Scaling up Maternal & Child health Through Free Health Care Services, one year on

1. Background

In Sierra Leone the maternal mortality ratio at 857 per 100,000 live births and Child mortality rate at 140 per 1,000 live births (SLDHS 2008), are still far from the 600 per 100,000 and 95 per 1,000 targets respectively of the Millennium Development Goals (MDGs) of 2015.

Due to economic and other barriers, a significant proportion of Sierra Leoneans did not use public health services; as such the country had extremely low utilization rate of 0.5 per person in 2009. Evidence showed that the biggest barrier for accessing health care in Sierra Leone was financial. With this type of situation Sierra Leone was off track to meet the MDGs.

To influence health indicators and meet the MDGs, the government needed to ensure more patients seek care in health facilities by removing barriers to accessing health care.

The Government of Sierra Leone and health development partners are committed to achieving universal access to health care in order to reduce the high infant, child and maternal mortality rates in line with the MDGs.

To achieve this, one of the priorities on His Excellency’s Agenda for Change (PRSP II) for the Health Sector is to address the unacceptably high child and maternal mortality and morbidity.

The Ministry of Health and Sanitation was aware of the need not only to remove barriers to access care, but also to improve the quality of care. This led to the development of the National Health Sector Strategic Plan (NHSSP) which aims to achieve improvement in quality of care through the successful implementation of the Basic Package of Essential Health Services (BPEHS).

Financing health services has remained a contentious and debatable issue in many countries of the world. In Sierra Leone, the government through its Ministry of Health and Sanitation (MoHS) noted the fact that significant action needed to be taken to address the high maternal and child mortality rates. As such, at the United Nations General Assembly in September 2009 His Excellency, President Ernest Bai Koroma who strongly believed in the sanctity of life, announced that all health care services will be free for pregnant women, breastfeeding mothers and children under 5 years of age. The focus was the removal of formal or informal fees and the putting in place of a number of initiatives needed to ensure that implementation of the policy was successful. In November of the same year, the President announced the launch date of April 27th 2010, giving the Ministry of Health and Sanitation and partners time to prepare for the forecasted increase in utilization. The policy premium included the following:

- Free care for pregnant women, breastfeeding mothers and children <5 years of age.
- Free consultations including antenatal, postnatal and deliveries; treatment, minor surgeries, obstetric emergencies, Basic Emergency Obstetrics and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetrics and Neonatal Care (CEmONC), x-rays and laboratory services, medicines and logistics.

"My government is making this happen because we believe that motherhood should be a blessing to our families, and not a threat to a woman's life. We believe that a child should be a bundle of joy and not a source of tears and despair. Let us secure the future of our nation by securing the lives of children. Let us guarantee the happiness of our families and make it a testament of our collective aspiration for a better, healthier and happier nation." President Dr. Ernest Bai Koroma at the launch of the Free Health Care, 27th April, 2010.
Better Information, Better Decision, Better Health

2. Inputs for the operationalisation of the Free Health Care.

In order to operationalize the FHC, the Ministry of Health & Sanitation created a planning and implementation framework that comprised of 6 subcommittees, namely; Human Resources for Health, Infrastructure; Logistics and equipments; Health Financing; Monitoring and Evaluation; Communication that fed into a Steering Group.

2.1 Infrastructure: Prior to the implementation of the FHC, health facilities were fairly inadequate and ill equipped. It was agreed that each district should have one CeMONC and five BeMONC facilities upgraded to deliver FHC. The upgrading focused on the following: Water Supply; Electricity; Human Resources; Logistics and equipments including blood bank and referral system. Detailed information on the current infrastructure status is available in the Facility Improvement Team (FIT) 2010 Assessment report.

2.2 Human Resources: Provision of quality health care services requires the availability of the right number of personnel, with the right skill mix in the right place at all times. Low salaries for health professionals have led to low morale and commitment. Therefore, a substantial salary increase was made for health professionals, all of whom received at least a 100% increase in pay. In order to deliver the FHC, government supported by her partners increased the health manpower by fast tracking the recruitment of technical staff and motivated them through salary increase. This resulted in the recruitment of over 2,000 additional health staff, and led to the reduction in the number of health facilities with only one health care staff from 59% to 33%. {MoHS, 2010 Mid Year Preliminary Review}

2.3 Drugs and Medical Technologies: To implement the FHC for one year, the Government and partners procured about US$ 13million worth of drugs. In addition, health implementing partners bought drugs to support FHC implementation in the districts. However, towards the end of the first 12 months of the FHC policy implementation, drug stockouts have been reported at several health facilities.

2.4 FHC Financing
The estimated cost to implement the FHC policy for 2010 was US$35,840,173, of which US$31,016,801 was provided by partners. The key partners who contributed to the funding are GoSL, DFID, ADB, World Bank, UNFPA, and UNICEF. In addition, some health implementing partners provided direct financial support to districts for FHC implementation.

The details below depicts that out of the total available funds, 45% (US$12,390,000) was used to procured drugs and medical consumables for the targeted groups, 45% (US$12,400,000) was used for the payment of health workers salaries and 10% (US$2,262,801) for key activities for service delivery.
2.5 Monitoring & Evaluation

It is vital that we adequately monitor key indicators to help in tracking progress and find out where interventions are assisting to reduce key morbidity and mortality figures. New reporting cards were developed to capture data in service utilization, staffing, and drug supplies and consumption. Staff were trained in the use of these tools. Also, a system of community and civil society monitoring of the FHC implementation was established.

3. Output for one year implementation of FHC

3.1 Underfives Consultations

Children under five years of age are the proportion of the population most vulnerable to diseases and death rate is very high among them. It is therefore critical for any sick child to seek prompt medical attention. Figure 4 compares under-fives consultation from April 2009 – March 2010 (Pre-FHC) with April 2010 – March 2011 (One year period for implementation of FHC). The figure shows a marked increase in underfives consultation in the FHC period compared to the Pre-FHC. About 2,926,431 children under five sought consultation in public health facilities across the country for the 12 months of FHC implementation compared to 933,349 children in 12-month period preceding the FHC. The figure also shows that since September 2010 there has been a gradual downward trend in number of children seeking medical consultation.

Figure 5 shows the major causes for underfives consultations. Of the 2,926,431 the sought medical care in the first twelve months of FHC implementation 41% were for malaria, 27% for Acute respiratory infection, 8.5% diarrhoea, 4.3% worm infestation and 3.9% clinical malnutrition. Malaria, ARI and diarrhoea makes up about 77% of all underfives consultation. The policy implications of this data are that drugs for managing these conditions should always be available at health facilities and that the Ministry and Partners should endeavour to scale up the implementation of the IMNCI – an intervention strategy that has been proven to be of high impact and cost effective.

Malaria is one of the major causes of morbidity and mortality especially among the underfives. Figure 6 shows that of the 1,288,828 underfives who were diagnosed for malaria during the first 12 months of the FHC implementation, about 90% were treated with Artesunate (the drug of choice for treating malaria). In the 12 months preceding the FHC, only 51% of the 682,530 diagnosed with malaria were treated with Artesunate.
3.2 Nutrition Surveillance

The nutritional state of children is an important index of the well-being of a nation. It is often measured by assessing the number of children that are underweight for age. Figure 4 compares the nutritional status of children in the first 12 months of implementation of the FHC with that in the 12 month preceding the FHC. About 7.5% of the children screened in the FHC period were malnourished compared to 6.8% in the period before the FHC. The figure shows that the number of children that were found to be malnourished increased slightly towards the time of launching the FHC but this has shown signs of reduction in the past three months.

One of the important interventions for addressing nutrition is supplementation with Vitamin A. Figure 8 shows the trend in vitamin A uptake in 12-month period before the FHC and the preceding 12 months of the FHC. The figure shows that more children took vitamin A supplementation in the period of the FHC than in the period before the FHC.

3.3 Childhood Immunisation

Immunization has been proven to be the most cost effective strategy for preventing many childhood infectious diseases. The MoHS and partners would like to see that all children are fully immunised before their first birthday. A child is only certified as fully immunized if he/she has receive the correct doses of approved vaccine (BCG, OPV1, Penta1, OPV2, Penta2, OPV3, penta3, Measles and yellow fever) and on schedule. Figure 9 compares the percentage of children that received all their vaccines before their first birthday in the 12 months preceding the FHC with that for the first 12 months of the FHC. Overall, 88% of children under one year of age were fully immunized in the period before the FHC, compared to 76% during the FHC implementation. Possible reasons for the reduced coverage during the FHC period could be due to the breakdown of the existing cold chain systems, the increase in the number of new facilities without cold chain and the reduction in frequency of outreach activities.

4. Maternal Health

4.1 Antenatal Consultations

Antenatal visits provide a very good opportunity to optimize the outcome of pregnancy for the mother, her child and the rest of her family. Antenatal visits can therefore help to prevent, detect and manage those factors that adversely affect the health of mother and baby and to provide advice, reassurance, education and support for the woman and her family. This can be done through an initial risk assessment of the pregnancy to identify pregnant women at risk of complications. At ANC, pregnant women receive Tetanus Toxoid immunisation, multivitamins, intermittent preventive therapy for prevention of malaria, insecticide treated bednets and treatment for anaemia through iron, folic acid and anti-helmintic treatment.
The current strategy in the Ministry is to provide focused antenatal care during which pregnant women are educated about their diet, how to take care of the pregnancy, and making appropriate decision about delivery. Figure 10 compares ANC visits between the period April 2009 – March 2011 (Pre-FHC) and April 2010 – March 2011 (FHC-Period). It shows a significant increase in the number of pregnant women that made at least one ANC visit during the FHC period compared to pre-FHC period. The figures shows an undulating pattern in the number of pregnant women seeking ANC.

During ANC visit pregnant women receive TT vaccine to protect both the mother and unborn child against tetanus. Figure 8 compares the number of pregnant women who received two doses of tetanus toxoid vaccine in the first 12 months of FHC versus the 12 months preceding the FHC. The figure shows that more women received two doses of TT in the period of the FHC than that before the FHC. The figure also shows that in both periods the number of pregnant women receiving TT vaccine reduced drastically in the months of November and December. Possible reasons could be the mass campaigns that used the services of facility staff and the public holidays.

### 4.2 Institutional Deliveries

Institutional delivery is one of the most effective interventions to reduce maternal mortality. It is therefore important for pregnant women to deliver at health facilities so that possible complications can be managed and the delivery can be clean. Figure 12 shows that a higher number of deliveries were conducted in public health facilities in the first 12 months of FHC implementation than in the preceding 12 months. About 126,477 deliveries were conducted in first 12-month of FHC implementation compared to 87,302 in the 12-months preceding the FHC, an increase of 45%.

Figure 13 compares the deliveries conducted in health facilities with those conducted in communities (mostly by TBAs) in 2010. The figure shows a gradual increase in the number of facility deliveries with a corresponding decrease in the number of community deliveries.
4.3 Maternal Complications

Figure 14 compares the number of maternal complications managed at health facilities before and during the FHC implementation. According to the table, 20,135 maternal complications were managed at health facilities in the first 12 months of the FHC implementation compared to 8,055 during the 12 months before the FHC period, an increase of about 150% increase.

Figure 15 compares the maternal death rate at health facilities before and during the FHC. The maternal case fatality rate in the 12-month preceding the FHC was 2.8% compared to 1.1% in the first 12-month of FHC implementation.

4.4 Postnatal Consultations

Postnatal is the period just after delivery. It is important that mothers attend postnatal care at a health facility to ensure that they are healthy and capable of taking care of her newborn, and are equipped with all the information needed about breastfeeding, reproductive health and contraception, and the imminent life adjustments.

Use of modern family planning methods is a significant tracer for improving maternal health. Figure 17 compares the family planning uptake during the first 12 months of the FHC implementation and the 12 months preceding the FHC. There was about 140% increase in the number of new acceptors of modern family planning methods during the first 12 months of implementation of the FHC compared to the 12 months preceding.

4.5 Family Planning Services

Some health facilities are still inadequately equipped, thereby adversely affecting the quality of service provided.

The “Push” system rather than the desired “Pull” system is used, thereby leading to frequent stock-out of drugs at health facilities.

Frequent breakdown of cold-chain system.

Lack of accommodation for Health staff making it difficult for staff to settle down in their posted locations.

Most health facilities have only one staff, making it difficult to make out-reach visits.

TBAs continue to conduct deliveries in communities.

Even though the HR has increased, it is still inadequate e.g. Not enough doctors, midwives, Community Health Officers to match the service delivery demand.

Insufficient fuel and ambulances for setting up an effective referrals system.

5. Challenges to the Implementation of Free Health care in Sierra Leone

- Some health facilities are still inadequately equipped, thereby adversely affecting the quality of service provided.
- The “Push” system rather than the desired “Pull” system is used, thereby leading to frequent stock-out of drugs at health facilities.
- Frequent breakdown of cold-chain system.
- Lack of accommodation for Health staff making it difficult for staff to settle down in their posted locations.
- Most health facilities have only one staff, making it difficult to make out-reach visits.
- TBAs continue to conduct deliveries in communities.
- Even though the HR has increased, it is still inadequate e.g. Not enough doctors, midwives, Community Health Officers to match the service delivery demand.
- Insufficient fuel and ambulances for setting up an effective referrals system.
The successful implementation of the FHC policy was as a result of an unprecedented partnership among stakeholders within the health sector. It brought together government, development partners, INGOs, civil society groups and the UN family to work towards achieving a clear and strategic goal.

The preparatory activities leading to the implementation of the FHC, vis a vis, increased staff salaries, recruitment of additional staff, provision of drugs logistics and equipment and rehabilitation of health facilities created a conducive environment that lead to a successful implementation of FHC in 2010.

The FHC has clearly increased utilisation of health care services for the target group. Compared to the period before the FHC increasing number of children are now utilising health care services, increasing number of pregnant women are now delivering in health facilities and increasing number of lactating mothers are now seeking postnatal care. As a result case fatality rate among pregnant women admitted at hospitals has reduced by more than 50%.

Uptake of most health care services seem to be on the decline. This may be related to the occasional stock-out of drugs at pub-

FLASH BACK TO THE FREE HEALTH CARE INITIATIVE

Barriers to Accessing Health

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Reason for not accessing assistance from health facility

Lack of Finance 68%
Distance/Mobility 6%
No Staff 2%
No Drugs 2%
Beyond the Health Facility's Capabilities 1%
No Health Facility/Not Functioning 1%

Source: National Public Services Survey 2008

Initial trends after the launch of the FHC
H.E The President Dr. Ernst Bai Koroma declares his government's intention to meet the MDGs by removing financial barriers to health care for the most vulnerable group. At the UN General assembly, the Free Health Care Initiative was made known to the world.

Despite a global decline in maternal deaths, Sierra Leone still sits among the worst five countries in the world for women dying during childbirth and infant deaths. April 27, 2010, marks the turning point. On the country's 49th Independence day H.E the President, Dr. Ernest Bai Koroma declares free medical services for pregnant women, breastfeeding mothers and children under five in government hospitals and clinics for the first time ever. Here the president is seeing at the main Maternal referral hospital on the launch day of FHC.

At the Ola During Children’s Hospital in Freetown, President Koroma told a crowd in English and the local Krio language that pregnant women, breastfeeding mothers, and children younger than 5 years will no longer have to pay for health care in government facilities. When he said the words in Creole, people in the crowd shouted out in joy.

“For many years, many, many pregnant women, breastfeeding mothers, and children under 5 [years] have suffered and died because they simply could not pay fees for consultations, drugs and other services”, President Koroma said. “Today we are taking the biggest step ever to end this unenviable position.”

More than one thousand people in Kono and its environs have benefited from a Free Medical and Surgical Specialized service offered by the Sierra Leone Medical and Dental Association (SLMDA) with support from the Ministry of Health and its partners. The three days service initiated by the Health and Sanitation Minister, Haja Zainab Hawa, organized at the Koidu government hospital.