people can claim 75% of the health bills from government health insurance and also claim the remaining if they have private health insurance and in doing so, the citizens end up paying nothing for their health care services from their own pocket. As a complement to the WHO ranking analysis, a Commonwealth Fund survey showed that 42% French patients suffering from chronic diseases can fetch the appointments with doctors on the same day only; whereas only 26% patients can do so in the United States of America. Also France spends \$4,000 per person for health care while the United States of America, spends \$7,500 per person. The physician patient ratio in France is about 3.4 physicians to 1000 – a possible reasons why France provides the best health care in the world to its citizens as shown by the World ranking done by the World health Organization (WHO) in 2000 with France at the top of the list with 189 other countries ranked (highest starting with 1) as shown below (WHO, 2000):

1. France	13. Monaco	25. Germany
2. Italy	14. Greece	26. Saudi Arabia
3. San Marino	15. Iceland	27. United Arab Emirates
4. Andorra	16. Luxembourg	28. Israel
5. Malta	17. Netherlands	29. Morocco
6. Singapore	18. United Kingdom	30. Canada
7. Spain	19. Ireland	31. Finland
8. Oman	20. Switzerland	32. Australia
9. Austria	21. Belgium	33. Chile
10. Japan	22. Colombia	34. Denmark
11. Norway	23. Sweden	35. Dominica
12. Portugal	24. Cyprus	36. Costa Rica

37. USA	60. Philippines	83. Jordan
38. Slovenia	61. Mexico	84. Mauritius
39. Cuba	62. Slovakia	85. Grenada
40. Brunei	63. Egypt	86. Antigua and Barbuda
41. New Zealand	64. Kazakhstan	87. Libya
42. Bahrain	65. Uruguay	88. Bangladesh
43. Croatia	66. Hungary	89. Macedonia
44. Qatar	67. Trinidad and Tobago	90. Bosnia & Herzegovina
45. Kuwait	68. Saint Lucia	91. Lebanon
46. Barbados	69. Belize	92. Indonesia
47. Thailand	70. Turkey	93. Iran
48. Czech Republic	71. Nicaragua	94. Bahamas
49. Malaysia	72. Belarus	95. Panama
50. Poland	73. Lithuania	96. Fiji
51. Dominican Republic	74. Saint Vincent	97. Benin
52. Tunisia	75. Argentina	98. Nauru
53. Jamaica	76. Sri Lanka	99. Romania
54. Venezuela	77. Estonia	100. St. Kitts & Nevis
55. Albania	78. Guatemala	101. Moldova
56. Seychelles	79. Ukraine	102. Bulgaria
57. Paraguay	80. Solomon Islands	103. Iraq
58. South Korea	81. Algeria	104. Armenia
59. Senegal	82. Palau	105. Latvia

106. Yugoslavia	129. Peru	152. Togo
107. Cook Islands	130. Russia	153. Turkmenistan
108. Syria	131. Honduras	154. Tajikistan
109. Azerbaijan	132. Burkina Faso	155. Zimbabwe
110. Suriname	133. São Tomé	156. Tanzania
111. Ecuador	134. Sudan	157. Djibouti
112. India	135. Ghana	158. Eritrea
113. Cape Verde	136. Tuvalu	159. Madagascar
114. Georgia	137. Ivory Coast	160. Vietnam
115. El Salvador	138. Haiti	161. Guinea
116. Tonga	139. Gabon	162. Mauritania
117. Uzbekistan	140. Kenya	163. Mali
118. Comoros	141. Marshall Islands	164. Cameroon
119. Samoa	142. Kiribati	165. Laos
120. Yemen	143. Burundi	166. Congo
121. Niue	144. China	167. North Korea
122. Pakistan	145. Mongolia	168. Namibia
123. Micronesia	146. Gambia	169. Botswana
124. Bhutan	147. Maldives	170. Niger
125. Brazil	148. Papua New Guinea	171. Equatorial Guinea
126. Bolivia	149. Uganda	172. Rwanda
127. Vanuatu	150. Nepal	173. Afghanistan
128. Guyana	151. Kyrgyzstan	174. Cambodia

175. South Africa

176. Guinea-Bissau

177. Swaziland

178. Chad

179. Somalia

180. Ethiopia

181. Angola

182. Zambia

183. Lesotho

184. Mozambique

185. Malawi

186. Liberia

187. Nigeria

188. Republic of Congo

189. Central African
Republic

190. Myanma

Free Health Yahoo search results, (yahoo, June 2014)

Free health care in different parts of the world can be 100% or partial and the systems can take different forms. For instance, according to a *Daily News* article, “Another unhealthy year for Harlem” 100% free health care was provided for Central Harlem community because:

Central Harlem had the highest death rate of any community in the city with 8.8 deaths per 1,000 people in 2009, compared with 6.1 deaths per 1,000 people citywide.

East Harlem ranked third in the city with a rate of 8.3 deaths per 1,000 people.

According to another report by the Citizens’ Committee for Children of New York, the child poverty rate is 35.8% for Central Harlem and 44.2% for East Harlem, compared to the city-wide rate of 30.0% and 22.1% for Manhattan (Posted on **March 18, 2013**).

The factors in the Harlem city situation are similar to those in Sierra Leone leading to the introduction of free health

and poverty or child situation points out to the care is often introduced to issues and concerns for deaths and income levels overcoming barriers to



care i.e. high mortality poverty rate. This fact that free health address recognized high disease burden or as a means of health care services be

it for individuals, groups, communities or countries. Free health is also considered to be a human right issue by some although this view has been contested in some instances where it is considered to be often politically motivated rather than being a human right

issue. For instance, these two views were found on the internet regarding free health care in America. The first view holds that:

“The human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment.”

The second view holds the position that first view was a bad one:

“Too bad your facts are so inaccurate; the current law is supported by about 1/3 of the population. Healthcare is not a human right. While I agree everyone should have access to health care, that doesn’t mean it should be free. The health care law is strictly a power grab, very simple to understand”.

However, further analysis of free health were made in the same publication and coming up with this position (Troy Cantrell on **March 27, 2013 at 4:43 pm** said):

“In a single-payer system, all hospitals, doctors, and other health care providers would bill one entity for their services. This alone reduces administrative waste greatly, and saves money, which can be used to provide care and insurance to those who currently don’t have it”.

On “The Opinion Pages” of *The New York Times*, David Himmelstein and Steffie Woolhandler wrote about the benefits of a single payer system:

“A single-payer reform — a public, national health insurance plan that pays virtually all medical bills — would fix the health care mess; and, like Medicare, it’s clearly constitutional. Single-payer would save \$400 billion wasted each year on insurers’ overhead and the paperwork burden they impose on doctors and hospitals”.

Free health care is not new in the world although it may take different dimensions and can spring from different motivating factors. Below are different pictures gathered from the internet (<https://uk.images.search.yahoo.com/search/images>, June 2014) showing how free health has been portrayed and communicated in various parts of the world including government, mission or civil society driven initiatives.



Justice is No Yoke TopPun.com - Maximizing Prophets - Just Due It!

The Pun is Righter than the Sword TopPun.com - Maximizing Prophets - Justice is No Yoke

HEALTH CARE is a RIGHT Not a PRIVILEGE

Got Public Health?

Public health is contagious - spread the word! No smallpox, no polio, know public health! Public health is everybody's business. While health care is a right, not a privilege, an ounce of public health is worth a pound of health care. Exercise your right to work for public health - just due it! Of course, seven days without exercise makes one weak. Please remember to be nice to public health workers; they may have saved your life...

Dan Rutt, alias "Top Pun" (it's just, my pun name)

The Pun is Righter than the Sword TopPun.com - Maximizing Prophets - Justice is No Yoke

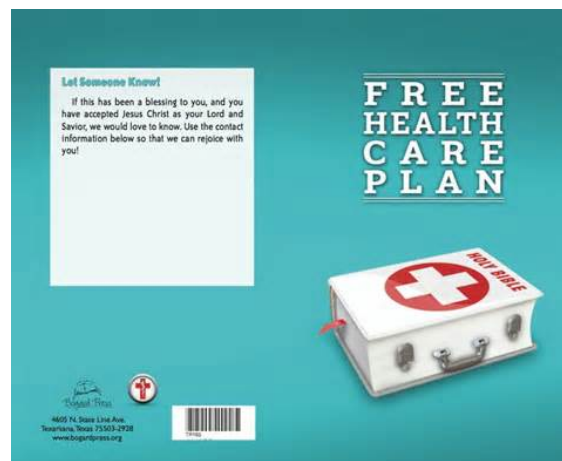


Free Medical Services

Free Medical Services are available to:

- Children under 6 years
- Adults over 60 years
- Pregnancies leading to caesarean sections
- First 24 hours of emergency medical service



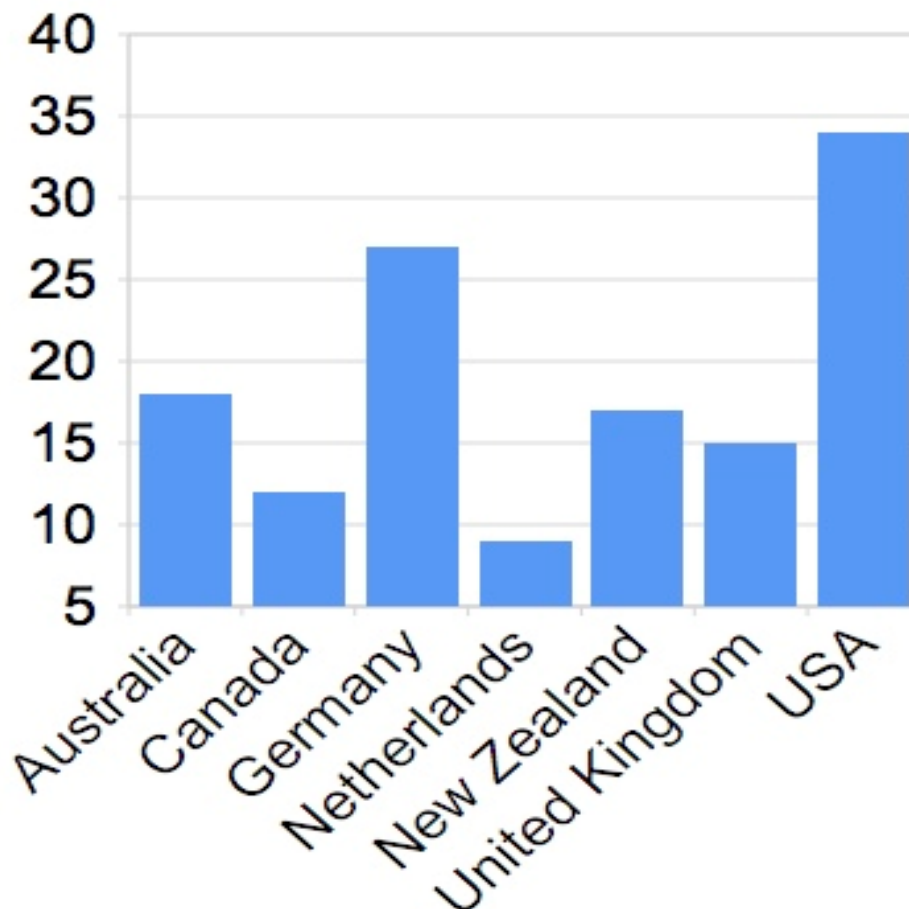



Free health care in Sierra Leone is therefore not the start of free health care in the world. It is therefore expected that the findings of the research will also not be just associated with the free health care in Sierra Leone and Moyamba District the research location.

Free Health Yahoo search results, (yahoo, June 2014)

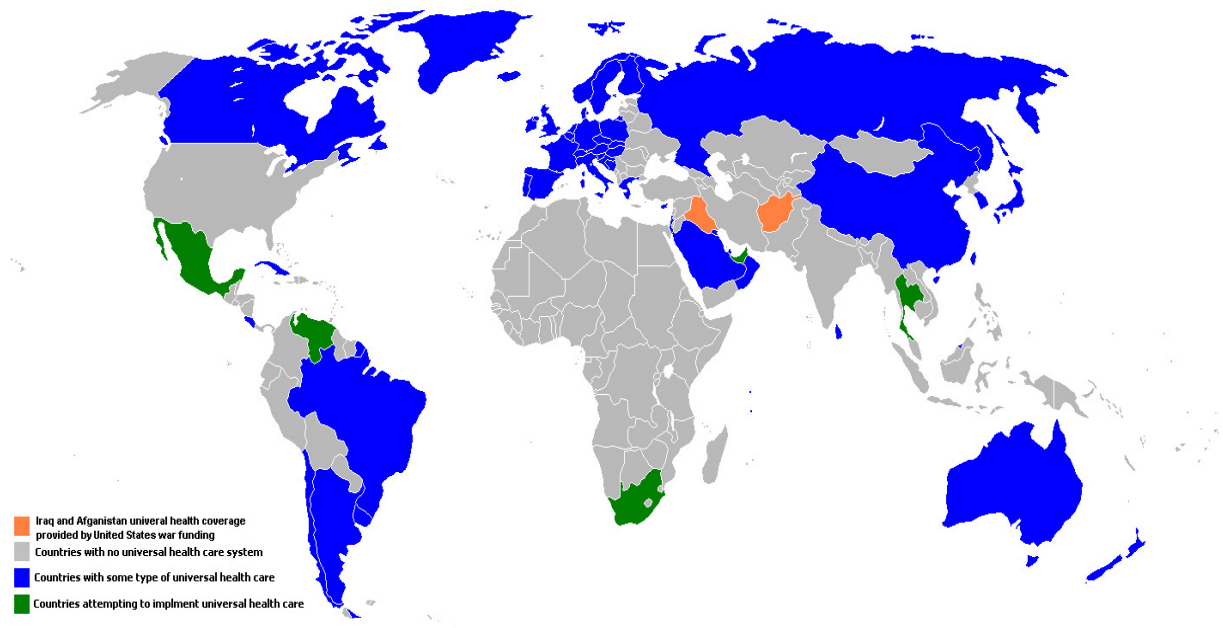
Free health care is in high demand in several parts of the world because the initiative frees the health service user payment at the point of service delivery. The graph below shows that even in the developed world, countries are demanding free health care.

Percent Saying Health-Care System Needs to be "Completely Rebuilt"



Despite efforts made by African countries to make free health available to their people, there is little or no recognition shown for that in the bigger picture presented on the

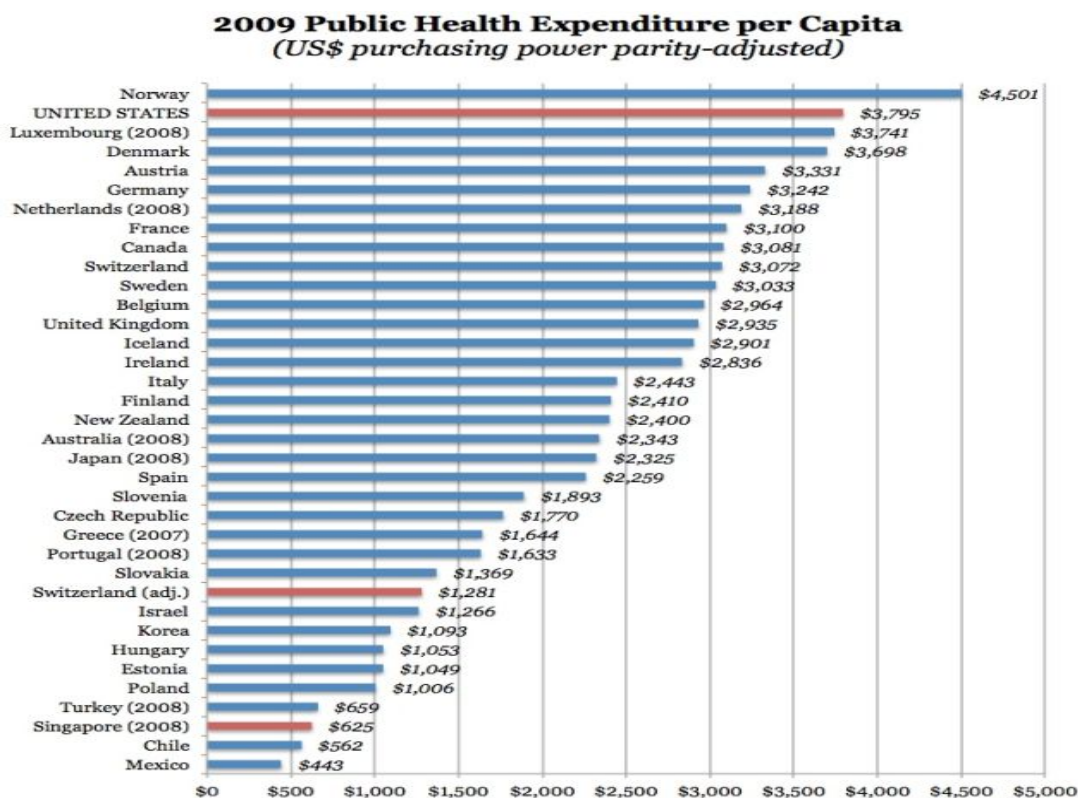
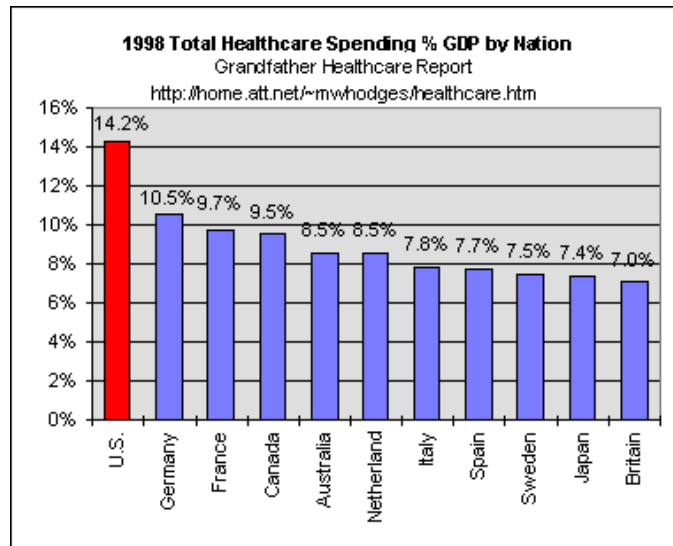
provision of free health care globally as shown in the world map presented below probably because the African efforts are not universal.



Internet source: (<https://uk.images.search.yahoo.com/search/images>, June 2014)

Despite the Southern African region which is considered to be thinking of introducing free health care, Burkina Faso and Sierra Leone are two clear examples on the West Coast of Africa that have introduced free health initiative for specific groups (in Sierra Leone) or specific geographic locations (Burkina Faso).

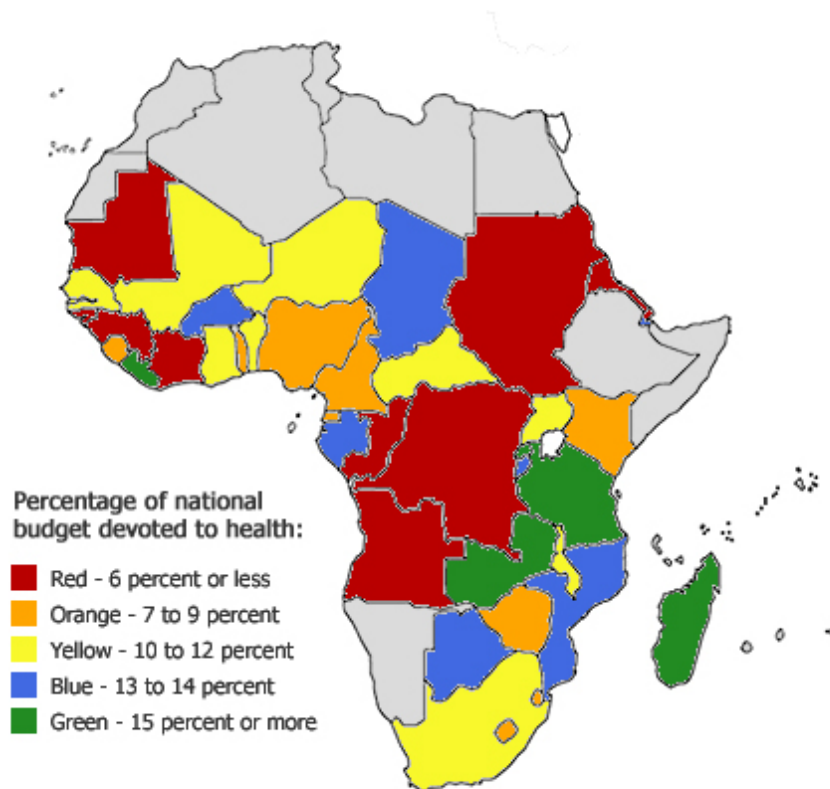
The reality however is that more free health schemes currently exist in western countries than it does in Africa. One of the major factors for that is the high cost of running a health care system, be it free or otherwise. Free health scheme of any type as different countries or institutions adopt different models is costly. The following graphics show health care cost in different countries in the past.



Internet source: (<https://uk.images.search.yahoo.com/search/images>, June 2014)

Health care spending in Africa is still low as shown by the continent's countries' budget allocations in the map below. As portrayed in the map, only very few countries are

allocating up the agreed Abuja 15% of the their countries' budget to health with only one of those very few countries in West Africa i.e. small Liberia on the west coast of Africa. Burkina Faso is next to Liberia in West Africa as the country allocates 13 – 14% of its annual budget to health. Sierra Leone which introduced free health care for pregnant women, lactating mothers and under five children in 2010 follows within the category of countries allocating 7 – 9% of their countries' annual budget to health. However, Sierra Leone is doing well than its closest neighbour which is Guinea Conakry that is allocating 6% or less of its annual budget to health (Global Health, Africa, health systems, June 2014). The worst health budget allocations are found mainly in the horn of Africa and the north of Africa



(Source: *Global Health, Africa, health systems*)

Notwithstanding the high cost of health care be it free or not for the end user, when properly managed and utilized, health care and more so free healthcare benefits are easier to identify or recognize. For instance the photo below shows beneficiaries of a free health care scheme in an African country (Sierra Leone) following the introduction of the Sierra Leone free health care initiative in 2010.



(Friday, May 21, 2010 in Africa Governance Initiative www.tonyblairoffice.org)

Free health care initiatives in a number of instances may have political linkage as earlier on revealed above by the views of someone in American. This is clearly seen from the internet extracts shown below:



Internet source: (<https://uk.images.search.yahoo.com/search/images>, June 2014)

No matter what is the motivation for the introduction of a free health care cover, the benefit can be enormous. For instance, millions of people are benefiting from the American free health care cover. As seen in the internet extract below, 54 million Americans have been covered by free preventive services (<http://weaselzipper.us/141667>, June 2014):



The Democrats ✓
 @TheDemocrats




54 million Americans now have free coverage for preventative services. [#ObamaCare](#)

 Reply
  Retweet
  Favorite
  More

55
 RETWEETS

15
 FAVORITES










11:45 AM - 30 Apr 13

Internet source: (<https://uk.images.search.yahoo.com/search/images>, June 2014)

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Based on the literature review covered so far, free health care can have different motivating factors, may be linked to politics or special interests, it may have serious health issues and under laying poverty as major driving forces, immense benefits, number of challenges like any other situation or health care system. It will therefore not be of surprise if any of the highlighted issues linked to free health care is found in the investigation of the effect of free health care on the health service delivery system in Moyamba District in Sierra Leone where free health care was introduced in 2010 aimed at addressing high maternal and child mortality rates.

Free healthcare is not new in some countries like Scotland where people living in the country can take advantage of a full and diverse range of healthcare with the National Health Service (NHS) and both private and available complementary medicine practices. A greater part of the NHS is provided free and any care assessed privately is directly paid for or usually through one of several private healthcare insurance schemes. Provided they have valid work permit, even newcomers to the UK are eligible for the Scottish Free Healthcare services. A valid visa that allows one to stay in UK for one full year also entitles one to the Scottish free healthcare. In Scotland, the use of private healthcare, alternative and complementary medicines have in recent years increased mainly as a result of employers offering the options as a part of flexible benefits to their staff. The free healthcare provided by the Scottish NHS includes doctor, dentist, hospital treatment and other options (Talent Scotland, 2011).

Besides governments, humanitarian or faith-based organizations have been involved in free healthcare service provision in different parts of the world. For instance in Basseterre, St. Kitts, 40-member US Based team of health professionals provided residents free healthcare with focus on screening and advice on prevention. According to an official of the Seventh Day Adventist various free healthcare services provided by the team through the Newtown and other Community Health Centres included dental evaluation and treatment, medication and optical services. Besides, St. Kitts, the team has provided free healthcare services to Jamaica, Guyana, Trinidad and Tobago, St. Luca, South Africa and Ghana in West Africa during the 10 years of existence of the team. In this scheme, each member of the team covers his/her expenses for the free healthcare service provision trip away from US while the various hosts assist the team with logistics and transportation (SKNVibes, 2011).

America – Health care system

In The Daily Conversation, Obama Clearly Explains: USA Affordable Health Care Act – Obamacare (Obama, May 2013)

Freeing users from health care cost (free health care) had happened in different parts of the world in different forms. Some are 100% for certain category of beneficiaries like the Sierra Leone free health care initiative but others can be about subsidizing cost of health care services at the point of service provision as it is in the case of the new USA Affordable Health Care Act that is implemented as The USA President Barack Obama put it:

“...is for people who have insurance through their employers and clarified that the other part of the law to be implemented are the exchanges that will

allow individuals to buy insurance in an "exchange" where companies will compete for their business” (Obama, May 2013).

The feasibility of free health care of any sort or model like many other big ventures is always prone to skepticism. For instance, according to Obama, people had doubts about the Affordable health Care – Obamacare. He therefore in his explanation of what the Obamacare was all about said, "I think that any time you're implementing something big, there's going to be people who are nervous and anxious about is it going to get done, until it's actually done” (Obama, May 2013).

The USA Affordable Health Care Act is already benefiting 85 – 90% Americans with health insurance says Obama. Like all other free or subsidized health care systems, the Obamacare has its own challenges and the one confirmed by Obama himself is the lack of health insurance for the 10 – 15% (about 30 million Americans) with preexisting conditions for getting health insurance or they are without health insurance because they are too poor to get because they work with small business companies that cannot afford to provide them one (Obama, May 2013).

Europe – health care systems (few examples)

You Tube: The Scottish Parliament: Plenary Session (Scottish Parliament, November 2013)

<http://www.scottish.parliament.uk> - *Scottish Parliament Plenary Session:*

Scottish Government Debate: Person-centred Healthcare

Scottish Government has a Scottish parliament that has an Official You Tube Channel. The Scottish parliament exists to determine, debate, decide and legislates issues of importance. The Scottish Government Debate: Person-centred Healthcare of November 6 & 15, 2013; as the name goes covered person-centred healthcare.

The Scottish parliament like what is shown in the Burkina Faso free health care evaluation findings believes in person-centred healthcare as the best approach for getting the best health outcomes. To achieve that, the parliament believes that the approach should support actions that ensure individuals are supported to be active partners in their own care; in which case all parts of the healthcare system should be focused on the patient, and that should include both community and hospital care. The idea further supports Scotland's modernization programme to test measures to make Government public services more accessible for patients, while reducing bureaucracy for the Government public services and freeing their time to focus on patients (**Scottish Parliament, November 2013**). The parliament also expects that the government should guarantee the readiness of the healthcare system for critical periods like winter.

It is believed by the Scottish parliament that all people in Scotland should be supported to live a longer, healthier life and the parliament is convinced that this support can only be

delivered in a person-centred healthcare system that is well-resourced and have motivated workforce; and also considers mental well-being to be a foundation for good health and good healthcare. Like all free health care systems, the Scottish Parliament holds the view that the Scottish Person-centred Healthcare system has challenges or barriers one of which is mental health. The parliament therefore thinks that Scottish healthcare system requires additional work to break down barriers and tackle the stigma that continues to exist around mental ill-health (**Scottish Parliament, November 2013**).

The Advantages and Disadvantages of Governments providing Free Health Care

The world over, governments provide various services for their citizens and one of the key areas governments focus their attention on providing such services is health care more so public health care. In some of those cases, governments provide for their citizens or some portions of their population free health care or health insurance schemes that take away end user fee payment by the citizens or health care service beneficiaries. In those instances, the citizens have the benefit of receiving free health care services whenever they need it. However, everything that is provided for free including free health care services though may have its benefits or advantages, may also have its drawbacks or disadvantages. Therefore, there are disadvantages as well as advantages associated with free health care services provided by governments for their citizens anywhere in the world including Sierra Leone and the Moyamba District (the research location). There are three dimensions to this phenomenon:

“Firstly, with the anticipation of free health services, there is a high likelihood of poor quality of services. According to the Ministry of Health’s Strategic Plan 2011-2015, Fiji has one of the lowest total health expenditure as a percentage of their gross domestic product (GDP) when compared to other Pacific Island countries. As a result of a lack of finances, it can be expected that health services and products may not be of high quality. Moreover, cheaper and less effective medication may be given in place of quality and effective drugs. It should not be expected that citizens have the best quality of health services due to the limited budget and expenditure of the ministry.

Another disadvantage of free health care is the shortage of doctors and nurses. The Minister of Health (Fiji), Dr Neil Sharma said that doctor shortages were a common occurrence in every part of the world and Fiji was no exception (Malo 2011, p.5). For instance, at Rakiraki Hospital one doctor looks after over ten thousand people and only three doctors cater for the twenty-nine thousand population of Tavua (Malo 2011, p.5). From this information it can be seen that the doctor to patient ratio is very low.

Thirdly, free health care services leads to overcrowding in hospitals. With the availability of free medical services, citizens have the opportunity to make the most use of the services provided to them and this in turn leads

to overcrowding. It is an all too common site to see long queues and..."

(SumeetKumarS2, March 2013).

(<https://answers.yahoo.com/question/index?qid=20080919203510AAwuoZG>)

What are the advantages/disadvantages of having free healthcare in the US?

Below are some separate individual comments based on live situations or experiences with free health care in different parts of the world:

"Well I would tell you to ask someone from Canada, I have a friend that lives there, she said it takes forever to see a doctor and the quality of health care is very poor. It would cost the taxpayers too much for free health care there has to be another alternative. Obama thinks he can talk a good game and things will just happen. He has got lots of off the wall ideas that most economists will tell 'ya just don't' have a prayer of working., you can't have all this free stuff without raising taxes no way in heck, he says he will do that, but the people that will hurt most will be the poor and middle income, it always does. There is no such thing as free health care people will pay one way or another whether in taxes or at the grocery stores or at the pump. The world economy is in turmoil now, not just the United States, so anytime I hear the word FREE, I am weary because I know it's just not the truth!"

"Free health care would be great but it is not feasible. Who would want to be a doctor if there was no way of making money? So the talent pool

would diminish. If the government ran it would be like the DMV. We all know how that runs. You would have to wait in line for an operation. In England my friend waited a year and a half for a kidney stone surgery. Here in the states my wife had it done in less than a week. We have the best health care in the world. What we need is the government staying out of our pocket so we can afford health care. Democrats want you to use universal health care, but they will hire private doctors for themselves.” (<https://answers.yahoo.com/question/index>, 2014).

According to a web based source called “BalancedPolitics.org”, the answers to the question:

“Should the Government Provide Free Universal Health Care for All Americans?”

in a nutshell provide insight into free health from the perspective of an American Citizen(s) as highlighted below:

“Yes

The number of uninsured U.S. residents has grown to over 45 million (although this number includes illegal immigrants, etc.).

Health care has become increasingly unaffordable for businesses and individuals.

We can eliminate wasteful inefficiencies such as duplicate paper work, claim approval, insurance submission, etc.

We can develop a centralized national database which makes diagnosis and treatment easier for doctors.

Medical professionals can concentrate on healing the patient rather than on insurance procedures, malpractice liability, etc.

Free medical services would encourage patients to practice preventive medicine and inquire about problems early when treatment will be light; currently, patients often avoid physicals and other preventive measures because of the costs.

People will have an easier time starting their own business or working part-time if health insurance is covered.

Patients with pre-existing conditions can still get health coverage.

No

There isn't a single government agency or division that runs efficiently; do we really want an organization that developed the U.S. Tax Code handling something as complex as health care?

"Free" health care isn't really free since we must pay for it with taxes; expenses for health care would have to be paid for with higher taxes or spending cuts in other areas such as defense, education, etc.

Profit motives, competition, and individual ingenuity have always led to greater cost control and effectiveness.

Government-controlled health care would lead to a decrease in patient flexibility.

The health-care industry likely will become infused with the same kind of corruption, back-room dealing, and special-interest-dominated sleaze that is already prevalent in other areas of government.

Patients aren't likely to curb their drug costs and doctor visits if health care is free; thus, total costs will be several times what they are now.

Just because Americans are uninsured doesn't mean they can't receive health care; nonprofits and government-run hospitals provide services to those who don't have insurance, and it is illegal to refuse emergency medical service because of a lack of insurance.

Government-mandated procedures will likely reduce doctor flexibility and lead to poor patient care.

Healthy people who take care of themselves will have to pay for the burden of those who smoke, are obese, etc.

In an effort to cut costs, price & salary controls on drugs, medical equipment, and medical services are likely to be put in place, meaning there is less incentive to pursue medical-related research, development, and investment, nor pursue medical careers in general.

A long, painful transition will have to take place involving lost insurance industry jobs, business closures, and new patient record creation.

Loss of private practice options and possible reduced pay may dissuade many would-be doctors from pursuing the profession.

Malpractice lawsuit costs, which are already sky-high, could further explode since universal care may expose the government to legal liability, and the possibility to sue someone with deep pockets usually invites more lawsuits.

Government is more likely to pass additional restrictions or increase taxes on smoking, fast food, etc., leading to a further loss of personal freedoms.

Patient confidentiality is likely to be compromised since centralized health information will likely be maintained by the government.

Health care equipment, drugs, and services may end up being rationed by the government. In other words, politics, lifestyle of patients, and philosophical differences of those in power, could determine who gets what.

Patients may be subjected to extremely long waits for treatment.

Like social security, any government benefit eventually is taken as a "right" by the public, meaning that it's politically near impossible to remove or curtail it later on when costs get out of control.

“Overview/Background

It's no secret that health care costs are spiraling out of control in this country. On average, we now spend more per person on health care than both food and housing. Insurance premiums are multiplying much faster than inflation, which prevents economic growth and leaves businesses with less money to give raises or hire more workers. While the quality and availability of medical care in the United States remains among the best in the world, many wonder whether we'd be better off adopting a universal government-controlled health care system like the one used in Canada. The Obama administration passed a health care bill that takes the U.S. part of the way towards a government-controlled system. How far it takes us is

up for dispute. The new law is sure to be debated and modified for years to come. This debate discusses whether a complete government takeover of health care should be undertaken.

Yes

The number of uninsured U.S. residents has grown to over 45 million (although this number includes illegal immigrants, etc.). Since health care premiums continue to grow at several times the rate of inflation, many businesses are simply choosing to not offer a health plan, or if they do, to pass on more of the cost to employees. Employees facing higher costs themselves are often choosing to go without health coverage. No health insurance doesn't necessarily mean no health care since there are many clinics and services that are free to indigent individuals. However, any costs not covered by insurance must be absorbed by all the rest of us, which means even higher premiums. In all fairness, the 45 million uninsured number has been called into question since it includes illegal immigrants, people making over \$75K who choose not to buy coverage, and others who have options for coverage but choose not to get it. The true number of people without options is closer to 15 million.

Health care has become increasingly unaffordable for businesses and individuals. Businesses and individuals that choose to keep their health plans still must pay a much higher amount. Remember, businesses only have a certain amount of money they can spend on labor. If they must

spend more on health insurance premiums, they will have less money to spend on raises, new hires, investment, and so on. Individuals who must pay more for premiums have less money to spend on rent, food, and consumer goods; in other words, less money is pumped back into the economy. Thus, health care prevents the country from making a robust economic recovery. A simpler government-controlled system that reduces costs would go a long way in helping that recovery.

We can eliminate wasteful inefficiencies such as duplicate paper work, claim approval, insurance submission, etc. Think back to all the times in your life you've had to fill out a medical history, answering the same questions over and over. Think about all the insurance paperwork you've had to fill out and submit. Our current health care system generates an enormous amount of overhead. Every time we go to the doctor, a claim must be submitted, an approval department has to go over the claim, checks have to be mailed, and patients are sent co-pay bills, and so on. The thing that's especially wasteful is that each doctor's office usually maintains their own record-keeping system. A universal healthcare plan would allow us to build one centralized system. There would be no need for maintaining insurance information or wasting time submitting claims. The work savings in the banking and postal areas alone would be worth billions every year and that will be an advantage for the system.

We can develop a centralized national database which makes diagnosis and treatment easier for doctors. Most doctors' offices maintain a separate record-keeping system. This is why you always have to fill out a lengthy health history whenever you go to a new physician. This is a problem for several reasons. First of all, it's wasteful of both time and money. Second of all, patients may lie, forget, or do a poor job of explaining past medical problems. Doctors need accurate information to make a proper diagnosis. Last of all, separate systems means we have a tougher time analyzing data at a national level. For example, are incidents of a certain disease dropping? How often is a certain illness associated with a specific set of symptoms? A centralized national system would allow us to do data analysis that we never dreamed possible, leading to medical advances and increased diagnosis efficiency. The main argument against a centralized database is that certain insurance providers may deny coverage if they find certain past medical problems. However, if the government is paying for everything that should never be a problem.

Medical professionals can concentrate on healing the patient rather than on insurance procedures, malpractice liability, etc. Doctors have to take classes now simply to understand all the insurance plans out there; they are often restricted by insurance practices, such as what tests can be ordered. Doctors must practice defensive medicine to avoid getting sued. Some physicians are even leaving the profession rather than deal with all

these non-medical headaches. A simplified universal health system would allow doctors, nurses, and other medical professions to simply focus on doing what's best for the patient. Medicine is a complex enough subject as it is. Our current system just adds to an already mentally-draining profession.

Free medical services would encourage patients to practice preventive medicine and inquire about problems early when treatment will be light; currently, patients often avoid physicals and other preventive measures because of the costs. Because many people are uninsured and those that do have insurance face high deductibles, Americans often forego doctor visits for minor health problems or for preventive medicine. Thus, health problems that could be caught at an early stage or prevented altogether become major illnesses. Things like routine physicals, mammograms, and HIV tests could prevent major problems. This not only affects the health of the patient but the overall cost of the system, since preventive medicine costs only a small fraction of a full blown disease. A government-provided system would remove the disincentive patients have for visiting a medical professional when they are sick or need consultation.

People will have an easier time starting their own business or working part-time if health insurance is covered. One of the things that keeps Americans tied indefinitely to their current, full-time positions is the fear

of losing health insurance, or the fear of paying some outrageous amount per month for a new individual/family policy. This amounts to a bit of modern day slavery, since people with kids or some potentially expensive health condition can't easily leave their jobs. Many Americans would like to work part-time so they can spend more time with kids, pursue a new degree, or spend time do the fun things they love before they die. Others have a great business idea but can't afford the startup costs & risks when health care is added in. Universal health care provides these opportunities.

Patients with pre-existing conditions can still get health coverage. One of the biggest weaknesses of our current health care systems is that patients with a past or current medical condition such as cancer or asthma often cannot obtain affordable health coverage. Some insurance companies won't even give a policy to such individuals, or if they do, they will cover everything BUT their past diagnosed conditions. Anyone with an expensive illness or disease must then often face one of two choices: use up all their own money, or leave the condition untreated. In a universal system, no one with a pre-existing condition would be denied coverage. People could change jobs without fearing the loss of health insurance.

No

There isn't a single government agency or division that runs efficiently; do we really want an organization that developed the U.S.

Tax Code handling something as complex as health care? Quick, try to think of one government office that runs efficiently. Fannie Mae and Freddie Mac? The Department of Transportation? Social Security Administration? Department of Education? There isn't a single government office that squeezes efficiency out of every dollar the way the private sector can. We've all heard stories of government waste such as million-dollar cow flatulence studies or the Pentagon's 14*billion* dollar Bradley design project that resulted in a transport vehicle which when struck by a mortar produced a gas that killed every man inside. How about the U.S. income tax system? When originally implemented, it collected 1 percent from the highest income citizens. Look at it today. A few years back the government published a "Tax Simplification Guide", and the guide itself was over 1,000 pages long! This is what happens when politicians mess with something that should be simple. Think about the Department of Motor Vehicles. This isn't rocket science--they have to keep track of licenses and basic database information for state residents. However, the costs to support the department are enormous, and when was the last time you went to the DMV and didn't have to stand in line? If it can't handle things this simple, how can we expect the government to handle all the complex nuances of the medical system? If any private business failed year after year to achieve its objectives and satisfy its customers, it would go out of business or be passed up by competitors. Consider the health care bill passed by the Obama administration in 2009 -- it's over 2000

pages and barely scratches the surface for how the law will be implemented in the United States of America (USA)!

"Free" health care isn't really free since we must pay for it with taxes; expenses for health care would have to be paid for with higher taxes or spending cuts in other areas such as defense, education, etc. There's an entitlement mentality in this country that believes the government should give us a number of benefits such as "free" health care. But the government must pay for this somehow. What good would it do to wipe out a few hundred dollars of monthly health insurance premiums if our taxes go up by that much or more? If we have to cut AIDS research or education spending, is it worth it?

Profit motives, competition, and individual ingenuity have always led to greater cost control and effectiveness. Government workers have fewer incentives to do well. They have a set hourly schedule, cost-of-living raises, and few promotion opportunities. Compare this to private sector workers who can receive large raises, earn promotions, and work overtime. Government workers have iron-clad job security; private sector workers must always worry about keeping their jobs, and private businesses must always worry about cutting costs enough to survive.

Government-controlled health care would lead to a decrease in patient flexibility. At first glance, it would appear universal health care would *increase* flexibility. After all, if government paid for everything under one plan, you could in theory go to any doctor. However, some controls are going to have to be put in to keep costs from exploding. For example, would "elective" surgeries such as breast implants, wart removal, hair restoration, and lasik eye surgery be covered? Then you may say, that's easy, make patients pay for elective surgery. Although some procedures are obviously not needed, who decides what is elective and what is required? What about a breast reduction for back problems? What about a hysterectomy for fibroid problems? What about a nose job to fix a septum problem caused in an accident? Whenever you have government control of something, you have one item added to the equation that will most definitely screw things up--politics. Suddenly, every medical procedure and situation is going to come down to a political battle. The compromises that result will put in controls that limit patient options. The universal system in Canada forces patients to wait over 6 months for a routine pap smear. Canada residents will often go to the U.S. or offer additional money to get their health care needs taken care of within the health system of Canada.

The health-care industry likely will become infused with the same kind of corruption, back-room dealing, and special-interest-

dominated sleaze that is already prevalent in other areas of government. In President Obama's push for health insurance "reform", we saw firsthand how politics rears its ugly head. In order to secure 60 votes in the Senate, the Democrats put in special payoffs for Nebraska (the "Cornhusker kickback"), Louisiana (the "Louisiana Purchase") and Florida in order to secure votes from reluctant senators. In other words, the merits of the bill and the good of the nation took a backseat to politics as usual. Another example was the proposed tax on "Cadillac Health Plans", which was one of the few things in the 2000+ page bill that economists predicted would actually help *reduce* overall costs. Unfortunately, Obama's biggest political supporters--big unions--were set to be hit. So of course, a deal was struck to exempt his union supporters, whereas non-union members in the same boat still faced the tax hikes. With something as important as health care, can we really have politicians and special interests taking power? How long before funding or regulatory decisions on certain drugs, treatments, research, etc. are decided based on those who give the most political support, as opposed to which will save lives and improve quality of life of the citizens or residents for which the schemes are designed?

Patients aren't likely to curb their drug costs and doctor visits if health care is free; thus, total costs will be several times what they are now. Co-pays and deductibles were put in place because there are medical

problems that are more minor annoyances than anything else. Sure, it would be nice if we had the medical staff and resources to treat *every* ache and pain experienced by an American, but we don't. For example, what if a patient is having trouble sleeping? What if a patient has a minor cold, flu, or headache? There are scores of problems that we wouldn't go to a doctor to solve if we had to pay for it; however, if everything is free, why not go? The result is that doctors must spend more time on non-critical care, and the patients that really need immediate help must wait. In fact, for a number of problems, it's better if no medical care is given whatsoever. The body's immune system is designed to fight off infections and other illnesses. It becomes stronger when it can fight things off on its own. Treating the symptoms can prolong the underlying problem, in addition to the societal side effects such as the growing antibiotic resistance of certain infections that develop over time.

Just because Americans are uninsured doesn't mean they can't receive health care; nonprofits and government-run hospitals provide services to those who don't have insurance, and it is illegal to refuse emergency medical service because of a lack of insurance. While uninsured Americans are a problem in regards to total system cost, it doesn't mean health care isn't available. This issue shouldn't be as emotional since there are plenty of government and private medical

practices designed to help the uninsured. It is illegal to refuse emergency treatment, even if the patient is an illegal immigrant.

Government-mandated procedures will likely reduce doctor flexibility and lead to poor patient care. When government controls things, politics always seep into the decision-making. Steps will have to be taken to keep costs under control. Rules will be put in place as to when doctors can perform certain expensive tests or when drugs can be given. Insurance companies are already tying the hands of doctors somewhat. Government influence will only make things worse, leading to decreased doctor flexibility and poor patient care within the system.

Healthy people who take care of themselves will have to pay for the burden of those who smoke, are obese, etc. Universal health care means the costs will be spread to all Americans, regardless of your health or your need for medical care, which is fundamentally unfair. Your health is greatly determined by your lifestyle. Those who exercise, eat right, don't smoke, don't drink, etc. have far fewer health problems than the smoking couch potatoes. Some healthy people don't even feel the need for health insurance since they never go to the doctor. Why should we punish those that live a healthy lifestyle and reward the ones who don't? This is a

question that will remain to be asked.

In an effort to cut costs, price & salary controls on drugs, medical equipment, and medical services are likely to be put in place, meaning there is less incentive to pursue medical-related research, development, and investment. Regardless of whether medical costs are paid for publicly or privately, the costs are extremely expensive and going higher every year. Rising costs of drugs, diagnostic tests, advanced treatments, physician & nurses' salaries, and so on all contribute to the skyrocketing overall cost. Politicians are likely to jump in and try to limit costs by putting in price caps on various items they deem "excessively profitable." This de-incentivizes businesses from investing in new drugs or medical advances. As an example, new drugs often take over a decade to develop, test, and pass FDA standards. That means companies must spend sometimes millions of dollars over the development period without grossing dollar one! The only thing that keeps companies in the market at all is the potentially lucrative payout of that patent along with the ability to sell their new drugs at whatever cost the market will bear. Drug price controls, or even the mere *threat* of price controls, will likely dissuade many companies from taking on the new investment. Consequently, medical advances are likely to curtail or reduced within the health system.

A long, painful transition will have to take place involving lost insurance industry jobs, business closures, and new patient record creation. A universal health plan means the entire health insurance industry would be unnecessary. All companies in that area would have to go out of business, meaning all people employed in the industry would be out of work. A number of hospital record clerks that dealt with insurance would also be out of work. A number of these unemployed would be able to get jobs in the new government bureaucracy, but it would still be a long, painful transition. We'd also have to once again go through a whole new round of patient record creation and database construction, which would cost huge amounts of both time and money for the country and its citizens or beneficiaries of the intended health care system in the country.

Loss of private practice options and possible reduced pay may dissuade many would-be doctors from pursuing the profession. Government jobs currently have statute-mandated salaries and civil service tests required for getting hired. There isn't a lot of flexibility built in to reward the best performing workers. Imagine how this would limit the options of medical professionals. Doctors who attract scores of patients and do the best work would likely be paid the same as those that perform poorly and drive patients away. The private practice options and flexibility of specialties is one of things that attract students to the profession. If you take that away, you may discourage would-be students

from putting themselves through the torture of medical school and residency. A recent study showed that nearly 1/3 of doctors would leave the profession if the Obama health care bill was put into law in the USA.

Malpractice lawsuit costs, which are already sky-high, could further explode since universal care may expose the government to legal liability, and the possibility to sue someone with deep pockets usually invites more lawsuits. When you're dealing with any business, for example a privately-funded hospital, if an employee negligently causes an injury, the employer is ultimately liable in a lawsuit. If government funds all health care, that would mean the U.S. government, an organization with enormous amounts of cash at its disposal, would be ultimately responsible for the mistakes of health care workers. Whether or not a doctor has made a mistake, he or she is always a target for frivolous lawsuits by money-hungry lawyers & clients that smell deep pockets. Even if the health care quality is the same as in a government-funded system, the level of lawsuits is likely to increase simply because attorneys know the government has the money to make settlements and massive payouts. Try to imagine potential punitive damages alone. When the government has the ability to spend several *trillion* dollars per year, how much will a jury be willing to give a wronged individual who is feeble, disfigured, or dying? This is a situation that needs critical attention.

Government is more likely to pass additional restrictions or increase taxes on smoking, fast food, etc., leading to a further loss of personal freedoms. With government-paid health care, any risky or unhealthy lifestyle will raise the dollar cost to society. Thus, politicians will be in a strong position to pass more "sin" taxes on things like alcohol, high-fat food, smoking, etc. They could ban trans fat, limit MSG, eliminate high-fructose corn syrup, and so on. For some health nuts, this may sound like a good thing. But pretty soon, people will find they no longer have the option to enjoy their favorite foods, even in moderation, or alternatively, the cost of the items will be sky high. Also, it just gives the government yet another method of controlling our lives, further eroding the very definition of America, Land of the Free – the American dream the people have lived for long and wish to continue to live and enjoy all through.

Patient confidentiality is likely to be compromised since centralized health information will likely be maintained by the government. While a centralized computer health information system may reduce some costs of record keeping, protecting the privacy of patients will likely become very difficult. The government would have yet another way to access information about citizens that should be private. Any doctor or other health professional would be able to access your entire health history. What if hackers get into the health care data and remove individuals' or

people's health information within the health care system?

Health care equipment, drugs, and services may end up being rationed by the government. In other words, politics, lifestyle of patients, and philosophical differences of those in power, could determine who gets what. Any time you have politicians making health care decisions instead of medical or economics professions, you open a whole group of potential rationing issues. As costs inevitably get out of control and have to be curtailed, *some* ways will be needed to cut costs. Care will have to be rationed. How do you determine what to do with limited resources? How much of "experimental" treatments will have to be eliminated? If you're over 80, will the government pay for the same services as people under 30? Would you be able to get something as expensive as a pacemaker or an organ transplant if you're old? Would your political party affiliation or group membership determine if you received certain treatments? What if you acquire AIDS through drug use or homosexual activity, would you still receive medical services? What if you get liver disease through alcoholism, or diabetes from being overweight, or lung cancer from smoking--will the government still help you? Just think of the whole can of worms opened by the abortion & birth control issue? You may or may not trust the current president & Congress to make reasonable decisions, but what about future presidents and

congressional members? Will they be trusted for the same thing?

Patients may be subjected to extremely long waits for treatment. Stories constantly come out of universal health care programs in Britain and Canada about patients forced to wait months or years for treatments that we can currently receive immediately in America. With limited financial and human resources, the government will have to make tough choices about who can get treatment first, and who must wait. Patients will not like be forced to suffer longer or possibly die waiting for treatment.

Like social security, any government benefit eventually is taken as a "right" by the public, meaning that it's politically near impossible to remove or curtail it later on when costs get out of control. Social security was originally put in place to help seniors live the last few years of their lives; however, the retirement age of 65 was set when average life spans were dramatically shorter. Now that people are regular living into their 90s or longer, costs are skyrocketing out of control, making the program unsustainable. Despite the fact that all politicians know the system is heading for bankruptcy in a couple decades, no one is rushing to fix it. When President Bush tried to re-structure it with private accounts, the Democrats ran a scare campaign about Bush's intention to "take away your social security". Even though he promised no change in benefits, the

fact that he was proposing change at all was enough to kill the effort, despite the fact that Democrats offered zero alternative plans to fix it. Despite Republican control of the presidency and both houses, Bush was not even close to having the political support to fix something that has to be fixed ASAP; politicians simply didn't want to risk their re-elections. The same pattern is true with virtually all government spending programs. Do you think politicians will ever be able to cut education spending or unemployment insurance? ...Only if they have a political death wish. In time, the same would be true of universal health care spending. As costs skyrocket because of government inefficiency and an aging population, politicians will never be able to re-structure the system, remove benefits, or put private practice options back in the systemthat is, unless they want to give up hope of re-election. With record debt levels already in place, we can't afford to put in another "untouchable" spending program, especially one with the capacity to easily pass defense and social security in cost.” (Laura Bramble, 2014)

Pros & Cons of Free Health Care

Globally, free health care schemes are not new because in reality, free universal health coverage is a topic many people have been debating for quite a while in the United States and other parts of the world. The free health care idea in simple terms means that every single citizen in some cases, certain group of people (as in the case of Sierra Leone), and certain geographic areas will be able to receive health coverage, regardless of whether

they are able to pay for it. This means that no matter how poor or rich a person is, he or she will be able to see a doctor or health worker or volunteer depending on where they are and the nature of their health care system and get medication no matter what. Free health or universal health care ensures that all citizens, regardless of ability to pay, have health insurance or services when they need it. Free health care or universal health care has been shown to have economic, as well as medical, benefits and is therefore greatly linked to countries' economies. For instance the United States is the only industrialized nation without some form of single-payer universal health care system. According to Physicians for a National Health Program, one-third of the average American dollar spent on health care goes toward administrative cost, to the tune of \$350 billion dollars per year. Over 45 million Americans over 15 percent of the population have no health insurance coverage at all. Many doctors, politicians and health care experts argue that the United States should adopt a system along the lines of those offered by Canada and leading European countries. There are many advantages to this type of system.

Notwithstanding that benefit, as with anything else, there are both advantages and disadvantages to the concept of free health care or health insurance (Isabel Prontes, 2014).

This is why the question of “what are the benefits of free health care or universal health care systems, will continue to be asked. Hence, various answers both positive and negative will continue to come up including but not limited to the following answers mainly focus on the American setting:

“Saving Lives

One significant advantage (perhaps the most important one) of free universal health care is that it could honestly save people's lives. This is a right people are constantly denied because of their inability to pay for adequate (or any) health care coverage. Even people who have full-time jobs are often incapable of purchasing health care (as many jobs do not offer coverage). Free health care would eliminate a large part of this problem.

Loss of Quality

One possible disadvantage of free health care would be a drastic loss in quality. Many people worry that free health care would cause the health care offered in hospitals and medical clinics not to be of the same quality of excellence. This would simply be inevitable as hospitals and medical centers would have many more patients to see.

Access to Care

Access and availability of health care would be another potential disadvantage to having free universal health care in the United States. Long waiting lists for receiving health care could be a serious problem, and people might simply not be able to get access to the health care they need on a timely basis.

Lower Costs

One possible benefit to free health care would be a reduction in the cost of United States-made consumer products. Free, nationalized health care would take the burden off of companies who are currently paying extremely high health care costs to their employers. These savings would be passed onto consumers in the form of lower product prices.

Considerations

As seeing, there are both serious pros and cons regarding the issue of free health care, it is a difficult issue to debate. In 2005, a survey done by the American Consumer Institute

had results showing that American consumers are divided with regards to the support of a nationalized health plan that would have doctors, hospitals and clinics all under federal control. The public is split up approximately 50/50 when it comes to this issue; some people prefer nationalized health care and others simply like the way it is right now.

History

Because much of the industrialized world began providing universal health care to its citizens, the United States has fallen from first in life expectancy in 1945 to the mid-teens. The United States ranks 23rd in infant mortality and 67th in immunizations.

Consistency

All doctors would be in-network under universal health care. Unemployment or pre-existing conditions would not prevent medical treatments.

Significance

Public health would improve as everyone could receive treatment, reducing the spread of communicable diseases. Waiting times in emergency rooms would decrease, as hospitals would not be treating the uninsured for common maladies.

Wages

Annual pay raises could be increased if funds were not diverted to cover increasing health insurance premiums. Workers would use fewer sick days and could work later in life.

Competition

Companies would not need to add health insurance costs to the price of goods sold, making them competitive with companies in countries with universal health care.

Administration

Voters would have a say in administrative costs, benefits and taxes, possibly reducing overhead.

Greater Access to Preventative Care

Universal health-care systems make it free to visit doctors for minor illnesses, which promote better general health along with early detection and treatment. The result is healthier, more productive workers. The current U.S. system, with its deductibles, discourages this type of medical care. Many Americans wait to get care until they are truly ill, with catastrophic effects. As reported in the 2005 Biennial Health Insurance Survey put out by the Commonwealth Fund, over 25 percent of all Americans did not see a doctor when they were sick, did not have prescriptions filled, or did not follow through with recommended treatment. According to an article in the September 12, 2009 New York Times, around 18,000 Americans die every year due to lack of health care.

Fairer Coverage

Despite claims that universal care would cause rationing of care, which opponents claim does not occur in the present health-care system, universal care will open up care for more Americans. The current system rations care only to those who can afford to pay, which generally means those whose employers offer health benefits. Those Americans whose employers do not provide coverage must purchase private health care, which is expensive, so many choose to go without. Universal health care would give an equal amount of coverage to all, regardless of where they work, and take health care expenses off the shoulders of employers.

Lower Costs

Americans spend more on health care per person than any other nation in the world. A large percentage of the dollars spent on health care go to items that have nothing to do with the quality of care, such as administration, sales and marketing, overhead, billing and executive pay. Single-payer systems in the United States, such as Medicare and the VA system, spend five to eight cents of each dollar toward overhead and administration, as opposed to the 31 cents of every dollar that goes toward these costs in the present for-profit system, according to Yes! magazine and the Physicians for a National Health Program

Better Health

While the United States has the highest health-care costs per person, the overall health of other nations in the world that maintain a universal health system is superior to Americans. According to a list of nations and their life expectancies, the United States ranks 49th in life expectancy, behind most European countries and Canada, all of which have universal health care systems. In a 2005 study published in The Economist that measures quality of life, based on several factors including health, the United States ranked 13th. The United States is 9th on Forbes magazine 2007 list of fattest countries in the world behind Pacific Island nations and Kuwait. The United Kingdom came in 28th and Canada came in 35th.” (Isabel Prontes, 2014) and (Laura Bramble, 2014).

ECONOMIC ASPECT OF HEALTH CARE SYSTEMS: Advantage and Disadvantage Incentives in Different Systems

The world over, in the business setting up and running of health care systems or the economics of health care field studies demand and supply of health care resources, that process involves looking at allocation of the resources, within a given health care system which is actually the organizational arrangements and processes through which a society makes informed decision or choices concerning the way health care system is established and run that is the production, consumption, and distribution of health care services. This is relevant because health care resources are limited, each society has to make decisions in terms of the distribution, consumption, and production of these services as it was the case in Sierra Leone when the government of His Excellency Dr. Earnest Bai Koroma decided to introduce free health care in 2010. Major among the factors that influence the delivery of health care in any health care system is the evolving system for financing and reimbursement for health care services and this includes government and partner or donor resources as it is mainly the case in Sierra Leone. The means of paying for health care services is also a key influencing factor for the type and the way services are delivered and the organizational approaches to delivering the services.

Three main parties principally influence the health care market. That is patients or consumers (individual or group), health care providers or producers (government, private or humanitarian agencies), and third-party payers (individual or group). In health care as well as it is also in other areas or fields, according to the principles of economic theory, consumers or patients on the demand side seek to maximize their utility or satisfaction, and that is largely determined by the consumption of medical services and quality of care. Also on the supply side, producers or health care providers seek to maximize profit. In the principle of economic theory in health care system unlike some other field is full of

uncertainty when it comes to the demand and supply sides this is mainly because the incidence of illness and the cost of treatment are uncertain from an individual consumer's perspective, the third-party payers, including private health insurance companies and governments, play an important role in the health care system. These third-party payers serve as intermediaries between the consumer and the provider especially for end user payments. As a result of this unique situation in health care systems, in order to manage the financial risk associated with the purchasing of health care services, third-party payers seek to minimize their costs and control for their budgets often with the choice of system established and run.

Different countries are using different approaches but the fact remains that pressures are rising throughout the developed or industrialized world to constrain the rise in expenditures on personal health care services, For instance the financing of health system that has evolved over the past 30 years in the United States involved a complex blend of public and private responsibilities a pattern not uncommon in other parts of the world as health systems have evolved overtime in several other countries as it has it has been in the United States of America for the last three decades but in European countries the system varies substantially because public financing systems that exist in many of the countries. The European countries' public focused health care system financing approaches although done in different ways are interesting approaches worth investigating or learning for better understanding of the existing American health care financing system.

Unlike the system mostly seen in developing countries like Sierra Leone, health care systems in developed or industrialized countries are classified into four categories. That

is traditional sickness insurance, national health insurance (NHI), national health services (NHS), and mixed. The important difference in the different classified systems from an economics perspective is how financial risks are spread across from the purchaser of health care, through the provider of care, and on to the insurer.

For instance in Germany the health care system is health care system is characterized by the socialized health insurance program, or sickness funds. Approximately 88% of Germans have social health insurance, 10% have private insurance, and the remaining 2% are covered by public programs. The government mandated health care system financing the basis for the German system that is driven by employers and employees. In the German health care system, the sickness funds are financed by contributions from employers and employees according to a percentage of earned income. Coverage of employees by a sickness fund extends to all dependent family members. The sickness funds negotiate reimbursement rates with the individual hospitals and the association of the insurance physicians. As a sustainable mechanism, ambulatory care is provided by fee-for-service, office-based physicians and hospitals are paid at fixed fees (G. John Chen, 2014) and (Steven R. Feldman, 2014).⁵

There are advantages and disadvantages with the German health care system that includes the advantage of a comprehensive health care and the disadvantage of having inefficient care due to the lack of any competition between sickness funds because there is little pressure to provide quality care. Another disadvantage is linked to the more or less monopoly power of the sickness funds, that leads to low rate of reimbursement of outpatient services and the system also causes an *assembly line* or crowded style of

medicine. The increasing aging population of the Germans is an added challenge for their health care system. Continuing aging of the population indeed is a major problem that is stressing the German health care system. Motivation mechanism through incentivized system was introduced effective 1993 to improve efficiency in the German health care system.

Away from Germany across the Atlantic Ocean, Canada has a compulsory NHI program administered by each of its 10 provinces. The Health system in Canada at the national and provincial levels that is the federal decentralized NHI is general tax revenues driven with all provinces, having governmental authority in charge of their hospital insurance programs but with differences in the arrangements for patient movement services. A lifetime health care coverage is provided in Canada through the NHI program built on the first-dollar coverage without beneficiary contribution or co-payment. The health care package provided through the first-dollar coverage is a comprehensive *package* of both hospital and medical services for the beneficiaries.

The physicians in the Canadian health care system ambulatory care and in hospitals are commonly paid on a performance basis or fee-for-service basis, that is linked to the fee schedules negotiated between physicians' associations and provincial governments as the systems are managed by individual provincial governments. In Canada, there are few private, for-profit hospitals and most of their acute-care hospitals are mainly private, nonprofit institutions with their operating expenditures financed through the NHI system, while most of their capital expenditures are financed by the provincial governments, using some complex and shared financing system involving the federal and provincial governments' tax revenue with an agreed formula used.

A comprehensive coverage of the population is the strength of the Canadian national health initiative (NHI) while its main weakness is in respect to its economic efficiency because the hospital, the physician, and the patient have no incentive to be economical in the use of health care resources. On the other hand, dependency on central control and lack of incentives at the individual level result in inefficient use or under utilization of health resources or services as beneficiaries or patients consider medical care provided through the system as free public goods or services. The beneficiaries are not given any incentive to choose cost-effective forms of care based on how the system is set up. The Canadian health care system does not make room for the beneficiaries to be incentivized for use of community health centers rather than rush directly to the emergency department when he or she is in need of urgent care. Thus making the waiting time longer and in turn waiting time or time lost in accessing health care services replaces financial cost as a regulator of demand and knowing that time is money.

The provincial government authorities control the global health care budget quite tightly but do not provide incentives for the physicians for the efficient use of the health resources. The Canadian health care system does not make provision or incentives for the providers to evaluate the system with the aim of improving system. The system also lacks incentives for altering input mixes to affect practice style and the health care providers and a *single payer* tend to support the status quo while the health service providers on their side, organize themselves into strong associations and have strong monopoly power, that they use in turn to defend their legitimate interests. The monopoly power of sole-source financing of the Canadian National Health Initiative keeps provider

interests in check at the expense of not intervening in the organizational practice of medicine or health care service delivery itself.

In the United Kingdom (UK), the National Health Service (NHS) is a comprehensive health service package available to all British residents. The NHS is financed by general taxes. The medical services are provided free to the residents while Ten percent (10%) of the British population carries private health insurance coverage. The pay scheme in the British National Health System in general pays practitioners on a capitation basis and hospital physicians, referred to as consultants, and are mainly paid on a salaried basis. In Britain, every member of the population is entitled to register with a general practitioner and use the services without fee or end user payment with the general practitioners providing primary care to patients and serving as gatekeepers to specialist care whenever needed. However, the National Health Service patients cannot directly go to specialists but needs to be referred first. That means, they must go first to their general practitioners who in turn send them to specialists based on need. Capitation payment budget is determined each year with National Health Service deciding what amount will be made available to general practices for a year.

Making the U.K. NHS different, other health systems the system in UK separated the responsibility for purchasing services from the responsibility for providing them in a type of arrangement referred to as the internal market in which hospitals and other providers compete for service contracts from district health authorities that, in turn, purchase services on behalf of their resident populations or beneficiaries. The UK health care systems allow the hospitals and community service units to form or apply to be NHS

Trusts while groups of general practitioners with more than 7000 patients can become general practice fundholders various locations with the United Kingdom. The National Health Service Trusts are not-for profit organizations within the British health system or NHS but outside the control of the District Health Authorities (DHAs). The District Health Authorities (DHAs), general practitioner fundholders, and private patients provide funding sources for the NHS trusts within the internal market in the NHS in the United Kingdom while general practice fundholders on the other hand provide budgets to fund diagnostics and ambulatory care all in the same system where the government functions as the producer of health care services and as well as a third-party intermediary in the system.

The United Kingdom National Health Service has advantages and amongst them is the provision of comprehensive medical care coverage of the population in the UK. Compared to the other national health care system mentioned here such as the United States of America and the Canadian health care systems, the NHS in UK is the least for specialist friendliness. The system in UK is highly dependent on general health care practitioners for provision and rationing of the health care system and this is done by giving general practitioners a gatekeeper role and a strong financial incentive that in turn reduces specialty referral. This led to a situation that was highlighted through a strongly worded complaint from general practitioners when the *British Medical Journal* published the effectiveness of terbinafine as a treatment for onychomycosis, a condition that the British general practitioner does not wish to consider a medical condition requiring treatment ((Steven R. Feldman, 2014)).

Another European country France is a prototype model of a traditional European NHI system. Financing of the French NHI system is done by the country's payroll taxes on employers and employees. A combination of NHI with solo-based, fee-for-service private practice in the ambulatory care sector and a mixed hospital care sector is seen in the French health care system wherein two thirds of all acute beds are in the public sector and one third are in the private sector giving the system a mix of the two (public and private). In France, physicians in the outpatient clinics are independent and free to practice and the French health care system is different from that of the Canadian NHI and the NHS in the United Kingdom because in the France there is no gatekeeper in the French health care system where patients are free to choose their own physicians. Negotiation between the physicians and the government representatives paved way for the fee schedule that was set up within the French health care system. Within the same French health care system, physicians in the ambulatory sector and in private hospitals are reimbursed on the basis of a negotiated fee schedule. Physicians based in public hospitals are reimbursed on a part-time or full-time salaried basis while the private hospitals are reimbursed on the basis of a negotiated per-diem fee. There is a global budget system in France through which all public hospitals and some private hospitals are financed within the health care system and the French NHI on the other hand pays these hospitals at fixed sums equal to the expense of the previous year ((Steven R. Feldman, 2014)).

Two disadvantages of the French health care system are that there are limitations within the system in terms of efficiency in the use of medical resource and also on the demand side, because of uncertainty about the results of treatment and the wide availability of insurance coverage, patients tend to seek more medical services than necessary thereby

increasing the use of health care resources including time. In addition to the downside of the French health care service users, physicians are always tempted to order more diagnostic tests in order to reduce the risk of misdiagnosis or improper therapy on their side. Also, there is additional drawback in the French health care system in that in the system, the fee-for-service reimbursement of physicians provides strong incentive for physicians to increase their volume of services so as to raise their income. In the same way, the per-diem reimbursement of private hospitals provides incentives to increase patient lengths of stay in the French health care system. The French health care system provides few incentives since the NHI covers most of the costs, for physicians and patients to be economical in their use of medical care and this situation leads to the under or over utilization of the French health care services.

The French global health budgeting has the advantage of reducing the problem of excessive or inefficient use of services, because the system in a way supports the existing allocation of resources within the hospital sector. On the other hand, the French health care system is a bit restrictive in terms of expansion because it is relatively easy for a hospital to receive an annual budget to maintain its ongoing activities but extremely difficult to receive additional compensation for higher service levels, such as introduction of new advanced technology not already in the system (G. John Chen, 2014) and (Steven R. Feldman, 2014)

Africa: including South Africa and West Africa – Burkina Faso and then Sierra Leone

Health care in South Africa from the Wikipedia, the free encyclopedia

Health care system in South Africa as it is in many other countries is a mix of public and private health care with majority of the people using the public services while the well to do population of about 20% uses the better quality private system living the 80% to utilize the underfunded and understaffed public services mainly because the country only allocates about 8,7% of its DGP or US\$437 per capita with 42% government expenditure (WHO, 2008) and (Ataguba, John Ele-Ojo, 2010).

In South Africa, the public sector uses a Uniformed Patient Fee Schedule as a guide to billing for services mainly going to the low income 80% portion of the population a probable reason why the scheme is being used mainly in all the provinces of South Africa, although in Western Cape, Kwa-Zulu Natal, and Eastern Cape, it is being implemented on a phased schedule. There is what is called Uniformed Patient Fee Schedule (UPFS) categorization scheme implemented in November 2000 wherein different fees for every type of patient and situation were paid. The scheme put patients into three categories defined in general terms, but it also includes a classification system for placing all patients into either one of these categories, depending on the situation and any other relevant variables that the categorization takes into account. Out of the three categories there are those paying patients that fully pay for services; there are patients that are either being treated by an extremely funded private practitioner, or there are patients that are fully subsidized referred cases to hospitals by Primary Healthcare Service providers or patients that are partially subsidized with their costs partially covered based on their income levels. In addition to those categories, there are also

specified occasions in which services are provided to South Africans or South African residents free of cost (Republic of South Africa, 2009).

South Africa has a history of free health care spanning from the post second war era from 1945 to 1960 with a mix of paid end user health care system and subsidized HIV/AIDS treatment in the periods leading to and into the democratic era starting from 1994 when the government tried to introduce health care systems with the public sector providing services for most of the population of South Africa. It is therefore stated that since the African National Congress (ANC) came into power in 1994, it has implemented a number of measures for addressing South Africa's health care situation mainly inequalities in the health care system in South Africa, the Rainbow Nation. Outstanding amongst those efforts is the introduction of free health care in 1994 for all children under the age of six together with pregnant and breastfeeding women making use of public sector health facilities, This free health care scheme in 1996 was extended to all those using primary level public sector health care services. Also in 2003 there was an extension of free health to free hospital care to for children older than six with moderate and severe disabilities as way of making the scheme more inclusive (Republic of South Africa, 2006 & 2001).

National health

Despite efforts made in the past, there are still inequalities within the South African health care system that has prompted the current government to start working towards that establishment of a national health insurance (NHI) system out of concerns raised by the South African population. People in South Africa believe there are discrepancies within the national health care system, including but not limited to unequal access to healthcare amongst different socio-economic groups in

the country. Details of the health insurance scheme although not well known from start, the scheme seeks to find ways to make health care more available to those who currently finds it difficult to afford or those whose situations prevent them from attaining the services they need. The 80% and 20% population divide using the poorly funded and understaffed public health care mainly for the low income majority and the high quality private healthcare system mostly for the well to do minority the health care in South Africa is fully benefiting the total population most of whom are in low or middle income class in the country and they are the ones that need the health care support most.

The plan for the health care system is to have the national health insurance to propose a single National Health Insurance Fund (NHIF) for health insurance in South Africa that will be expected to be funded by the country's general taxes and some sort of health insurance contribution. Targeted by the new initiative for health system in South Africa is a system that will provide health care services to all residents of South Africa with no other social service deduction. The proposed fund is supposed to work as a way to purchase and provide health care to all South African residents without detracting from other social services. In the scheme, people receiving health from both public and private health care systems contribute towards the funding of the national health insurance scheme in the country. The intention of government is for the national health insurance to meet the cost of health care for the portion of the South African population that cannot afford to pay their own health costs

Health the world over is paid for in any case by someone be it individuals or institutions or governments and therefore whatever health care scheme is introduced be it subsidized or fully free, will only reduce or prevent end user fee payment. For instance in South Africa, the vast majority of health care funds comes from individual contributions coming from upper class patients paying directly for health care in the private sector and as such, there are those who doubt the national health insurance as they consider the scheme to be extorting money from the high income class patients to pay for the cost of the low income class' NHI and oppose its fundamental techniques which they say thereby over burdening the upper class minority population ((Republic of South Africa, 2006 & 2001). Despite the challenges posed by the fears created by the high class 20% population, the plan of the government of South Africa is to create a system that will bring an end the financial burden and improve the system in the public health sector and amongst the 80% of low class or the low income portion of the South African population.

Maternal and Child Healthcare

Data on the State of the World's Midwifery for 58 countries including South African released in June 2011 by United Nations Population Fund highlighted the health situation in South Africa mainly in the area of maternal and child health. The released data covered the area of midwifery workforce and policies relating to newborn and maternal mortality for all the 58 countries covered in the report. Specific details on the South African maternal and child health situation from the report showed that in 2010 maternal mortality rate per 100,000 births was 410 compared 236.8 in 2008 and 120.7 in 1990. For the under 5 children the report showed a mortality rate of 65 per 1,000 births and showed that 30% of the country's

under five child mortality. The United Nations Population Fund did the report to bring out the state of the fourth and fifth Millennium Development Goals (MDGs) in looking at how the MDGs particularly those two can be achieved (UNFPA, 2011). Maternal and child health are two challenging areas within the health care systems for many countries and therefore several countries make extra efforts to improve those areas within their health care systems. Probably that is why the Southern African government provided free health care for pregnant women, breastfeeding women and under five children in 2003 similar to the free health care initiative introduced in Sierra Leone in 2010 in the face of an extremely high maternal and child mortality rates in the country.

Burkina Faso – free health initiatives

Evaluation and Program Planning: Research on Implementing Evidence Based Practices in Community Based Addiction Treatment Programs: Policy and Program Implications, volume 34, Issue 4, November 2011, Pages 333-342 (Valery Ridde et al, 2011)

In one health district in Burkina Faso, a state-led and two community-based (two action research) free health care projects excluding the indigent from user fees payment at health facilities which are uncommon in Africa were undertaken in 2005 (state-led) and 2007 – 2010 (community-based) respectively. An evaluation of the projects using individual and group interviews with key stakeholders including health workers and community members looking at the strengths and weaknesses of key components of the

interventions that included the relevance and uptake of the intervention, selection and information on worst-off beneficiaries, and financial arrangements within the implementation of the interventions.

Effective mechanisms to exempt the indigent from user fees at health care facilities are rare in Africa. A State-led intervention (2004–2005) and two action research projects (2007–2010) were implemented in a health district in Burkina Faso to exempt the indigent from user fees. This article presents the results of the process evaluation of these three interventions.

The evaluation findings brought out that there is room for improvement for the one state-led and two community-based interventions; stakeholders appreciated the community-based more than the state-led approach with regards to targeting of beneficiaries for the waiver of health care fees payment. This was because the community-based approach helped to clearly define the selection criteria, inform the waiver beneficiaries, use a participative process and use endogenous funding. The downside, challenge or weakness of the community-based approach was that using endogenous funding led to restrictive selection by the community. The evaluation therefore showed that the community-based approach was most effective of the tested inventions but it also required improvement to better inform scale up of the initiative.

It was therefore concluded from the findings that important to the effective functioning of the free health care especially the community-based approach are stakeholders' information and the funding for indigent coverage (**Valery Ridde et al, 2011**)

Health care system in Sierra Leone

Sierra Leone News: Civil Society Organizations (CSOs) demand Free Health Care in Constitutional Review

Exactly four years after the introduction of free health care initiative in Sierra Leone the people of Sierra Leone are now calling on their government to make free health for pregnant women, lactating mothers and under five children a right for the people of Sierra Leone by strongly advocating for it to be added to the country's constitution given a constitutional review opportunity about the same period. The advocacy process involved Save the Children, Health Alert, Ministry of Health and Sanitation, National Youth Coalition, Children's Forum Network, Women's Group, Community Concern Network and other partners who openly called for the continuation and sustaining of the free health care initiative to making it a constitutional right for pregnant women, lactating mothers and children under five years of age in Sierra Leone. One of the advocates Joana Tom Kargbo in her own words said:

“prior to the introduction of the free health care, Sierra Leone was ranked “the worst in the world” in terms of infant and maternal mortality which indicated, that one in eight women were at risk of dying during pregnancy and one in twelve newborns die each year.”

According to her, at global level, more than half of the world's countries have some degree of guaranteed specific rights to public health and medical care for their citizens embedded in their national constitutions but went on to urge the constitutional review

committee by saying that “Sierra Leone is one of 86 countries whose constitutions do not guarantee their citizens any kind of health protection,” and “We can be the first West African country to have written in our constitution, right to free health care. It is time for Sierra Leone to make this positive history.” Expression of the views of the country’s population.

In response, the Head of Communications and Outreach at the Constitutional Review Committee (CRC), Mohamed Faray Kargbo in his own words said that the constitutional review process is “a citizen-led project” aimed at seeing that the wishes and aspirations of the people of Sierra Leone will be captured in the nationwide civic education and public consultation to eventually make up the final version of the revised constitution of Sierra Leone at the end of their job. He maintained that the constitutional review committee will not add anything to the final reviewed document that is not in line with the will of the people of Sierra Leone. Mr. Kargbo however added that the amendments that will be done to the constitution stated will be based on popular demand and consensus in all the regions in Sierra Leone. Mr. Kargbo in addition encouraged advocacy to be both rigorous and also vigorous and therefore he went on to say that the people of Sierra Leone in their efforts to advocate must speak with one voice as a united force that is always stronger. Making free health care in Sierra Leone a right for pregnant women, lactating mothers and under five children is a view that was supported by the Director of the Reproductive and Child Health Division in the Ministry of Health and Sanitation of the Government of Sierra Leone, Dr. S. A. S. Kargbo and the representative from Health Alert who is also the Executive Director of Health Alert, Mr. William Sao Lamin who also added their voices to that popular demand made by Sierra Leoneans as their contribution to the

country's constitutional review process as reported by Nancy Koroma on Tuesday April 08, 2014 in Awoko Newspaper in Sierra Leone (web-based newspaper).

Healthcare services in Sierra Leone

In Sierra Leone, the health care services are provided by a mixture of governmental, private and non-governmental organizations (NGOs) including UN Agencies, international NGOs, national NGOs, community based organizations (CBOs), mission or faith-based organizations, institutions like learning institutions and private sector including individual practitioners. The Sierra Leone government has the country divided into 13 health districts based on the administrative districts of Sierra Leone. Serious gaps in health infrastructure resulted from the country's protracted civil war but following the end of the war in 2002, the situation is gradually improving with the mix of support coming from all the stakeholders or health care service providers listed above (Sierra Leone, 2008).

In Sierra Leone with the exception of free health categories or services and mostly NGO supported health services, end user medical care is generally charged for in Sierra Leone either in a form of fee for service or cost recovery in the public facilities or end user fees paid at private health facilities or service points. There are over 100 NGOs operating in the health care sector in Sierra Leone. Within Sierra Leone, the Ministry of Health and Sanitation has the overall responsibility for providing health care to all residents of Sierra Leone and that responsibility which was mainly centralized before the war was decentralized after the war with district level local authorities or governments sharing the responsibility of health care service provision for their people. The central or local

government in executing that responsibility through the Ministry of Health and Sanitation (MOHS) at central or local or district level through the District Health Management Teams (DHMTs) receives support in the health sector by over 100 NGOs that operate in the country's health sector providing various kinds of assistance including financial, technical, infrastructural, provision of equipment, furniture, transportation, drugs and other medical supplies. All of the country's efforts be it central, decentralized, government or non-governmental had been and continue to be aimed at increasing health care coverage within Sierra Leone. In Sierra Leone there are thirteen District Health Management Teams with one in each of the 13 health districts in the country with their respective District Councils that have the overall mandate of providing health care service to people across each of the 13 health districts. The various District health Management Teams on average have 50 peripheral health units (PHU) and over 100 professional health staff. In each health district, the District Health Management Team although works with other partners both government and non-governmental, bears the overall responsibility for planning, organizing and monitoring health provision, training of personnel, working with communities and supplying equipment and drugs as well as reporting the results of their work to the central level for management information and planning purposes (MOHS, 2008).

The PHUs are designed to be the delivery points where Primary health care (PHC) is delivered at three different levels of health facilities at the community level called peripheral health units (PHUs). The lowest of those three level facilities is the maternal and child health post (MCHP). The medium level facility is the community health post

(CHP) and the highest among the three is the community health centre (CHC) which is normally situated at chiefdom (sub-geographic areas within a health district) level serving as an immediate referral point for the other two and also oversees the operations of the other two. Those community level facilities provide curative, preventive and promotive health care as well as health administrative services within their respective operational units called catchment areas. Within a chiefdom is usually one community health centre, many community health posts but more of the maternal and child health posts. They perform roles similar in nature but the roles increase from the level of the maternal and child health posts to that of the community health centres. The chain of referral within the primary health care service delivery is usually from the level of the community by community health volunteers to maternal and child health posts, that are many, then to the community health posts if they are closer before going to the community health centres from where referrals go to hospitals at district level and then to central level or specialist hospitals depending on the nature of the cases. For instance maternal or obstetric cases are sent to gynecologists or obstetricians and children's complicated cases sent to children's hospitals. The population coverage for the peripheral health units increases from maternal and child health post that usually covers about 500 – 1,000 people going through community health posts that usually cover 1,000 – 5,000 people to the community health centres that cover usually cover 5,000 – 10,000 people ((MOHS, 2008).

Public health

The health care system in Sierra Leone especially the public health before the introduction of the free health care had been generally weak with poor health statistics. For instance, in 2007 the country had the highest level of child mortality in the world (BBC, 2008) while the maternal mortality ratio before the introduction of free health was one of the world's worst (Amnesty International, 2009). The country also had other very high health indicators such as the infant mortality rate of 123 deaths per 1000 live births in 2009 and a life expectancy of 48 years (when some developed countries like Switzerland, have life expectancy above 80 years) but the situation after the end of the war in 2002 has shown gradual improvement with mortality reducing from 302 deaths 1000 per live birth in 1990 to 192 deaths per 1000 live births in 2009 (UNICEF, 2011) and to 140/1000 live birth in 2010 (MOHS, 2010).

There is high disease burden and more so of communicable diseases including epidemic outbreaks such as cholera, yellow fever, meningitis and Lassa fever outbreaks (MOHS, 2008). The country has a low general HIV/AIDS prevalence of 1.6% far less than Sub-Saharan average of 6.1% but more than the global average of 1% (UNAIDS, 2008).

Free healthcare scheme

Following commitment made by the president of the Republic of Sierra Leone at the UN General Assembly in 2009, the government of Sierra Leone in April 2010 launched "Free Health Care Medical Insurance", a health care initiative that targets free healthcare for pregnant, lactating mothers and children under five years of age (Sierra Express Media, 2010) and (BBC, 2010). One of the key partners supporting the free health care initiative in Sierra Leone United Nations Population Fund (UNFPA) representative showing the available support for the initiative explained to people that medical equipment at the start of the

implementation were ordered and some drugs distributed as part of the new healthcare scheme but the coverage was not 100% (BBC, 2010). The initial set up cost of the free health care scheme introduced in 2010 was \$19 million and initiative was expected to save the lives of more than a million mothers and children (BBC, 2010). Without even starting the free health implementation, Sierra Leonean health workers were scared that the initiative will bring them increased workload and therefore went on strike in March 2010 just a month to the start of the actual implementation of the scheme. The health workers were also concerned about increase in their work time likely to result from the increased workload. The government of Sierra Leone addressed the pre-free health implementation strike through health worker salary increase of up to 200 – 500%, first of its kind in the history of Sierra Leone in the health care sector (BBC, 2010). The president himself, His Excellency Dr. Ernest Bai Koroma officially launched free health initiative in Sierra Leone during the 49th independence anniversary of the country on April 27, 2010 (Voice of America. 27 April 2010). People had two main concerns with the introduced health care scheme and those were the lack of awareness of the right to free health care by the women that the initiative targets and the continuation of funding for the scheme as people thought a poor management of the country's mineral resources will make it difficult or impossible to sustain the implementation of the initiative. (Anne Jung, 2012).

Although the free health in Sierra Leone came out of government commitment and was launched by the president of Sierra Leone, the scheme is heavily dependent on donor support with the bulk of that support coming from the United Kingdom through the British office for International Development (DFID) or United Kingdom Aid (UKAid), the United Nations, the World Health Organization (WHO) as they supported the refurbishment of hospitals, drug supply and the provision of blood banks as well as

transportation for supply chain management (BBC, 2010). With a 10 year US\$70.5 million Reproductive and Child Health Care mainly supporting the free health care scheme, UKAid or DFID alone is providing US\$22.6 million excluding US\$7 million DFID provided to UNICDEF for provision of drugs for pregnant women one of the three target groups within the free health care scheme making United Kingdom support for the US\$70.5 million 10 year budget to go up to 41.8% (Global Post, 2010).

Traditional medicine

The health care system in Sierra Leone is a mix of modern and traditional medicine with the Ministry of Health and Sanitation in enhancing cooperation between the two diversities in medicine has constructed a training school at Makeni, a healing centre at Kono and has also carried out training in workshops to increase understanding and improve on working relationships between the two sectors (MOHS, 2008).

Different source in and out of Sierra Leone acknowledge the positive effect of free health care in Sierra Leone. For instance according to HUFFSPOST IMPACT, UNITED KINGDOM, The Free Health Care Initiative is Making a Difference in Sierra Leone (WHO, 2012 & 2014).

The United Nations (UN) and World Health Organization (WHO) health statistics before the introduction of free health care in Sierra Leone showed very high maternal and child mortality rates that made Sierra Leone a country with some of the world's worst maternal and under five death rates with about 200/1000 under five child deaths. Two years before the introduction of free health abject poverty preventing up to 84% of people needing health care unable to see a doctor was the major under lying cause of the extremely high

maternal and child mortality in Sierra Leone. The war and post war situations were also compounding the problem.

A change in the worst health situation was needed way before the introduction of the free health care initiative and it all actually started when the President of Sierra Leone announced his country's commitment to give pregnant women, lactating women and under five children at the UN General Assembly in September 2009 and had the initiative launch in April 2010 by the Dr. Excellency Dr. Bai Koroma aimed at benefitting 100s of thousands of women and up to a million children.

The free health care initiative brought around a change in the health situation in Sierra Leone for the better as someone put it: "I'm delighted to say that the latest statistics have shown we are succeeding. The FHCI has had an incredible affect on the awful health indicators of just a few years ago".

In addition, a World Health Organization (WHO) publication in expressing the positive effect of the free health care initiative first few years of implementation and the impressions created stated that:

"In the first year alone, there was a 214% increase in the number of children attending outpatient units. More women who needed care most were attending facilities, and we reduced - by an amazing 61% - the number of women dying from pregnancy complications at facilities. We are delighted, encouraged and proud of what has been achieved in so short a time" (WHO, 2014).

The President of the Republic of Sierra Leone who pioneered the introduction of the free health care in the country in his own words said:

“It has not been easy. As President, I believed it was essential for me to take leadership of this from the outset, planning and overseeing its implementation. We had to make sure the health care was not just available to our country's women and children, but that the quality of care would also improve” (WHO, 2014).

In showing the effort made in ensuring that the free health care works, the president explained what the government did in to help increase health workers commitment to the increased responsibility that comes with the implementation of the free health care and he said:

“...we increased the number of health workers and ensured they were given big salary rises to reflect the importance of their positions. Nurses who used to get just \$50 a month, now earn \$200 and doctors have had their pay increased from \$250 to \$1000” (WHO, 2014).

Notwithstanding the effort made so far, the president himself acknowledged that there is much to be done still, but they have made a fantastic start. Inspired by the success of the introduced free health care in Sierra Leone, the president expressed their plan as government to develop Sierra Leone's health financing policy, that will ensure all Sierra Leonean residents get protected from the financial burden of accessing health care, as a way of moving the country toward so that we move towards universal health coverage as a scale up to the 2010 introduced free health care initiative.

Free health in Sierra Leone like in all other places has its own challenges which the President His Excellency Dr. Ernest Bai Koroma also acknowledged by saying that the Free Health Care Initiative has not happened without challenges and the greatest of which

according to him are the aspects of sustainability of what he called a plausible scheme and also the enhancement of the quality of services offered in the health facilities across the country. Due to that concern, President Koroma stated that they ensured allocation of more resources to health but relying on donor or international partners sighting the United Kingdom as one of those leading partners that provided the country technical and financial support to move the free health care forward. He therefore urged health partners in Sierra Leone to increase and sustain their support to the scheme and the country as he continued to express his satisfaction over the free health care achievement made so far (first few years of implementation).

The president in ending up his expression of views on the free health care in Sierra Leone he explained how determined Sierra Leone is in moving the country forward with a broader socio-economic transformation in mind as well as the achievement of the United Nations Millennium Development Goals with focus on reduction of child mortality and improvement of maternal health (MDGs 4 & 5) but he remained to be mindful of the global food and economic crisis. He therefore in conclusion called on world leaders and groupings like the G8 and specially the United Kingdom increase and sustain their efforts in order to reach the most poor and vulnerable in world society while stressing in his conclusion that “Two years on, we must sustain progress and I will do my best to ensure that the progress we have made is accelerated so that we can reach our common goals” (WHO, 2014).

Sierra Leonean Context: Before the introduction of the free health care initiative

With the Abuja declaration, countries in Africa agreed to allocate 15% of the annual national budgets to health. This is however not the case in many of the countries. For instance, Sierra Leone is only allocating 6 – 9% of its national annual budget to health despite the introduction of free health care in Sierra Leone in 2010. Sierra Leone may be better than Guinea Conakry in terms of health budget allocation since Guinea allocation is 6% or less, yet Sierra Leone still has a long way to meeting the 15% Abuja target. The low budget allocation to health in Sierra Leone may not be unconnected with the level of health burden in the country including inadequate infrastructure, in adequately equipped health facilities, low paid health personnel with subsequent low staff moral, low staff performance, high disease burden, one of the world's highest maternal ratio and child mortality rate. The awful health situation existed before the country's brutal civil war and continued thereafter with the war even making the situation worst.

Sierra Leone after 11 years of war for years had been close to the bottom of the United Nations Human Development Index (UN HDI) with some of the world's lowest health indicators. Weak salaries and incentives leading to poor service delivery have been part of the causes of the low health indicators. Service fees or drug cost are charged to users of health services part of which is used to meet some unpaid health workers' needs especially in public health facilities. In doing so even women and children that should be receiving free services by law or existing health policy are charged some informal user fees. To address the health needs of women and children under five years, His Excellency President Earnest Bai Koroma, President of the Republic of Sierra Leone in November 2009 announced at the UN General Assembly his country's plan to introduce a free healthcare initiative in Sierra Leone. The initiative was launched on April 27, 2010 for

pregnant women, lactating mothers and children under five years of age throughout the country with support from World Bank and other donor agencies (GoSL, June 2010).

“Big change... On November 5, 2009 H.E. the President of Sierra Leone announced the abolition of health user fees and the introduction of free health care for pregnant women, breastfeeding mothers, and children under 5 years of age starting from April 27th 2010. A package of medical care that includes all treatments and medicines were available at no cost for these groups. This package ensures the provision of minimal essential quality of care for all and includes services that have the greatest impact on the major health problems (especially that of maternal and child health). This is a huge step forward for a country at the bottom of the Human Development Index, with some of the worst maternal and child mortality rates in the world. The Government has identified cost as the biggest barrier to accessing healthcare in the country (MOHS, 2008). Pregnant and breastfeeding women and young children are by far the largest groups in need of health services and yet are often excluded from them by cost, referring to health facilities when it is too late. With this major change in policy the government and its development partners will remove this barrier, paving the way for greater use of and earlier referral to health services. Moreover, the systemic changes that this new policy will bring about within the provision of healthcare will produce a stronger, more efficient and effective health service for all Sierra Leoneans (GoSL, 2010).

Challenges in the Sierra Leone’s healthcare system before the introduction of the free healthcare service included lack of appropriate qualified healthcare workers, insufficient

supplies of drugs and equipment, poor co-ordination and management and also charges levied at point of service delivery. The government's position is that turning the situation around especially the charges is not only a funding issue but a culture people have lived within a weak healthcare system that requires system changes. That will involve providing drugs and equipment; improving terms and training for health professionals, and strengthening management, planning and monitoring. The free healthcare services include treatment and medicines. It is available in all government health facilities and it is not a temporary offer but requires government and health workers working together. It makes the largest groups (pregnant women, breastfeeding women and young children) in need have easy access to health services. With the free healthcare, the target beneficiaries are not eligible for registration fees, official fees or unofficial fees yet they should receive the Sierra Leone free health care services as it was spelt out in a Government of Sierra free healthcare services position paper (GoSL, 2010).

The Sierra Leone free health care initiative was spelt out in a Government of Sierra Leone position paper shortly before it was launched on April 27, 2010 in order to provider government partners and the general population what the initiative was all about. Details provided in the position paper included the under mentioned

“How will the change be brought about?”

Currently, the health system in Sierra Leone is characterized by a lack of appropriately qualified health care workers, insufficient supplies of drugs and equipment, poor co-ordination and management, and charges levied at point of service delivery. Changing this requires a huge effort not just in

terms of funding, but also in terms of culture change. The Government recognizes that systemic change is needed and is addressing this as follows:

Providing drugs and equipment

...Strengthening procurement and supply chain management systems to ensure that there are sufficient drugs and equipment supplied at point of use, as well as putting in place an efficient warehousing, storage and distribution system to avoid stock outs of quality essential drugs, equipment and supplies. Health facilities will also be equipped to deliver quality health and emergency obstetric services, so this includes better equipping of maternity wards and operating theatres.

Improving terms and training for health professionals

...Providing an adequate number of qualified health workers with appropriate skills in facilities across the country. This will be done by:

Qualified health workers will receive a salary increase in recognition of the additional workload

Performance based incentives to top up staff salaries, removing the need to charge patients

Deploying Cuban doctors and Nigerian doctors and nurses in the short term

Training Maternal and Child Health (MCH) Aides in basic obstetric and neonatal care

Training Community Health Officers and qualified midwives to supervise the MCH Aides

Introducing improved and regular training programmes, with a number of personnel currently being trained in management, public health and midwifery in Ghana

Strengthening management, planning and monitoring

...Strengthening oversight, co-ordination and management at all levels to ensure transparency and efficiency, and monitor performance of health professionals. In addition, there will be a strengthening of Government Standard Operating Procedures for the management of Essential Medicines and the building of capacity of the Facilities and Maintenance units both centrally and at district level. This will help ensure that health facilities are well stocked and equipped long into the future. Management at the centre will be trained to be able to better plan, manage, supervise and monitor the delivery of the new model of healthcare. Existing professional and non-professional bodies will also be strengthened to ensure there are mechanisms for monitoring and addressing medical malpractices. The new system will also include a thorough Monitoring and Evaluation framework to collect accurate and timely data on the performance of the wider health system. This will enable policy-makers and health professionals to address the population's needs more closely. Another aspect of monitoring will be the reporting of any health

professionals who attempt to charge for services. The Ministry of Health and Sanitation is currently working with her partners, the police, Local Councils, DHMT, Paramount Chiefs and the ACC to ensure appropriate mechanisms are in place. Communities and Government need to work together to expose corrupt practices and challenge those who stand in the way of this important new programme. To this end, communities are encouraged to feel a sense of ownership of their health system. The community should assist in educating others and in monitoring the use of the facilities” (GoSL, 2010).

Key messages contained in frequently asked questions and answers for free health care introduced in Sierra Leone on April 27, 2010 are as follow:

“Q: What is the Free Health Care initiative?

A: The Government has made a commitment to provide free medical treatment to all pregnant women, breastfeeding mothers and children under five years of age at all Government hospitals and clinics.

Q: When will it come into effect?

A: From April 27th 2010.

Q: Who are the beneficiaries?

A: All pregnant women, breastfeeding mothers and children under five years of age.

Q: Why is government introducing the Free Health Care Services?

A: To reduce the number of pregnant women, breastfeeding mothers and young children up to age of 5 years old dying due to ill health in childhood and complications during pregnancy and childbirth. Sierra Leone has currently some of the worst child and maternal mortality statistics in the world. Evidence from other countries such as Uganda or Burundi show that increased access and usage of health care facilities should lead to reduce levels of mortality and morbidity over time.

Q: How can we sustain the Free Health Care Service?

A: An adequate supply of free essential drugs will be provided to all government health facilities to treat pregnant women, breastfeeding mothers and young children up to the age of 5 years. International donors are also supporting the Government to introduce the initiative. Qualified health workers will receive a salary increase in recognition of fact they will no longer be able to charge a fee for drugs or their services and the additional workload associated with free health care.

Q: How will people know about the free Health service?

A: Through public awareness using different channels of communication including community meetings, radio jingles, drama, radio/TV panel discussions and posters.

Q: Where will you be able to get the Free Health Care Service?

A: It will be available in all government health facilities; clinics, health centers and hospitals. Make sure you ask your local health workers about it!

Q: Will the service last for only few days?

A: No. This is part of the Government's long term plan for improving health services in Sierra Leone.

Q: What do I do if someone tries to charge me when I try to access these services?

The Ministry of Health and Sanitation is currently working with partners, the police, Local Councils, DHMT and the Local Paramount Chiefs and the ACC to ensure appropriate mechanisms are in place. We will need to work together to expose any corrupt practices and challenge those who stand in the way of this important new programme.

Q: What measures will authorities take in event of corruption by health workers?

A: Both the Government and donor partners take this issue very seriously. Any health worker trying to charge will be investigated.

Q: Does the free health service cover dental problems for pregnant women and lactating mothers?

A: Yes. All services including dental and emergency services will be free when the service is accessed at a government PHU, health clinic or hospital.

Q: What mechanism will be in place to screen whether breastfeeding mothers are actually lactating or not?

A: The health worker will determine who falls within the target group.

Q: Does the free Health service include free caesarian section?

A: Yes. All services including dental and emergency services will be free when the service is accessed at a government PHU, health clinic or hospital.

Q: Will drugs be available at all PHUs?

A: Yes. A mechanism will be put in place to ensure sufficient drugs are available at all government health facilities to treat pregnant women, breastfeeding mothers and young children up to the age of 5 years.

Q. What is the role of the community to make sure it becomes a success?

A: The community should have ownership of this policy and should ensure that beneficiaries are aware of it and that facilities do not charge the target group. The community should assist in educating those women who are eligible to receive free treatment and in monitoring the appropriate use of the facilities.

Q: Will referral/transportation of emergency cases from PHU to Hospital be free?

A: Where ambulances are available in the Districts then in emergency cases transportation from PHU to hospital will be free of charge for target beneficiaries, with the cost absorbed by District budgets. The Ministry of Health and Sanitation is planning further improvements in the transportation/referral system over the coming year in line with the Health Sector Strategic Plan” (GoSL, 2010).

An international news agency called IRIN in an international news analysis in its Thursday 29 April 2010 edition as part of a project of the UN Office for the Coordination of Humanitarian Affairs (UNOCHA) analyzed the Sierra Leone free health care initiative as per the inserted article

“SIERRA LEONE: Health fees scrapped but gaps remain”

DAKAR, 27 April 2010 (IRIN) - Donors and NGOs welcomed the Sierra Leone government's launch on 27 April of free health care for some 1.5 million women and children, but health experts say it is just one step in a long, complex process as critical gaps in the health system remain to be analyzed and addressed.

Under the new directive government health facilities are to provide free care to under-five children and pregnant and lactating women within Sierra Leone including Moyamba District.

“Having worked in our health system for years, I can say this is the biggest change [the system] has ever undergone,” Dr. S.A.S. Kargbo, Director of Reproductive and Child Health In the ministry of Health and Sanitation said in a statement released by Save the Children, which has worked closely with the government on the initiative.

"And its impact on saving the lives of women and children will be truly significant.”

In Sierra Leone one in five children die before age five and one in eight women die from pregnancy-related complications, according to the UN Children's Fund (UNICEF).

Ready?

But health fees are not the only thing standing in the way of decent public health services. President Ernest Bai Koroma and top health officials recently toured hospitals around the country to check their readiness, and found a lack of running water and electricity, insufficient generators, facilities "acutely short of personnel" and inadequate beds and medical equipment, according to a government press statement.

Cuban and Nigerian doctors work in Sierra Leone to fill part of the personnel gap. Sierra Leone has about three doctors per 100,000 people; the World Health Organization recommends at least 228 persons to one doctor a state that will take time in Sierra Leone.

The government says it is on track – with the financial backing of several donors and NGOs – to get health facilities up to speed, but this will take months, even years.

A 10-day strike by health workers was called off on 28 March after President Koroma announced a pay hike for health workers, but many of their grievances are still far from resolved.

"The main concerns for health workers are compensation, working conditions, lack of career advancement and study opportunities and a lack of equipment," Frederic Coker,

head of a coalition of striking doctors, told IRIN days after the salary announcement. “But we agree that not all of our demands can be met at once.”

Broader process

Vidhya Ganesh, Deputy UNICEF Representative in Sierra Leone, said it was important to see free health care as one step in a broader process in the country’s health care system.

“A great deal of preparation has taken place [for the launch], including getting medicines in place and communicating the policy,” she told IRIN. “But by no means will all challenges to the health sector be resolved in one move; this is an ongoing process.”

But there is concern that public hospitals will be under immediate pressure with a flood of people seeking free care as end user cost had been part of the barriers to health care.

“We know from experience in other countries that have implemented free care that the first months are critical,” Laurence Saily, Interim Head of Mission for Médecins Sans Frontières-Belgium, told IRIN as an expression of view showing no surprises in the process.

The government must have a strategy in place to equip and staff health centres as needed, she added because the right equipments are required to perform well.

The health ministry plans to increase the number of midwives trained each year from 30

to 150, according to the Reproductive Health Director Dr. S.A.S. Kargbo.

Many health care workers have been using revenue from user fees to cover their wages, says Save the Children, which endorses a government strategy to increase medical staff salaries to reflect the new workload as this is considered to motivate the health workers.

Quality Care

But many patients go to clinics even when health care costs; their concern is quality care.

Hadja Kadiatu Jalloh, Community Health Officer in Makeni, 200km northeast of the capital Freetown, told IRIN some of the challenges they face as health workers i.e.: “Free care] is a nice idea...but medicines have to be available. If you tell people to come and a diagnosis is made but the drugs are not available that’s a problem.”

A woman sitting nearby with her child said for her cost was not an issue. For her, the priority lies in the life of her child and said “I am interested in the life of my child, so I was not thinking about the money when the child fell ill; I decided immediately to come to hospital in to save the life of my child as that was my priority and not the money.”

The woman, who did not give her name, is a fish trader; she said her maximum daily profit was about 10,000 Leones (US\$2.50). The Makeni hospital currently charges 11,500 Leones (\$2.95) for admission to the paediatric ward; an ordinary delivery can cost about \$10” (IRIN, 2010).

Sierra Leone Context: After introduction of the free health care initiative

UNICEF Sierra Leone You Tube web publication (UNICEF, February 2014)

According to UNICEF Sierra Leone video published on the web in February 2014, the free health care is effective as it states that the initiative is already saving thousands of lives and that UNICEF and the European Union will continue to support the initiative.

The Krio video puts it this way:

“Thousands of lives in Sierra Leone have already been saved through the Free Health Care Initiative. In 2010 the President of Sierra Leone launched the Free Health Care Initiative. Now children under five, pregnant women and breast-feeding mothers can seek medical care and much needed medicines without worrying about the costs. UNICEF in partnership with the European Union will further support the Government in ensuring that the Free Health Care Initiative can continue” (UNICEF, February 2014).

Lancet Elsevier Ltd 2013 volume 381, Issue 9862, pages 191 – 192: Sierra Leone's free health-care initiative: work in progress (Lancet, January 2013)

FHCI challenges (distance, transportation, ill equipped health facilities, lack of electricity and poverty make it difficult to meet the non-health costs associated with the FHCI)

More than two (2) years have passed since Sierra Leone granted pregnant women, new mothers, and young children free health care, but their needs often remain unmet. Amy Maxmen reports.

Marta Amara's water broke on Nov 5, 2012. Community members carried her in a hammock to the nearest health facility, nearly 10 km away from her village in rural Sierra Leone. A baby's tiny arm emerged soon after she arrived, but not its head. Realizing that the birth would be too complicated in a centre ill-equipped for surgery, staff urged her to pay a taxi driver the equivalent of US\$29 to take her on a 2-hour trip to the district hospital in Kenema. They arrived after nightfall to discover a hospital lacking electricity. Amara then paid for transportation to an emergency clinic operated by Médecins Sans Frontières (MSF). By the time she arrived, her baby was dead and she was internally bleeding from a hole in her uterus. MSF obstetrician and gynaecologist Betty Raney stitched the wound, which saved Amara's life but rendered her infertile. "Women and children die because of delays in care", Raney says. She sees preventable deaths daily, despite the country's 2-year-old policy for free health care for pregnant women and children younger than 5 years (*Lancet*, January 2013).

Amara's experience reveals a number of the initiative's shortcomings: she arrived at the clinic hours after she started labour; she paid for travel when ambulances should be provided for free; and the hospitals were not prepared for surgery. Certainly, health care is better than it was. More than five times as many children are treated for malaria with the recommended artemisinin now than in 2008, according to household surveys. And now that cost is no longer a barrier in a country where 74% of the population lives on less than \$2 per day, health-care use has increased by 60% (*Lancet*, January 2013),

Movement of drugs and medical equipment and leakages within the system are part of the challenges found in the implementation of free health care initiative in Sierra Leone. That was what made UNICEF and other partners teamed up to support the system with transportations and introduction of many checks and balances. With their added support in addressing the issue of transportation and leakages, by November, 2011, the drugs were flowing across the nation again (Lancet: Elsevier, 2013). Other challenges are related to poor infrastructure, low diagnostic capacity, availability of running or improved source of water, bad roads with difficult river crossings making it difficult to access health facilities even in emergencies, lack of blood for transfusion during emergencies and in treatment of severe malaria and diarrhoea in children and in cases of caesarian sections for pregnant women. Free health care initiative has not taken away all the numerous challenges that had existed in the health care system over the years leading to the introduction of the initiative despite helping to improve the system in a way.

These words from the Director of Reproductive and Child Health Division Dr. S. A. S. Kargbo reinforced the some of the highlighted challenges in the health care system in Sierra Leone that the free health care initiative is faced with. As he put it, electricity and blood banks are a top priority. Before health care was free, so few mothers visited hospitals that a night-time need for electricity was not apparent and blood could often be provided by a patient's relatives. He also added that once the allure of free health care increased demand, the deficiencies of the old system surfaced. These were his own words: “now they come at night, and we are not prepared”, According to him it is because the infrastructure for electricity cannot sustain 24-hour use in many districts. He is therefore happy with support coming in with electricity like the donation of 42 solar

power systems made by WE CARE Solar, a solar energy charity in Berkeley, California and there intends to continue seeking similar support for the country's health care system. Health worker shortage is one of key challenges in the implementation of the free health care initiative. According to Dr. Kargbo, a deficiency in skilled labour will take several more years to be resolved. He therefore said that "If all of the foreign doctors working here went away we couldn't sustain the hospitals".

There are however simple or improvised solutions to some of the challenges. For instance birth waiting houses are helping pregnant women from far distances to health facilities to wait close to the facilities when they at term to avoid the huddle of long stretched and dangerous roads at time of labour and more so emergencies when they end up using commercial motorbikes or hammocks. Non-governmental organization partners helping with the simple but useful initiatives. This added initiative plus an emergency line to call an MSF ambulance in Bo District in Sierra Leone with the support of MSF helped reduced maternal mortality by 61% according to MSF November, 2012 report.

Another simple approach in Moyamba is a community system strengthening tool called Child Health and Development Competence Tool which the health staff uses to increase communities understanding, participation, ownership and sustainability of health interventions. That has encouraged collective efforts leading to improvement in road conditions that in turn helped health facility access or improvement in sanitation and better health practices. This measure, plus an emergency line to call an MSF ambulance, helped the organization reduce maternal mortality by 61% in Bo, according to their report released in November, 2012.

Additional challenges to free health care and improvement in maternal and child deaths include cultural that encourage home or traditional birth attendant deliveries even when they are untrained in some cases. The lack of family planning with frequent births and teenage pregnancies are amongst the additional things that further challenge the free health care initiative in Sierra Leone. For instance a nurse at the national maternal and child health referral hospital in the capital city of Sierra Leone (Freetown), said she finds it difficult to tell clients about the importance of family planning because as she said: “The poorer mothers want a lot of children so that some of them will survive to care for them “. She further added that unmarried pregnant girls between ages 12 and 18 years account for a high proportion of maternal injuries and mortalities at the hospital.

According to Lancet Elsevier’s 2012 web publication, if the cultural practices that negatively impact maternal and child health such as frequent births, teenage pregnancy, non use of family planning, it will be difficult for Sierra Leone to achieve the UN's Millennium Development Goals for reduced maternal and infant mortality (Lancet, January 2013).

High maternal & under five child mortality rate still hangs over Sierra Leone

The FHCI is working, pregnant women, lactating mothers and children under five years of age are accessing public health facilities without bothering about payment of health cost in the normal circumstances and lives are saved but the high maternal and child mortality in Sierra Leone is far from over. The FHCI is therefore just in progress as women are still dying in child birth and under five children are still dying often due to the challenges related to non-health costs.

Lancet (Elsevier Ltd, 2013) exactly explained it this way:

“To international applause, President Ernest Bai Koroma announced the free health-care initiative on April 27, 2010. Koroma's intention was to reverse Sierra Leone's position as one of the world's most deadly places to give birth and to be born. World Bank statistics show that one woman dies in childbirth for every 112 births in Sierra Leone. That rate is 2.5 times higher than in nearby Ghana, 42.4 times higher than in the USA, and 222.5 times higher than in Sweden, where the rate is one death per 25 000 births. Furthermore, nearly one in five children born in Sierra Leone dies before they reach 5 years of age” (Lancet, January 2013).

According to the article (Lancet: Elsevier 2013), taking off health care cost has exposed other gaps in the health care system in Sierra Leone as manifested as the challenges to free health care initiative (non-health costs). Notwithstanding, the challenges, there are recognizable improvements in the health care system as a result of the introduction of the free health care initiative. This was what Yvonne Nzomukunda, MSF's medical coordinator in Sierra Leone said: “Today we see fantastic improvements in health and sanitation”. She also added that: ... “but compared to other countries in the region, we still lag far behind”. Aid organizations and donors including UNICEF, UK's Department for International Development, the European Union, UNFPA, MSF and several others are contributing and still remain committed to supporting the free health care initiative and health care in general in Sierra Leone.

No miracles should be expected with regards to maternal and child deaths in Sierra as a result of the introduction of free health care in the country. The rate of improvement is

slow but it cannot be given up at all. With that in mind, Dr. S. A. S Kargbo, Director of Reproductive and Child Health Division said: “Our country is very young, and there are many things that have set us back ... when we go two steps forward, we're still just moving one step at a time” (Lancet, January 2013).

Health for All Coalition: Latest Report Summary (HFAC, 2010)

A civil society organization in Sierra Leone had helped to monitor the free health care initiative from the start of implementation in 2010. They have presence in all the 13 health districts in the country. The organization has staff and volunteers that help to monitor the free health care implementation in hospitals and at chiefdom or community level in addition to the deployed district level coordinators. Looking at what works well and what could be improved. The organization carried out monitoring after the first three months into implementation and came out these summary findings, threats and recommendations for the initiative:

“Key positive findings

Key positive findings common to all districts include:

- Increased attendance of Free Health Care beneficiaries was recorded at all Government Health Facilities
- All facilities visited by HFAC monitors had at least one member of staff ready to provide their best service
- Service was available in most Government health facilities visited
- There was an increased commitment amongst health workers due to the agreed increase in salary

- There was an appreciation of the GOSL and the Free Health Care Initiative by community people throughout Sierra Leone
- The promised Cash for Facilities was available in most PHUs visited

Shortfalls

Shortfalls common to all districts include:

- There was a stock-out of essential drugs at most health facilities visited by monitors
- There was no blood in the majority of blood banks visited, and these blood banks were of insufficient quality for safe storage of blood
- Theft or sale of Free Health Care drugs and other medical materials such as beds and bed nets were recorded on several occasions across the country
- There was an inadequate number of health workers on duty at most PHUs
- In most facilities visited no records were maintained for infant and maternal mortalities
- The exclusion of key Faith Based Organisations mean that in some areas the community has no access to Free Health Care
- The concept of the Free Health Care Initiative is not well understood in many communities due to a lack of sensitization activities
- Most health facilities visited had poor infrastructure including an inadequate supply of water” (HFAC, 2010).

Sierra Leone – Analysis of findings

Free Health Care in Sierra Leone One Year On: National Public and Stakeholder’s Perceptions of the Free Health Care Initiative (HFAC, 2013)

The civil society organization (Health for All Coalition – HFAC) helping to monitor the implementation of free health care in Sierra Leone the free health care initiative and its implementation to improve health care services one man’s business but a business of all Sierra Leoneans. The Director, Health for All Coalition in his own words said:

“The task of working towards an improved health care service is too important to be entrusted to one institution or individual – Sierra Leoneans must be encouraged to play an active role in health service developments and in the Free Health Care Policy” (HFAC, 2013).

The statement of the HFAC Director, is in line with the finding of the Burkina Faso free health care project beneficiaries perception evaluation as well as the positions of the Scottish Parliament because they believe that for free health care to work well, the process should be participatory involving stakeholders and the beneficiaries.

Others investigating the free health care systems had used individual and group interviews and the Health for All Coalition also used survey questionnaires to carry out a survey on stakeholders’ and experiences of the FHCI over the first 12 months of its existence having 100 respondents per district in Sierra Leone.

The survey looked for awareness about the free health care initiative (95.3% aware overall with varying levels of awareness across the country (99% in Moyamba District) ; Categories of eligible people for the free health care (about 80% overall knew the correct categories – meaning more people know about the initiative but less know about the

details (89% for Moyamba District)); when the initiative was introduced (overall, 43.5% were aware of when it started and only 4.2% knew it has no stated end date); overall, 95.7% (87% in Moyamba District) said they visited public health facility when they were sick during the first year of the free health care implementation and overall 4.3% and 13% in Moyamba District were not going to health facilities when sick either because the husband did not allow or there was no money or because of the attitude of the health workers, and overall 28.5% (21% in Moyamba District) were satisfied with the services received but 51% respondents said the services were very good, 78% said the services were good and 74% said the services are fair (the data show inadequate understanding of the free health care rights).

In conclusion, the free health care initiative has encouraging results but there are issues around inadequate detailed knowledge of the initiative, collection of illegal payment from beneficiaries in some places, inadequate involvement of beneficiaries & other stakeholders in the initiative which government should help stop by promoting learning and sharing among facilities doing well and those not doing well and also by promoting better involvement and participation of beneficiaries and stakeholders in the free health care initiative and more so the implementation.

Focus group discussion with various stakeholders held with Health for All Coalition and Save the Children, UK, Sierra Leone looked at success and challenges for the first year implementation; suggested solutions for the challenges and the top two priorities per district for future implementation. The overall findings brought out successes, challenges,

solutions to the challenges as suggested by the participants and the top two priorities for each of the health districts in Sierra Leone that will help future implementation.

Successes

- Reduced deaths amongst pregnant women, lactating mothers and under five children
- Awareness on the importance of health care utilization increased
- Community health messages including immunization increased
- Reduction in consequences of maternal deaths including time spent on traditional rituals
- Free health care beneficiaries utilization of health services increased
- Health workers commitment to work slightly increased with the exception of few workers in few areas including the Western Area Rural
- Health right awareness increased
- Peripheral health unit (PHU) to hospital referrals improved
- Recognition of increase in some health staff salaries as success in the free health care initiative
- Health infrastructure and rehabilitatee improved with the introduction of the free health care initiative
- Some improvement in communication amongst health workers
- Drugs and medical supplies distribution system, security and transparency improved with the introduction of the free health care initiative

- Basic health facility equipment provided and installed with the introduction of the free health care initiative
- Improvement in the district level medical stores as a result of the free health care implementation
- Reduction in maternal deaths resulting from birth complications as a result of increased access to user cost free caesarean sections
- Health management information system improved at peripheral health unit and hospital levels
- Number of health workers in some places like the Western Area increased as a result of the free health care
- More children and pregnant women immunized
- Understanding of roles resulting from training traditional birth attendants within the free health care initiative is helping in the reduction of home deliveries in Sierra Leone
- Increased demand for health care services

Challenges

- Despite the highlighted successes of the free health care from the Health for All Coalition and Save the Children UK, Sierra Leone survey (focus group discussions) the participants came up with several challenges facing the implementation of the initiative that included:

- Drug and medical supplies related challenges such as the inadequacy of drugs and medical supplies, shortage of drugs and medical supplies and the irregular or late supply of drugs and medical supplies
- Transportation related challenges including the poor nature of the roads, road network and transportation including ambulance for transfer of patients and mobility for health workers and community volunteers or committees.
- Non-cooperative or respectful working relation between the District Health Management Teams and the Chiefdom or Local Authorities' monitoring teams
- Absenteeism and attitude of health workers at their respective facilities/locations
- The lack of traditional birth attendants expected incentives
- Charging of illegal fees for free health care target groups by some health workers
- The absence of nutrition programs that provide food supplies to some health facilities
- Non or untimely availability of vehicle for drug and medical supplies distribution and monitoring
- Increased health facility utilization including people from outside the respective health facility catchment areas leading to increased workload for the health workers
- Shortage and inadequately trained health workers to meet the increased service demand
- Little or no incentives for community volunteers that support health activities or service delivery
- Inadequate communication systems in some places

- Non or delayed absorption of trained health workers into the government employment with subsequent delayed payment after graduation
- Health workers accommodation especially at community level health facilities
- Unequal distribution of health facilities with some communities quite remote from existing health facilities leading to the need for additional facilities and rehabilitation and equipment of new and rehabilitated facilities.
- Lack of incentive for blood donors and inadequate blood banks leading to unavailability of blood when needed
- Absence of adequate and well prepared district medical stores in some districts leading to poor management of drugs and medical supplies
- Funding and sustainability of the free health care initiative in the midst of huge gap even at the start
- Request for users payment and inadequacy of operational costs for ambulance where they are available
- Free health care focus on public health facilities leaving out faith-based or private health facilities (often more trusted by users than the public health facilities).
- Delayed disbursement of government funds for implementation, monitoring and supervision
- Lack or inadequate staff motivation including postings, relocations, salaries, transportation for staff
- Leakage or thrift of drugs and medical supplies and also the World Food Program Nutrition support to health facilities.
- Poor data quality and timeliness or health records.

Payment for services, health workers' attitude, health workers shortage, worker in-service training, issues with establishment regarding putting staff on pay roll after basic training, adequacy of staff payment and regular and appropriate payment, what should be the role of traditional birth attendants (TBAs) and the need for a policy on their operations , insufficient and untimely supply of drugs and medical supplies, long distances and bad roads to access health facilities, lack or unavailability of ambulance when needed, the poor maintenance culture of health facility equipment, the need for salary increased not realised by all health workers and funding gap were concerns emphasised by participants.

Participants agreed on that the free health care has been greatly success considering reduction of maternal and child death that occurred as a result of the initiative. It was also agreed that because more people are attending clinics, awareness increased because of the health talks at the facilities.

Inadequate communication between health staff management and service providers' lack of adequate transportation, inadequate monitoring and supervision were also highlighted.

Participants' suggestions from the focus group discussions during the Health for All Coalition and Save the Children UK, Sierra Leone's survey one year into the implementation of the free health care for addressing their highlighted challenges included:

Having at least two qualified health workers or professionals at peripheral health units to ensure that one professional is always available to provide service even when one is away

Address health worker, auxiliary staff and volunteer issues including basic and in-service trainings, absorption after graduation, timely and adequate payment, incentives and motivation (remote allowance, accommodation and volunteer reward)

Enforcement of health worker professionalism, ethics and commitment to work by government

Development of national traditional birth attendants' policy highlighting their new role focused on referral of pregnant women to health facilities for antenatal services and delivery through a national consultative process

A school for Maternal and Child Health Aides (MCHAs) school to increase their number and improve on their recruitment process

Improvement on health infrastructure (old and new), provision of quality equipment and maintenance of health equipment including training and payment of technicians

Improvement in stakeholders coordination and collaboration involving the Ministry of Health and Sanitation, Local or District Councils, Chiefdom Authorities, the District Management Team (DHMT), peripheral health units (PHUs), hospitals and the drug and medical supplies procurement unit backed by training and good quantification of actual required drugs and medical supplies with the aim of improving the supply chain management.

Transportation and road network support for drugs and medical supplies, monitoring and supervision and outreach services and storage (space, training and effective management)

Increased education of the population on available health service schemes such as the free health care fees for service or cost recovery policy

Improvement on blood donation and storage including the provision of incentives for free blood donors to help improve the functionality of all basic emergency obstetric centers' blood banks

Improvement of health facility (hospitals and peripheral health units) cleanliness through contract servicing and increased awareness raising on nutrition, hygiene and sanitation

Local ownership of health interventions ensuring adherence to policies, procedures, standards and processes

Improvement on communication and monitoring and supervision of commodities, equipment and services within the health care system for both government and partners

Increased civil society advocacy for extension of the free health care to non-public health facilities i.e. faith based and private facilities.

All the health districts covered in the survey including Moyamba District (the research district) came up with two top priorities they thought could help with future implementation of free health care in their districts that were as follow:

“Kono: Provision of adequate supply of essential drugs to ensure full coverage of all beneficiaries and provision of utility vehicles and motorbikes for regular drugs distribution and effective monitoring and supervision.

Tonkolili: Provision of adequate blood banks and incentives for blood donors and trained and qualified staff with adequate accommodation and utility vehicles.

Kenema: The inclusion of faith based hospitals in the FHCI and timely and adequate supply of essential drugs and commodities.

Kambia: Increased collaboration and partnership between DHMT, HFAC, Local Council, and Local Authority and the provision of adequate drugs and logistical support for health facilities.

Kailahun: The provision of utility vehicles and motorbikes for drugs distribution, monitoring and supervision and construction of roads.

Bo: Adequate and timely supply of essential drugs and Funding for fuel to support referral system.

Western Area: Provision of adequate numbers and sufficient quality of human resources and address the funding gaps.

Pujehun: Inclusion of all health personnel in the FHC salary package and additional ambulances and utility vehicles.

Moyamba: Regular and timely supply of drugs and other medical supplies and strengthen monitoring and supervision.

Koinadougou: Timely, adequate, and regular supply of drugs, quality and quantity of staff and in-service training and supportive supervision

Bombali: Inclusion of faith based hospitals and logistical support for the maintenance of utility vehicles for the early distribution of drugs.

Porto Loko: Adequate and regular supply of all essential drugs to health facilities and community stakeholder partnerships – District Councils and DHMTs to take responsibility and ownership for all health related activities.

Bonthe: Adequate staffing of all referral hospitals and PHUs – there should be at least three adequately trained staff at each PHU and timely and adequate supply of essential drugs” (HFAC, 2013).

Drug supplies, staff training and transportation for staff and patients were strong among the district priorities in general.

In conclusion, drug procurement and supplies, control of illegal charges came out strongly as well as the fact that there is success but much more actions need to be taken to

improve the implementation in Sierra Leone and government therefore there is need to use the survey findings and recommendations to inform improvement plans for the free health care initiative in Sierra Leone.

6. Research questions

The research was set out to answer and answered the following research questions:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?
- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

7. Study type

A retro and prospective study aimed at investigating the Moyamba District health care delivery system two years before and after the introduction of free health care for

pregnant women, lactating mothers and under five children in Moyamba District in Sierra Leone.

8. Study sample frame work

Entire Moyamba District (all functional health facilities/systems, the communities – pregnant women and lactating mothers with under five children) was used in this research. This was complemented by views of stakeholders at the national and the Moyamba District level as well.

9. Sample size

All (100%) of the primary health care facilities in Moyamba District with one health professional from each of the peripheral health units in the district interviewed and or involved in focus group discussions with other community members, stakeholders at least one person from each health service providing non-governmental organization (NGO) working in Moyamba District, representatives of the Moyamba District Council, the Moyamba District Health Management Team (DHMT), representatives of community members at both chiefdom and village/community levels. Representatives from the national level were also involved in the research. All the research respondents participated either by completing questionnaire interviews and or by participating in focus group discussions or personal interactions with the researcher or colleagues of the researcher that assisted with the research data collection focused on two years before and after the introduction of the free health care system for pregnant women, lactating mothers and under five children (within Moyamba District, Sierra Leone).

10. Limitations:

Disruption in the existence and effective functioning of the introduced free health care services resulting from factors including but not limited to lack of funding and personnel cooperation.

11. Research Methodology

This section includes a very detailed description of the research methodology used to collect and analyze the data for this study. It provides enough details and it is precise enough to enable another researcher to exactly replicate this study. The data collection methods and analysis used in this research are amongst those recommended by the St. Clements PhD thesis guide (Thesis Guidelines, St. Clements) and they are similar to what other people have done for similar investigation in Sierra Leone (HFAC & SCUK, SL, 2011) and in Burkina Faso (Valery Ridde et al, 2011).

The researcher collected qualitative and quantitative data in the investigation of the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone. With photographing where necessary observations, focus group discussions and questionnaires were used to collect primary data while secondary data was collected through desktop analysis including use of the Moyamba District Health Information System (DHIS 2008 to 2012 i.e. two years before and two years after the introduction of the free health care initiative in Sierra Leone including Moyamba District). The investigator developed a research proposal and tools necessary for the required data collection. The proposal was shared with the Office of the health partners (NGO Desk) of the Ministry of Health and Sanitation (MOHS) at national

level and with the Moyamba District Health Management Team (MDHMT) at the study location (Moyamba District) with request for their permission to carry out the intended research on the Effect of Free health Care on pregnant Women, Lactating Mothers and Children Under Five in Moyamba District in Sierra Leone. The researcher also sought permission and support from Plan colleagues and Plan Sierra Leone where he works to help where and when necessary during the course of the research while still working in the organization but without comprising job or research quality in any case. After securing the necessary permissions (that were verbally given), the researcher orientated various stakeholders (MOHS/MDHMT/Plan/Communities) on the study and sought their support throughout the study. The issue of consent was discussed and addressed during the orientation and data collecting meetings or interactions and respondents that responded to questionnaire interview had the consent section at the top of the questionnaires completed indicating that they should only continue to complete the questionnaires if they consent to do so. They were given the option to sign and some did while some did not sign but completed the questionnaires meaning they consented to do so. In collecting secondary data, the investigator in the desktop analysis collected data from the district level as well as community level through peripheral health units within the study location i.e. Moyamba District. The primary data collection also involved respondents at national, district and community levels. Health care providers, civil society, users of health care services, especially pregnant women, lactating mothers and or mothers of children under five years of age were interviewed using pretested questionnaires. Information that was sought from both the secondary and primary data collection processes was included but not limited to antenatal and postnatal services,

maternal and child morbidity and mortality, personnel and system related information regarding the free health care. Triangulation technique was used in the collection of the data with data analyzed using simple but effective means (excel). The process of data collection and analysis was the sole responsibility of the researcher but the services of others were sought for different services where and when necessary. All necessary data collection preparations were finalized between January 1, 2013 and April 30, 2013. The actual data collection took place immediately after the completion of the third year of the introduction of the free health care initiative in Sierra Leone including the study location (Moyamba District). Therefore, the data was collected from May 1, 2013 to December 31, 2013. The collation of data and analysis of the findings and final research report writing with the inputs of the research supervisor stretched from December 2013 to April 2014. The final report was ready against the end of the extended course period that is June 2014.

Triangulation allowed data collected in this research to be cross checked ensuring data collected through a specific means is validated in a way to enhance data validity and quality. Below are the specific details of the data collection, methods and plan used in this research.

Research Plan for investigating the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone from April 27, 2010 to April 26, 2012 (investigation and discussions on the situation two years before and two years after the introduction of the initiative),

Focus group discussions (health workers and beneficiaries):

National level representatives

District level representatives

Chiefdom level representatives

Community level representatives

Observation (including photographing):

Health facilities in Moyamba District

Selected communities in Moyamba District

Selected individuals/groups in Moyamba District

Interviews (using simple questionnaires):

National level (including health staff)

District level (including health staff)

Health service providing partners/non-governmental organization (NGOs) in Moyamba District

Civil Society group monitoring the FHCI at national level and at the district level for Moyamba

Community health workers

Community members (beneficiaries of the FHCI – direct & indirect beneficiaries)

Use of secondary data:

Previous health data for Moyamba District – two years before the FHCI and two years into the FHCI

The FHCI position paper

The FHCI annual performance report

Guide for the planned focused group discussions (personal inter-face and focus group discussion plan):

In communities, discussions were held with:

Children/youth

Women (including pregnant women and lactating mothers)

Men (including relatives of the direct beneficiaries i.e. pregnant women, lactating mothers and children under five years of age)

Discussions were around the following topics (same as those covered in the questionnaire interviews):

Knowledge of FHCI in Sierra Leone

Knowledge of Sierra Leone's health care system/operations

Knowledge of the effects of the FHCI in Sierra Leone

Thinking around the effect – whether it is good, needs scale up to non-governmental health facilities and whether it should be replicated in other countries other than Sierra Leone

Challenges in the implementation of the initiative on benefits such as non-direct health costs, workload on health staff, staff attitude to the new initiative, availability of drugs and medical supplies/equipment etc.

General comments and recommendations for the FHCI

Actual Thesis/Research Field Work Plan

#	Activity	Time frame
1	Development and sharing of mini thesis framework with Course Director for approval	January - December 2012
2	Approval of mini thesis frame work by Course Director	January - December 2012
3	Development of research plan and tools	January 2012 - December 2012
4	Sharing of research idea and seeking of approval from Moyamba District Medical Officer	January 2012 - December 2012
5	Preparation of ground for field work	January 2013 – April 2013
6	Actual field work	May 2013 – December 2013
7	Collation and analysis of research findings	December 2013 – March 2014
8	Write up and submission of thesis to Course Director for approval	April 2014 - June 2014

Actual Field work plan

Location	Time
Freetown	1 st – 31 th May 2013
Moyamba town	1 st – 31 th May 2013
Chiefdom level work	1 st June 2013 – 31 st December 2013
Community level work	1 st June 2013 – 31 st December 2013

Completion of missed actions at the various levels	1 st June 2013 – 31 st December 2013
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Note: Discussions, interviews or observations were carried out face-to-face, through support from colleagues or phone conversations and emails. The initial schedules changed due to slow responses received in some instances but the researcher was flexible enough to allow time for the necessary information to be collected in order to add value to the research.

12. Analysis and Findings

Here discussion of the results of the research using triangulation with simple analyzing technique described in the methodology was used. The answers to the research questions or the results related to the research hypothesis are clearly stated in this section. All conclusions made at this point are directly supported by the data presented. This section is very logical and precise as presented below in providing answers to the research hypothesis which is: “Free health care for pregnant women, lactating mothers and under five children improves health care service delivery” and the following four research questions:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?

- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

Research findings and analysis

The research gathered data through questionnaires, focus group discussions, interpersonal communication (IPC) and observations in and out of the research district of Moyamba in Sierra Leone and Moyamba District Health Information System (DHIS). In the event, a total of over 1000 people were reached using different approaches. Data from the questionnaire interviews came in from 116 respondents, the focus group discussions involved about 900 people in separate meetings held at national level (with a meeting in Kenema with national level stakeholders in Health and water sanitation and hygiene/health (WASH) service delivery in Sierra Leone), Moyamba District Headquarters (in Moyamba Town including the Moyamba District Council staff, health workers within the district), chiefdom/community level (involving women, men, young people and social workers in Moyamba District). The IPC involved interactions with stakeholders in health service delivery in Sierra Leone, Moyamba District including the community health workers, stakeholders at the local council within Moyamba District,

Moyamba District Health Management Team members, non-governmental organization workers in Moyamba District, civil society representatives, community members including local authorities, health workers and beneficiaries of the health services including pregnant women, lactating mothers/mothers with children under years old and fathers of children under five years old.

Research findings from the various approaches used are as follow:

Questionnaire: the questionnaires were applied to respondents at national, district, chiefdom and community levels with data collected and analyzed using tables, percentages and graphs for the variables used as presented below.

The Effect of Free Health Care Initiative in Moyamba District, Sierra Leone

Research findings

Table 1: Questionnaire Respondents by Sex			
<i>Variable</i>	Male	Female	Total
No.	36	81	116
%	31	69	100

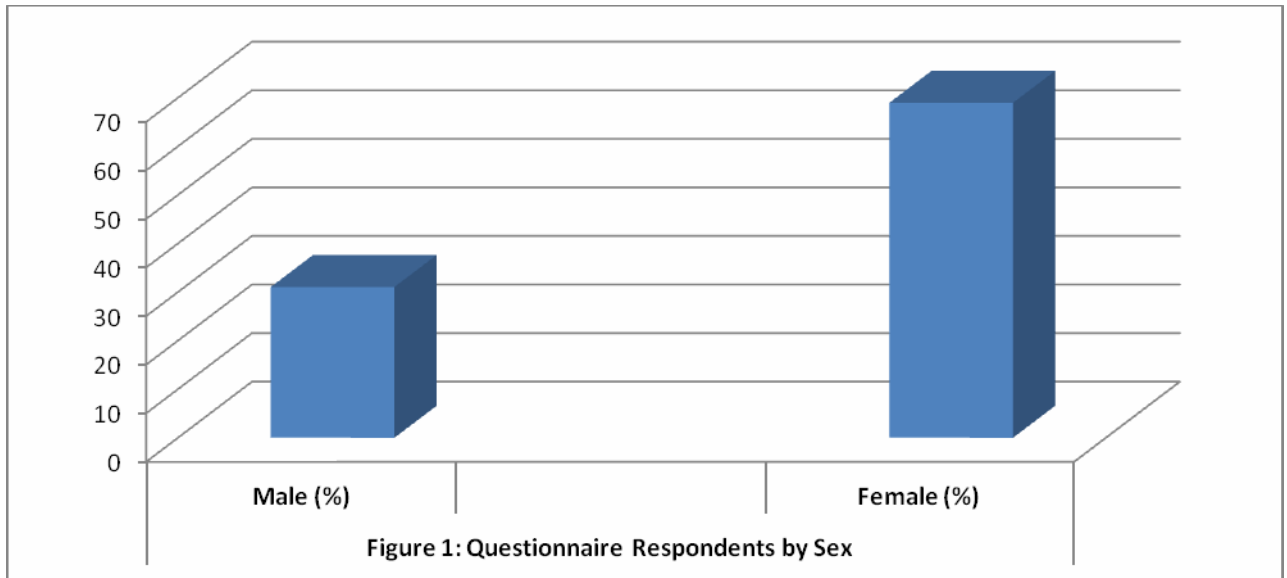


Figure 1: Questionnaire Respondents by Sex

Table 1 and Figure 1 show that the questionnaire respondents were 31% and 69% males and females respectively. The data show that more women than men were interviewed. Two reasons for this is that majority of the community level health workers in Sierra Leone including Moyamba District are women manning peripheral health units (PHUs) and all the PHU staff in Moyamba District were interviewed and the next reason is that FHC is targeting more of women who utilize the services as pregnant women, lactating mothers using the services for themselves or for their under five year old children all of whom make up the targeted categories for the FHCI in Sierra Leone. The views of women are therefore relevant in this research. As a result, even though the gender balance was stroke amongst participants in the focus group discussions, overall population reached still continued to be more women against men and that remains and adds value to the research findings as women know more and utilize the FHC services more than men and hence better responses from women than men.

<i>Variable</i>	Table 2: Questionnaire respondents by Age category		
Age	<18 years	Above 18 years	Total
No.	0	116	116
%	0	100	100

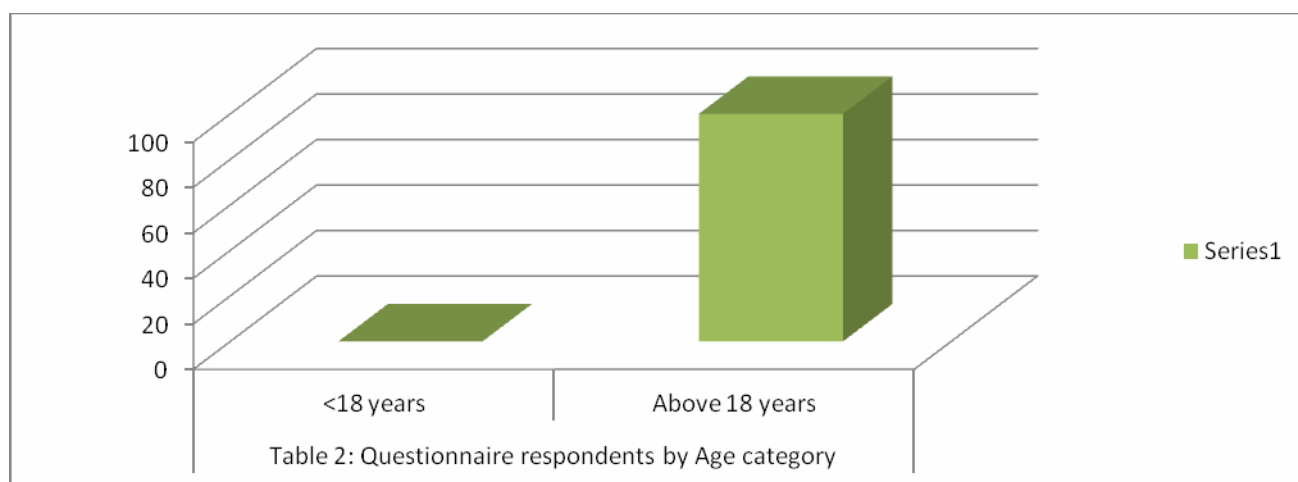


Figure 2: Questionnaire respondents by Age category

Table 2 and figure 2 show that all the research questionnaire respondents were above 18 years old. This was the case mainly because of the categories of people (100%) targeted for the questionnaires such as health service providers, health workers pregnant women and lactating mothers that are usually above 18 years old. People between 15 years and 18 years were however involved in the focus group discussions thereby capturing the views of young people on FHCI in Sierra Leone and Moyamba District. The views of children in Sierra Leone are considered valued as the communities hold the view that children do not hide the truth rather, they speak out what they know.

Table 3: Respondents by Category / Entity

Inst/Org/Community	No.	%
Government	84	72
NGO	14	12
Community	6	5
Private	6	5
Individual	4	3
Others (University)	2	2
Total	116	100

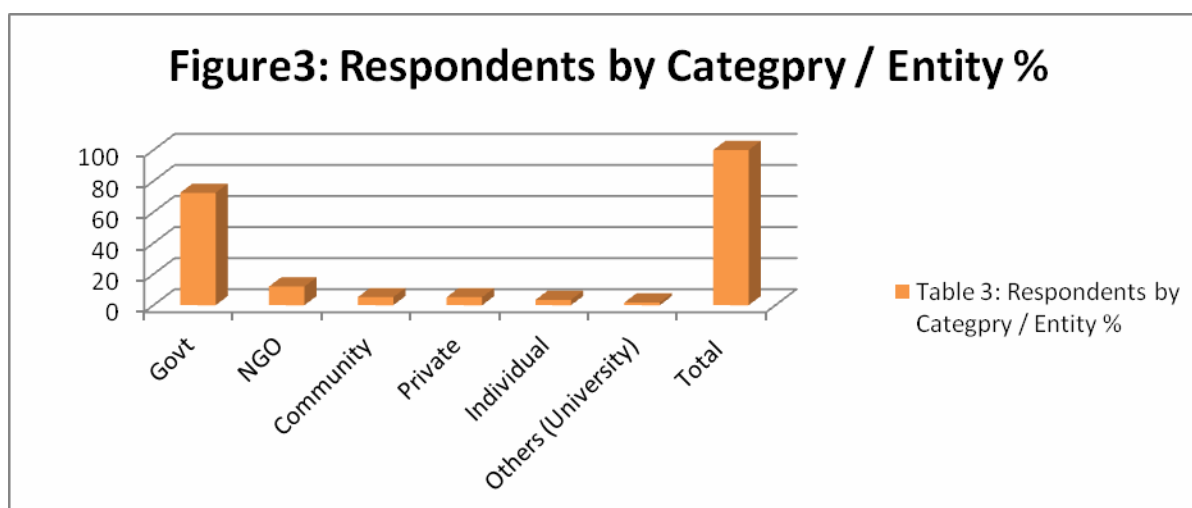


Figure 3: Respondents by Category / Entity

Table 3 and Figure 3 show that 72% of the respondents to the questionnaire interviews were linked to government functionaries while 12% were NGO, 5% community, 5% private, 5% individuals and 2% others (university) were linked to those respective categories or entities. Majority of those in the government category are community health workers also living in the

communities like any other community member and thus truly reflected the views of their respective communities. That means, the community representation was indirectly very high in the research which is a valuable component in bringing out beneficiary perception of free health care initiative in Sierra Leone and the research location (Moyamba District).

Table 4: Respondents' Location		
Location	No.	%
Freetown	14	12
Moyamba Town	33	28
Chiefdom Headquarters	11	10
Village level	58	50
Total	116	100

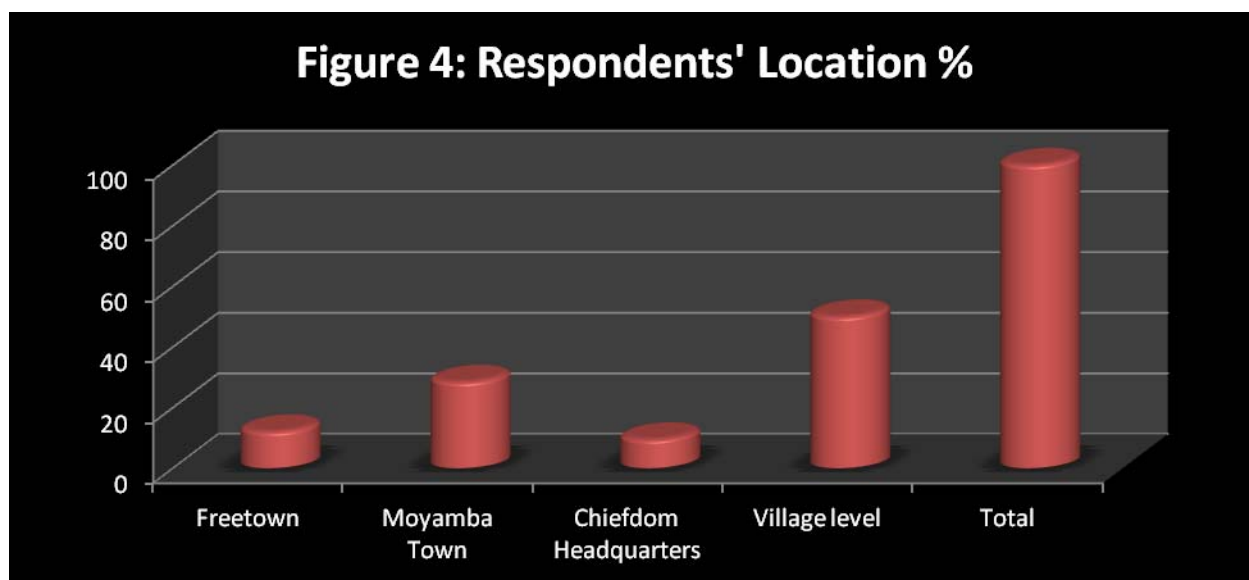


Figure 4: Respondents' Location

According to table 4 and figure 4, respondents to the research questionnaires came from various locations in the following proportions: Freetown (capital city of Sierra Leone) - 12%. Moyamba Town (Head Quarters of Moyamba or the research District) - 28%, Chiefdom level (Chiefdom Headquarters in 14 Chiefdoms in Moyamba District) – 10% and village level (villages or communities within Moyamba District) -50%. This shows that majority of the respondents live within various communities in Moyamba (the research District) and reflects the views of majority of those using the free health care services in Moyamba District. Focus group discussions also involved a lot of communities and residents of Moyamba District where the effect of the FHCI is investigated in this research.

Table 5: Knowledge of FHC in SL			
Knowledge of Free Health Care Initiative in Sierra Leone	Yes (%)	No (%)	Total
No.	115	1	116
%	99	1	100

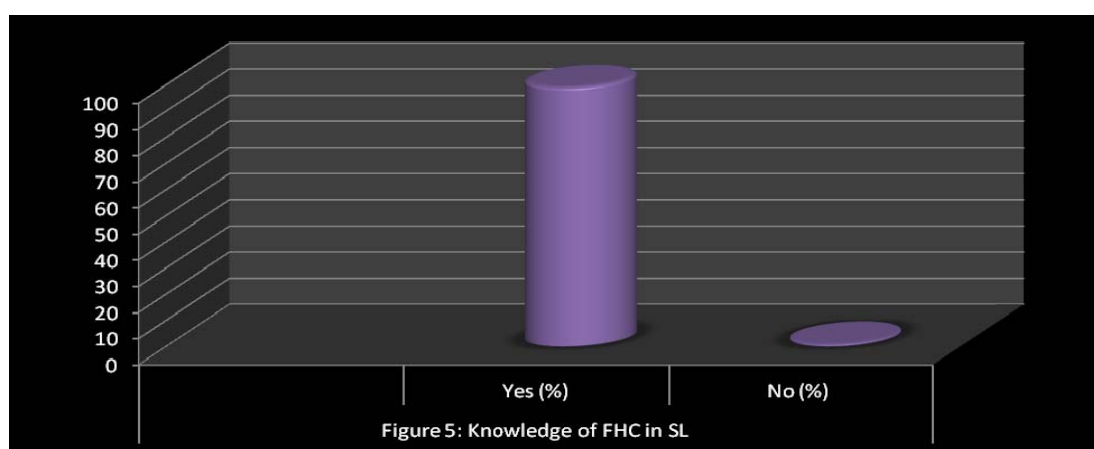


Figure 5: Knowledge of FHC in SL

Table 5 and Figure 5 show that 99% of respondents know about the free health care initiative in Sierra Leone and Moyamba District. Meaning they know that it exists but that does not tell how well informed they are about the initiative and that was probed in other research findings below. The focus group discussions also showed similar high knowledge (just knowing about the existence of the initiative) about the existence of the FHCI in Sierra Leone including Moyamba District as almost everyone showed that they know about it. The high level of knowledge of the free health care initiative in Moyamba District is similar to what prevails in other parts of Sierra Leone as well as what other findings have shown (HFAC, 2013).

Table 6: Knowledge of when FHC was Launched in Sierra Leone			
Launched	1Yr or less	Over 1 yr	Total
No.	0	115	100
%	0	100	100

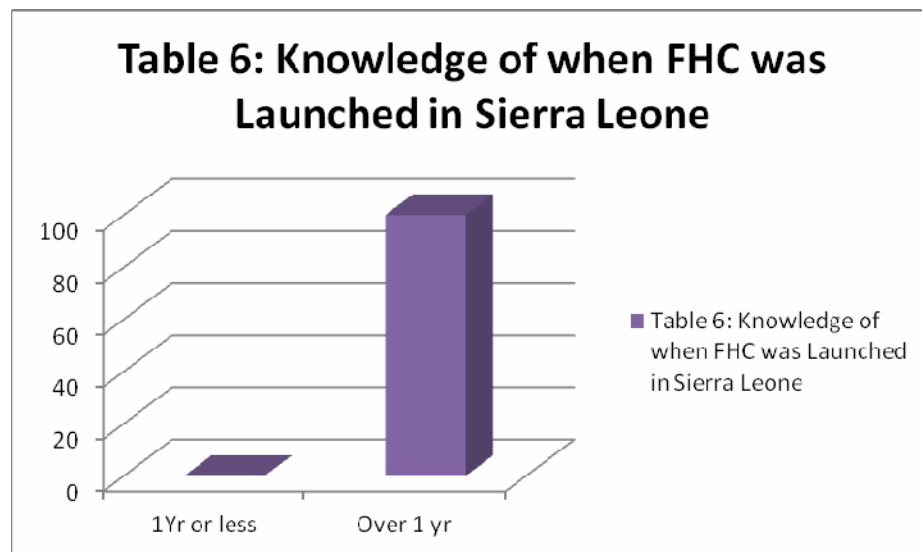


Figure 6: Knowledge of when FHC was launched in Sierra Leone

According to Table 6 and figure 6, everyone interviewed (100%) knew as of the time of the interview that the FHC was launched over one year ago. The same picture was presented at the focus group discussions. According to the respondents especially those in focus group discussions the high knowledge of existence and when the initiative was launched is associated with the high level of publicity the initiative received before, during and even after its launch because it is considered to be an initiative of the ruling President of the Republic of Sierra Leone Dr. Earnest Bai Koroma which he and his party used it as a strong campaign instrument (as expressed by some of the respondents).

Table 7: Knowledge of reason why the FHC was launched in Sierra Leone

	Yes (%)	No (%)	Total
No.	115	1	116
%	99	1	100

Figure 7: Knowledge of reason why the FHC was launched in Sierra Leone

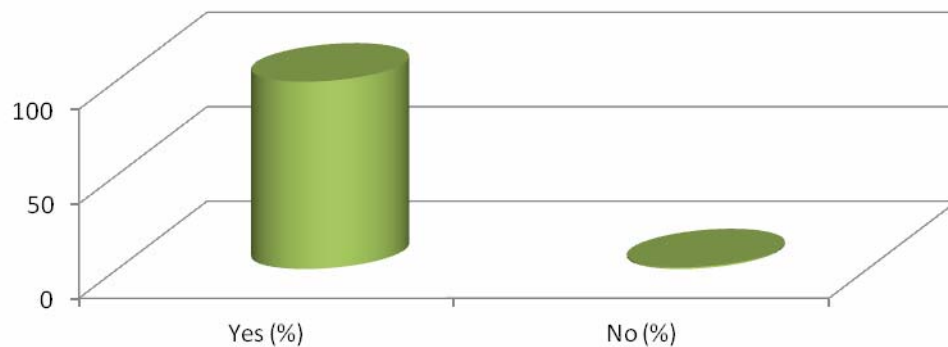


Figure 7: Knowledge of reason why the FHC was launched in Sierra Leone

Table 7 and figure 7 show that almost every one interviewed (99%) knew why the free health care initiative was launched in Sierra Leone on April 27, 2010. This response which did not bring out what the respondents know as the reason why the free health care was introduced, was further probed as shown down in response to other questions that followed this one.

Table 8: Reasons why FHCI was launched in SL											
Variable	< 5S	Lactating mothers	improved health service delivery	Address user fees for mothers & under five children	High maternal & infant mortality	Poverty	To reduce infant & maternal mortality	To help improve health status of lactating mothers, pregnant women & <5s and prevent mortality in the communities	For lactating mothers, pregnant women	For lactating mothers, pregnant women access to free health care	Total
No.	2	1	1	1	6	3	84	6	5	17	126
%	1	1	1	1	5	2	67	5	4	13	100

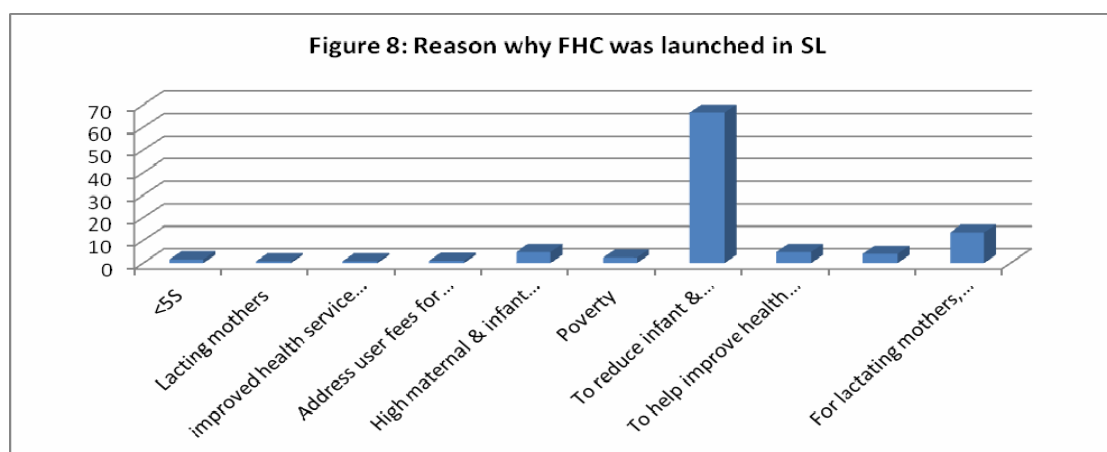


Figure 8: Reasons why FHCI was launched in SL

Table 8 and figure show reasons given by all respondents for launching of the FHCI in Sierra Leone. There were nine (9) different responses totaling up to 126 responses with some of the respondents giving more than one answer and some of the respondents not providing any information for the question. In total, 67% of all responses received was that FHCI was introduced or launched to reduce infant and maternal mortality (the goal of the initiative), 13% indicated that it was for lactating mothers and pregnant women while the other responses ranging between 1% and 5 % of all responses received for this question showed a breakdown of the reasons into parts that are correct but not complete (as listed per table 8 above). This show that knowing that the initiative exists and when was launched does not mean knowing the exact reasons why it exists. This show of gap in details of knowledge about the free health care initiative is as found in Moyamba District similar to what exists in other parts of Sierra Leone except for districts where extra efforts in the form of projects or intensified media efforts have improved the knowledge gap. For example, in Bombali, Tonkolili, Kenema and Bo where a World Bank funded Government of Sierra Leone implemented project through Non-Governmental Organizations (NGOs) i.e. International Rescue Committee (IRC), Concern Worldwide and Plan International Sierra Leone as implementing agents improved communities knowledge on free health care through participatory approaches called “Community Monitoring” and “Non-Financial Award” aimed at improvement of primary health service delivery in Sierra Leone.

Table 9: Eligible Target Categories for Free Health Care in Sierra Leone						
Variable	Everyone	Pregnant women	Lactating mothers	Under five children	Others (specify)	Total
No.	0	115	113	115	2	345
%	0	33	33	33	1	100

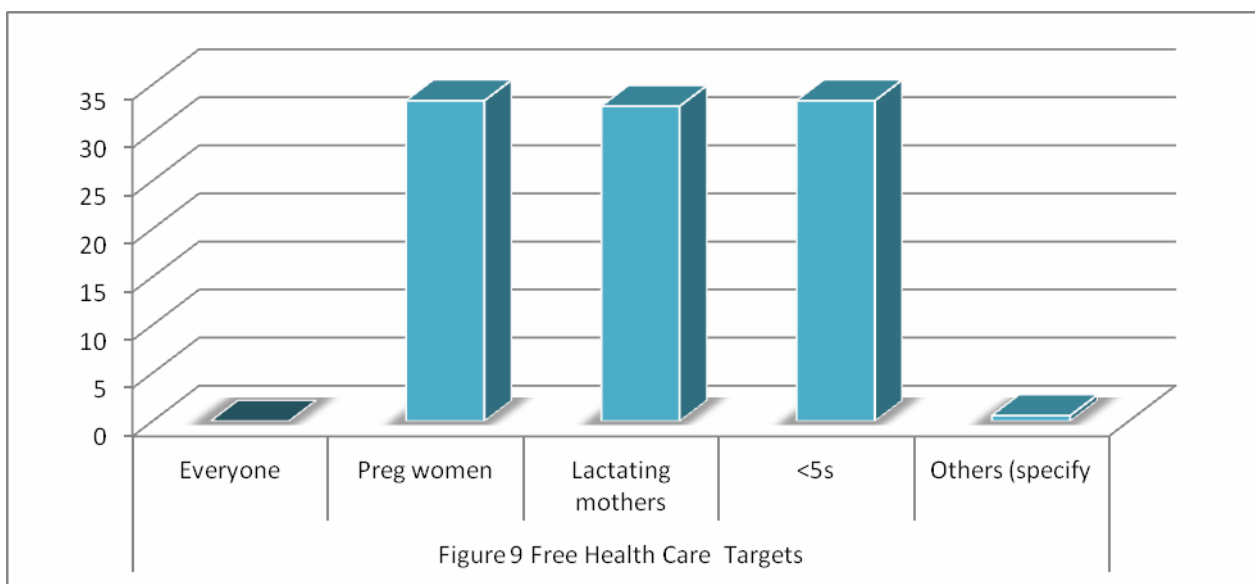


Figure 9: Eligible Categories for Free Health Care in Sierra Leone

Table 9 and figure 9 show that all responses received identified pregnant women, lactating mothers and under five children as the eligible targets for free health care in Sierra Leone including Moyamba District accounting for 99% of all the responses spread across the three categories (33% each). One percent (1%) of the responses indicated that FHC covers the handicap or physically challenged persons (more of what the respondent (1 person) wish to see happening rather than what the initiative actually provides. This response was more likely due to the fact that most of the respondents were women including pregnant women and lactating mothers who are using the services more other members of the research communities. Knowledge of eligibility for the services is important because the services cannot be properly utilized if the beneficiaries are not clear on whom and who should not or should use the services. the lack of such knowledge according to some of the respondents especially in the focus group discussions, leads to frustration and misunderstanding between service providers and communities who think that they are been deprived when in fact they were not eligible. This according to community

members and health workers, is a cause for unnecessary suspicion, mistrust, quarrels and sometimes physical confrontations, abandonment of health services, extra cost to seek services from distant and alternate places and in some cases subsequent lack of service by deprived or poor community members resulting in loss of lives in some cases said some community members in the focus group discussions.

Table 10: Geographic areas covered FHC in Sierra Leone							
<i>Variable</i>	Entire country	W/A	S/P	E/P	N/P	No response	Total
No.	108	0	1	0	0	7	116
%	93	0	1	0	0	6	100

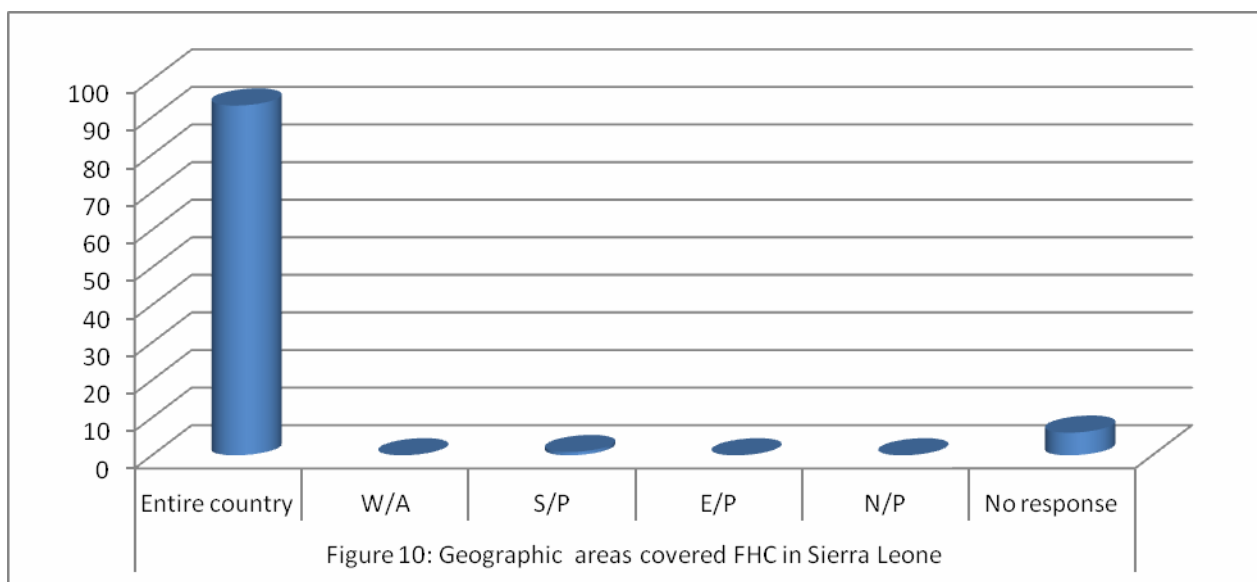


Figure 10: Geographic areas covered FHC in Sierra Leone

Table 10 and figure 10 show the respondents' knowledge of the geographic areas covered by the FHC in Sierra Leone. Ninety-three percent (93%) of the respondents indicated that the FHC is for

the entire country and 1% indicated that it is for the Southern Province (where the research district of Moyamba is located) while 6% of the respondents did not respond to the question (an emerging category of responses that was not anticipated before the start of the research/interviews). Women in focus group discussions indicated that they were using the free health care services because they knew about it and knew that the initiative and services existed in the communities and that was why they were using the services.

Table 11: Different levels of Health Facilities in Sierra Leone								
Variable	MCH P	CHP	CHC	D/Hosp	p/Hosp	Others	No response	Total
No.	86	66	86	77	53	5	9	
%	23	17	23	20	14	1	2	100

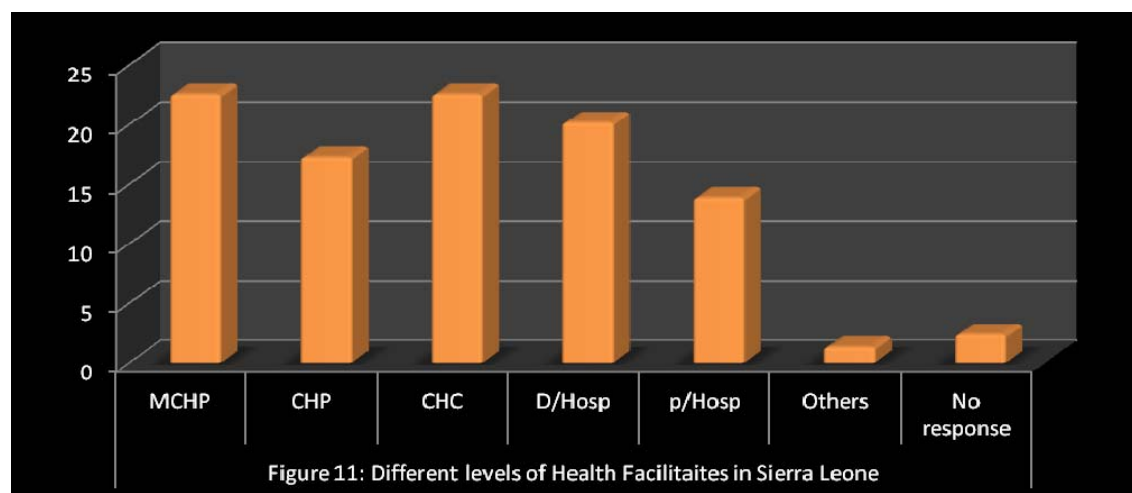


Figure 11: Different levels of Health Facilities in Sierra Leone

Table 11 and figure 11 show respondents' knowledge of available different levels of health facilities in Sierra Leone. Out of the responses received, 23% were for maternal and child health posts (MCHP), 17% for community health posts (CHP), 23% community health centres (CHC), 20% district hospitals (D/Hosp), 14% provincial hospitals (P/Hosp), 1% for other categories

(traditional healers) while 2% of the responses did not state anything. Free health care is provided at all the different levels of health facilities in Sierra Leone provided the health facility is a public health facility because free health care is provided at the public or government health facilities and not the other except if by design the supporting entity, be it a mission, non-governmental organization and or institution decides to provide free health care at the point of delivery.

Table 12: Knowledge of Health Service Categories in Sierra Leone (Health System)						
<i>Variable</i>	Government	Mission	Private	Others	No response	Total
No.	110	33	26	4	4	177
%	62	19	15	2	2	100

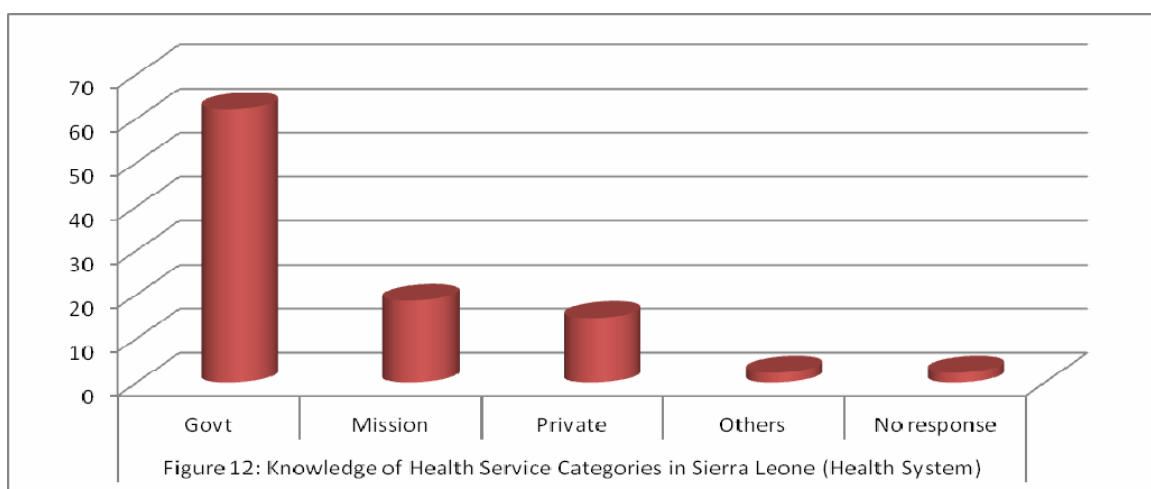


Figure 12: Knowledge of Health Service Categories in Sierra Leone (Health System)

Table 12 and figure 12 show respondents' knowledge of available different categories of health facilities in Sierra Leone. Out of the responses received, 62% were for government facilities, 19% mission, 15% private, and 2% others while 2% of the respondents did not state anything. The importance of knowing the different categories of health facilities in Sierra Leone in relation to

the free health care is that free health care services are provided in government or public health facilities as up to the writing of this research report, it was not extended to private and other categories of health facilities. The idea of extending it to other categories of health facilities is anticipated by the public but has not been part of the agenda for the initiative as the provision of drugs and medical supplies to public health facilities where it has already been introduced is still a challenge as findings in this research and other investigations (HFAC, 2013) showed that there is inadequacy in drugs and medical supplies.

Table 13: Knowledge of Health Service Schemes Operated in Sierra Leone

Variable	Fees for service/cost recovery	FHC	Others	No response	Total
No.	91	103	2	3	199
%	46	52	1	2	100

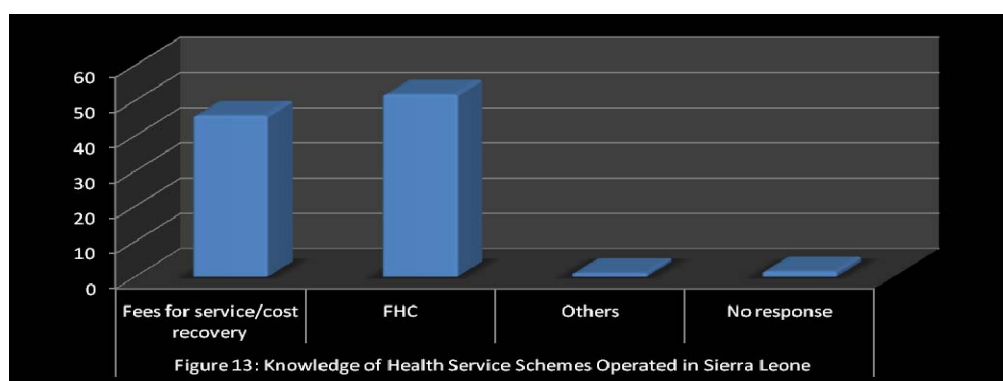


Figure 13: Knowledge of Health Service Schemes Operated in Sierra Leone

Table 13 and figure 13 show respondents' knowledge of existing health service schemes in Sierra Leone at the time of the research or data collection (2013). Of all responses received, 46% stated fee for service/cost recovery, 52% stated free health care, 1% others and 2% did not state anything. Although other findings as stated above show high knowledge of the existence of free health care in Sierra Leone and the research district which is Moyamba District, testing the

knowledge of different health schemes in Sierra Leone show that not everyone knows about the available different health schemes in Sierra Leone or Moyamba District.

Table 14: Respondents' Preferred Health Service Scheme in Sierra Leone

<i>Variable</i>	Fees for service/cost recovery	FHC	Others	No response	Total
No.	42	86	0	3	131
%	32	66	0	2	100

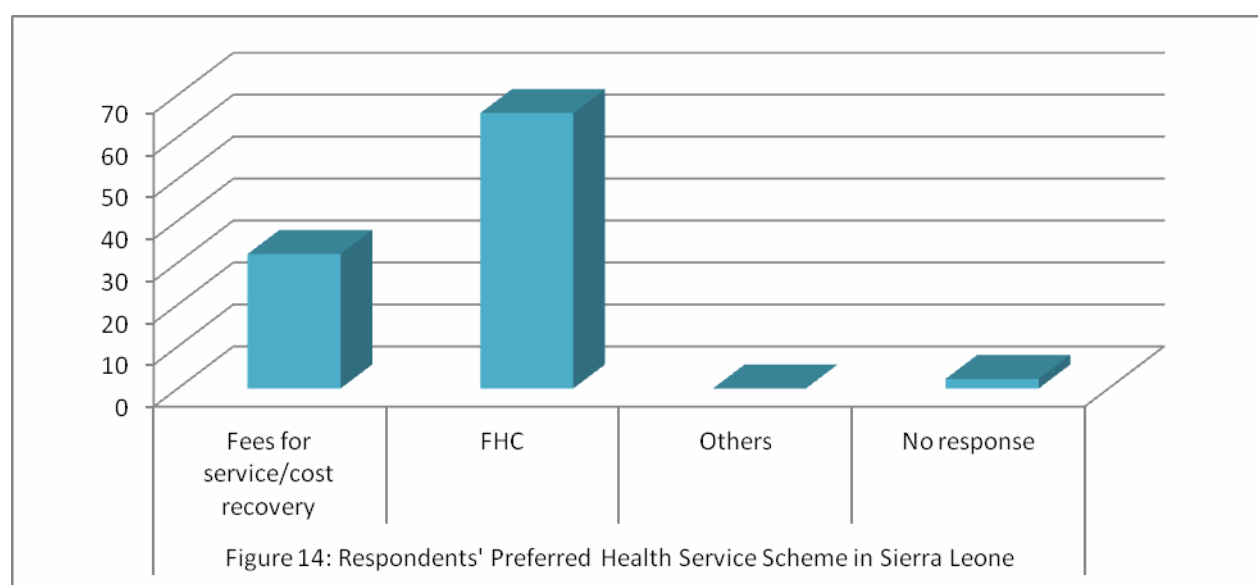


Figure 14: Respondents' Preferred Health Service Scheme in Sierra Leone

Table 14 and figure 14 show responses received for preferred health service scheme with 32% for fee for service/cost recovery and 62% for free health care initiative. Linking this finding with knowledge of the available health schemes above show that people are more likely to use the scheme they are aware of. As such, it is seen that more people know about the free health and

more people prefer to use the free health care compare to cost recovery which lesser number of people know about and lesser people prefer.

Table 15: Effect of FHC in Moyamba District (% by Categories)																		
Variable	Preg women			Lactating mothers			<5s			Health Workers			MOHS			Others		
	very effective	fairly effective	Not effective	very effective	fairly effective	Not effective	very effective	fairly effective	Not effective	very effective	fairly effective	Not effective	very effective	fairly effective	Not effective	very effective	fairly effective	Not effective
No	48	51	8	51	51	8	51	47	7	52	48	7	47	42	8	28	17	7
%	45	48	7	46	46	8	49	45	6	49	45	6	48	45	7	54	33	13
																		Total responses
																		586
																		No response
																		8
																		1
																		N/A

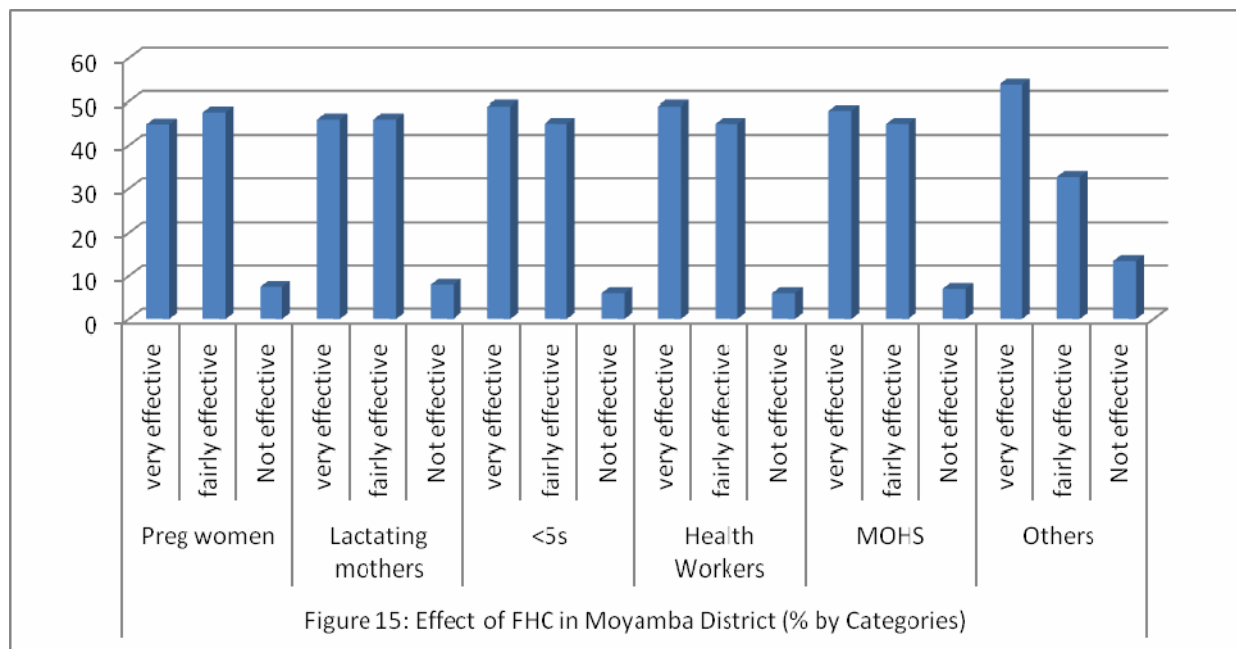


Figure 15: Effect of FHC in Moyamba District (% by Categories)

Table 15 and figure 15 show the effect of free health care (FHC) in Moyamba District on various categories as follow: pregnant women – for this category, all responses received show that 45%

feel that FHC is very effective, 48% indicated that it is fairly effective while 7% indicated that it is not effective. For lactating mothers - all responses received showed that 46% feel that FHC is very effective, 46% indicated that it is fairly effective while 8% indicated that it is not effective. For under five children - all responses received show that 49% feel that FHC is very effective, 45% indicated that it is fairly effective while 6% indicated that it is not effective. For health workers - all responses received show that 49% indicated that FHC is very effective, 45% indicated that it is fairly effective while 6% indicated that it is not effective. Ministry of Health and Sanitation (MOHS) - for this category, all responses received show that 48% feel that FHC is very effective, 45% indicated that it is fairly effective while 7% indicated that it is not effective. For others - all responses received show that 54% feel that FHC is very effective, 33% indicated that it is fairly effective while 13% indicated that it is not effective; while table 15 shows that 1% of all responses received did not indicate anything. According to all responses received, free health is very effective for majority of people and fairly effective for so many while very less number of people said it is not effective. That is an indication that the free health in Moyamba District is effective.

Table 16: Respondents' Views on the impact of FHCI - Whether it is good & Has Impact on the EFFECT Highlighted in Table 15 & Figure 15 above)

<i>Variable</i>	Yes	No	No response	
No.	88	13	15	116
%	76	11	13	100

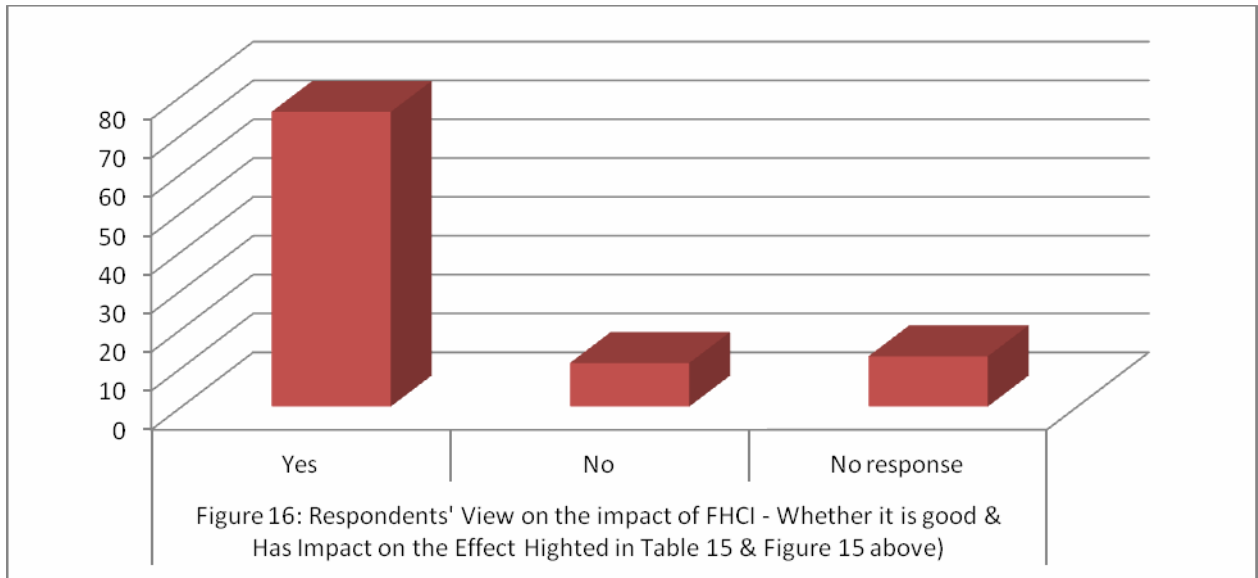


Figure 16: Respondents' Views on the impact of FHC - Whether it is good & has Impact on the EFFECT Highlighted in Table 15 & Figure 15 above)

Table 16 and figure 16 show that 76% of respondents' views are that FHC has impact on pregnant women, lactating mothers, under five children, health workers, the Ministry of Health and Sanitation and other health service providers like private or missions. Eleven percent (11%) do not hold that view while 13% did not respond to the question whether FHC has impact on those categories or not. Seventy-six percent (76%) of respondents holding the view that free health care has impact on various categories of beneficiaries including pregnant women, lactating mother and under five children show that the initiative is impactful. This finding and the one immediately above which show that majority of the people reached in the investigation showed that free health is very effective are complementary and join to support the fact that the free health care is effective in Moyamba District. It thus supports the hypothesis that free health care initiative for pregnant women, lactating mothers and under five children improves health service delivery in Moyamba District in Sierra Leone.

Table 17: Views of Respondents -Whether to Apply FHC to Other Health Categories (Yes/No)				
<i>Variable</i>	Yes	No	No response	Total
No.	75	14	27	116
%	65	12	23	100

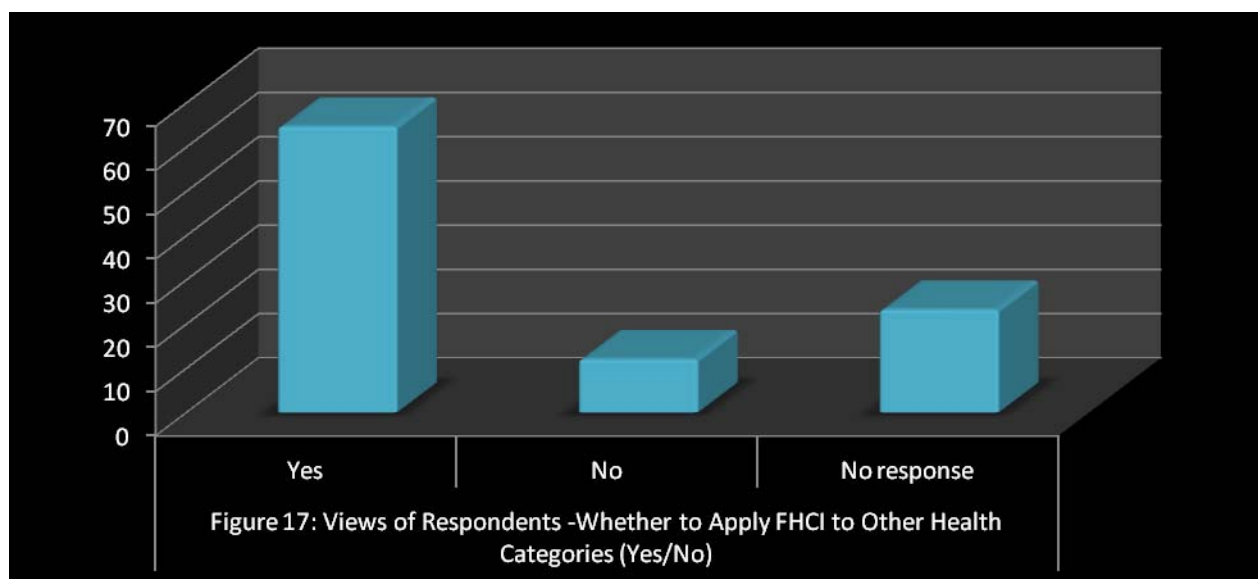


Figure 17: Views of Respondents -Whether to Apply FHC to Other Health Categories (Yes/No)

Table 17 and figure 17 show the views of respondents on whether FHC should be extended to other health categories apart from those of government or public (based on the effect of the initiative in their views). Data collected showed 65% of the respondents said yes, 12% said no while 23% provided no response to the question. This shows that majority of people talked to recommend that the initiative be extended to other categories of health facilities in addition to public health facilities. This has connection with the view that the initiative is working (effective and impactful). That is why people recommended that the system be extended to other categories of health facilities including private, mission and others not already covered by the initiative. It was therefore not surprising that the civil society including women's groups, youth networks and

the Ministry of Health and Sanitation in April 2014 requested the country's constitutional review committee to include free health care for pregnant women, lactating mothers and under children as a constitutional right and have it stated in the Sierra Leone reviewed constitution (Awoko Newspaper, April 2014) (web-based newspaper).

Table 18: Views of Respondents -Whether to Apply FHCI in Other Countries (Yes/No)				
<i>Variable</i>	Yes	No	No response	Total
No.	76	9	31	116
%	66	8	27	100

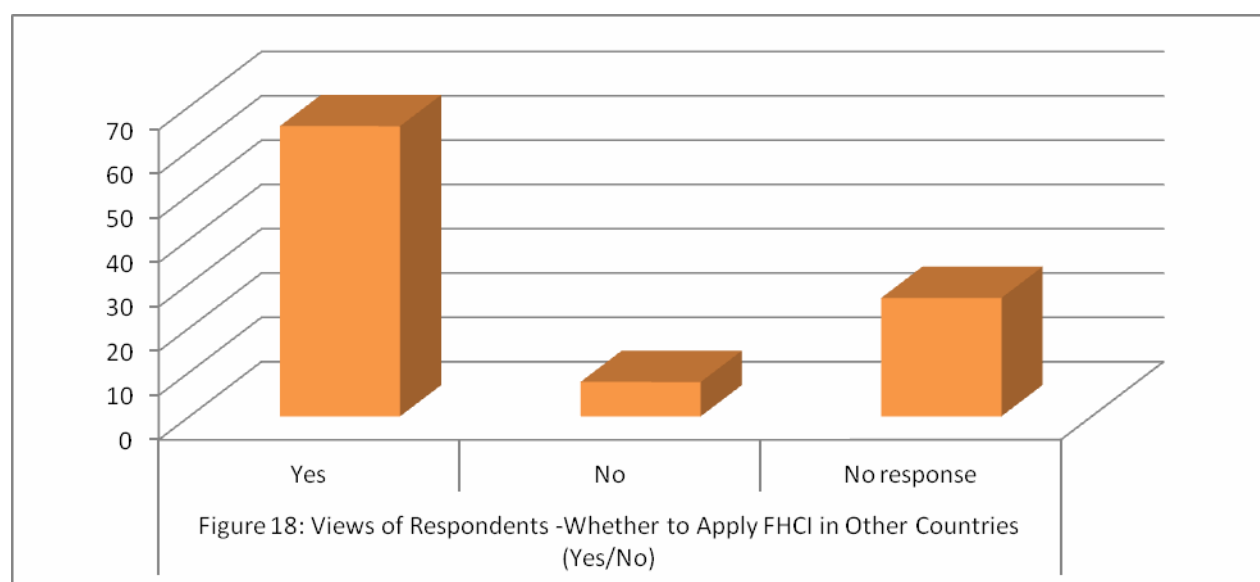


Figure 18: Views of Respondents -Whether to Apply FHCI in Other Countries (Yes/No)

Table 18 and figure 18 show the views of respondents on whether FHC should be extended to other countries apart from Sierra Leone (based on the effect of the initiative in their views). Data collected showed 66% of the respondents said yes, 8% said no while 27% provided no response to the question. The research showed that majority are in favour of extending free health care to

other countries other than Sierra Leone. However, a large number of people reached did not respond to the question. The lack of response amongst the respondents of which 60% were from Chiefdom level (10% chiefdom headquarters and 50% from village level) may not be unconnected with the respondents' lack of knowledge of the environment outside Sierra Leone as some only know about their immediate communities.

Table 19: Respondents' Knowledge of FHCI Challenges

<i>Variable</i>	Cost of health care service	Non- health service costs (specify)	Health workers (specify challenges)	Government	Donors	Other health service providers including non-for profit health facilities	Any others (specify)	No response	Total
No.	46	27	53	42	23	12	2	31	236
%	19	11	22	18	10	5	1	13	100

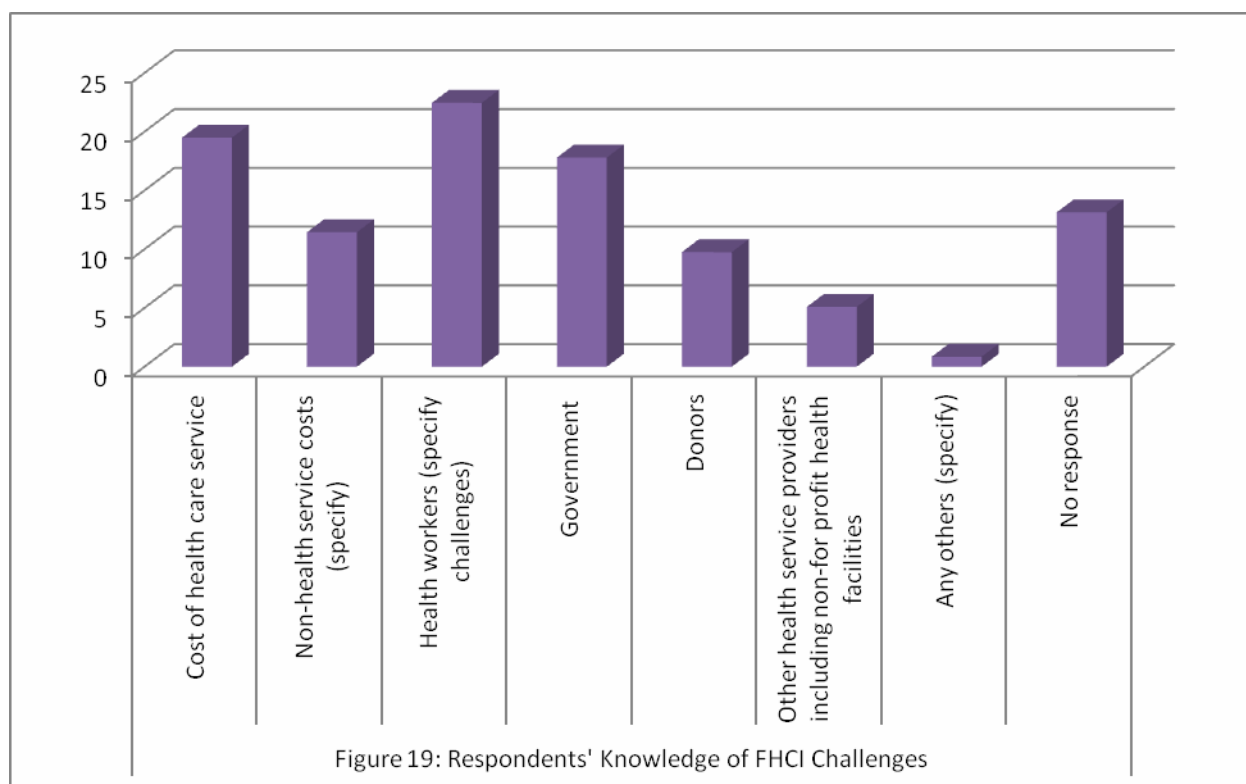


Figure 19: Respondents' Knowledge of FHCI Challenges

Table 19 and figure 19 show respondents' knowledge of FHCI challenges. The data show that 19% of all responses received pointed to associated health service cost (illegal charges & charging for people outside the targeted beneficiaries i.e. pregnant women, lactating mothers and children under five years of age); 11% highlighted non-health cost challenges like transportation, 12% pointed to challenges with health workers such as heavy workload with more people attending the clinics, unavailability or inadequate drug supplies leading to humiliation from beneficiaries, 18% were identified as challenges linked to government and they included poor monitoring and supervision, 10% were said to be donor related e.g. funding stream and continuation of the required support, 6% of the identified challenges were linked to others/any other categories not mentioned already. These (non-mentioned ones) included quality of services provided, the effect on private health service providers especially for profit facilities such as

reduction in their incomes (details on FHCI challenges are provided in the qualitative data gathered from the questionnaires or the focus group discussions (presented further down the research findings). Data from this research show that free health care initiative in Moyamba District is working, effective, and impacting on the lives of its target beneficiaries i.e. pregnant women, lactating mothers and children under five years of age but the initiative has its own challenges that are linked to various areas. Those areas of free health care challenges can be categorized as beneficiary related, service provider related, government related, private sector related, supply chain related, management (monitoring and supervision) related, and donor related. Further and further probing is likely to bring out more categories or challenges further researches on free health care initiative in Sierra Leone can investigate. The same challenges highlighted from the questionnaire interview also emerged in the focus group discussions. That really shows that they do exist and if the free health care should improve, the identified challenges need to be looked into or addressed. That means the sustainability and degree of effect or impact of free health in Moyamba District and by extension Sierra Leone, will depend on how much attention is paid to managing the identified challenges highlighted by various categories of people in Sierra Leone but more so in the Moyamba District which was the focus of this study.

Table 20a: Respondents General comments on the Effect of FHCI at Country Level in Sierra Leone								
<i>Variable</i>		increased utilization	reduced maternal deaths	reduced <5 deaths	increased user satisfaction	Others (specify)	No response	Total
No.	Yes	89	97	97	60	5	5	409
	No	8	11	11	21	3	2	
%	Yes	22	24	24	15	1		100
	No	2	3	3	5	1		

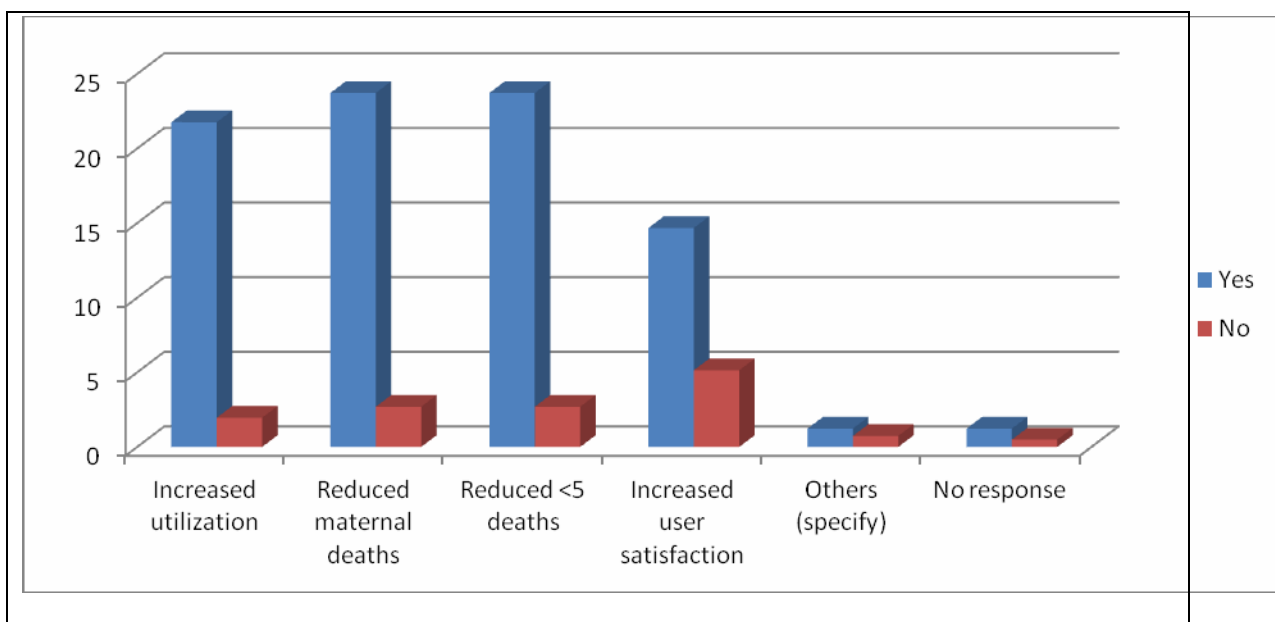


Figure 20a: Respondents General comments on the Effect of FHCI at Country Level in Sierra Leone

Table 20a and figure 20a show respondents' general comments on the effect of FHCI at country level. The data collected with responses show that 22% said it does and 2% said FHCI does not increase utilization, 24% said it does and 3% said it does not reduce maternal deaths, 24% said it does and 3% said it does not reduce under five child deaths, 15% said it does and 5% said it does not increase user satisfaction, 1% said it does and 1% said it does not have effect on other things while 1% did not say anything. Data available from the research show that it is the view of respondents that free health in Sierra Leone and by implication in Moyamba District has increased utilization, reduced maternal mortality, reduced under five mortality, increased user satisfaction in addition to other impacts created. That means, the initiative is effective as data show that it is achieving what it set as a goal to achieve i.e. reduced maternal and under five child mortality in Sierra Leone.

Table 20b: Respondents General comments on the Effect of FHCI in Moyamba District in Sierra Leone

<i>Variable</i>		Increased utilization	Reduced maternal deaths	Reduced <5 deaths	Increased user satisfaction	Others (specify)	No response	
No.	Yes	84	93	90	61	5	10	390
	No	9	8	9	19	2	0	
%	Yes	22	24	23	16	1	3	100
	No	2	2	2	5	1	0	

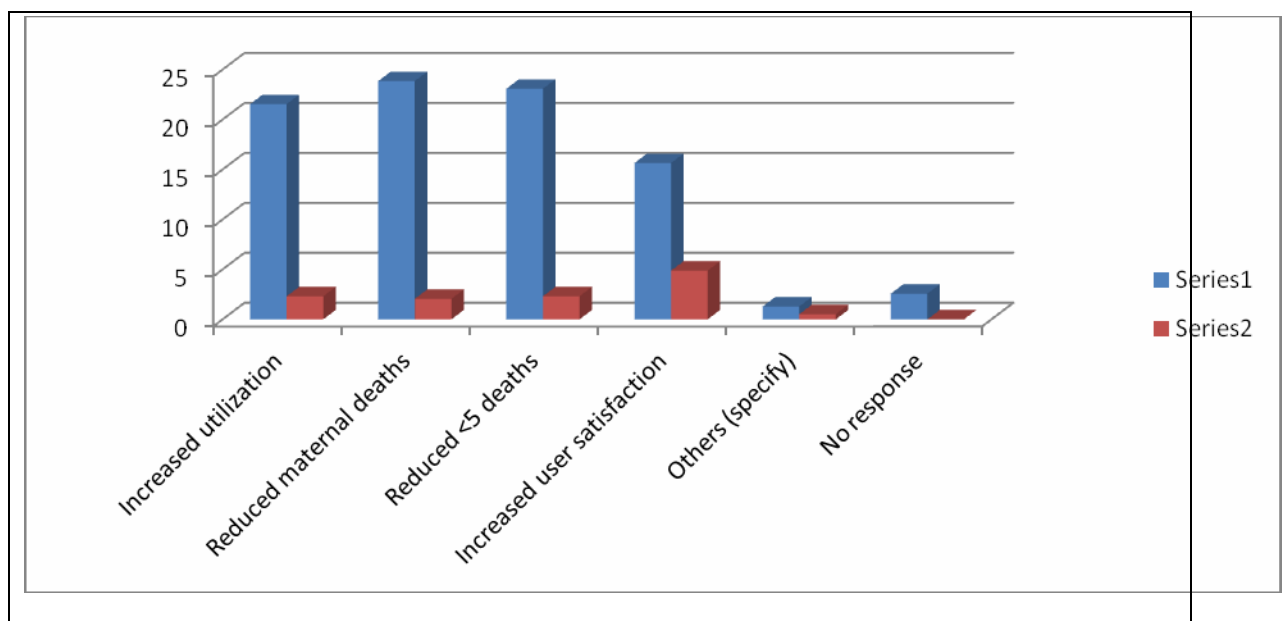


Figure 20b: Respondents General comments on the Effect of FHCI in Moyamba District in Sierra Leone

Table 20b and figure 20b show respondents' general comments on the effect of FHCI in Moyamba District, Sierra Leone. The data collected show that 22% said it does and 2% said

FHCI does not increase utilization, 24% said it does and 2% it does not reduce maternal deaths, 23% said it does and 2% said it does not reduce under five child deaths, 16% said it does and 5% said it does not increase user satisfaction, 1% said it does and 1% said it does not have effect on other things while 3% did not say anything. As shown for the national level, free health care in Moyamba District according to respondents, has increased utilization, it has reduced maternal mortality, it has reduced under five mortality, and it has increased user satisfaction in addition to other effects it might have created. That therefore show that free health care in the research district of Moyamba is effective and is creating impact because it is achieving the goal it was set to achieve from the national level down to the various parts of Sierra Leone because it is reducing maternal and under five child mortality which is the goal of the initiative. The data available from this research has therefore shown that the effect of free health care in Moyamba District has been positive as it is achieving its set goal or objective i.e. reduced maternal and under five child mortality despite highlighted challenges including health cost (illegal charges), inadequacy and untimely availability of drugs and medical supplies, inadequate monitoring and supervision, supply chain issues, low health workers moral and heavy worker load, doubts over donors' continued interest and sustainability of the required support.

Qualitative data from the questionnaire interviews, focus group discussions (FGD), inter-personal communications (IPC) and observations used.

Within and at the end of the closed ended questions were expressed their views on did not capture. The focus similar views of the group



Photo: Focus group discussion with health workers in Moyamba District, Sierra Leone

questionnaire used with mostly provisions where respondents what the closed ended questions group discussions captured participants. Information

captured from the inter-personal communications was also similar to information captured through open ended questions in the questionnaire interviews and the FGDs.

The relevant qualitative data collected in the three approaches highlighted above included:

Why was FHC introduced?

- To take care of under fives, lactating mothers
- In Sierra Leone, many pregnant and under five children were dying because of the relatives' lack of money to take care of their children and pregnant women
- It was to reduce infant mortality in Sierra Leone
- To reduce under five child morbidity & mortality and maternal mortality rate in Sierra Leone
- It was introduced to help the poor people who previously failed to go to the health facilities to seek medical care and to minimize maternal & infant mortality
- To reduced maternal and infant mortality rate and to help access safe delivery
- It was introduced to help reduce infant mortality and maternal mortality rate in Sierra Leone since some people cannot afford the medication for their families
- It was introduced and it is effective because it has made maternal mortality rate and infant mortality rates to come down
- It is very effective in Sierra Leone because it has reduced maternal and infant mortality rates
- To reduce infant sickness and deaths among children under five years of age and to reduce maternal mortality and morbidity rates in the country
- It was introduced to help reduce infant mortality and maternal mortality rates in Sierra Leone since some people cannot afford the medication for their families

- It was introduced in Sierra Leone to improve the health service delivery in Sierra Leone especially for the vulnerable groups of lactating mothers, children under five and pregnant women
- Before the FHC was introduced, children under five years were dying before their first birthday and women during pregnancy or child birth
- For free access to health care for vulnerable groups - pregnant women, lactating mothers and under five children
- Generally to improve the health care of the country
- To access service delivery
- The FHC was provided for pregnant women, lactating mothers and children under five years to prevent them from dying as some cannot afford money themselves or for health care. As such the government provided the FHC for the country to help the country
- Introduced in order to minimize the death rates of under fives, pregnant women and lactating mothers
- To improve the health status of the citizens of Sierra Leone
- Because the people are poor
- To help prevent maternal and infant mortality and also to improve the quality of service delivery to women in hospitals and clinics
- To save the lives of Sierra Leoneans that cannot afford medicine or medical care and to reduce or totally abolish death rates in Sierra Leone especially the targeted groups i.e. pregnant women, under five children and lactating mothers
- To help the less privileged
- To enable pregnant women, lactating mothers and children under five years of age to access free health care
- To address the high national maternal mortality and infant mortality rates

- To help improve on the health service delivery and to address the issue of user fees especially for mothers and children in Sierra Leone as well as Moyamba District, the research district.

Information gathered by respondents in using various means on why free health care initiative was introduced in Sierra Leone or Moyamba District or any part of Sierra Leone, it show that people have good knowledge of why the initiative was introduced. In summary, the information is saying that the initiative was introduced to improve health service delivery, improve access to health service delivery for people that were not able to access due to cost and their poor backgrounds, and that the initiative was targeting vulnerable groups i.e. pregnant women, lactating mothers and children under five years of age aimed at reducing maternal and child mortality. This been the main reasons for which the President His Excellency Dr. Earnest Bai Koroma led Government of the Republic of Sierra Leone introduced the free health care initiative in Sierra Leone, it shows that the respondents know the purpose of the initiative. This good knowledge of the initiative portrayed by information gathered in the qualitative data is also supported by the quantitative information gathered from the closed ended questionnaires. The available Moyamba District health data also used in this research did not bring out the beneficiaries knowledge on why the free health care was introduced but available data showing that the services were utilized with significant increase and improvement in the service delivery, outputs and outcomes including reduced maternal and under five mortality, is a show of good knowledge of the initiative. This is because one can only utilize services that one knows exists. Without knowledge of the services (whether it exists or who they targets are) the reported impact shown in this research would not have been reported or seen.

FHC challenges

Lack of monitoring: respondents hold the view that lack or inadequate monitoring of the overall free health care initiative is responsible for the charging of illegal costs for health service delivery

in communities. The arguments advanced by respondents or participants in the research especially the focus group discussions and the interpersonal interactions with stakeholders including the beneficiaries and the Moyamba District Council is that if the initiative is adequately monitored, a health worker cannot charge for a service that should be free. There will be fear that the supervisor or a monitoring team will know of that when they visit the service providing areas or communities. It was therefore thought by the research participants that an effective and adequate monitoring and supervision will help address this challenge.

No thorough monitoring mechanism: this point was raised in a separate instance but it is not unconnected with the one above which talked about lack or inadequate monitoring and supervision. In this instance it was however brought out that even when monitoring is said to be done, it is never done thoroughly by the responsible government bodies like the national and district level authorities. The discussions were such that if the national to district and district to community health facility monitoring and supervision mechanisms were well set and managed, there will be much more improvement in the delivery of the free health care as compared to what it is at the time of the research or data collection that actually happened in 2013. The research respondents' view is that this aspect should be the responsibility of government both central and local as there is some devolution of health care management to the local councils especially the primary health care services that mainly delivers the free health care services in communities including those in Moyamba District the research location.

According to health workers reached in this research, patients sometimes do not regard or respect health workers and the patients do not also respect time in seeking health services. This action according to the discussions held, affects the free health care service delivery. For the health workers it makes them treat such patients unprofessionally with marginalization, harshness, uncompromising stands and sometimes charging them for what should be free or within the free

health care initiative. The response from patients in some cases can vary from direct confrontation to avoiding the health workers or even stop using the health facility served by the health worker involved. This in some cases according to the research discussions with respondents or focus group discussion participants, limits access, utilization and in turn increases health problems that should have been addressed by the health workers involved or the health facilities where they workers. Community members or beneficiaries on their side said such situations occur as a result of mistrust, following suspicion or clear evidence that the health worker or health facility involved is charging them for what should be free, selling their health commodities illegally, is being generally hostile to patients, is often absent from the facility, keeps patients waiting unnecessarily, treats patients or clients unfairly for instance by prioritizing those that are well to do or have money or those that are relatives, friends and it can be a host of other things according to them. The consequences of such health worker behaviours push patients away and can cost communities, families lost of lives. For instance, a family refusing to utilize a health facility close to them because of their poor relationship with the staff may decide to take an emergency case to a far away health facility and in the event loose the live of the patient on the way to the far health facility especially when the roads are bad and transportation is at times not even available. This challenge as presented by health workers and the beneficiaries can prevent the introduced free health care initiative from achieving its goal of reduced maternal and child mortality in Sierra Leone. It was agreed that effective monitoring and supervision of the service delivery system includes the health workers and the communities with the promotion of effective community participation in their own health care service delivery can help address the challenge.

The other categories are also requesting for FHC: this in the discussions was said to be a challenge to free health care because the public health facilities where free health services are available are not in all places. In some places health services are provided by private or faith-based health facilities. It therefore came up in the discussions that the other categories of health

services providers not covered by the free health care are requesting to be covered. In like manner, they said that free health does not cover other categories of the population outside the pregnant women, lactating mothers and children under five years of age groups. Therefore, it came up that those other categories not covered are also requesting that they be covered by the free health care initiative. The extension of the initiative to non-public health facilities and targets outside the current target covered by the initiative came from the background that cost is charge for services outside the facilities covered and for targets outside pregnant women, lactating mothers and under five children. This re-enforces the position that peoples' lack of money to pay for cost of their health care at the point of delivery is an influential factor to access health care achieve desirable health outcomes. The discussants therefore agreed amongst themselves that extending the free health to other health facilities (private and missions) and other population categories beyond pregnant women, lactating mothers and under five children will help improve the results of free health care in Sierra Leone and Moyamba District as well as other parts of Sierra Leone.

No cost for health services and people refuse to buy since media is broadcasting that there is a lot of drugs supplied to the health facilities. This according to the discussions is an issue because in actual fact, drugs and other medical supplies provided for the free health care service delivery is at times not enough but it is communicated to the public that they are available. In circumstances that the official supplies are not available, the health workers get supplies from private sources at their own cost. The health workers in turn attempts to recover those type of costs (sometimes realistic but sometimes, they do so with even the official supplies claiming that they got them at their own costs). As such, the public or patients refuse to pay in any of such attempts be it realistic or not. This situation leads to stock out, non-functioning of some of the facilities at certain times and hence, the undesired consequences of increased health burden and mortality even amongst the free health care targets. It came out of the discussions that effective monitoring

and supervision and community participation in their health service delivery can help address this challenge.

Transportation (Mobility) system to get to health facilities constrains clients/service seekers. Also cost of keeping accompanying relatives to health facilities from remote communities in terms of accommodation, feeding can be huge on poor families even when the health service itself is free. These were said to be part of non-health costs that affects health service seeking behavior in Moyamba District as they are also the case in other parts of the country. In some instances, health care facilities are far from the users. In some cases, the unavailability of the means of transportation, the bad roads and the long distances make it difficult for users to seek timely health care which in some cases prevents some people from seeking the services at all. People thought one way of addressing these challenges could be extension of the free health services to non-public facilities and also by increasing available public health facilities especially for the hard to reach areas.

Some people refuse to go for FHC services instead create political saga: the challenge here as discussed in the research is that some people (members of government: central or local) politicize the free health care initiative such that the opponents of the ruling governing party do not feel comfortable to utilize the services. From another angle, it was said that some people refuse to use the free health care services at their own risk on the grounds that it was introduced by a government they do not favour and therefore do not want to have anything to do with what they considered related to such governments. In some ways, such people think utilizing the free health care will mean promoting the image of the government that introduced it and by so doing; they will give them advantage in terms of votes. This challenge according to those that participated in the qualitative data gathering discussions can be overcome by taking politics out of the health service delivery system.

Funding may stop and may be the FHCI will not continue. This was a concern of the focus group participants, some of the questionnaire respondents and other people reached through the research interactions with national level, district level and community level views gathered. According to them, the view was expressed because they learnt that the cost of the free health care is high and ever since it was introduced, government has always been stretched in seeking funding to support the initiative. Some stakeholders talked to including the Moyamba District Health Management Team members, know that that since the start of the free health care in Sierra Leone, there has always been gaps in funding and drugs and medical supplies have never been completely adequate for a very long time. There have been stock outs as one was reported to have occurred in September of 2010 the year when the initiative was launched. After that, there has been facility level stock outs leading to stand offs between health service providers and beneficiaries who had always expected to received services and adequate drugs each time they visit the health facilities but that in some cases that do not happen because of shortages at community health facility levels, district level or national level. This concern raised by the research participants is a genuine one and in their discussions or various contributions, suggested solutions to this genuine fear including government increased allocation of budget to health and more so to cover the free health care initiative. This suggestion participants said should be then complemented by sustained donor drive and resource mobilization from national to district or local government level aimed at sustaining the initiative in the districts and country as a whole to increase financial and material support to health service delivery in Sierra Leone.

The private sector loses their customers. This was expressed as a challenge in the implementation of free health care mainly as a concern from the private sector perspective. What participants were saying is that where the free health care was effectively working, patients will hardly go to private health facilities where they will need to pay when the same services were

paid for in the private facilities. As such, the private facilities lost customers and consequently income which in turn may lead to closing down of some of such private facilities since they run on profit basis. It was believed amongst discussants of the issue that if the quality of the private services is higher and a low profit margin is maintained, the private facilities will still continue to get customers and income especially when



Photo: District level focus group discussion at Moyamba District Council

some public health facilities fail to meet patients' satisfaction in the delivery free health care services.

There are no essential drugs and enough supplies. This was a challenge that came mainly from health workers. They said because there are generally challenges with getting drugs and medical supplies to support the free health care initiative, they are at times supplied with less or no essential drugs that beneficiaries require more. This according to the health workers puts huge burden on the workers because the beneficiaries do not understand what comes in and what do not come in to the health facility in terms of drugs and medical supplies. What the beneficiaries are concerned about is meeting their health needs once they visit the health facilities. It was suggested by the health workers that good tracking of health product consumption and good quantification of what is needed by the country and the various levels of health entities will help address this challenge.

Lack of quality report and effective analysis, dissemination and utilization of available reports - this was cited as a challenge during interactions with research participants stating that it is more of a challenge especially in trying to see how much is achieved by free health care initiative, challenges and lessons learnt in its implementation especially in trying to report back to donors and other stakeholders as a good practice for accountability. This they said is not just for free

health care but a challenge in the general health care system in the country despite improvements the reporting with the introduction of the health management information system (HMIS) which includes the district health information system (DHIS) used at the district level. For instance the Moyamba District health Management team (DHMT) said the DHIS has helped improve health reporting system in their district but the changes in the versions used are constraining their data management. They cited the fact that they are complementing that with mobile phone health data collection to help get timely facility data from the communities to the district level through the transmission of data using text messaging from the community health facility staff to the DHMT M & E officers at the district level on weekly basis. It was therefore added to the discussions that the reporting challenge do exist but it may be more of a problem in other areas than it is in the Moyamba District where the district in previous years had received recognition for been the best performer in maternal and child health care service delivery. This challenge the health workers including the DHMT in Moyamba said is not unconnected with their challenges in getting adequate support for effective monitoring and supervision. The participants ended up agreeing that with more and timely support for effective monitoring and supervision and trying to have stability in the version of the HMIS software used in Sierra Leone will help in addressing the challenge with lack of quality report.

According to health workers, low salaries for health workers lack of encouraged as far as living conditions are concerned considering most of the areas the health facilities especially the community health facilities are located are not motivating particularly for the Maternal and Child Health Aide (MCHAs) that are mostly at the community health facility level. Sometimes payment of even the low salaries or benefits to health workers are delayed payment especially in reaching areas that require payment for public transport or motorbikes including the District office from remote communities. This has been a challenge in the implementation of the free health care initiative although the introduction of the initiative came with increase in the salaries

of health worker. The health workers said the increase was made to insignificant low salaries and as such did not make much difference. It is a challenge because often the de-motivated staff think they are over worked with the increased attendance resulting from the introduction of the free health care. As such, they are often amongst the hostile staff that do not care about patient satisfaction and what happens to patients if they refuse to utilize their health facilities. Health workers feel a review and further increase of their salaries to match the current work load will help address this challenge and subsequently improve health care service delivery and the success of free health care initiative.

Health workers feelings expressed show that beneficiaries' ignorance about free health care initiative in terms of details is a challenge in the implementation of the initiative. This shows that despite the good knowledge of free health care initiative established amongst people assessed during this research, ignorance amongst beneficiaries concerning the details of how the initiative operates i.e. who benefits and who does not, how drugs and medical supplies are provided and how government gets support for the free health care is not clear or not known by beneficiaries. That poses a lot of challenges all by itself because it makes beneficiaries expect more than they are entitled to or can be actually provided for. This in the discussions was said it could be minimized through effective and sustained communication to let the public know more about the details of free health care initiative and not just its existence.

More workload on health workers with no time left to rest, cook (mainly for the female staff) or even eat in some cases – this is a challenge as discussed because it leads to poor quality service delivery especially with non-motivated staff. It was said mainly by health workers that it is possible to address the challenge by ensuring that adequate staffing is provide to support the implementation of the free health care initiative.

The attitude of health workers towards patients or clients came up strongly from the community members that it is a challenge for some health workers and their health facilities. It prevents people from going to the facilities concerned or the health workers concerned. This, both health workers and community members agreed can be addressed by the application of professionalism in the execution of health workers' duties and responsibilities. They acknowledged that the health workers can be wronged by the beneficiaries in some case but with professionalism, they can handle such matters amicably.

Poorly planned – some people hold the view that the free health care initiative is good but it was poorly planned and that is why it is not meeting all the necessary requirements such as having the adequate staff and staff satisfaction for implementation of the initiative. Likewise, there is a feeling expressed during interactions with responds that if it is well planned, government should be able to support the implementation of the initiative and not wholly and solely rely on donors for most parts of the support required to implement the initiative. The similar arguments were advanced that with good planning, the monitoring and supervision of the initiative would have been well planned for. This aspect remains to be the view of people contacted despite the fact that they indicated their awareness of a civil society organization called Health for All Coalition's ongoing monitoring of the free health care initiative. People hold that view because they think the health system itself should have an effective monitoring and supervision mechanism that is well funded and followed up so that the role of the civil society should only be that of validation or complementary effort and not monitoring of the entire process.

Lack of disciplinary action against health workers for unprofessional actions in the implementation of the free health like illegal charges, disrespectful treatment of patients or clients, neglect of emergency cases and many more is a challenge. For instance, lack of timeliness in the provision of services is a challenge that comes with unprofessional attitudes and it often

turns away patients and clients. Unarguably, it was agreed that if the unprofessional attitudes are addressed that will help improve free health care implementation.

Lack of health facilities in some remote parts of the country and Moyamba District is a challenge for free health care as those that cannot avoid to reach existing health facilities will always go for any kind or standard of health service available to them including unprofessional service delivery and drug peddling or services from quacks. “To put up more structures” was what some of the people reached in this research proposed as a solution to the lack of adequate health facilities in order to reach more people or everyone entitled to free health care in Sierra Leone as well as in Moyamba District. Fewer facilities in large communities can also be a challenge for health workers especially when mobility is not available for them to cover their catchment communities with outreach services or carry out home visits. Addressing this will also help improve free health care service delivery as it will for any other public health scheme.

Low capacity of some health workers is a challenge in the delivery of free health care initiative in Sierra Leone and also in Moyamba District. The effort to provide more staff to meet the increased staff requirement for the increased workload ends up having staff in the health service delivery system. As a solution, participants recommended the strengthening of health workers through capacity building that should include hands on capacity support or supportive supervision of health workers. It was further said that increased capacity of the health workers will lead to improved service delivery, quality results with lives saved and subsequent donor satisfaction that may lead to sustained donor interest and support.

People feel the cost recovery had income for the health facilities that was used to upkeep the facilities and help improve services delivered but that is absent in the free health care initiative. They hold the view that the new fee for service will not generate anything significant for the

facilities because majority of those that utilize the services are now covered by the free health care. The health workers in particular think the new schemes put in place to support facilities like the performance based financing need to be effective and paid timely enough for their desired purposes.

Huge burden on government – this was cited as a challenge because considering Sierra Leone to be low income country, it will be difficult for the country to meet the required resources for sustained implementation of the free health care initiative even with donor support which in accrual sense will not last forever. Government therefore needs to recognize the situation as it is and prioritize the free health care in budgetary allocations at all times.

People rely on government to be responsible for their health and therefore not do anything to contribute towards their own health care. This is a problem people said because they think the success of the free health care like all other health care systems relies on the involvement and participation of those that the system concerns. To address this challenge, people need to get involved in their own health care system including the free health care system in Sierra and the research district (Moyamba).

Donor strategy not to work directly or in collaboration with government can be a challenge in the free health care implementation especially when tracking and coordination of donor resources and partner implementations are not 100% in Sierra Leone as well as at the operational district level. This according to the discussions can be address by both government and partner or donor efforts to account, track and collaborate in terms of health service delivery in the Sierra Leone and Moyamba District inclusive.

Corrupt attitude of some Sierra Leoneans – this was cited by research participants as a challenge because the issue of illegal charges, leakage in the drug and supply chain, inadequate accountability to various stakeholders by health workers or government, and people going to health facilities just to get the medical supplies because they are free and may be with the aim to sell them thereafter or with children beyond five years just because they want to get free services, are all due to corruption from both sides (service providers and users). It was agreed that if corruption is eliminated in the country and the health care system by all parties with government taking the lead, that will greatly improve the implementation of the free health care initiative.

Health workers feel the large size of treatment registers used (sometimes even bigger than the consultation tables they have at the facilities) in the face of high patient or client attendance is a challenge that slows service delivery and increases patient or client dissatisfaction that leads to undesirable outcomes such as frustration on the side of both the health workers and users. Sometimes it even results into abandoning of the facilities because patients are at times impatient to wait for too long at the facilities regardless of the work load at the facilities. A review of the M & E tools in light of this concern may be a solution to this challenge.

Out of the information gathering at different points came this contribution from respondents:

"If Free Health Care Initiative (FHCI) is to be more effective, the health workers said in their contributions that government and partners involved and even the communities should help to:

- improve the standard of living of the health workers
- All remote allowances should be paid for every quarter
- Provide drugs that are most needed in the peripheral health units (PHUs)
- Provide study leave for health workers who want to upgrade themselves
- Provide electricity for health workers at PHU level (solar or otherwise)
- Prompt payment of performance based financing – “PBF”

Health workers not achieving their set goals do not favour improvement in their remuneration. It therefore came out of the discussions that health workers should try by all means to achieve their set goals especially the free health goal which is to reduce maternal and child mortality (MDG 4 and 5) in contributing towards Sierra Leone's achievement of the MDGs by 2015. That will give government reason for reconsidering the situation of health workers and it will be easier to justify the case of health workers even to donors.

Lack of proper management and maintenance of equipment and service delivery supplies is a challenge especially when the items are inadequate from start. This is a challenge associated with health workers and communities' attitude towards health service delivery. Therefore it was agreed that change of staff attitude and increased community participation will help address this challenge.

Some people feel too many conditions of donor agents tied to funding provided to the country or their communities is a challenge as it limits funds accessed and how the accessed funds can be used. There were suggestions that reducing some of the donor conditions can help improve resource mobilization and use for the continuity of the free health care.

Transportation of drugs and medical supplies from the central level down to the service delivery points in the communities is a challenge because at times the items get stock at the central or district levels without reaching the communities. Participants therefore suggested that assisting to transport drugs to health facilities/PHUs will be a useful support in the free health care implementation.

Communities in some cases hold the view that their health care is compromised by the health workers with the introduction of free health care. Their feeling is that because the health workers

are overloaded with increased attendance, they do not care about quality service delivery rather they just try to get rid of patients or clients. This people thought could be addressed with increased workforce to meet the demands of the free health care implementation at all levels.

Why respondents prefer any of the health schemes in Sierra Leone?

Based on discussions with various categories of respondents and using different approaches people said the preferred free health care initiative (FHCI) for the following reasons:

- Because it is aimed at reducing child & infant mortality
- Because it reduces morbidity & mortality rates in Sierra Leone
- Because it helps children, pregnant women & lactating mothers to prevent them from sickness and death
- Because it is free of cost or costs no money
- Because it reduces infant and maternal mortality
- Because the beneficiaries are receiving services whatever the case may be
- Government responsibility proposed for targeted groups
- Because it decreases the infant and maternal mortality rates in Sierra Leone and it promotes health services in Sierra Leone
- Reduces infant & maternal morbidity & mortality in general in Sierra Leone including lactating mothers
- Because it reduces the death rate of the target groups since its introduction in 2010
- Because it makes health services accessible & affordable to the most vulnerable groups
- It increases service utilization and helps reduce maternal and infant deaths
- Because even the poor people in the villages are now aware of medical facilities and also facility delivery (they are not doing like before)

- Because people are poor (high poverty rate in Sierra Leone) and they cannot afford their health service costs and it makes health care affordable, accessible and available to them. It saves people who are not able to pay for their families health care costs (the less privileged)
- It sustains the welfare of health workers; it helps health workers to give quality
- Because it can serve all categories of people whether rich or poor and in the other areas it has helped to prevent the death of children and mothers
- Because it has improved the health standards in Sierra Leone
- Because no cost is required from the patients at point of service delivery. Although there are challenges on both (schemes) in service provision (government - in terms of delay and service delivery i.e. health workers mismanage the service delivery (FHCI) and the FFS/CR because of the cost attached.

Out of the same research participants reached, some people preferred the fee for service (FFS) or cost recovery (CR) health scheme for the following reasons:

- Because it covers the entire country treatment wise (no specific categories targeted)
- Because it serves other people (outside the FHC categories)
- Helps for the replenishment of income to purchase for other days - it recovers cost (Sustainability)
- Because it provides the necessary drugs at the health facility (all the drugs needed to help cure patients unlike the FHCI which provides inadequate drugs and does not provide essential drugs that are needed)
- It is very difficult to deal with the negative implications of the FHCI
- Because the FHCI only provides few drugs are supplied and it takes time to get subsequent supplies

- Because it is sustainable as small fees are paid replace drugs and also makes people respect the things (drugs & other medical supplies/services) they pay for
- Certain categories shall pay to keep the health facilities working
- Because it is grass root approach that makes drugs available at all times

Health Data from the Moyamba District for the period 2008 to 2012

The research also sought health data from the Moyamba District Health Management Team (DHMT) through its monitoring and evaluation (M & E) unit. The data covered child immunization, nutrition, morbidity and mortality and maternal health including antenatal clinic attendance, use of intermittent preventive treatment in pregnancy (IPTp) for malaria and maternal mortality.

The data covered the period 2008 to 2012. That is two years (2008 and 2009) before the free health initiative was launched in 2010 (April 27, 2010) and two years (2011 and 2012) after the launch of the initiative.

The data was gathered through the District Health Information System (DHIS) that is a part of the Ministry of Health and Sanitation's (MOHS) Health Management Information System (HMIS) used at the district level in all parts of the country. It was difficult to compile and analyze the data for the period 2008 to 2012 because the system went through changes including changes in design or layout within the period for the fact that it is new and its tested and improved over time. The data derived from the system and analyzed in relation to the research for 2008 to 2012 looking at the health service delivery in Moyamba District is as presented below.

Moyamba District Health data: 2008 to 2012

The data provided below is derived from the Moyamba District Health Information System (DHIS) which is part of the Ministry of Health and Sanitation's Health Management Information System (HMIS). Data generated and collected on monthly basis from all functional health

facilities in Moyamba District as done for all the other parts of Sierra Leone is entered into the DHIS for various services and variables or indicators related to the health service delivery at the district level ranging from child health to maternal health and general clinic for both static and outreach services. The data entered into the data base is transmitted to the national level in the Directorate of Planning and Information in the Ministry of Health and Sanitation (MOHS). The database system is new to Sierra Leone and is therefore still going through a process of development with database used revolving from one version to the other. That makes the analysis of data collected over a long period like the one used for this research (2008 to 2012) quite challenging because the variables or indicators for which the data was collected from the start of the use of the database kept changing in some cases with the changes in the versions of the database. Some based on lessons learnt since the process started as a pilot but some changing as a result of changes in the scope of work, services provided or as a result of new development in the global health landscape such as the increase in the number of recommended minimum antenatal clinic visits up to four and the introduction of new vaccines e.g. the rotavirus vaccine and the pneumonia vaccine introduced recently.

The findings or data presented below was derived from the Moyamba District DHIS 2008 to 2012.

Table 21: Early breast feeding of children within one hour after birth in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Early breastfeeding</i>	6093	9252	12967	14855	12528

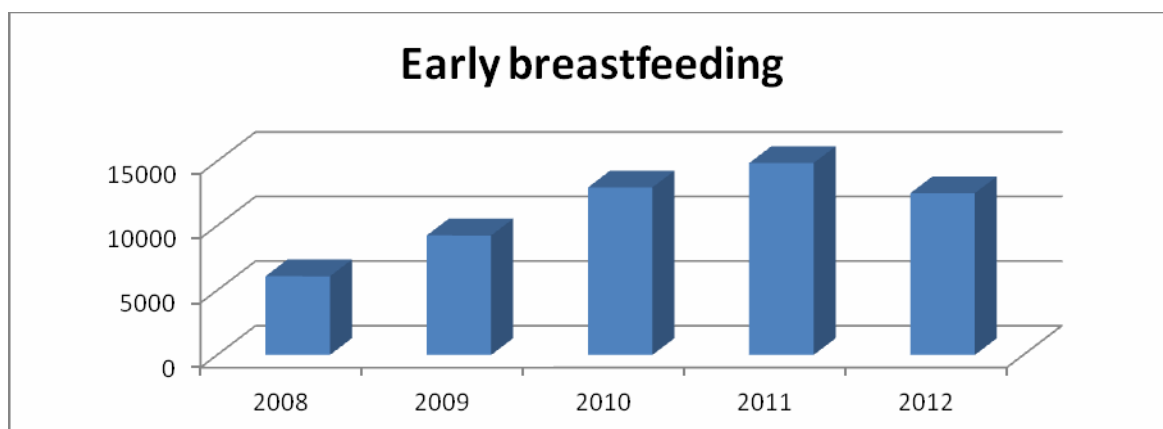


Figure 21: Early breast feeding of children within one hour after birth in Moyamba District: 2008 - 2012

Table 21 and figure 21 above show that 6,093 children in 2008 and 9,252 children in 2009 were immediately breastfed i.e. within the first hour after birth. The table and figure also show an increase in early breastfeeding from 2010 when the free health care initiative was launched through 2011 with 12,947 children in 2010 and 14,855 children in 2011 and a slight decline to 13,528 children in 2012. Yet more children were breastfed immediately after birth (within one hour) two years after the launch of the free health care than they were before the launch of the initiative.

Table 22: Slept under LLITN last night (Children Under five years of age): 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Slept under LLIN last night</i>	12442	9240	10915	12313	10874

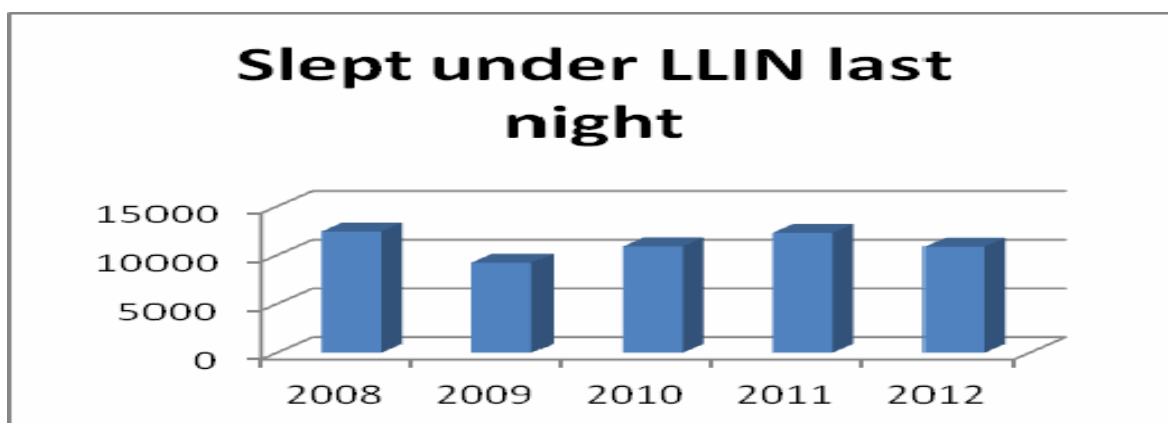


Figure 22: Slept under LLIN last night (Children Under five years of age): 2008 - 2012

Table 22 and figure 22 show a higher use of long lasting insecticide treated mosquito nets (LLIN) in 2008 (12,442 children under five years of age). The usage however dropped in 2009 (9,240 children) and increased in 2010 and 2011 (10,915 and 12,313 children respectively) following the launch of the free health care initiative but slightly dropped in 2012. Although there was a drop in 2012, more children under five years of age still slept under long lasting insecticide treated nets than they did in 2009 (a year before the launch of the free health care initiative). The high net usage in 2008 according to the Moyamba District Health Management Team was attributed to the supply of nets to pregnant women and children under five years of age at the start of that year as part of the interventions of a five year European Union funded malaria prevention and control project that was implemented in the research district (Moyamba) and Port Loko District (a neighbouring district) between 2007 and 2012 by an International NGO, Plan International Sierra Leone. The project was in itself was providing free health care services to the people of Moyamba and Port Loko Districts implemented with a lot of innovations including the use of community system strengthening tools that increased utilization and the provided services.

Table 23: Children under five years of age with fever in the last 2 weeks (per years): 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Fever last 2 wks	13943	4344	52082	96401	77365

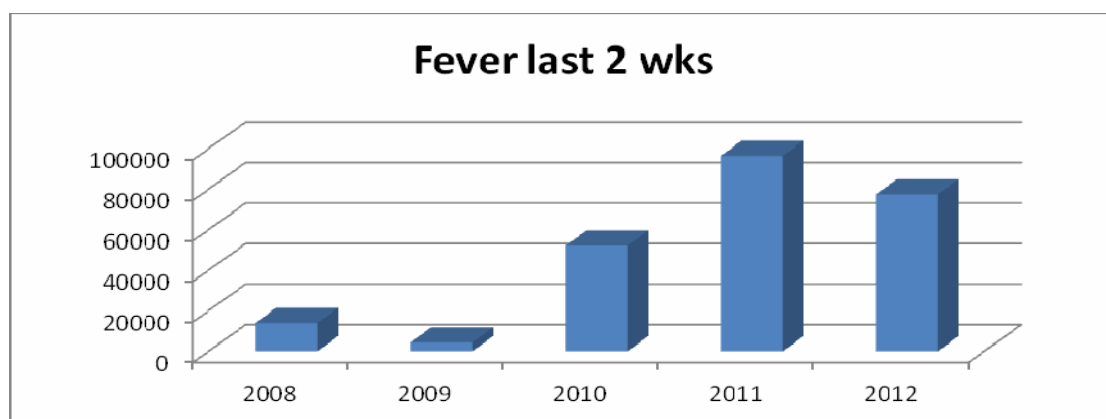


Figure 23: Children under five years of age with fever in the last 2 weeks (per years): 2008 – 2012

Table 23 and figure 23 show that in 2008; 13, 943 people (mainly children under five years of age) and in 2009; 4,944 people (mainly under five children) with fever in the last two weeks accessed health services while 52,082 in 2010; 96,301 in 2011 and 77,365 people (mainly under five children) accessed health care services. The data show that far too many people especially under five children with fever were able to access health care services in Moyamba District within the period after the launch of the free health care initiative than they did before the launch of the initiative. This supports the argument that payment for health services can prevent or limit users' access to health care services including access to and the use health commodities like the long lasting insecticide treated mosquito nets (LLINs) in this case.

Table 24: Appropriate malaria drug treatment in 24h (all ages): 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Appropriate malaria drug treatment in 24h (all ages)	10749	3756	41472	48003	16050

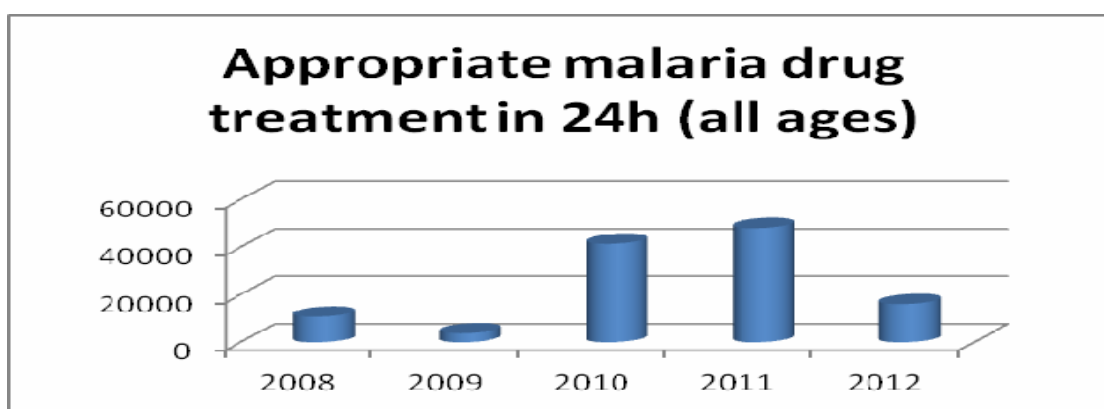


Figure 24: Appropriate malaria drug treatment in 24h (all ages): 2008 – 2012

Table 24 and figure 24 show that 10,749 people (mostly children under five years of age) in 2008 and 3,75(24 hours) after the launch of the free health care initiative than they did before the launch of the initiative for one of the top three killer diseases especially for children in Sierra Leone including Moyamba District inclusive. Six (6) in 2009 received appropriate malaria drug or treatment with 24 hours which is the recommended timing for malaria treatment while 41,471 people in 2010; 48,003 in 2011 and 16,050 people (mainly children under five years of age) received appropriate malaria drug in Moyamba District (a period after the launch of the free health care initiative). This show that more people received appropriate malaria treatment within the World Health Organization's recommended period of 24 hours after coming down with the ever.

Table 25: Diarrhoea cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age): 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Diarrhoea last 2 wks</i>	12963	2236	12781	12273	13737

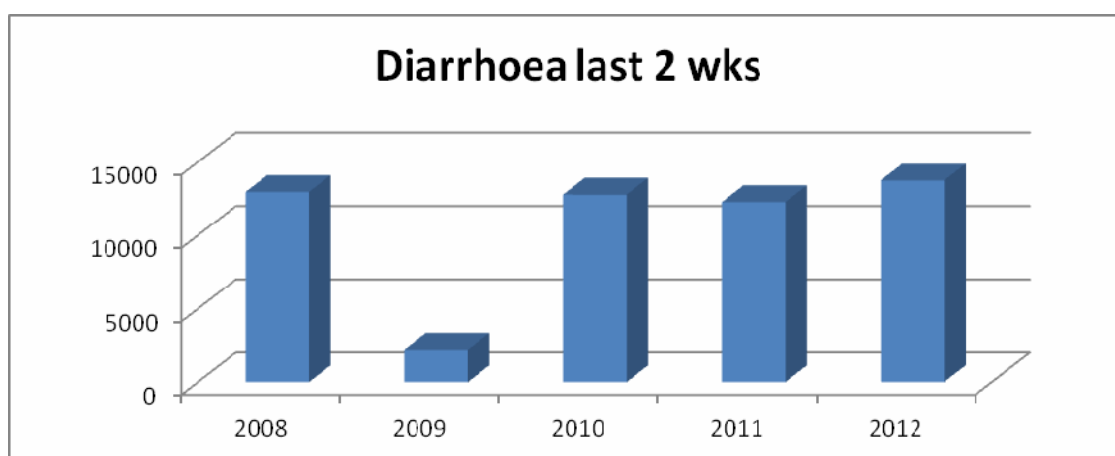


Figure 25: Diarrhoea cases reported and treated within 2 weeks of occurrence in

Moyamba District (mainly among children under five years of age): 2008 - 2012

Table 25 and figure 25 show the number of diarrhoea cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age). 12,973 cases in 2008; 2,235 in 2009; 12,781 in 2010; 12,273 in 2011 and 13,737 cases were seen and treated in Moyamba District. Although a high number of cases were treated in 2008, the data showed that more people accessed health services and received treatment for diarrhoea (one of the leading causes of childhood deaths in Sierra Leone according to DHS 2010) in Moyamba District after the launch of the free health care than they did before the launch.

Table 26: Cough or acute respiratory infection - ARI) cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age): 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Cough last 2 wks</i>	8688	3315	38819	65067	66450

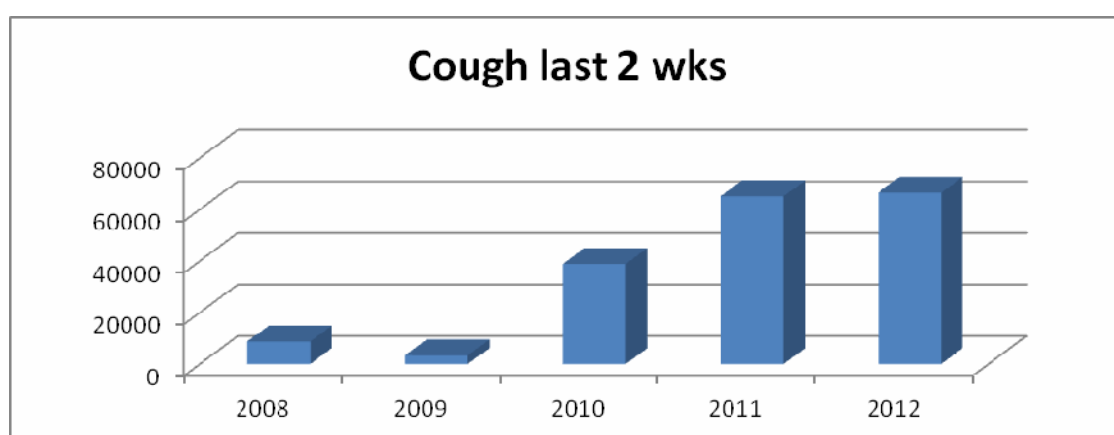
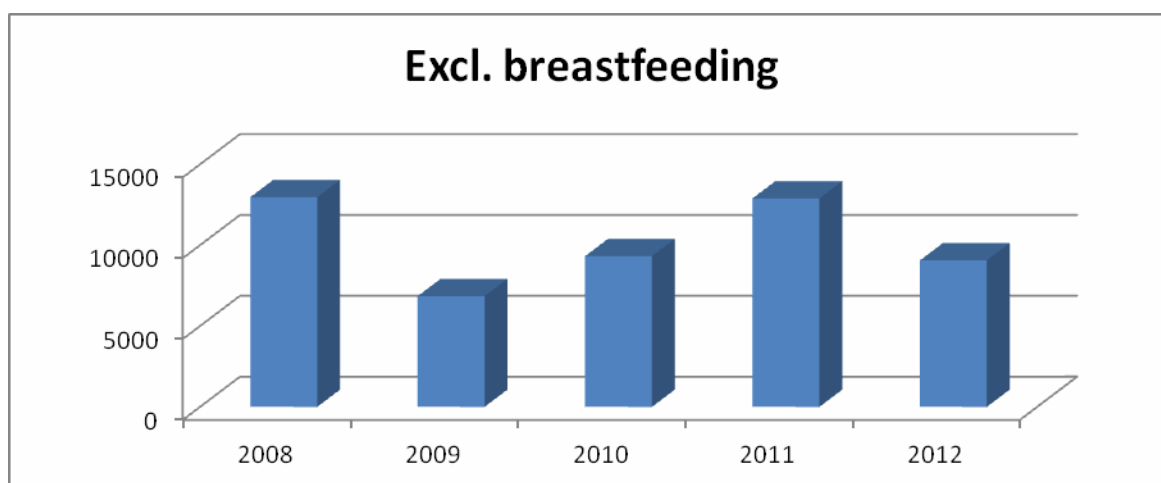


Figure 26: Cough or acute respiratory infection - ARI) cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age): 2008 - 2012

Table 26 and figure 26 show the number of ARI cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age). 8,688 cases in 2008; 3,315 in 2009; 38,819 in 2010; 65,067 in 2011 and 66,450 cases were seen and treated in Moyamba District. The data showed that more people accessed health services and received treatment for acute respiratory infections or cough in Moyamba District after the launch of the free health care than they did before the launch which is one of the three leading killer diseases accounting for the high child mortality in Sierra Leone (according to the Government of Sierra Leone's Free Health Care Position Paper of 2010).

**Table 27: Children exclusively breastfed before six months of age in Moyamba District:
2008 - 2012**

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Excl. breastfeeding</i>	12969	6848	9322	12894	9058



**Figure 27: Children exclusively breastfed before six months of age in Moyamba District:
2008 - 2012**

Table 27 and figure 27 above show that 12,960 children in 2008 and 6,848 children in 2009 were exclusively breastfed within their first six months of life before the launch of the free health care initiative. The table and figure also show an increase in exclusive breastfeeding from 2010 when the free health care initiative was launched through 2011 with 9,322 children in 2010 and 12,894 children in 2011 and a slight decline to 9,058 children in 2012 yet more children were exclusively breastfed than they were before the launch of the initiative. This is an increased in behaviour change for lactating mothers that is aimed at protection of the newborn and subsequent prevention of child mortality.

Table 28: Children that received the 3rd dose of Pentavalent Vaccination in Moyamba

District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
<i>Under five children who received Penta 3 vaccination in Moyamba District</i>	8947	11438	12411	14149	14513

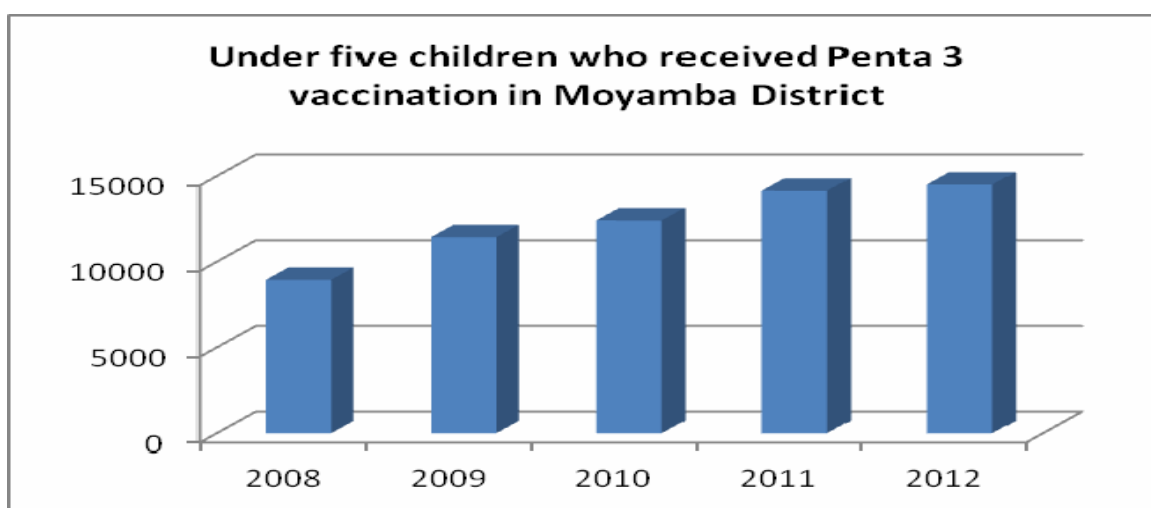


Figure 28: Children that received the 3rd dose of Pentavalent Vaccination in Moyamba District: 2008 - 2012

According to table 28 and figure 28 above children who received pentavalent vaccination number three (3) steadily increased in Moyamba District after the launch of the free health care initiative. The data show that 8,847 children under five years of age in 2008; 11, 438 in 2009; 12,411 in 2010; 14,149 in 2011 and 14,513 in 2012 received the vaccination (Penta 3) in Moyamba District. The Pentavalent vaccine number three (Penta 3) is the last of the three doses a child is supposed to take in order to complete the required vaccination. Taking of Penta 3 is supposed to coincide with taking of Measles Vaccine and the completion of the required vaccination for a child under within the first year of life.

Table 29: Children who received Measles Vaccination in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Measles	17323	11491	12770	13722	14094

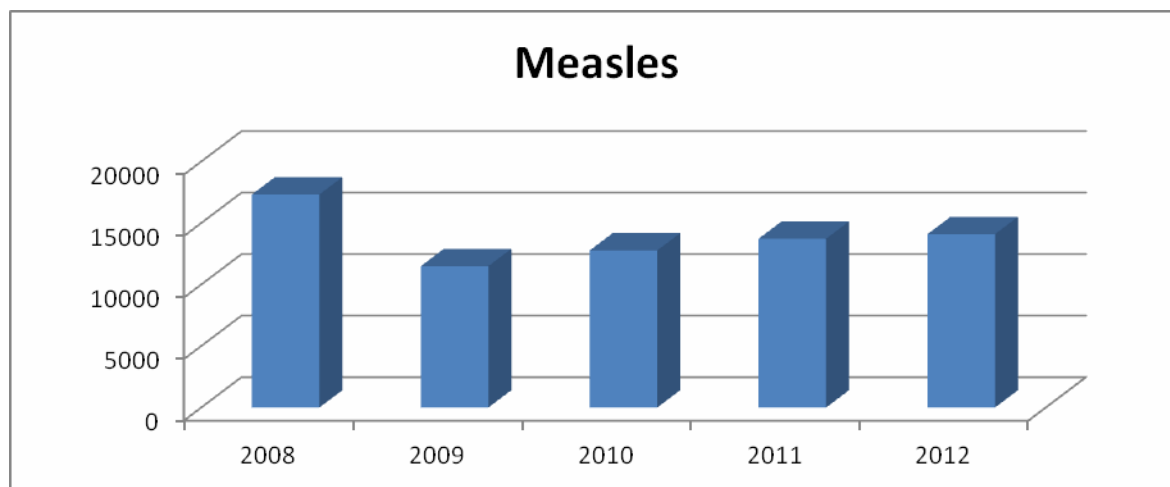


Figure 29: Children who received Measles Vaccination in Moyamba District: 2008 - 2012

Table 29 and figure 29 above show that 12,323 children under five years of age received measles vaccination in 2008; 11,491 in 2009; 12,770 in 2010; 13,722 in 2011 and 14,094 in 2012. The data showed that despite a very high coverage in 2008 which was associated with the start of a four year European Union funded Plan International Sierra Leone and partners' implemented child survival and development project that covered the entire district, there was a drop in measles vaccination coverage in 2009 which rose steadily thereafter from 2010 when the free health care initiative was launched on to 2012. The administration of measles vaccine normally indicates the completion of all childhood vaccination schedules in Sierra Leone thereby preventing the child from several childhood diseases that contribute to the high child morbidity and mortality in the country. Some mothers were not utilizing the service although it was free even before the free health care because health workers in some cases were taking illegal fees for the vaccination of children on the ground that they were paying the cost of transportation for the

getting the vaccines to the service delivery points in some cases as well as the vaccination card or under five clinic cards. The situation as shown from the data improved with the introduction of the free health care initiative despite some other challenges highlighted in other parts of this research document.

Table 30: Children under five years of age fully immunized in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Fully Immunization child	25481	11077	12235	13131	13631

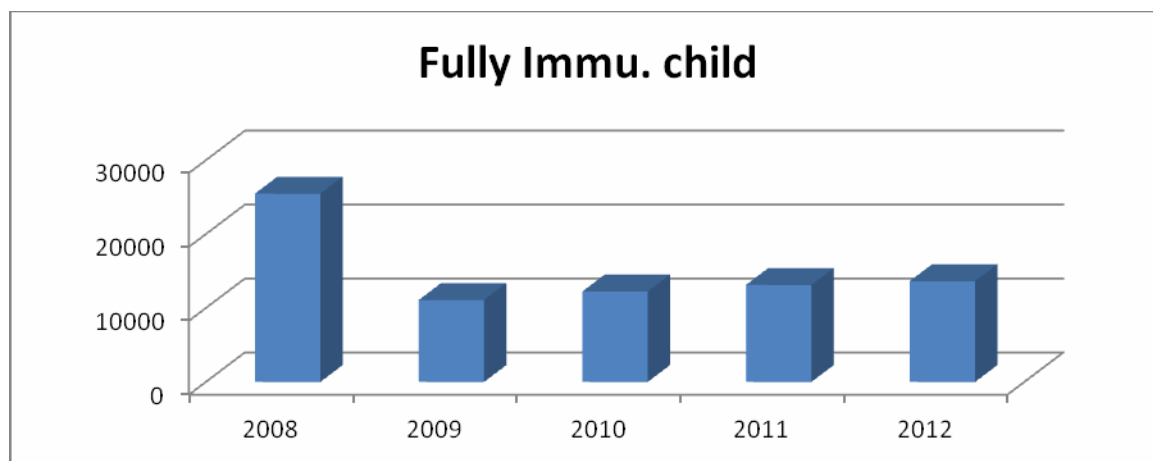


Figure 30: Children under five years of age fully immunized in Moyamba District: 2008 - 2012

Table 30 and figure 30 show a similar trend as found in table 29 and figure 29 because as stated above under table and figure 29, taking of measles vaccination normally marks the completion of childhood vaccination in Sierra Leone as it is the case in several other countries. Outside the normal situation, few children miss out on other vaccination schedules before the measles vaccination and as such take the measles vaccination at the recommended nine (9) months while they are still supposed to take the ones they missed out on. In those few instances, the taking of the measles vaccination does not mark the completion of childhood vaccination the child involved. Hence, the slight drop in the figure for fully immunized children against those that received the measles vaccination presented above. The data thus show that in 2008, 25,481 children under five years of age were fully immunized in Moyamba District (higher coverage than the subsequent years because of the child survival and developed project that commenced in the entire district that year with a lot of support to the district health system very similar and may be more robust to the free health care initiative because all the services provided were free of cost backed up with strong monitoring and supervision support. The data further showed a drop in the number of fully immunized children in 2009 to 11, 077 but steadily showed some increase with the introduction of the free health in 2010 through 2012 with 12,235 children under five years of age fully immunized in 2010; 13,131 in 2011, and 13,631 in 2012 within the district.

Table 31: Number of deaths of children under five years of age in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Under five deaths	562	634	171	654	561

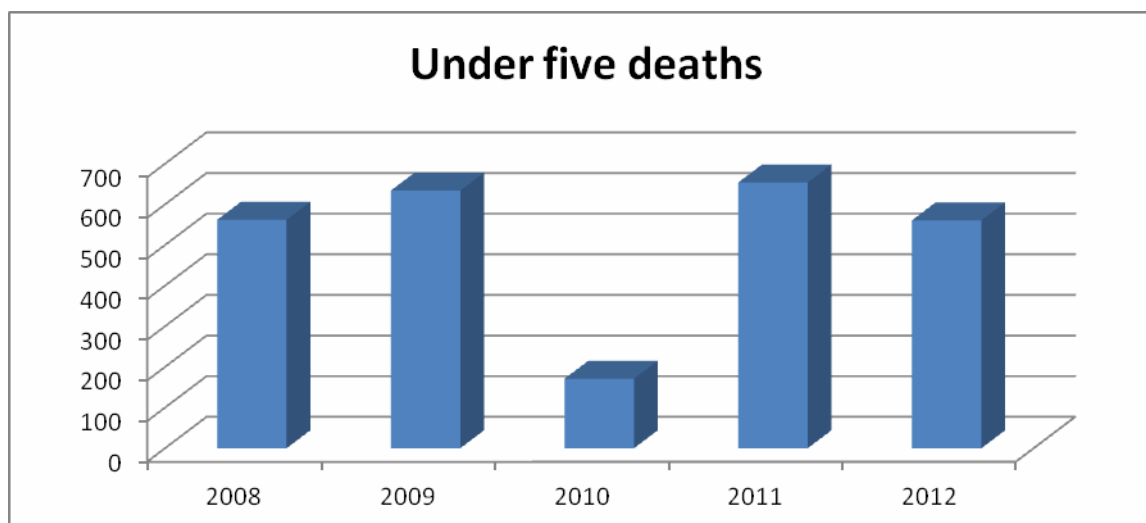


Figure 31: Number of deaths of children under five years of age in Moyamba District: 2008 - 2012

Data in table 31 and figure 31 show that 562 children under five years of age died in 2008; 634 in 2009; 171 in 2010; 654 in 2011 and 561 in 2012. The trend in absolute numbers showed that under five child death was high in 2008 and higher 2009 but dropped dramatically in 2010 the year the free health was introduced but rose to its highest in 2011 and then dropped in 2012 by a slight margin. The picture is slightly different in terms of proportion of under five child death per 1000 live births as shown and explained below for the table 32 and figure 32.

Table 32: Percentage of children under five years of age dying in Moyamba District per year: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Under five child mortality rate	70	66	17	64	51

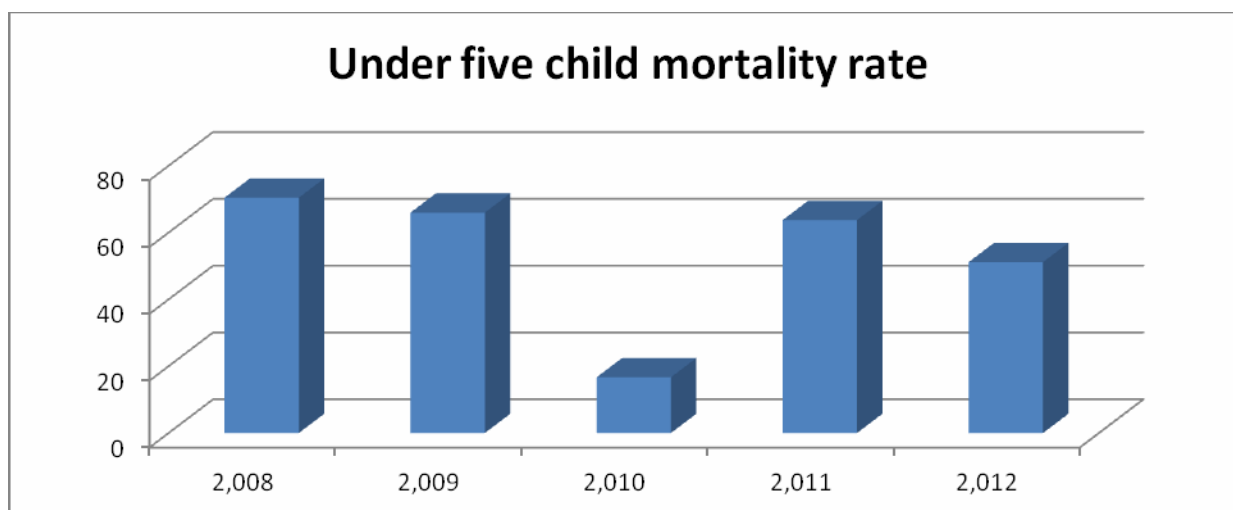


Figure 32: Percentage of children under five years of age dying in Moyamba District per year: 2008 – 2012

As stated in the data description for table 31 and figure 31, the trend of under five child deaths in absolute figures slightly differ from the figures in proportion per 1000 child deaths per year. According to table 32 and figure 32; 70 under five year old children per 1000 live births died in Moyamba District in 2008 while 66/1000 died in 2009. That trend dramatically changed in 2010 (the year the free health was introduced) when the figure dropped to 17 under five child death per 1000. The death rate according to the available data increased again in 2011 to 64 deaths per 1000 but dropped to 51 per 1000 in 2012. This trend may not be unconnected with qualitative data gather through this research which pointed out that the free health is working but not without challenges that affects the results such as staff motivation, availability of drugs and medical supplies and effective monitoring and supervision.

Table 33: Number of children under five years of age with weight for age above standard in Moyamba District per year: 2008 – 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Weight age above 2 stand deviation	40636	61183	69010	69010	97502

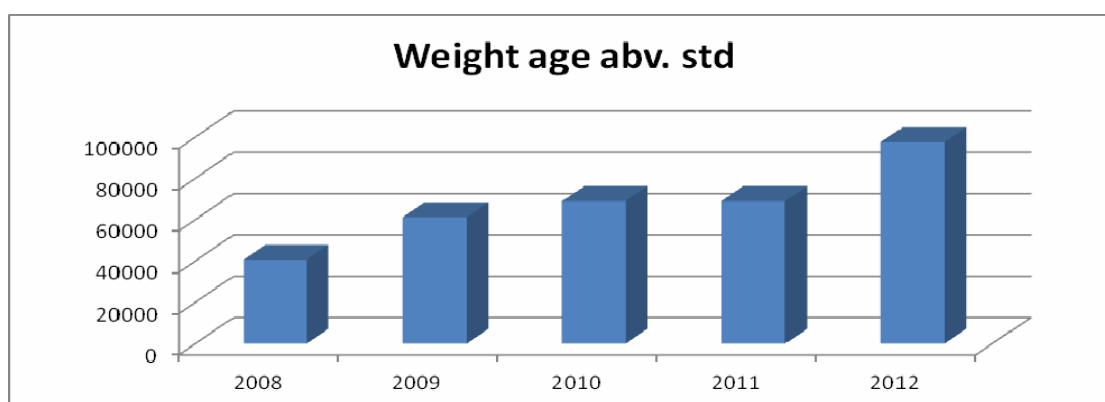


Figure 33: Number of children under five years of age with weight for age above standard in Moyamba District: 2008 - 2012

The data from table 33 and figure 33 show that under five year old children in Moyamba District with weight for age above standard (70 percentile) increased from 2008 to 2012. There were 40,636 under five year old children in 2008, 61,183 in 2009; 69,090 in 2010 and 2011 and 97,502 in 2012. Pregnant women and lactating mothers get nutrition education and demonstration or support when they access health access and as barriers to accessing health service were removed with the introduction of free health care initiative more women benefited from nutrition education, demonstration or support that in turn reflects on the nutritional status of their children as portrayed by available data.

Table 34: Number of children under five years of age with clinical malnutrition in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Clinical malnutrition	33166	32462	8440	13641	9193

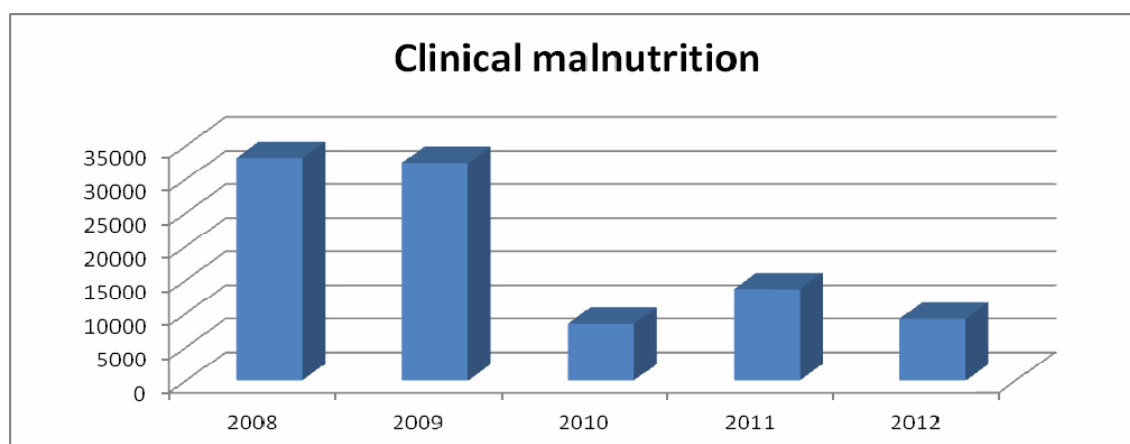


Figure 34: Number of children under five years of age with clinical malnutrition in Moyamba District: 2008 - 2012

Clinical malnutrition as shown in table 34 and figure 34, dropped drastically from 2010 when the free health care initiative was introduced in Sierra Leone and Moyamba District inclusive likely because women receive nutrition education, demonstration and or support during antenatal and postnatal clinic attendances that increased with the introduction of the initiative. Their children in turn benefit from the knowledge/skills and support gained by their mothers. This in turn reflects on their nutritional status. The available data showed that there were 33,166 malnourished (moderate and severe) children under five years of age in Moyamba District in 2008 and 32,462 children in 2009 but the figure dropped significantly in 2010 when the free health care was introduced to 8,440 and remained within that range through 2012 with just slight changes with 13,641 in 2011 and 9,193 in 2012 clinical malnutrition cases recorded in the District

Table 35: Number of pregnant women who made 2nd antenatal clinic visit in Moyamba District

<i>Variable</i>	2008	2009	2010	2011	2012
ANC 2nd visit	11187	13393	14584	14019	14659

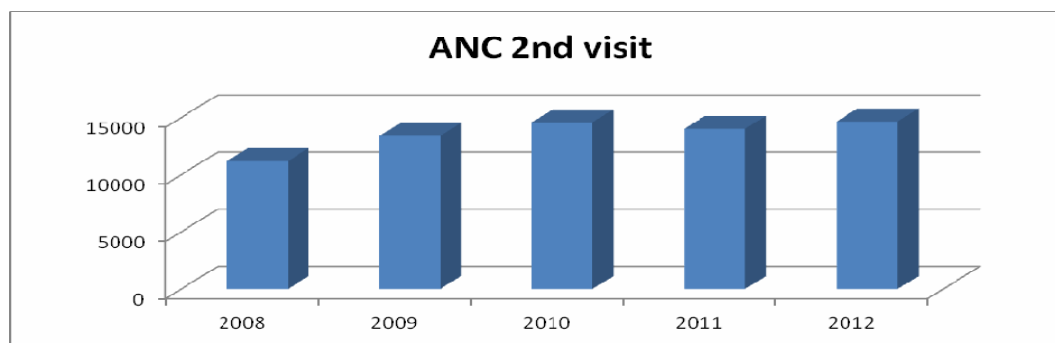


Figure 35: Number of pregnant women who made 2nd antenatal clinic visit in Moyamba District: 2008 - 2012

Table 35 and figure 35 show that more pregnant women paid the second antenatal visit to clinics from the time of the introduction of the free health care initiative in 2010 to 2012. According to the available data, 11,187 pregnant women in 2008; 13,393 in 2009; 14,584 in 2010; 14,019 in 2011 and 14,659 in 2012 attended antenatal clinic two times in their pregnancies. The increase in second antenatal clinic visit may be linked to the free access to health services for pregnant women resulting from the introduction of free health care initiative in Sierra Leone with Moyamba District inclusive in 2010. Second antenatal clinic visit is important because before and at the time of the introduction of the free health initiative, that was the recommended number of times any pregnant woman was expected to at least attend clinic. The at least two antenatal clinic visit recommendation was meant to allow the pregnant woman to receive the necessary services that will help save her life and that of her unborn baby or babies such as tetanus vaccination, intermittent preventive treatment for malaria in pregnancy (IPTp), anti-anaemia drugs (ferrous sulphate and folic acid), de-worming tablets, nutrition and parenting advice. The minimum recommended visit has however changed in the recent past from two to three and even four as recommended by the World Health Organization (WHO). The third or fourth antenatal clinic visits were not tracked in this research because the second visit was the recommended minimum that was tracked for most of the period for which the health data used for this research i.e. 2008 to 2012 were generated or collected.

Table 36: Number of pregnant women who received 2nd IPT in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
IPT 2nd dose, PW	9759	11252	14938	15845	14938

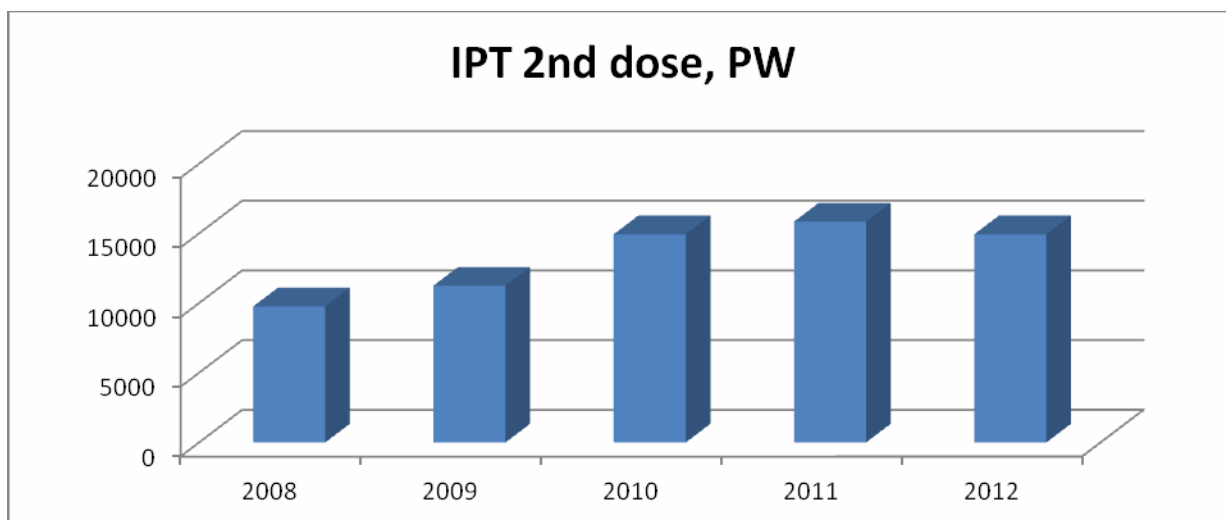


Figure 36: Number of pregnant women who received 2nd IPT in Moyamba District: 2008 - 2012

Intermittent preventive treatment in pregnancy (IPTp) like the second antenatal visit, increased from 2008 to 2012 despite the slight drop in 2011 in the number of pregnant women that received the second IPTp in Moyamba District. As shown in table 36 and figure 36 above, a total of 9,759 pregnant women received IPTp second dose in 2008; 11,252 in 2009; 14,938 in 2010; 13,928 in 2011 and 2012. This indicator is important because malaria is one of the major killers diseases in Sierra Leone and pregnant women and children under five years of age are the most vulnerable

groups affected by malaria in the country as it is the case in many other parts of the malaria affected areas of the world.

Table 37: Number of deliveries in Moyamba District: 2008 – 2012.

<i>Variable</i>	2008	2009	2010	2011	2012
Total No. of deliveries	7980	9610	10263	10263	10967

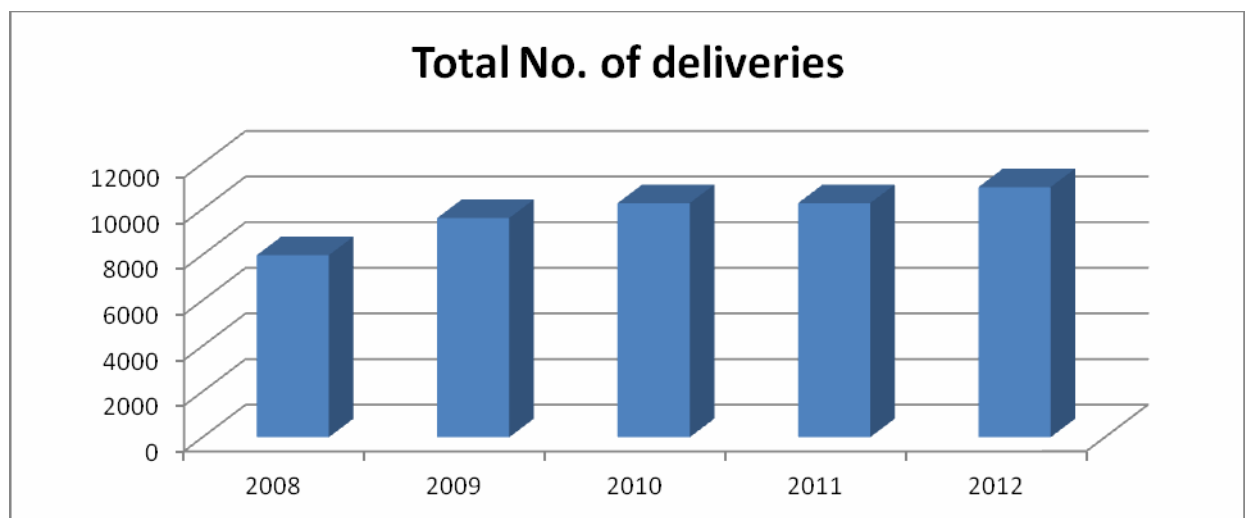


Figure 37: Number of deliveries in Moyamba District: 2009 - 2012

Table 37 and figure 37 show a steady increase in deliveries (live births) recorded in the research district (Moyamba) from 2008 to 2012 i.e. two years before and two years after the introduction of free health care initiative in Sierra Leone. The data show that there were 7,980 deliveries in 2008; 9610 in 2009; 10,268 in 2010; 10,263 in 2011 and 10,967 in 2012. Health facility attended by skilled personnel is a proxy indicator for maternal death. That means if the health facility and skilled personnel deliveries increase, the number of maternal deaths are in turn expected to reduce. Therefore, the free health care introduction which has increased this proxy indicator has helped to reduce maternal death in Moyamba District in Sierra Leone.

Table 38: Number of mothers with children under five years of age who delivered in health facility in Moyamba District: 2008 – 2012

<i>Variable</i>	2008	2009	2010	2011	2012
No. of deliveries in PHU	3550	5790	9668	9668	10154

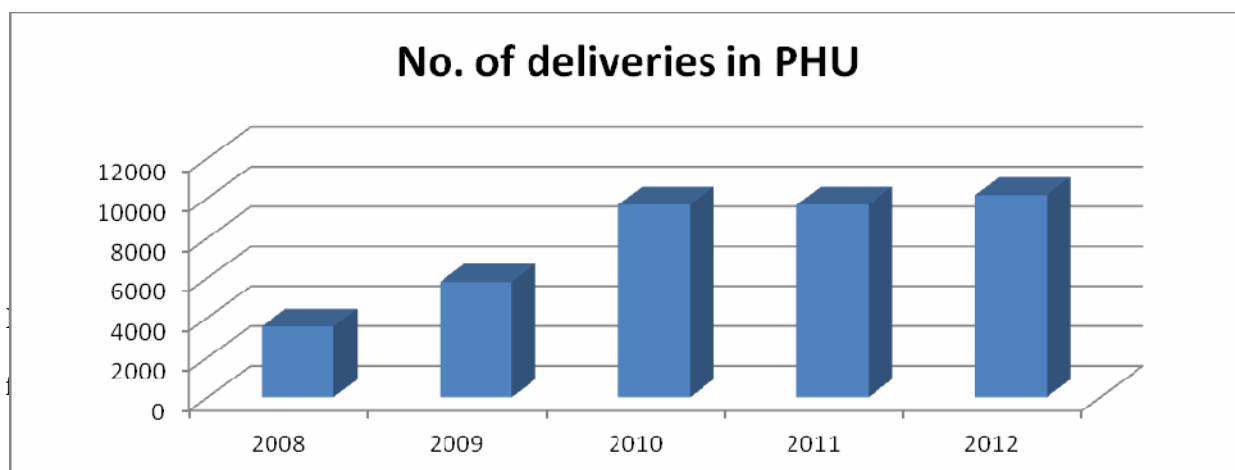


Figure 38: Number of mothers with children under five years of age who delivered in health facility in Moyamba District: 2008 - 2012

Like the number of life births or deliveries seen in table 37 and figure 37 above, the number deliveries mother with children under five years of age who were delivered in health facility or peripheral health units (PHU) steadily increased from 2008 through 2012 with a slight drop in 2011 that was however still far above the pre-free health care period. This indicator is a proxy for maternal mortality ratio and therefore an increase in the number of health facility deliveries recorded in Moyamba District especially with significant increase from the time of the introduction of the free health care initiative in 2010 is important in the investigation the effect of free health care initiative in the Moyamba District. Being a proxy indicator for maternal

mortality, the increase recorded in the Moyamba District Health Information System (DHIS) from 2008 to 2012 show that maternal mortality in the district is improving.

Table 39: Number of child birth related deaths in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
No. of maternal deaths	62	20	15	21	22

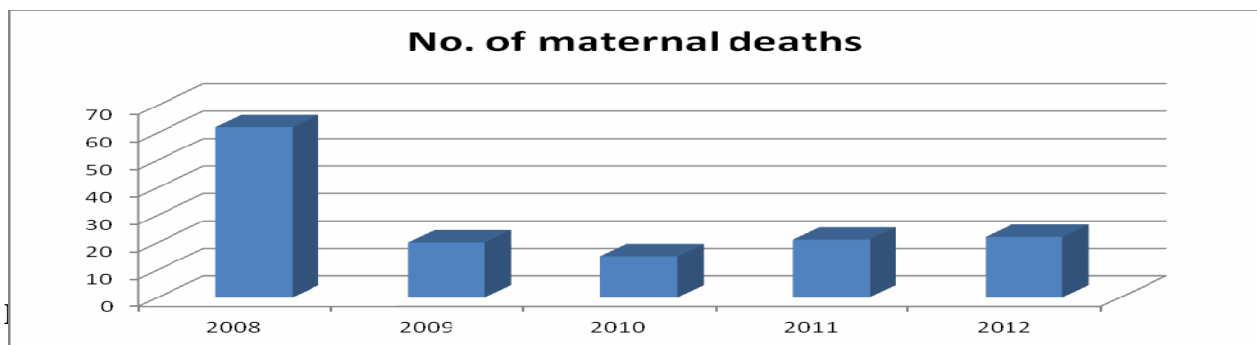


Table 39: Number of child birth related deaths in Moyamba District: 2008 - 2012

As seen in the proxy indicator for maternal mortality in table 38 and figure 38 above, maternal mortality in Moyamba District according to the research data derived from the Moyamba District Health Information System, as presented in table 39 and figure 39 show a significant improvement in maternal mortality in the research district for the period investigated. The available data put number of mothers dying of child birth related issues from pregnancy to six weeks after delivery (maternal mortality) in Moyamba District within the researched period i.e. 2008 to 2012 as follow: 62 deaths in 2008; 20 deaths in 2009; 15 deaths in 2010; 21 deaths in 2011 and 22 deaths in 2012.

Table 40: Maternal mortality ratio in Moyamba District: 2008 - 2012

<i>Variable</i>	2008	2009	2010	2011	2012
Maternal mortality ratio	777	208	146	204	201

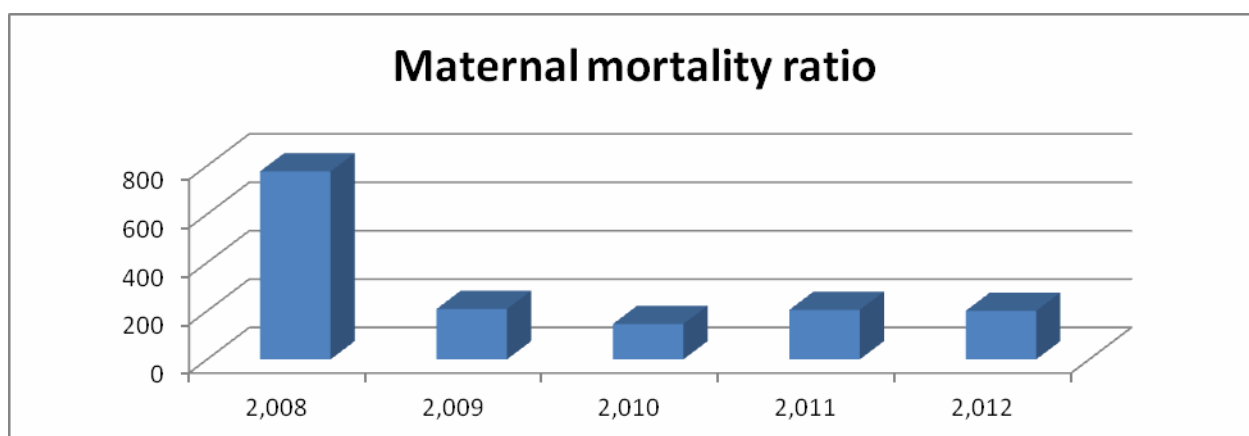


Figure 40: Maternal mortality ratio in Moyamba District: 2008 - 2012

Table 40 and figure 40 show the maternal mortality ratio in Moyamba District from 2008 to 2012 i.e. two years before and two after the introduction of the free health care initiative in the district like all other parts of Sierra Leone on April 27, 2010. The data show that 777 mothers per 100,000 live births died in 2008; 208/100,000 died in 2009; 146/100,000 died in 2010; 204/100,000 died in 2011 and 201/100,000 died in 2012. The data derived from the Moyamba District Health Information System (DHIS) is far improved compared to the national average according the 2010 Demographic Health Survey (DHS) carried out by the government of Sierra Leone and partners in 2010 which puts maternal mortality at 857/100,000 live births. The

research data is within range for what the UNICEF health report for Sierra Leone showed and the Multi-Indicator Survey (MICS) 2010 shows for the country as they put maternal mortality at 192/100,000. Against that background and the data is more or less validated to be credible as a true reflection of what is happening in Moyamba District. The maternal mortality ratio for 2008 compared to that of 2012, from the research shows a significant improvement in the maternal mortality in the district starting from 2009 to 2012. That therefore means the improvement in maternal mortality in the Moyamba District cannot be wholly and solely attributed to the introduction of the free health care initiative in the district. This is important because it was made clear by respondents in focus group discussions or interactions with stakeholders in and out of the district that the entire Moyamba District also benefited from a four year (2008 – 2012) US\$1.5 million European Union funded child survival and development project implemented by Plan International in Sierra Leone and partners including the Moyamba District Health Management Team (DHMT) that also confirmed that and the Reproductive and Child Health \ Expanded Programme on Immunization (EPI) Programme from the central level. Fluctuation in the improvement may also not be unconnected with challenges highlighted in focus group discussions and comments gathered from the questionnaire respondents including inadequate drug and medical supplies, poor monitoring and supervision, inadequate staff motivation and effective management, and illegal charges for services that are supposed to be free.

Table 41: Summary of the Moyamba District health data from January 2008 to December 2012

Variables	2008	2009	2010	2011	2012
Early breastfeeding	6093	9252	12967	14855	12528
Slept under LLITN last night	12442	9240	10915	12313	10874
Fever last 2 wks	13943	4344	52082	96401	77365
If yes, appropriate malaria drug 24h	10749	3756	41472	48003	16050

Diarrhoea last 2 wks	12963	2236	12781	12273	13737
Cough last 2 wks	8688	3315	38819	65067	66450
Excl. breastfeeding	12969	6848	9322	12894	9058
Penta 3	8947	11438	12411	14149	14513
Measles	17323	11491	12770	13722	14094
Fully Immunization child	25481	11077	12235	13131	13631
Under five deaths	562	634	171	654	561
Weight age above std	40636	61183	69010	69010	97502
Clinical malnutrition	33166	32462	8440	13641	9193
ANC 2nd visit	11187	13393	14584	14019	14659
ANC 3rd visit	11606	14801	12893	11616	13012
IPT 2nd dose, PW	9759	11252	14938	15845	14938
Total No. of deliveries	7980	9610	10263	10263	10967
No. of deliveries in PHU	3550	5790	9668	9668	10154
No. of maternal deaths	62	20	15	21	22

The investigator's position is that:

1. The introduction of the free health care initiative was aimed at removing the barriers to accessing health care services especially targeting the vulnerable groups of pregnant women, lactating mothers and under five children. The findings of this study according to tables and figures 20a, 20b and 40, free health care for pregnant women, lactating mothers and under five children has helped to improve maternal morbidity and mortality in Moyamba District in Sierra Leone with a reduction from 777/100,000 in 2008 to 201/100,000 in 2012 (two years before and two years after the introduction of the initiative). There was also a significantly higher reduction recorded in 2010 the year when the initiative was first launched.
2. Free health care for pregnant women, lactating mothers and under five children has helped to improve morbidity and mortality of children under five years of age in Moyamba District in

Sierra Leone. According to views of respondents to questionnaires, participants of focus group discussions and those interacted with as someone said “the free health care has helped improve maternal and child mortality”. This view was expressed by majority of the people reached in this investigation by various means. Questionnaire specific responses according to tables and figures 15 and 16 under five child mortality reduced with the introduction of the free health care initiative in Moyamba District (two years before and two years after the introduction of the free health care). Table and figure 31 also supported this view because according data in table 31 and figure 31, 562 children under five years of age died in 2008; 634 in 2009; 171 in 2010; 654 in 2011 and 561 in 2012. The trend in absolute numbers showed that under five child death was high in 2008 and higher 2009 but dropped dramatically in 2010 the year the free health was introduced but rose to its highest in 2011 and then dropped in 2012 by a slight margin. The picture is slightly different in terms of proportion of under five child death per 1000 live births as shown and explained below for table 32 and figure 32. As stated in the data description for table 31 and figure 31, the trend of under five child deaths in absolute figures slightly differ from the figures in proportion per 1000 child deaths per year. According to table 32 and figure 32; 70 under five year old children per 1000 live births died in Moyamba District in 2008 while 66/1000 died in 2009. That trend dramatically changed in 2010 (the year the free health was introduced) when the figure dropped to 17 under five child death per 1000. The death rate according to the available data increased again in 2011 to 64 deaths per 1000 but dropped to 51 per 1000 in 2012. This trend may not be unconnected with qualitative data gathered through this research which pointed out that the free health is working but not without challenges that affects the results such as staff motivation, availability of drugs and medical supplies and effective monitoring and supervision.

3. Free health care for pregnant women, lactating mothers and under five children that forms the bulk of the affected population that utilize health care services in Sierra Leone with Moyamba District inclusive, according to the findings of this research, has mixed effect on the health personnel in Moyamba District in Sierra Leone in that although they consider the initiative to be

good in that it is making them reach more people, they also strongly feel that the free health care initiative has increased their workload and pressure from the beneficiaries to provide them the said free health care at all times and sometimes for categories of the population not targeted for the free health care. This sometimes results in misunderstanding and confrontation between health personnel and beneficiaries. For instance, according to the health workers from the questionnaire responses, focus group discussions, inter-personal interactions and observations, their workloads have increased with the introduction of the free health, their salaries and benefits or living conditions are not commensurate to their job and living environments especially in the remote communities with transportation and accommodation challenges in addition to other basic social amenities like communication do exist. According to one health worker in the research location,

“free health care initiative is good but it has increased our workload and does not leave any time for us for rest or even for preparation of meals and other personal business at the end of the day and the compensation does not match that much effort despite increase inc salaries upon the introduction of the initiative.”

4. The effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone is positive because it has helped to improve the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District in Sierra Leone despite the challenges highlighted in the findings. This is supported by tables and figures 22 (under five year old children that sleep under long lasting insecticide treated nets (LLIN), 24 (appropriate treatment of children under five years of age with malaria treatment with 24 hours), 25 (diarrhoea case reported and treated) and 26 (cough or acute respiratory infection (ARI). The views of respondents to the various data collection approaches used (questionnaires, focus group discussions, personal interactions and observations) and the Moyamba District health data for

2008 to 2012, the initiative has improved facility service delivery, drugs/medicaments, and also it has helped to improve leadership and management but there is need for improvement. For instance, health workers think the workload is increased and that affects their personal lives and they need more compensation to match the increased workload; they also feel the required support in terms of drugs and medical supplies is not adequately and timely provided in a number of cases and that affects their work, relation with beneficiaries with consequent effect on the utilization of the provided health services and the resulting outcomes of health care services in the research location as well as other parts of the Sierra Leone. Considering table 26 and figure 26 that show the number of acute respiratory infection (ARI) cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age); 8,688 cases in 2008; 3,315 in 2009; 38,819 in 2010; 65,067 in 2011 and 66,450 cases were seen and treated in Moyamba District. The data showed that more people accessed health services and received treatment for acute respiratory infections or cough in Moyamba District after the launch of the free health care than they did before the launch which is one of the three leading killer diseases accounting for the high child mortality in Sierra Leone (according to the Government of Sierra Leone's Free Health Care Position Paper of 2010). This dramatic increase in the number of reported and treated cases show that the need for supplies increased with the introduction of the free health care initiative thus overwhelming the existing system and hence the inadequate and often untimely supplies to the health facilities.

The research findings overall have provided positive answers to the research questions supported the hypothesis that free health care is effective in Moyamba District in Sierra Leone. The said questions in the research that the findings have provided positive answers to are:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?

- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

13. Anticipation of Objections.

In this section the knowledge gained in the research and the literature review was used to anticipate any objections other scholars might have to the position and conclusions. Fairness was ensured in this section but explanation on why the position reached in the research stood up to these objections as provided below.

Health care outcomes including morbidity and mortality can be affected by the cost of health service especially at the point of delivery. It is therefore not surprising to see that Sierra Leone had one of the world's worst health indicators especially with regards to maternal and child mortality. Up to 2005 the country had maternal and child mortalities at 1800/100,000 and 286/1000 respective (DHS, 2010) which has shown some improvement in the recent past. Cost of health care at point of service delivery is believed to influence outcome of health in Sierra Leone. Over 70% of the population live on less than a dollar a day (PRSP II, GoSL, 2008) and 68% of payment for cost of health care in Sierra Leone in the recent past was from individuals (GoSL, 2010). Therefore the

findings of this research on “The effect of free health care for pregnant women, lactating mothers and under five children, on health service delivery in Moyamba District in Sierra Leone” that have shown free health care for pregnant women, lactating mothers and under five children has positive effects on the health service delivery in Moyamba District in Sierra Leone should not surprise anyone because according the position paper on the free health care (GoSL, 2010) cost is one of the factors that was influencing access and the country’s high maternal and child mortality. It was this realization that influenced the President of Sierra Leone His Excellency (H.E.) Dr. Earnest Bai Koroma to commit himself and his government to the introduction of the free health care for pregnant women, lactating mothers and under five children that was launched on April 27, 2010. The introduction of the free health care initiative was aimed at removing the barriers to accessing health care services especially targeting the vulnerable groups of pregnant women, lactating mothers and under five children. The findings according to tables and figures 15, 16 and 20, free health care for pregnant women, lactating mothers and under five children has helped to improve maternal morbidity and mortality in Moyamba District in Sierra Leone. This position is also supported by the views of the research questionnaire respondents, focus group participants, stakeholders the investigator interacted with in Moyamba District including the District Council and the District Health Management Team (DHMT) members and research related observations made during the course of this study. For instance according to analysis of table 20a and figure 20a show general views or comments of respondents, free health care initiative at country level. The analysis show that the data collected with responses show that 22% said it does and 2% said FHCI does not increase utilization, 24% said it does and 3% said it does not

reduce maternal deaths, 24% said it does and 3% said it does not reduce under five child deaths, 15% said it does and 5% said it does not increase user satisfaction, 1% said it does and 1% said it does not have effect on other things while 1% did not say anything. Data available from the research show that it is the view of respondents that free health in Sierra Leone and by implication in Moyamba District has increased utilization, reduced maternal mortality, reduced under five mortality, increased user satisfaction in addition to other impacts created. That means, the initiative is effective as data show that it is achieving what it set as a goal to achieve i.e. reduced maternal and under five child mortality in Sierra Leone.

Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone?

Clearing barriers to access to health services is what the free health care for pregnant women, ;lactating mothers and under five children has done in Moyamba District as in other parts of the Sierra Leone following the introduction of the initiative on April 27, 2010. That in turn has improved maternal morbidity and mortality (Tables and figures 20a & 20b). The views of respondents in the various data collection methods used including focus group discussions and interpersonal interactions. Those views were expressed in statements such as the one altered by one of the community respondents of a focus group discussions which say: “free health care has helped to improve child mortality in Moyamba District”. Considering the purpose of the free health care (Free health care position paper, GoSL, 2010), this result should not be a surprise as the imitative is aimed at reducing maternal and child morbidity and mortality. Despite

challenges that go with the free health care in Sierra Leone with Moyamba District inclusive, IREIN News Agency, UNICEL's Sierra Leone at a glance and the first year report of the free health in Sierra Leone (Health for All Coalition & Save the Children Sierra Leone, 2011) support this same position that free health is improving health care service delivery in Sierra Leone including Moyamba District (the research district).

Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone?

As it is the case for the effect of free health care on maternal morbidity and mortality, removal of barriers to access health services is what the free health care for pregnant women, lactating mothers and under five children has done in Moyamba District as in other parts of the Sierra Leone following the introduction of the initiative on April 27, 2010. That in turn has improved under five child morbidity and mortality (Tables and figures 15 and 16) according to the views of respondents in the various data collection methods used including focus group discussions and interpersonal interactions. Those views were expressed in statements such as the one altered by one of the community respondents of a focus group discussions which say: "free health care has helped improve child mortality in Moyamba District". No surprises in this finding as the free health care year one report shows the same picture i.e. improvement in the health care system in Sierra Leone with Moyamba District and under five child morbidity and mortality inclusive according to a civil society monitoring report (Health for All Coalition & Save

the Children Sierra Leone, 2011) and the UNICEF Sierra Leone at a Glance (UNICEF, 2011)

What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone?

i. Free health for pregnant women, lactating mothers and under five children that forms the bulk of the affected population that utilize health care services in Sierra Leone with Moyamba District inclusive, according to the findings of this research, has effect on the health personnel in Moyamba District in Sierra Leone in that it has increased their workload and increased pressure from the beneficiaries to provide them the said free health care at all times and sometimes for categories of the population not targeted for the free health care. This sometimes results in misunderstanding and confrontation between health personnel and beneficiaries. For instance, according to the health workers from the questionnaire responses, focus group discussions, inter-personal interactions and observations, their workloads have increased with the introduction of the free health, their salaries and benefits or living conditions are not commensurate to their job and living environments especially in the remote communities with transportation and accommodation challenges in addition to other basic social amenities like and communication.

What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District?

The investigated free health care has effect on the health service delivery system in terms of facilities, equipment, drugs, medical supplies, leadership and management of health care system in Moyamba District show that the effect is both positive and negative. Positively, the free health as stated above has helped improved maternal and under five child health care and has also shown that the initiative has effect on health personnel. This is supported by views of respondents and responses got from questionnaire interviews and focus group discussions. Respondents' views in several ways supported this position. Similarly, in the view of the respondents, free health care in Moyamba District and other parts of Sierra Leone has challenges that have effect on the health care system related to the facilities (some are too far apart thus constraining users' access despite the delivery of free services); the equipment or supplies including drugs and medical supplies (supplies made to health facilities are inadequate leading to suspicion, dissatisfaction and sometime confrontation between health workers and users and even non-use of the services), leadership and management (the increased services require increased monitoring and supervision but according to respondents to this research, monitoring and supervision are inadequately done and this in turn is said to affect quality of services delivered, reports produced and hence drop in donor and beneficiary satisfaction). The initiative also adds pressure on government for funding, and how to sustain what has been started. These are all views of research respondents but it should also not be of surprise because it stands out clearly even in the first year report prepared by the Health for All Coalition (a civil society organization independently monitoring the free health in the whole of Sierra Leone including the Moyamba District) and Save the Children, Sierra Leone (HFAC & SCUK, Sierra Leone, 2011)

Below are various instances from the literature reviewed above that support the research findings out of Africa, in Africa but outside Sierra Leone and in Sierra Leone.

From the European perspective: Scottish Government has a Scottish parliament that has an Official You Tube Channel. The Scottish parliament exists to determine, debate, decide and legislates issues of importance. The Scottish Government Debate: Person-centred Healthcare of November 6 & 15, 2013; as the name goes covered person-centred healthcare.

The Scottish parliament like what is shown in the Burkina Faso free health care evaluation findings believes in person-centred healthcare as the best approach for getting the best health outcomes. To achieved that, the parliament holds the view that the approach should support actions that ensure individuals are supported to be active partners in their own care; in which case all parts of the healthcare system should be focused on the patient, and that should include both community and hospital care. The idea further supports Scotland's modernization programme to test measures to make Government public services more accessible for patients, while reducing bureaucracy for the Government public services and freeing their time to focus on patients (**Scottish Parliament, November 2013**). **The parliament also believed that the government should guarantee that the readiness of the healthcare system for critical periods like winter.**

It is believed by the Scottish parliament that all people in Scotland should be supported to

live a longer, healthier life and the parliament is confident that this support can only be delivered in a person-centred healthcare system that is well-resourced and have motivated workforce; and also considers mental wellbeing to be a foundation for good health and good healthcare. Like all free health care systems, the Scottish Parliament knows that the Scottish Person-centred Healthcare system has challenges or barriers one of which is mental health. The parliament therefore thinks that Scottish healthcare system requires additional work to break down barriers and tackle the stigma that continues to exist around mental ill-health (**Scottish Parliament, November 2013**). This is according to **You Tube: The Scottish Parliament: Plenary Session (Scottish Parliament, November 2013)** - <http://www.scottish.parliament.uk> - *Scottish Parliament Plenary Session: Scottish Government Debate: Person-centred Healthcare*

The American perspective: According to “The Daily Conversation, Obama Clearly Explains: USA Affordable Health Care Act – Obamacare” (Obama, May 2013), **freeing users from health care cost (free health care) had happened in different parts of the world in different forms. Some are 100% for certain category of beneficiaries like the Sierra Leone free health care initiative but others can be about subsidizing cost of health care services at the point of service provision as it is in the case of the new USA Affordable Health Care Act that is implemented as The USA President Barack Obama put it: “...for people who have insurance through their employers and clarified that the other part of the law to be implemented are the exchanges that will allow individuals to buy insurance in an "exchange" where companies will compete for their business” (Obama, May 2013).** The feasibility of free health care of any sort or model like many other big venture, is always prone to skepticism. For instance, according to Obama people had doubts about

the Affordable health Care – Obamacare. He therefore in his explanation of what the Obamacare was all about said, "I think that any time you're implementing something big, there's going to be people who are nervous and anxious about is it going to get done, until it's actually done" (Obama, May 2013).

The USA Affordable Health Care Act is already benefiting 85 – 90% Americans with health insurance says Obama. Like all other free or subsidized health care systems, the Obamacare has its own challenges and the one confirmed by Obama himself is the lack of health insurance for the 10 – 15% (about 30 million Americans) with preexisting conditions for getting health insurance or they are without health insurance because they are too poor to get because they work with small business companies that cannot afford to provide them one (Obama, May 2013).

The African and specially the West African perspective from Burkina Faso gives this account: Evaluation and Program Planning: Research on Implementing Evidence Based Practices in Community Based Addiction Treatment Programs: Policy and Program Implications, volume 34, Issue 4, November 2011, Pages 333-342 (Valery Ridde et al, 2011)

In one health district in Burkina Faso, a state-led and two community-based (two action research) free health care projects excluding the indigent from user fees payment at health facilities which are uncommon in Africa were undertaken in 2005 (state-led) and 2007 – 2010 (community-based) respectively. An evaluation of the projects using individual and group interviews with key stakeholders including health workers and community members looking at the strengths and weaknesses of key components of the interventions that included the relevance and uptake of the intervention, selection and

information on worst-off beneficiaries, and financial arrangements within the implementation of the interventions.

Effective mechanisms to exempt the indigent from user fees at health care facilities are rare in Africa. A State-led intervention (2004–2005) and two action research projects (2007–2010) were implemented in a health district in Burkina Faso to exempt the indigent from user fees. This article presents the results of the process evaluation of these three interventions.

The evaluation findings brought out that there is room for improvement for the one state-led and two community-based interventions; stakeholders appreciated the community-based more than the state-led approach with regards to targeting of beneficiaries for the waiver of health care fees payment. This was because the community-based approach helped to clearly define the selection criteria, inform the waiver beneficiaries, use a participative process and use endogenous funding. The downside, challenge or weakness of the community-based approach was that using endogenous funding led to restrictive selection by the community. The evaluation therefore showed that the community-based approach was most effective of the tested interventions but it also required improvement to better inform scale up of the initiative.

It was therefore concluded from the findings that important to the effective functioning of the free health care especially the community-based approach are stakeholders' information and the funding for indigent coverage (**Valery Ridde et al, 2011**)

Sierra Leonean in country and external account of the introduced free health care in the country that support these research findings is provided as follow:

According to UNICEF Sierra Leone You Tube web publication (UNICEF, February 2014) and the UNICEF Sierra Leone video published on the web in February 2014, the free health care is effective as it states that the initiative is already saving thousands of lives and that UNICEF and the European Union will continue to support the initiative. The Krio video clip put it this way:

“Thousands of lives in Sierra Leone have already been saved through the Free Health Care Initiative. In 2010 the President of Sierra Leone launched the Free Health Care Initiative. Now children under five, pregnant women and breast-feeding mothers can seek medical care and much needed medicines without worrying about the costs. UNICEF in partnership with the European Union will further support the Government in ensuring that the Free Health Care Initiative can continue” (UNICEF, February 2014).

According to the Lancet Elsevier Ltd 2013 volume 381, Issue 9862, pages 191 – 192: Sierra Leone's free health-care initiative: work in progress (Lancet, January 2013), FHCI has challenges (distance, transportation, ill equipped health facilities, lack of electricity and poverty make it difficult to meet the non-health costs associated with the FHCI) just as the findings of this research has shown.

More than 2 years have passed since Sierra Leone granted pregnant women, new mothers, and young children free health care, but their needs often remain unmet. Amy Maxmen reports.

Marta Amara's water broke on Nov 5, 2012. Community members carried her in a hammock to the nearest health facility, nearly 10 km away from her village in rural Sierra Leone. A baby's tiny arm emerged soon after she arrived, but not its head. Realising that the birth would be too complicated in a centre ill-equipped for surgery, staff urged her to pay a taxi driver the equivalent of US\$29 to take her on a 2-hour trip to the district hospital in Kenema. They arrived after nightfall to discover a hospital lacking electricity. Amara then paid for transportation to an emergency clinic operated by Medicines Sans Frontières (MSF). By the time she arrived, her baby was dead and she was internally bleeding from a hole in her uterus. At the hospital, MSF obstetrician and gynaecologist Betty Raney stitched the wound, which saved Amara's life but rendered her infertile. "Women and children die because of delays in care", Raney says. She sees preventable deaths daily, despite the country's 2-year-old policy for free health care for pregnant women and children younger than 5 years (Lancet, January 2013).

Amara's experience reveals a number of the initiative's shortcomings: she arrived at the clinic hours after she started labour; she paid for travel when ambulances should be provided for free; and the hospitals were not prepared for surgery. Certainly, health care is better than it was. More than five times as many children are treated for malaria with the recommended artemisinin now than in 2008, according to household surveys. And now that cost is no longer a barrier in a country where 74% of the population lives on less than \$2 per day, health-care use has increased by 60% (Lancet, January 2013),

Movement of drugs and medical equipment and leakages within the system are part of the challenges found in the implementation of free health care initiative in Sierra Leone. That was what made UNICEF and other partners teamed up to support the system with

transportations and introduction of many checks and balances. With their added support in addressing the issue of transportation and leakages, by November, 2011, the drugs were flowing across the nation again (Lancet: Elsevier, 2013). Other challenges are related to poor infrastructure, low diagnostic capacity, availability of running or improved source of water, bad roads with difficult river crossings making it difficult to access health facilities even in emergencies, lack of blood for transfusion during emergencies and in treatment of severe malaria and diarrhoea in children and in cases of caesarian sections for pregnant women. Free health care initiative has not taken away all the numerous challenges that had existed in the health care system over the years leading to the introduction of the initiative despite helping to improve the system in a way.

These words from the Director of Reproductive and Child Health Division Dr. S. A. S. Kargbo reinforced the some of the highlighted challenges in the health care system in Sierra Leone that the free health care initiative is faced with. As he put it, electricity and blood banks are a top priority. Before health care was free, so few mothers visited hospitals that a night-time need for electricity was not apparent and blood could often be provided by a patient's relatives. He also added that once the allure of free health care increased demand, the deficiencies of the old system surfaced. These were his own words: “now they come at night, and we are not prepared”, According to him it is because the infrastructure for electricity cannot sustain 24-hour use in many districts. He is therefore happy with support coming in with electricity like the donation of 42 solar power systems made by WE CARE Solar, a solar energy charity in Berkeley, California and there intends to continue seeking similar support for the country’s health care system.

Health worker shortage is one of key challenges in the implementation of the free health care initiative. According to Dr. Kargbo, a deficiency in skilled labour will take several more years to be resolved. He therefore said that “If all of the foreign doctors working here went away we couldn't sustain the hospitals”.

There are however simple or improvised solutions to some of the challenges. For instance birth waiting houses are helping pregnant women from far distances to health facilities to wait close to the facilities when they at term to avoid the huddle of long stretched and dangerous roads during labour periods and more so emergencies when they end up using commercial motorbikes or hammocks. Non-governmental organization partners helping with the simple but useful initiatives. This added initiative plus an emergency line to call an MSF ambulance in Bo District in Sierra Leone with the support of MSF helped reduced maternal mortality by 61% according to MSF November, 2012 report.

Another simple approach in Moyamba is a community system strengthening tool called Child Health and Development Competence Tool which the health staff use to increase communities understanding, participation, ownership and sustainability of health interventions. That has encouraged collective efforts leading to improvement in road conditions that in turn helped health facility access or improvement in sanitation and better health practices. This measure, plus an emergency line to call an MSF ambulance, helped the to reduce maternal mortality in Bo and Moyamba Districts (as seen in the research findings and as per MSF 2012 report).

Additional challenges to free health care and improvement in maternal and child deaths include cultural that encourage home or traditional birth attendant deliveries even when they are untrained in some cases. The lack of family planning with frequent births and

teenage pregnancies are amongst the additional things that further challenge the free health care initiative in Sierra Leone. For instance a nurse at the national maternal and child health referral hospital in the capital city of Sierra Leone (Freetown), said she finds it difficult to tell clients about the importance of family planning because as she said: “The poorer mothers want a lot of children so that some of them will survive to care for them”. She further added that unmarried pregnant girls between ages 12 and 18 years account for a high proportion of maternal injuries and mortalities at the hospital.

According to Lancet Elsevier’s 2012 web publication, if the cultural practices that negatively impact maternal and child health such as frequent births, teenage pregnancy, non use of family planning, are not addressed it will be difficult for Sierra Leone to achieve the UN's Millennium Development Goals for reduced maternal and infant mortality (Lancet, January 2013).

High maternal & under five child mortality rate still hangs over Sierra Leone

The FHCI is working, pregnant women, lactating mothers and children under five years of age are accessing public health facilities without bothering about payment of health cost in the normal circumstances and lives are saved but the high maternal and child mortality in Sierra Leone is far from over. The FHCI is therefore just in progress as women are still dying in child birth and under five children are still dying often due to the challenges related to non-health costs.

Lancet (Elsevier Ltd, 2013) exactly explained it this way:

“To international applause, President Ernest Bai Koroma announced the free health-care initiative on April 27, 2010. Koroma's intention was to reverse Sierra Leone's position as

one of the world's most deadly places to give birth and to be born. World Bank statistics show that one woman dies in childbirth for every 112 births in Sierra Leone. That rate is 2.5 times higher than in nearby Ghana, 42.4 times higher than in the USA, and 222.5 times higher than in Sweden, where the rate is one death per 25 000 births. Furthermore, nearly one in five children born in Sierra Leone dies before they reach 5 years of age” (Lancet, January 2013).

According to the article (Lancet: Elsevier 2013), taking off health care cost has exposed other gaps in the health care system in Sierra Leone as manifested as the challenges to free health care initiative (non-health costs). Notwithstanding, the challenges, there are recognizable improvements in the health care system as a result of the introduction of the free health care initiative. This was what Yvonne Nzomukunda, MSF's medical coordinator in Sierra Leone said: “Today we see fantastic improvements in health and sanitation”. She also added that: ... “but compared to other countries in the region, we still lag far behind”. Aid organizations and donors including UNICEF, UK's Department for International Development, the European Union, UNFPA, MSF and several others are contributing and still remain committed to supporting the free health care initiative and health care in general in Sierra Leone.

No miracles should be expected with regards to maternal and child deaths in Sierra as a result of the introduction of free health care in the country. The rate of improvement is slow but it cannot be given up at all. With that in mind, Dr. S. A. S Kargbo, Director of Reproductive and Child Health Division said: “Our country is very young, and there are many things that have set us back ... when we go two steps forward, we're still just moving one step at a time” (Lancet, January 2013).

The Health for All Coalition is a Civil Society Organization that is partnering with other health service providing organizations in Sierra Leone in monitoring the introduced free health care initiative and more so its implementation across the country.

The Health for All Coalition: Latest Report Summary (HFAC, 2010) supports the findings of this research as expressed below.

A civil society organization in Sierra Leone had helped to monitor the free health care initiative from the start of implementation in 2010. They have presence in all the 14 health districts in the country. The organization has staff and volunteers that help to monitor the free health care implementation in hospitals and at chiefdom or community level in addition to the deployed district level coordinators. Looking at what works well and what could be improved. The organization carried out monitoring after the first three months into implementation and came out with these summary findings and recommendations for the initiative:

“Key positive findings

Key positive findings common to all districts include:

- Increased attendance of Free Health Care beneficiaries was recorded at all Government Health Facilities
- All facilities visited by HFAC monitors had at least one member of staff ready to provide their best service
- Service was available in most Government health facilities visited
- There was an increased commitment amongst health workers due to the agreed increase in salary

- There was an appreciation of the GOSL and the Free Health Care Initiative by community people throughout Sierra Leone
- The promised Cash for Facilities was available in most PHUs visited

Shortfalls

Shortfalls common to all districts include:

- There was a stock-out of essential drugs at most health facilities visited by monitors
- There was no blood in the majority of blood banks visited, and these blood banks were of insufficient quality for safe storage of blood
- Theft or sale of Free Health Care drugs and other medical materials such as beds and bed nets were recorded on several occasions across the country
- There was an inadequate number of health workers on duty at most PHUs
- In most facilities visited no records were maintained for infant and maternal mortalities
- The exclusion of key Faith Based Organizations mean that in some areas the community has no access to Free Health Care
- The concept of the Free Health Care Initiative is not well understood in many communities due to a lack of sensitization activities
- Most health facilities visited had poor infrastructure including an inadequate supply of water” (HFAC, 2010).

Free Health Care in Sierra Leone One Year On: National Public and Stakeholder’s Perceptions of the Free Health Care Initiative (HFAC, 2013)

The civil society organization (Health for All Coalition – HFAC) helping to monitor the implementation of free health care in Sierra Leone the free health care initiative and its implementation to improve health care services one man’s business but a business of all Sierra Leoneans. The Director, Health for All Coalition in his own words said:

“The task of working towards an improved health care service is too important to be entrusted to one institution or individual – Sierra Leoneans must be encouraged to play an active role in health service developments and in the Free Health Care Policy” implementation (HFAC, 2013).

The statement of the HFAC Director, is in line with the findings of the Burkina Faso free health care project beneficiaries perception evaluation as well as the positions of the Scottish Parliament because they believe that for free health care to work well, the process should be participatory involving stakeholders and the beneficiaries.

Others investigating the free health care systems had used individual and group interviews and the Health for All Coalition also used survey questionnaires to carry out a survey on stakeholders’ and experiences of the FHCI over the first 12 months of its existence having 100 respondents per district in Sierra Leone.

The survey looked for awareness about the free health care initiative (95.3% aware overall with varying level of awareness across the country (99% in Moyamba District) ; Categories of eligible people for the free health care (about 80% overall knew the correct categories – meaning more people know about the initiative but less know about the

details (89% for Moyamba District)); when the initiative was introduced (overall, 43.5% were aware of when it started and only 4.2% knew it has no stated end date); overall, 95.7% (87% in Moyamba District) said they visited public health facilities when they were sick during the first year of the free health care implementation and overall 4.3% and 13% in Moyamba District were not going to health facilities when sick either because the husband did not allow or there was no money or because of the attitude of the health workers, and overall 28.5% (21% in Moyamba District) were satisfied with the services received but 51% respondents said the services were very good, 78% said the services were good and 74% said the services are fair (the data show inadequate understanding of the free health care rights).

In conclusion, the free health care initiative has encouraging results but there are issues around inadequate detailed knowledge of the initiative, collection of illegal payment from beneficiaries in some places, inadequate involvement of beneficiaries and other stakeholders in the initiative which government should help stop by promoting learning and sharing among facilities doing well and those not doing well and also by promoting better involvement and participation of beneficiaries and stakeholders in the free health care initiative and more so the implementation.

Focus group discussion with various stakeholders held with Health for All Coalition and Save the Children, UK, Sierra Leone looked at successes and challenges for the first year implementation; suggested solutions for the challenges and the top two priorities per

district for future implementation. The overall findings brought out successes, challenges, solutions to the challenges as suggested by the participants and the top two priorities for each of the health districts in Sierra Leone that will help future implementation.

Successes

- Reduced deaths amongst pregnant women, lactating mothers and under five children
- Awareness on the importance of health care utilization increased
- Community health messages including immunization increased
- Reduction in consequences of maternal deaths including time spent on traditional rituals
- Free health care beneficiaries utilization of health services increased
- Health workers commitment to work slightly increased with the exception of few workers in few areas including the Western Area Rural
- Health right awareness increased
- Peripheral health unit (PHU) to hospital referrals improved
- Recognition of increase in some health staff salaries as success in the free health care initiative
- Health infrastructure and rehabilitee improved with the introduction of the free health care initiative
- Some improvement in communication amongst health workers
- Drugs and medical supplies distribution system, security and transparency improved with the introduction of the free health care initiative

- Basic health facility equipment provided and installed with the introduction of the free health care initiative
- Improvement in the district level medical stores as a result of the free health care implementation
- Reduction in maternal deaths resulting from birth complications as a result of increased access to user cost free caesarean sections
- Health management information system improved at peripheral health unit and hospital levels
- Number of health workers in some places like the Western Area increased as a result of the free health care
- More children and pregnant women immunized
- Understanding of roles resulting from training traditional birth attendants within the free health care initiative is helping in the reduction of home deliveries in Sierra Leone
- Increased demand for health care services

Challenges

- Despite the highlighted successes of the free health care from the Health for All Coalition and Save the Children UK, Sierra Leone survey (focus group discussions) the participants came up with several challenges facing the implementation of the initiative that included:

- Drug and medical supplies related challenges such as the inadequacy of drugs and medical supplies, shortage of drugs and medical supplies and the irregular or late supply of drugs and medical supplies
- Transportation related challenges including the poor nature of the roads, road network and transportation including ambulance for transfer of patients and mobility for health workers and community volunteers or committees.
- Non-cooperative or respectful working relation between the District Health Management Teams and the Chiefdom or Local Authorities' monitoring teams
- Absenteeism and attitude of health workers at their respective facilities/locations
- The lack of traditional birth attendants expected incentives
- Charging of illegal fees for free health care target groups by some health workers
- The absence of nutrition programs that provide food supplies to some health facilities
- Non or untimely availability of vehicle for drug and medical supplies distribution and monitoring
- Increased health facility utilization including people from outside the respective health facility catchment areas leading to increased workload for the health workers
- Shortage and inadequately trained health workers to meet the increased service demand
- Little or no incentives for community volunteers that support health activities or service delivery
- Inadequate communication systems in some places

- Non or delayed absorption of trained health workers into the government employment with subsequent delayed payment after graduation
- Health workers accommodation especially at community level health facilities
- Unequal distribution of health facilities with some communities quite remote from existing health facilities leading to the need for additional facilities and rehabilitation and equipment of new and rehabilitated facilities.
- Lack of incentive for blood donors and inadequate blood banks leading to unavailability of blood when needed
- Absence of adequate and well prepared district medical stores in some districts leading to poor management of drugs and medical supplies
- Funding and sustainability of the free health care initiative in the midst of huge gap even at the start
- Request for users payment and inadequacy of operational costs for ambulance where they are available
- Free health care focus on public health facilities leaving out faith-based or private health facilities (often more trusted by users than the public health facilities).
- Delayed disbursement of government funds for implementation, monitoring and supervision
- Lack or inadequate staff motivation including postings, relocations, salaries, transportation for staff
- Leakage or thrift of drugs and medical supplies and also the World Food Program Nutrition support to health facilities.
- Poor data quality and timeliness or health records.

- Payment for services, health workers' attitude, health workers shortage, worker in-service training, issues with establishment regarding putting staff on pay roll after basic training, adequacy of staff payment and regular and appropriate payment, what should be the role of traditional birth attendants (TBAs) and the need for a policy on their operations, insufficient and untimely supply of drugs and medical supplies, long distances and bad roads to access health facilities, lack or unavailability of ambulance when needed, the poor maintenance culture of health facility equipment, the need for salary increased not realized by all health workers and funding gap were concerns emphasized by participants.
- Participants agreed on that the free health care has been greatly success considering reduction of maternal and child death that occurred as a result of the initiative. It was also agreed that because more people are attending clinics, awareness increased because of the health talks at the facilities.
- Inadequate communication between health staff management and service providers' lack of adequate transportation, inadequate monitoring and supervision were also highlighted.

Participants' suggestions from the focus group discussions during the Health for All Coalition and Save the Children UK, Sierra Leone's survey one year into the implementation of the free health care for addressing their highlighted challenges included:

- Having at least two qualified health workers or professionals at peripheral health units to ensure that one professional is always available to provide service even when one is away
- Address health worker, auxiliary staff and volunteer issues including basic and in-service trainings, absorption after graduation, timely and adequate payment, incentives and motivation (remote allowance, accommodation and volunteer reward)
- Enforcement of health worker professionalism, ethics and commitment to work by government
- Development of national traditional birth attendants' policy highlighting their new role focused on referral of pregnant women to health facilities for antenatal services and delivery through a national consultative process
- A school for Maternal and Child Health Aides (MCHAs) school to increase their number and improve on their recruitment process
- Improvement on health infrastructure (old and new), provision of quality equipment and maintenance of health equipment including training and payment of technicians
- Improvement in stakeholders coordination and collaboration involving the Ministry of Health and Sanitation, Local or District Councils, Chiefdom Authorities, the District Management Team (DHMT), peripheral health units (PHUs), hospitals and the drug and medical supplies procurement unit backed by

training and good quantification of actual required drugs and medical supplies with the aim of improving the supply chain management.

- Transportation and road network support for drugs and medical supplies, monitoring and supervision and outreach services and storage (space, training and effective management)
- Increased education of the population on available health service schemes such as the free health care fees for service or cost recovery policy
- Improvement on blood donation and storage including the provision of incentives for free blood donors to help improve the functionality of all basic emergency obstetric centre's blood banks
- Improvement of health facility (hospitals and peripheral health units) cleanliness through contract servicing and increased awareness raising on nutrition, hygiene and sanitation
- Local ownership of health interventions ensuring adherence to policies, procedures, standards and processes
- Improvement on communication and monitoring and supervision of commodities, equipment and services within the health care system for both government and partners
- Increased civil society advocacy for extension of the free health care to non-public health facilities i.e. faith based and private facilities.

All the health districts covered in the survey including Moyamba District (the research district) came up with two top priorities they thought could help with future implementation of free health care in their districts that were as follow:

“Kono: Provision of adequate supply of essential drugs to ensure full coverage of all beneficiaries and provision of utility vehicles and motorbikes for regular drugs distribution and effective monitoring and supervision.

Tonkolili: Provision of adequate blood banks and incentives for blood donors and trained and qualified staff with adequate accommodation and utility vehicles.

Kenema: The inclusion of faith based hospitals in the FHCI and timely and adequate supply of essential drugs and commodities.

Kambia: Increased collaboration and partnership between DHMT, HFAC, Local Council, and Local Authority and the provision of adequate drugs and logistical support for health facilities.

Kailahun: The provision of utility vehicles and motorbikes for drugs distribution, monitoring and supervision and construction of roads.

Bo: Adequate and timely supply of essential drugs and Funding for fuel to support referral system.

Western Area: Provision of adequate numbers and sufficient quality of human resources and address the funding gaps.

Pujehun: Inclusion of all health personnel in the FHC salary package and additional ambulances and utility vehicles.

Moyamba: Regular and timely supply of drugs and other medical supplies and strengthen monitoring and supervision.

Koinadougou: Timely, adequate, and regular supply of drugs, quality and quantity of staff and in-service training and supportive supervision

Bombali: Inclusion of faith based hospitals and logistical support for the maintenance of utility vehicles for the early distribution of drugs.

Porto Loko: Adequate and regular supply of all essential drugs to health facilities and community stakeholder partnerships – District Councils and DHMTs to take responsibility and ownership for all health related activities.

Bonthe: Adequate staffing of all referral hospitals and PHUs – there should be at least three adequately trained staff at each PHU and timely and adequate supply of essential drugs” (HFAC, 2013).

Drug supplies, staff training and transportation for staff and patients were strong among the district priorities in general.

In conclusion, drug procurement and supplies, control of illegal charges came out strongly as well as the fact that there is success but much more actions need to be taken to improve the implementation in Sierra Leone and government therefore needs to use the survey findings and recommendations to inform improvement plans for the free health care initiative in Sierra Leone.

Almost all of the highlighted successes, challenges, solutions are just reinforcing the findings of this research as they are all in line and support each other. That adds on to the credibility of the research and its findings that the free health for pregnant women, lactating mothers and under five children is effective and improves maternal and child mortality in Sierra Leone including Moyamba District.

14. Conclusion and Summary.

The position and conclusions arrived at during the course of the study was restated in this section. The usefulness of the research was explained here with further explanation of why the position reached is the most tenable and relevant at this point in time. In this section suggestions for further research in the topic area were also outlined.

Position reached by the researcher during the course of the study is as follow:

1. The introduction of the free health care initiative was aimed at removing the barriers to accessing health care services especially targeting the vulnerable groups of pregnant women, lactating mothers and under five children. The findings of this study according to tables and figures 20a, 20b and 40, free health care for pregnant women, lactating mothers and under five

children has helped to improve maternal morbidity and mortality in Moyamba District in Sierra Leone with a reduction from 777/100,000 in 2008 to 201/100,000 in 2012 (two years before and two years after the introduction of the initiative). There was also a significantly higher reduction recorded in 2010 the year when the initiative was first launched.

2. Free health for pregnant women, lactating mothers and under five children has helped to improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone. According to views of respondents to questionnaires, participants of focus group discussions and those interacted with as someone said: “the free health care has helped to improve maternal and child mortality. This view was expressed by majority of the people reached in this investigation by various means. Questionnaire specific responses according to tables and figures 15 and 16 show that under five child mortality reduced with the introduction of the free health care initiative in Moyamba District (two years before and two years after the introduction of the free health care). Table and figure 31 also supported this view because according data in table 31 and figure 31; 562 children under five years of age died in 2008; 634 in 2009; 171 in 2010; 654 in 2011 and 561 in 2012. The trend in absolute numbers showed that under five child death was high in 2008 and higher 2009 but dropped dramatically in 2010 the year the free health was introduced but rose to its highest in 2011 and then dropped in 2012 by a slight margin. The picture is slightly different in terms of proportion of under five child death per 1000 live births as shown and explained below for the table 32 and figure 32. As stated in the data description for table 31 and figure 31, the trend of under five child deaths in absolute figures slightly differ from the figures in proportion per 1000 child deaths per year. According to table 32 and figure 32; 70 under five year old children per 1000 live births died in Moyamba District in 2008 while 66/1000 died in 2009. That trend dramatically changed in 2010 (the year the free health was introduced) when the figure dropped to 17 under five child death per 1000. The death rate according to the available data increased again in 2011 to 64 deaths per 1000 but dropped to 51 per 1000 in 2012. This trend may not be unconnected with qualitative data gather through this research which

pointed out that the free health is working but not without challenges (as expressed above in the research findings and the literature review) that affects the results such as staff motivation, availability of drugs and medical supplies and effective monitoring and supervision.

3. Free health care for pregnant women, lactating mothers and under five children that forms the bulk of the affected population that utilize health care services in Sierra Leone with Moyamba District inclusive, according to the findings of this research, has mixed effect on the health personnel in Moyamba District in Sierra Leone in that although they consider the initiative to be good in that it is making them reach more people, they also strongly feel that the free health care initiative has increased their workload and pressure from the beneficiaries to provide them the said free health care at all times and sometimes for categories of the population not targeted for the free health care. This sometimes results in misunderstanding and confrontation between health personnel and beneficiaries. For instance, according to the health workers from the questionnaire responses, focus group discussions, inter-personal interactions and observations, their workloads have increased with the introduction of the free health, their salaries and benefits or living conditions are not commensurate to their job and living environments especially in the remote communities with transportation and accommodation challenges in addition to other basic social amenities like communication. According to one health worker in the research location, “free health care initiative is good but it has increased our workload and does not leave any time for us for rest or even for preparation of meals and other personal business at the end of the day and the compensation does not match that much effort despite increase in salaries upon the introduction of the initiative.”

4. The effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone is positive because it has helped to improve the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District in Sierra Leone despite the challenges highlighted in the findings and literature review. This is supported by tables and figures 22 (under

five year old children that sleep under long lasting insecticide treated nets (LLIN), 24 (appropriate treatment of children under five years of age with malaria treatment with 24 hours), 25 (diarrhoea case reported and treated) and 26 (cough or acute respiratory infection (ARI). The views of respondents to the various data collection approaches used (questionnaires, focus group discussions, personal interactions and observations) and the Moyamba District health data for 2008 to 2012, the initiative has improved facility service delivery, drugs/medicaments, and also it has helped to improve leadership and management but there is need for improvement. For instance, health workers think the workload is increased and that affects their personal lives and they need more compensation to match the increased workload; they also feel the required support in terms of drugs and medical supplies is not adequately and timely provided in a number of cases and that affects their work, relation with beneficiaries with consequent effect on the utilization of the provided health services and the resulting outcomes of health care services in the research location as well as other parts of the Sierra Leone. Considering table 26 and figure 26 that show the number of ARI cases reported and treated within 2 weeks of occurrence in Moyamba District (mainly among children under five years of age); 8,688 cases in 2008; 3,315 in 2009; 38,819 in 2010; 65,067 in 2011 and 66,450 cases were seen and treated in Moyamba District. The data showed that more people accessed health services and received treatment for acute respiratory infections or cough in Moyamba District after the launch of the free health care than they did before the launch which is one of the three leading killer diseases accounting for the high child mortality in the Sierra Leone (according to the Government of Sierra Leone's Free Health Care Position Paper of 2010). This dramatic increase in the number of reported and treated cases show that the need for supplies increased with the introduction of the free health care initiative. Thus overwhelming the existing system and hence the inadequate and often untimely supplies to the health facilities.

The research findings overall have provided positive answers to the research questions and supported the hypothesis that free health care is effective in Moyamba District in Sierra Leone.

The said questions in the research that the findings have provided positive answers to are:

- Can free health care for pregnant women, lactating mothers and under five children improve maternal morbidity and mortality in Moyamba District in Sierra Leone? - Yes
- Can free health care for pregnant women, lactating mothers and under five children improve morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone? - Yes
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health personnel in Moyamba District in Sierra Leone? - Yes
- What is the effect of free health care for pregnant women, lactating mothers and under five children on the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District? – Yes.

In summary, “The Effect of Free Health Care for Pregnant Women, Lactating Mothers and Under Five Children on Health Service Delivery in Moyamba District in Sierra Leone” is positive despite challenges faced in the implementation of the initiative. It is effective because it is relevant to the needs of the people of Moyamba District as it is in all other parts of Sierra Leone and it is achieving its set objectives and goals which determine the effectiveness and efficiency of a program in a development context. This is true because the research findings show that:

- Free health care for pregnant women, lactating mothers and under five children is improving maternal morbidity and mortality in Moyamba District in Sierra Leone.
- Free health care for pregnant women, lactating mothers and under five children is improving morbidity and mortality of children under five years of age in Moyamba District in Sierra Leone.

- Free health care for pregnant women, lactating mothers and under five children has helped to increase the salaries of health personnel and their working environments which have in turn improved their commitment and service delivery as well as the quality of services delivered in Moyamba District in Sierra Leone.
- Free health care for pregnant women, lactating mothers and under five children has helped improved the health service delivery system in terms of facilities, equipment, drugs/medicaments, leadership and management in Moyamba District.

The research has therefore confirmed the hypothesis that:

“Free health care for pregnant women, lactating mothers and under five children improves health care service delivery”.

A Sierra Leonean expressed true feelings about the free health care initiative that summarizes the effect as follow: “I'm delighted to say that the latest statistics have shown we are succeeding. The FHCI has had an incredible affect on the awful health indicators of just a few years ago”.

In addition, a World Health Organization (WHO) publication in expressing the positive effects of the free health care initiative within the first few years of implementation and the impressions created stated that:

“In the first year alone, there was a 214% increase in the number of children attending outpatient units. More women who needed care most were attending facilities, and we reduced - by an amazing 61% - the number of women dying from pregnancy complications at facilities. We are delighted, encouraged and proud of what has been achieved in so short a time” (WHO, 2014).

In concluding that the effect of the free health care initiative on the health service delivery system in Sierra Leone including Moyamba District (the research district) is positive and supports the research hypothesis are the views of the President of the Republic of Sierra Leone expressed in his own words summarizing everything as follow: “Two years on, we must sustain progress and I will do my best to ensure that the progress we have made is accelerated so that we can reach our common goals” (WHO, 2014). That means there is progress made with the free health care and that “Free health care for pregnant women, lactating mothers and under five children improves health care service delivery”.

Usefulness of the study and why it is the most tenable:

This study is very useful as it has shown that the free health care in Moyamba District as outlined above is effective and is helping to improve maternal and child health by improving both maternal and child morbidity and mortality. It has also helped to improve health personnel situation including staff salaries (although more is expected in terms of salary increase to match the increased workload resulting from the introduction of the free health care as expressed by health workers in the research). The free health care initiative has also helped in improving health service delivery in the research location.

The study is tenable because when it was discussed with the Planning and Information Division responsible for Health Management Information in the Ministry of health Sanitation in Sierra Leone, it was applauded because according to the division, no such comprehensive study has been undertaken to investigate the free health care in Sierra Leone and as such the division looks forward to the researcher sharing the study findings with them for the benefit of the study location but more so for the country as a whole. The Moyamba District Health Management Team (DHMT) and the Moyamba District Council equally appreciated and accepted and even supported

the research in several ways including adding their views to the findings. They did so because they recognized it was in the right direction and timely since the findings according to the two institutions responsible for the overall health care system in the research location (Moyamba District) will inform a review and improvement in the free health care implementation in their district and also in other parts of Sierra Leone as the issues are the same across the country. The health personnel also found the study is very important because they see it as an opportunity to voice their concerns but also as an opportunity for the results of their hard work to be seen by other people including state actors. The health workers hold this view about the research because they think if stakeholders know about their concerns and expectations, actions may be taken in their favour that may help improve their situations. Beneficiaries of the free health care in Moyamba District also highly appreciated the research and supported it because they on the other hand considered it as an opportunity to voice out what they think are things not happened right in the implementation of the free health care such as the lack or the inadequacy of drugs in the facility when they visit the facilities.

Suggestions for further research in the topic area:

Definitely, this been a study for just one of the 13 health districts in Sierra Leone, there is a need for further research into the topic area that can cover more or all of Sierra Leone for a complete picture of the free health care implementation to come out just in case there are slight geographical differences from district to district. One further research area within the same research location or elsewhere is research into the drugs and medical supply chain systems because the lack and or inadequacy of drugs and other medical supplies came out strongly from both the health workers and the beneficiaries or communities. In addition, further research or investigation into challenges associated with free health care in Sierra Leone will be an interesting one to undertake as it is possible to identify more challenges and probe into deeper into the challenges than this research has done already.

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16. Annexes

Annex 1: Letter of notification to the Ministry of Health and Sanitation (Central level) and the Moyamba District Health Management Team (DHMT).

Central level letter of request for permission and support

4 Magazine Cut
Off Fourah Bay Road
Freetown

22nd January 2013

The Director of Donor Relations

Ministry of Health & Sanitation

5th Floor, Youyi Building, Brookfields, Freetown

Moyamba Town

Dear Sir,

Request for Permission and Support to Carry Out a Focus Group Discussion as Part of a Research on the Effect of Free Health Care (FHC) in Moyamba District for the first Two Years of the FHC Initiative in Fulfillment of a PhD Programme Requirement.

I hereby request your permission and support to carry out a research related focus group discussion (FGD) with health service providing partners of the Ministry of Health and Sanitation at the national level. The intended FGD will be in relation to a research on the “Effect of Free Health Care (FHC) in Moyamba District” for the first Two years of the FHC Initiative in fulfillment of a PhD Programme requirement. It will be about 15 to 30 minutes discussion and can therefore be part of one the Health Partners’ Steering

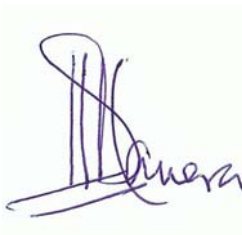
Committee meetings. The date and time of the FGD will be based on discussions with you following your permission to carry out the exercise.

The FGD is part of a research work I need to undertake for a PhD Programme in Health Care Administration through a Distant Learning Programme of the St. Clements University, Turks & Caicos Islands – British West Indies. The research intends to look at the effect of FHCI in Moyamba District by comparing the health care system in the district two years before and two years after the introduction of the initiative in April 2010 in relation to the national picture.

Attached is the university's approved research work plan for which your permission is required before starting preparations in January 2013 and actually carrying out the research work that involves the FGD anytime thereafter.

I am looking forward to your kind approval.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Ibrahim Kamara', is written over a light green rectangular background.

Ibrahim Kamara, PhD Student

Research Plan for investigating the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone from April 27, 2010 to April 26, 2012 (Discussion of the situation two years before and two years after the introduction of the initiative).

Focus group discussions (health workers and beneficiaries):

- National level representatives
- District level representatives
- Chiefdom level representatives
- Community level representatives

Observation (photographing):

- Health facilities in Moyamba District
- Selected communities in Moyamba District
- Selected individuals in Moyamba District

Interviews (using simple questionnaires):

- National level (including health staff)
- District level (including health staff)
- Health service providing partners in Moyamba District
- Civil Society group monitoring the FHCI at national level and at the district level for Moyamba
- Community health worker
- Community members (beneficiaries of the FHCI – direct & indirect beneficiaries)

Use of secondary data:

- Previous health data for Moyamba District – two years before the FHCI and two years into the FHCI
- The FHCI position paper
- The FHCI annual performance report
- National health statistics two years for and after the introduction of FHCI

Guide for the planned focused group discussions

Personal Inter-face and Focus Group Discussion Plan

- In communities, discussions will be held with:
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 - Knowledge of the effects of the FHCI in Sierra Leone
 - Thinking around the effect – whether it is good, needs scale up to non-government health facilities and whether it should be replicated in other countries other Sierra Leone
 - Challenges in the implementation of the initiative on benefits of such non-direct health costs, load on health staff, staff attitude to the new initiative, availability of drugs and medical supplies/equipment etc.
 - General comments and recommendations for the FHCI

Actual Thesis/Research Field Work Plan

#	Activity	Time frame
1	Development and sharing of mini thesis framework with Course Director for approval	January - December 2012
2	Approval of mini thesis frame work by Course Director	January - December 2012
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6	Actual field work	May 2013 – December 2013
7	Collation and analysis of research findings	December 2013 – March 2014
8	Write up and submission of thesis to Course Director for approval	April 2014 - June 2014

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Chieftdom level work	1 st June 2013 – 31 st December 2013
Community level work	1 st June 2013 – 31 st December 2013
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Moyamba District Health Management Team (DHMT) Letter

4 Magazine Cut

Off Fourah Bay Road

Freetown

22th January 2013

The District Medical Officer

Moyamba District Health Management Team

Moyamba Town

Dear Sir,

Request for Permission to Carry out a Research on the Effect of Free Health Care (FHC) in Moyamba District for the first Two Years of the FHC Initiative in Fulfillment of a PhD Programme Requirement

I hereby request permission to carry out a research on the “Effect of Free Health Care (FHC) in Moyamba District” for the first Two years of the FHC Initiative in fulfillment of a PhD Programme requirement.

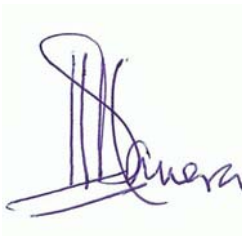
I am undertaking a research-based PhD Programme in Health Care Administration through a Distant Learning programme of the St. Clements University, Turks & Caicos Islands – British West Indies. The research intends to look at the effect of FHCI in Moyamba District by comparing the health care system in the district two years before and two years after the introduction of the initiative in April 2010.

Attached is the university's approved research work plan for which your permission is required before starting preparations in January 2013 and the actual field work anytime thereafter.

Once your approval is received, further discussions on how the actual work will go on will be discussed with you and other stakeholders. That will include talking to PHU staff on the issue during one of your PHU In-Charges' meetings.

I am looking forward to your kind approval.

Sincerely,

A handwritten signature in purple ink, appearing to read 'Ibrahim Kamara', is displayed on a light green rectangular background.

Ibrahim Kamara, PhD Student

Research Plan for investigating the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone from April 27, 2010 to April 26, 2012 (Discussion of the situation two years before and two years after the introduction of the initiative).

Focus group discussions (health workers and beneficiaries):

- National level representatives
- District level representatives
- Chiefdom level representatives
- Community level representatives

Observation (photographing):

- Health facilities in Moyamba District
- Selected communities in Moyamba District
- Selected individuals in Moyamba District

Interviews (using simple questionnaires):

- National level (including health staff)
- District level (including health staff)
- Health service providing partners in Moyamba District
- Civil Society group monitoring the FHCI at national level and at the district level for Moyamba
- Community health worker
- Community members (beneficiaries of the FHCI – direct & indirect beneficiaries)

Use of secondary data:

- Previous health data for Moyamba District – two years before the FHCI and two years into the FHCI
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Research Questionnaire

Questionnaire for investigation of the effect of free health care on pregnant women, lactating mothers and children under five years of age in Moyamba District in Sierra Leone – PhD Programme Requirement.

Consent: *Please explain purpose of research to respondent for consent (if consent is not given, select another respondent. If given, go ahead with the interview with the consenting respondent first signing here (signature/right thumbprint))*

.....
Instructions: *Please request the respondent to provide the most appropriate answer or option(s) for each of the questions in this questionnaire for the interviewer to enter or tick accordingly.*

Section 1: Personal identification

1a. Name of respondent: 1b. Sex: ☐ Male ☐ Female 1c Age: ☐ 18 Yrs & ☐ Less ☐ Over 18 yrs

2. Institution/Org. or Community: ☐ Govt. ☐ NGO ☐ Community ☐ Private ☐ Indivi ☐ Other
(Specify)

3. Location/District: ☐ Freetown ☐ Moyamba town ☐ Chiefdom Headquarter town
☐ Village level

Mailing & email addresses (if any):.....

.....

.....

Contact phone number (if any):.....

Section 2: General knowledge about Free Health Care Initiative (FHCI) in Sierra Leone

4. Do you know anything about the FHCI in Sierra Leone? ☐ Yes ☐ No

5. If yes, when was it launched? ☐ 1 yr or less ☐ Over 1 year ago

6. Do you know why it was introduced in Sierra Leone? ☐ Yes ☐ No

7. If yes, why was it introduced?

.....

.....

.....

.....

8. Which group of people does it target?

1) Everyone

2) Pregnant women

3) Lactating mothers.....

4) Children under five years

5) Others (specify)

9. Which geographic area of Sierra Leone is it supposed to cover?

☐ Entire country ☐ Western Area ☐ Southern Province ☐ Eastern Province ☐ Northern Province

Others (specify):

Section 3: Knowledge about Sierra Leone's health care system

10. Please tick the most appropriate option(s) for Sierra Leone's various levels of health facilities:

- i) ☐ Maternal & Child Health Post – MCHP ii) ☐ Community Health Post – CHP
- iii) ☐ Community Health Centre – CHC iv) ☐ District Hospital
- v) ☐ Provincial/Referral Hospital vi) ☐ Others (specify).....

11. Please tick the various service providing categories for the health facilities (if known):

i) Government

ii) Missions

iii) Private

Others (specify)

12. What are the various health service delivery schemes currently operating in Sierra Leone?

i) Fees for service/cost recovery – FFS/CR

ii) FHCI

iii) Other(s) (Specify

13. Which of the option(s) above in question 12 do you prefer and why?

i) FFS/CR:

ii) FHCI:

iii) Others (specify):

14. If FHCI is chosen in question 13 above, please comment on the effect of FHCI in relation to the following in Moyamba District:

i) Pregnant women:

a) Very effective b) fairly effective c) Not effective

ii) Lactating mothers:

a) Very effective b) fairly effective c) Not effective

b) Under five children:

a) Very effective b) fairly effective c) Not effective

b) Health workers:

c) Very effective b) fairly effective c) Not effective

d) The Ministry of Health & Sanitation - MOHS:

e) Very effective b) fairly effective c) Not effective

f) Other(s) (Specify):

g) Very effective b) fairly effective c) Not effective

15. Based on your responses above, are the effects or changes in health care systems and service delivery as a result of FHCI good? ☐ Yes ☐ No

16. If yes to question 15 above, should FHCI be extended to other categories of health service providers other than the government facilities? ☐ Yes ☐ No

17. If yes for question 15 & 16 above, can you recommend FHCI to be replicated in other countries other than Sierra Leone? ☐ Yes ☐ No

18. Do you know of any challenges with FHCI despite the good aspects (if any) with regards to?

i) Cost for health services:

.....

ii) Non-health service costs (please specify cost areas):

.....

iii) Health workers (specify challenges)

.....

iv) Government

.....

v) Donors

.....

vi) Other health service providers (including private or for-profit health facilities):

.....

vii) Any other(s) (specify):

.....

.....

19. Please give your general comments on changes in health care system and service delivery in Sierra Leone that has come as a result of the introduction of FHCI in the country and Moyamba District:

i) Country:

Increased utilization	Yes	or	No
Reduced maternal mortality	Yes	or	No
Reduced <5 mortality	Yes	or	No
Increased user satisfaction	Yes	or	No
Others (specify)			
.....			
.....			

ii) Moyamba District:

Increased utilization	Yes	or	No
Reduced maternal mortality	Yes	or	No
Reduced <5 mortality	Yes	or	No
Increased user satisfaction	Yes	or	No
Others (specify)			
.....			
.....			

Thank you Very Much for Your Responses and Consent to Participate in this Study

Interviewee: Name:

Sign

Date:

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Note:

Discussions, interviews or observations will be carried out face-to-face, through support from colleagues or phone conversations as scheduled for the various locations or at any available opportunity from March 1, 2013 to June 30, 2013