ANALYSIS OF FACTORS INFLUENCING THE EFFECTIVENESS OF THE FREE HEALTH CARE INITIATIVE POLICY IN SIERRA LEONE

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DECLARATION

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By;

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Declaration: Where other people's work has been used (from either a printed or virtual source, or any other source), this has been carefully acknowledged and referenced in accordance with academic requirements. The thesis "Analysis of factors influencing the effectiveness of the Free Health Care Initiative policy in Sierra Leone" is my work.

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LIST OF ABBREVIATIONS

ADB	African Development Bank
ANC	Antenatal Care
APC	All people's Congress
BPEHS	Basic Package of Essential Health Services
BEmOC	Basic Emergency Maternal Obstetric Care
CMO	Chief Medical Officer
CEmOC	Comprehensive Emergency Obstetric Care
DFID	Department for International Development
DHS	District Health Survey
DHMTs	District Health Management Teams
DPT	Diphtheria, Whooping cough, and Tetanus
EU	European Union
FCDO	Foreign Commonwealth Development Office
FHCI	Free Health care Initiative
GAVI	Global Alliance for Vaccine Initiative
GDP	Gross Domestic Product
GNI	Gross National Income
GoSL	Government of Sierra Leone's
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRMO	Human Resources Management Office
HRH	Human Resource for Health
IDB	Islamic Development Banks
IPTp	Intermittent Preventive Treatment of malaria during pregnancy
ITN	Insecticide Treated Bed net
IMF	International Monetary Fund
JPWF	Joint Program of Work and Funding
KI	Key informant

LMIS	Logistic Management Information System
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding
MoHS	Ministry of Health and Sanitation
MOFED	Ministry of Finance and Economic Development
M&E	Monitoring & Evaluation
NGOs	Non-Governmental Organizations
NHP	National Health Policy
NHSSP	National Health Sector Strategic Plan
PRSP	Poverty Reduction Strategy Paper
PBF	Performance-Base Financing
RCHSP	Reproductive and Child Health Strategic Plan
RCH	Reproductive and Child Health
SLPP	Sierra Leone Peoples Party
SSI	Semi-Structured Interview
THE	Total Health Expenditure
TBAs	Traditional Births Attendants
UHC	Universal Health Coverage
UK	United Kingdom
UNICEF	United Nation Children Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization

GLOSSARY OR KEY TERMS

Universal Health Coverage: According to WHO, universal health coverage (UHC) means that all persons can use needed health services (including prevention, promotion, treatment, rehabilitation, and palliation), of sufficient quality to be effective, without fear of financial hardship (1).

Gross Domestic Product: Gross domestic product (GDP) is the standard measure of the value of final goods and services produced by a country during a period (2).

Gross National Income: GNI is defined as GDP plus net receipts from abroad of wages and salaries and property income (3).

Public Financial Management (PFM): Is the art of budgeting, spending, and managing public monies (4).

Total Health Expenditure is the sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices (5).

Traditional Medicines: Refers to health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being (6).

Performance-Base Financing: Refers to any program that transfers money or goods to either patients when they take health-related actions (such as having their children immunized) or to healthcare providers, when they achieve performance targets (such as immunizing a certain percentage of children in a given area) (7).

Drugs/Medicines: Any dosage form containing a substance approved for the prevention and treatment of disease. The term “medicine” is increasingly used to distinguish it from a drug as a substance that is misused (8).

Pharmaceuticals: A pharmaceutical is any substance or pharmaceutical product for human or veterinary use that is intended to modify or explore physiological systems or pathological states for the benefit of the recipient. In this document, the terms drug, medicine, and pharmaceutical are used interchangeably (9).

Out-of-pocket spending: Direct payments by individuals for health services at the point of use, referred to as out-of-pocket spending (OOPS) (10).

User fees: A service or medicine may be fully subsidized and meant to be free at the point of service to the user. Or it may be partially subsidized, requiring the user to make a copayment (also referred to as a user fee) (10).

ABSTRACT

Background: In Sierra Leone, during 2010, in response to high maternal and child health mortality, the government provided FHCI for pregnant women, lactating mothers, and children under five years, excluding them from paying health user fees which were one of the barriers, limiting their uptake of healthcare services.

Methodology: The analysis covers ten years period since its launch. A literature review and qualitative study were done using a semi-structured interview guide, with five key informants, to explore factors influencing the effectiveness of the FHCI. The study explored the context, process, content, actors, and implementation of the policy.

Results: The FHCI was well formulated in responding to the high maternal and child mortality rate, it didn't just involved abolition of user fees for eligible beneficiaries but also involved a broad set of demand and supply-side reforms; and some of these reforms suffered still adaptations over the period reviewed, adding to the complexity of the study. The reform was having strong political will, donor support, improving conditions of services of health workers, drugs supplies, and others. Nevertheless, weaknesses appeared in the implementation process.

Conclusion: The FHCI enhanced the improvement of health coverage, reducing inequities for the beneficiaries, though precise attribution is difficult in such a complex intervention. The progress made in the past was eroded by the Ebola outbreak. The government should ensure developing strategies in raising sufficient domestic funding for the sustainability of the reform and in expanding the FHCI towards broader financing and health system strengthening policies aiming at UHC for the entire population.

KEY WORDS: Free Health Care, Maternal Health, Sierra Leone, Policy process, Implementation.

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CHAPTER 1

1.0 BACKGROUND

Financial protection should be provided for everyone seeking health care services in a manner that avoids catastrophic health spending (11) (12). In achieving Universal Health Coverage (UHC) a country must provide quality health care services for the needs of its population, which is free from catastrophic spending at the time of accessing health services (13). Catastrophic health spending is expenditure exceeding 40% of household income, after subtraction of spending for food including subsistence spending (14).

Sierra Leone is located in West Africa and is bounded by Liberia, Guinea, and the Atlantic Ocean. Approximately, 21% of Sierra Leoneans live in the Western Area, 23% in the East, and 35%, 20% in the North and South respectively (15). The population of Sierra Leone is approximately 7.6 million (16).

Sierra Leone emerged from a ten-year civil war in 2001 which led to the destruction of many lives, social infrastructures like the health sector, exodus of health workers, and economic instability. After the end of the war, tremendous progress has been achieved towards peace, economic stability, and attaining sustainable development, Nonetheless, the country still faces challenges in some areas (17) (18). In the post-conflict period, the country's maternal and child mortality was one of the worst globally, with one in eight women dying from complications due to pregnancy and childbirth and one in twelve children dying before their first birthday. The maternal death was mostly as a result of obstructed labor 17%, pre-eclampsia 14%, post-partum hemorrhage 6%, and others. Most of these causes were preventable with the right interventions (19).

Immediately after the end of the war, different health policies were developed and implemented in strengthening the fragile health system. A Poverty Reduction Strategy Paper (PRSP) was finalized in June 2001 with priority addressing challenges in the transition from conflict to a peaceful state and with a focus on poverty reduction and pro-poor economic growth (20).

In 2002 a National Health Policy (NHP) was developed which set out the broad directions of the health sector (21), followed by a local government act which was enacted in 2004 focusing towards decentralization of certain central functions of the government, that would enhance in promoting equal participation of the local government in decision making towards the improvement of the health care at the district level. It helped to promote the massive nationwide renovation of public health facilities that were destroyed during the war and led to increasing access to the health care facilities by the population (22).

In 2002 after an unsuccessful effort to the full implementation of a Drug Cost Recovery scheme, it was achieved in 2006. Revenue generation from public health facilities was the main goal of the scheme and in ensuring continuous availability of drugs and medical supplies which would reduce interruption of the shortage of supplies at these health facilities (23).

In line with the Poverty Reduction Strategy Paper (PRSP), focusing on improving social empowerment, economic and health services, in 2008, a Reproductive and Child Health Strategic

Plan (RCHSP) was launched to guide the achievement of the Millennium Development Goals (MDGs) and enhanced improvement in the delivery of Reproductive and Child Health (RCH) services in the country (19). In conjunction with the PRSP, Agenda for Change was launched by the government in strengthening Human Development like competency-based training packages in emergency obstetrics care and newborn (24). In 2010, the Basic Package of Essential Health Services (BPEHS) was developed to provide a direction for improving the health services delivery in Sierra Leone, in concurrence with the launching of the BPEHS, the National Health Sector Strategic Plan (NHSSP) 2010-2015 was launched to support and promote the successful implementation of the BPEHS. The NHSSP serves as a strategic framework to guide interventions at various stages of the health system in Sierra Leone. An operational plan, the Joint Program of Work and Funding (JPWF) was developed as an operational plan for the implementation of the NHSSP (25).

Before the launching of the Free Health care Initiative (FHCI), Sierra Leone had one of the highest maternal mortality ratios globally in which one out of eight women died during childbirth and one out of every ten children were dying before the age of five years (26). This mortality rate was 2.5 and 42.4 times more as compared to Ghana and the USA respectively. The NHSSP was used to guide the process of the FHCI (27) (28). In the process before the launch of the Free Health Care Initiative (FHCI) the government set up six technical working groups that were responsible for designing the health reform with collaboration from donor partners (19), with a focus on intervention areas such as increasing its health financing, ensuring availability of continuous drugs and medical supplies, increase in the recruitment of skilled health workers, communication of the policy to the public, improving on infrastructure, Monitoring, and evaluation and in strengthening it governance oversight, coordination, and management (27).

In 2010, the government of Sierra Leone launched FHCI exempting pregnant women, lactating mothers, and children under five years from paying user fees in public health facilities. This health policy reform came about in which this target group cited financial barriers limiting them from accessing health care services (19).

The FHCI was to provide essential health care services like antenatal, delivery, and postnatal care free of charge for the targeted groups in addition to interventions including curative and preventative health care services. The initiative was able to create an immediate impact in which there was an increase in cases been treated and surged in the utilization of the public health facilities by the FHCI beneficiaries (26).

In 2014, Sierra Leone was seriously hit by the Ebola outbreak which led to the weakening of the health system and also in a drop of the country GDP growth from 4.6% to 20.6% in 2014 and 2015 respectively (21).

1.1 PROBLEM STATEMENT

After a successful transition of power in 2007 from the Sierra Leone Peoples Party (SLPP) to the All people's Congress (APC), the president then after assuming power, prioritized the health sector as his topmost priority with a focus on reducing the high maternal and child mortality (26). Before the launching of the FHCI, around 50% of women reported challenges with distance to accessing health facilities, unavailability of drugs at the time of visit, and absence of health care workers at the point of service delivery as major problems experienced by them. Approximately 15% reported seeking permission from their husband was another challenge, close to 70% reported financial challenge, and around 89% of women experienced at least one of these challenges as a major issue preventing them from accessing health care services (29) (30). During the launch of the policy, the government was faced with financial issues, leading to the inefficient running of the health facilities, deficits in paying salaries, and difficulties in the provision of an adequate supply of drugs and medical supplies considering there was a loss of revenue by the government from these target groups (27).

1.2 JUSTIFICATION OF THE STUDY

After the launch of the FHCI, some improvements were seen in the governance sector, staff recruitment, and their management in terms of salary and availability of funds at the health facilities. There was a rapid renovation of health facilities, increased health financing, prioritization of maternal and child health, replacement of household expenditure by donor funding to some extent, with new monitoring and implementation put in place, regular audits alongside a communication campaign introduced (31). The FHCI received support from the government and donor partners during the initial implementation phase (26). After the end of the Ebola outbreak in 2014, Pharmaceutical procurement and distribution, and human resources strengthening which were priority areas, and were progressing at the initial phase of the FHCI are currently facing challenges. Health workers faced pressure from patients due to a shortage of drugs and medical supplies from the government rendering them ineffective in their responsibilities (31). This study aims to analyze challenges faced by the FHCI policy, factors influencing its effectiveness, as not enough is known about where these challenges originated. Findings from the study would inform policymakers about the origin of the challenges experienced by the FHCI and how they can be addressed.

1.3 STUDY QUESTIONS

1. What was the context and content of the FHCI policy?
2. Who were the actors involved in designing the FHCI policy?
3. What are the successes of the FHCI policy?
4. What are the challenges experienced during the implementation process of the FHCI policy?
5. How the government intends to prevent barriers to its effective implementation?

1.4 GENERAL OBJECTIVE

To analyze factors influencing the effectiveness of the Free Health Care Initiative policy in Sierra Leone since its launch.

1.5 SPECIFIC OBJECTIVES

1. To critically analyze the context, content, and actors that were involved in developing the FHCI policy.
2. To analyze challenges experienced in the implementation process of the FHCI.
3. To make recommendations to the government based on the findings from the study, in understanding the origin of the challenges experienced by the FHCI and how they can be addressed.

CHAPTER 2
2.0 METHODOLOGY
2.1 RESEARCH DESIGN

This study was conducted from May to August 2021 as a literature review, additionally, semi-structured interviews with key informants were done. This type of study design provides an insight into the context, content, interaction of various actors, and processes that were involved in the implementation of the FHCI policy. A descriptive literature review was done on existing studies, historical context, policy, and strategic documents relating to the FHCI implementation in Sierra Leone. A comparison was made with other countries that have implemented similar policies to broaden the scope of the study. To validate the information obtained during the literature review, semi-structured interviews were conducted with five key informants in the government and donor partners, on their professional views of the study objectives. The analysis of this study was done using an adapted version of Walt and Gilson's 1994 policy triangle conceptual framework (figure 1). This framework examines the interaction between the content (what); context (why); process (how); and actors (who); that were involved in shaping the policy (32), as it gives a direction on how the four elements interrelate in shaping policy-making (33).

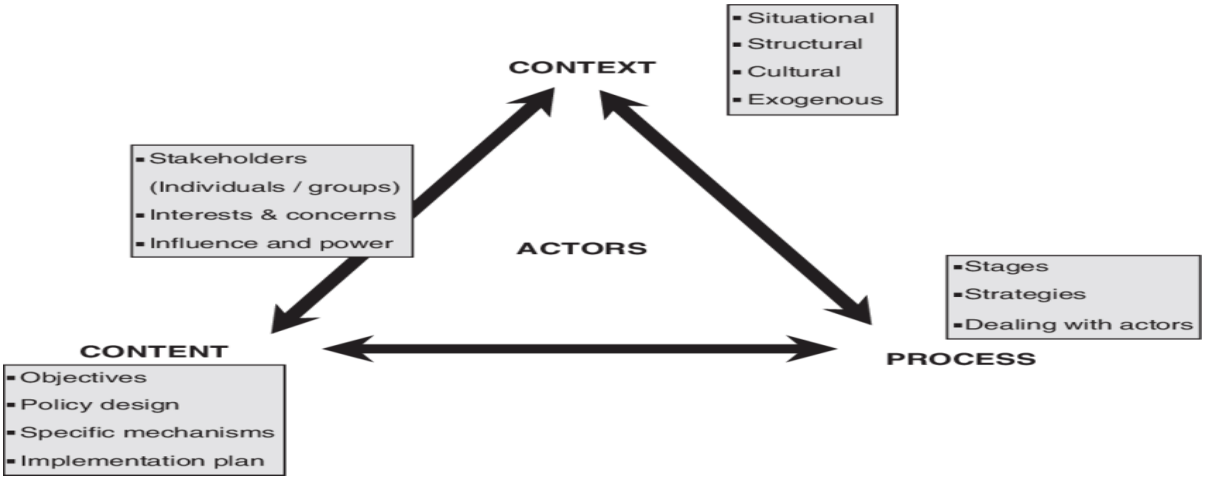

Figure 1: Adapted Walt and Gilson policy triangle conceptual framework (34)

2.2 STUDY AREA

Administratively, Sierra Leone is subdivided into four regions namely the Western Area where Freetown the capital city is found, East, South, and Northern Province. The regions are additionally subdivided into 14 districts and the districts are further divided into 152 chiefdoms. The capital city is where this study will be done among Ministry of Health and Sanitation (MoHS) key policy stakeholders, and donor partners as it is where most of the government Ministries and donor partners are located which are the offices of these policymakers.

2.3 SEARCH STRATEGY AND SOURCES OF DATA

Different search engines like PubMed, Google Scholar, VU library, and databases like United Nations websites, Sierra Leone Ministry of Health and Sanitation Websites were used to search for published articles, peer-review journals, the Government of Sierra Leone (GoSL) health system policies, and strategic documents, reports, published and unpublished documents from UN sites such as World Health Organization (WHO); United Nation Children Fund (UNICEF); United Nations Development Programme (UNDP); would be used in the analysis of Sierra Leone Free Health Care Initiative (FHCI). Interviewees were asked for a recommendation of documents relevant to the FHCI Policy. Search terms used include Free Healthcare Initiative, Sierra Leone, Health Policy, Maternal health, Free healthcare, Interest, Influence, Power, policy process, Health Reforms, Implementation, Actors, Free Health Care, Ghana, Stakeholders, Policy design, Strategies, Uganda, Policy content, Senegal, Mali, Nigeria, Burkina Fasso, Kenya, Socio-economic, Socio-cultural, Socio-political, Health actors, Post-conflict, were combined in various ways using Boolean operators AND and OR. Snowballing technique was used to extend the search for articles. Only published articles and unpublished documents relating to the study and written in English were included in the study. Articles published in the past fifteen years focusing on FHCI reform were used.

2.4 SAMPLING AND RECRUITMENT

Participants to be interviewed for the study were selected via purposeful sampling from the Ministry of Health and Sanitation (n=2); UNICEF (n=1); UNFPA (n=1) and Ministry of Local Government (n=1); based on their involvement in the FHCI from the inception till present, they were informed about the purpose of the study and the reasons why they were selected as participants. Those consenting to the interview were sent an informed consent form (appendix 2); and the research information sheet (appendix 1); containing a brief explanation of the study to be conducted. A time and date for the interview were agreed upon by the interviewer and interviewees.

2.5 DATA COLLECTION

2.5.1 Semi-Structured Interview (SSI) with Key Informants

Based on the findings from the literature review and to triangulate the findings, a semi-structured interview guide (appendix 3); was used based on the adapted Walt and Gilson conceptual framework (Figure 1). Interview with five key informants in the health care system of Sierra Leone was conducted, based on their professional involvement in the policy development, firstly, in understanding the contextual factors relating to the historical, socio-economic, socio-political, socio-cultural, health system, situational and structural factors of the FHCI. Secondly, the different interactions between actors relating to their influence, roles, and power. Thirdly, the content focusing on the objectives, thematic areas, gaps, plans, and strategies, and finally the process focused on the status of the health system before the launch, challenges experienced during the implementation, current challenges, and successes of the FHCI reform. The topic guide was pretested. The interview was done online in English and within an hour. A recorder was used to record the interview upon the informed consent of the participants followed by manual note-taking.

2.6 DATA PROCESSING AND ANALYSIS

The data collection for this study was done based on the study topic guide, and participants' anonymity was respected during the analysis of the findings. The analysis was done using an adapted version of Walt and Gilson's conceptual framework for policy analysis (32). Based on the topic guide, themes and sub-themes were developed and coded into a thematic framework approach of data analysis (appendix 4). Moreover, during data analysis, some outliers or emerging issues that arose as a result of the inductive approach were taken into consideration for analysis. Participants for the study were informed that no form of identification would be used during the processing of the data and their information will only be used for this study purpose, as a coding system was used during the analysis of the data. The interviews were transcribed and developed into a coding framework for analysis.

2.7 ETHICAL APPROVAL

Ethical concerns were considered, as participant's privacy and confidentiality were respected. The content, importance, and risk of this study were explained to them. Participation was voluntary and they could opt out of the study at any time without any penalties. Waiver approval for this study was sought from the Ethical Review Board of KIT, Royal Tropical Institute, Amsterdam. A written informed consent form was obtained from participants before partaking in the study. Their information is kept under lock and key and will be destroyed after the study.

2.8 DISSEMINATION OF RESULTS

The findings from the study will be communicated to stakeholders of the Ministry of Health and Sanitation (MoHS).

CHAPTER 3
3.0 RESULTS
3.1 CONTEXT
3.1.1 Political Context
After declaring the conflict over in 2002, Sierra Leone was in a state of social and economic collapse, leaving the country as one of the poorest globally. Thereafter, the country faced challenges in the provision of adequate public health interventions such as low quality of health services, shortage of drugs and medical supplies, and lack of health infrastructures (35). This was due to the destruction of governmental institutions, infrastructures, the exodus of health care workers, and the instability of the economy. These challenges were mostly observed in the rural areas thereby resulting in inequalities in accessing health care services (36). Comparatively, with other war-affected developing countries, the origin of Sierra Leone's political instability depended less on religious or ethnic contention but mainly in extreme poor governance structure, extensive corruption, disenfranchised and marginalization of the rural communities, in the overpowering and inefficient intervention of the central government in the provision of public services (20).

These issues were aggravated due to collapsing of the local government administration, immediately after independence and the deterioration of trade terms in the country, limited export produces. However, in the post-conflict recovery phase, there was rapid economic growth, structural reforms, and strong donor support (36) (37). Immediately after a peaceful democratic election was held in 2007, there was an improvement in public health, rebuilding of state infrastructures and public health facilities leading to improvement in the socio-economic sector and rapid return of citizens that fled the country before the war (38).

3.1.2 Socio-economic environment
Sierra Leone is ranked among the least developed countries with a Human Development Index of 178 out 187 countries, the country's Gross Domestic Product (GDP) growth rate was stagnated at 7% in the year 2003 - 2007. Moreover, in 2006, World Bank and International Monetary Fund (IMF); ranked the country among the heavily indebted poor countries (39). Additionally, in that same year, the average Gross National Income (GNI) per person was US$220 with around 48% of the population living below $1 per day (40).

3.1.3 Socio-cultural factors
In furtherance, preceding the FHCI, there were socio-cultural beliefs in pregnant women in which they prefer delivery to traditional birth attendants due to lack of affordable and accesses to healthcare facilities and attitude of healthcare providers, but with the invention of the FHCI it has transformed over time, along with teenage pregnancy which was among the risk factors of high maternal mortality according to DHS 2019 (41) (42).

3.1.4 Global context

In the 2010 World Health Report, there was a discussion around achieving Millennium Development Goals (MDGs); progress towards UHC, where everyone would have access to healthcare without incurring financial hardship at the time of seeking the services (1). This discussion prompted the government of Sierra Leone in the same year, in introducing the FHCI towards reduction of high maternal and child mortality (27).

3.1.5 Health system environment

However, the Sierra Leone health system is decentralized through the devolution of activities to the local government. Health policies are formulated by the Ministry of Health and Sanitation, and also provide technical leadership to the Councils which is the Local Government Authorities responsible for the implementation of health services, environmental health care, and provision of safe drinking water at the community level (43). In addition, technical guidance is provided by MoHS in the area of health regarding human resources for health and the provision of Drugs and medical supplies for health care facilities. The funding for human resources for health is mostly provided through the Human Resources Management Office (HRMO); by the Ministry of Finance and Economic Development (MOFED); and also provides finance for health care services through the Councils (44).

Moreover, administratively, Sierra Leone is divided into central government, 19 local councils, and 149 chiefdoms, and the local government is heavily reliant on the disbursement of funds from the central government with autonomy in the implementation of activities at the community level (38). The local government is responsible for the provision of public services to communities including health mostly executed through the District Health Management Teams (DHMTs); which managed the primary healthcare facilities (45).

3.2 POLICY PROCESS

During the 10 years' civil war, the health sector was severely devastated resulting in a mass exodus of trained health care professionals out of the country and destruction of infrastructures like health facilities. Immediately, after the war, some health workers didn't return to their working areas, leaving the population in the villages with limited healthcare providers (46). The consequences of the war resulted in the collapse of the public health system and gaps in the human resource of all cadres in all levels of health care in the public health sector, this inadequate staffing challenge has been an important barrier to a resilient and responsive health system (47). Regardless of these challenges, the country has been rebuilding its health system, though its health indicators were among the worst globally (48). The health indicators during that period preceding the FHCI were bad as indicated in (Table 2) (41).

Moreover, preceding the launching of FHCI in 2010, distance to health facilities was one of the factors limiting communities' uptake of health care services in the rural areas, added to the perceived quality of care, unavailability of drugs, and cost involved like user fees, transportation, and lost time. The unavailability of health workers and the attitude of health care providers were other factors leading them to seek alternative care like traditional medicines. This is followed by

the gender roles in which fathers are the decision-makers in the area involving seeking health care for a child especially regarding payments for health services (49) (29).

Additionally, inequity was cited as a major challenge in the health system, especially in terms of inequalities between geographical locations and also between income groups. A painted picture is the percentage of births attended for the richest quintiles was around 75% and almost 28% for the poorest quintiles (50) (51). However, there has been some improvement over time as reported in District Health Survey (DHS) 2019 (41).

The status of the health system at that moment was considered lacking adequate skilled and qualified health care providers, insufficient supplies of drugs and medical supplies, poor coordination and management, and fees charged at the point of service delivery as stated by key informant (KI),

"*Our health system was not well capacitated to deliver the FHCI during that period, the human resource for health was a serious issue, as there was a low number of healthcare providers compared to the population in the country. Health infrastructures were available but limited, availability of drugs and medical supplies in the health facilities was another challenge"* KI.

Added by a key informant,

"*And user fees for seeking health care was out-of-pocket payment, and during that time Sierra Leone was a post-conflict country with high poverty rate, as a result of that, most people were unable to afford health care bills" KI.*

It was incumbent by the government to intervene in the health system to enable Sierra Leone in meeting its MDGs towards reducing maternal and child health mortality rates (26) (19). There were significant gaps in human resources with poor working conditions for staff as well as low wages, challenges in gaining employment with the government, and the presence of ghost workers claiming salaries for a job never done (52), even for those who were on the government payroll, the condition of services were not attractive which resulted to charges of informal fees for health care service (53). In 2009, the ratio of doctors to the population was 1:33,000, which was not equivalent to the World Health Organization recommendation 1;12,000 minimum doctor to population ratio, most health staffs who were on employment were underqualified (54) (55). There was a weak Monitoring & Evaluation (M&E) system for health preceding the FHCI (27).

The health financing structure in Sierra Leone before the FHCI launching was pitiable, considering in 2007, Out-of-pocket spending (OOPs) as % of Total Health Expenditure (THE) was very high at around 83% as compared to 62% in 2013, (27) (56). The General government expenditure as part of total health expenditure was 6% in 2010 according to Global Health Expenditure Data base (15). The high OOPs on health signifies that access to health care services was either impossible or required catastrophic health spending, i.e. reduction in household basic needs (23). In 2008, a poverty reduction strategy paper (PRSP) was developed with a focus on improving access to public services like health care. The main areas addressed in the PRSP were increasing health financing, improving the quality of health care services, and achieving universal health coverage (20).

Preceding the implementation of the FHCI, there was no organized chain of procurement and distribution for drugs and medical supplies. Cost recovery medicines, a form of revolving drug fund was the main source of acquiring drugs in the health facilities leading to limited access to essential medicines, mainly for those with the inability to pay (27). In Sierra Leone UNFPA country program Action plan (2008 - 2010); it was indicated that (57), most health facilities were lacking, adequate reproductive health supplies, shortage of laboratory commodities like safe blood supplies, electricity, water supply, and other essential equipment which were hindering the delivery of emergency obstetric care, as validated by a key informant,

"*There was a shortage of drugs in the health facilities, the available drugs were expensive, the health system was having challenges, e.g. hospitals were not up to national standard in providing the interventions, the Peripheral Health Units (PHUs) were of low standard not upgraded to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) services, added to inadequate drugs, except pregnant women were been referred to regional or tertiary hospital and there was high mortality among these population" KI.*

3.2.1. Agenda-setting

After the end of the war, the president elected during that period was focusing on socio-economic development and peacebuilding. Following that period, in 2007, the newly elected political administration prioritized health in his agenda due to the high maternal and child mortality rate in the country. Moreover, barriers including user fees were cited by pregnant women and lactating mothers as the main driving force preventing them from the uptake of health care services (58). In 2009 at a donor's meeting in the UK, the President of Sierra Leone, Ernest Bai Koroma, announced his intention to launch a reform in April 2010, the introduction of free healthcare services for pregnant women, lactating mothers, and children under 5 years of age. According to a key informant,

"*These target beneficiaries were dying at an increased rate and were not having access to care due to financial challenges and even when they access healthcare, they had to spend lots of money out-of-pocket to finance their bills and government in his wisdom decided to increase the uptake of health services, user fees for health care services was waived for these categories" KI.*

Immediately after the announcement of the reform was made at the opening of parliament to MoHS, other governmental officials, and donor partners, an official launching document was made available to guide the process (26) (39) (28) (59). Considering the main barrier for the target population was paying user fees in accessing healthcare services, and while comparative to other countries, healthcare providers in Sierra Leone were underpaid, so launching the FHCI signified a key stride in improving access to healthcare interventions for the target beneficiaries and in increasing the wages of the health workforce, as corroborated by a key informant,

"*It improved on employment of health workers as more were employed by the government to provide the services and their salaries were increased" KI.*

The FHCI provided an opportunity for coordination between government, donor partners, and other ministries (60). The agenda was to provide free quality healthcare services for the target

beneficiaries and in providing for all vulnerable groups like people living with disabilities and mental health, universal access to free quality health care services (19).

3.2.2 Design of the process

During the process, the government failed to ensure that, adequate funding would have been available for the effective process of the reform especially, considering the removal of fees charge at these health facilities for the target beneficiaries, was used as incentives for health workers, this led to a shortage of cash flow at health facilities and shortfalls in the financing of wages and, drugs and medical supplies (27). The sub-committees charged with the responsibility to look at the area of finance in the costing of the FHCI activities identified shortfalls in the financing, design revenue mobilization mechanisms including the mobilization of government and implementing partners resources to fill the shortfall in the funding process of the FHCI and were to proffer strategies in mobilizing funds for the long term sustainability of the policy (27) (61).

3.3. POLICY CONTENT

The FHCI was launched by the president of Sierra Leone in April 2010 to address the high maternal and child mortality rates, which were among the worst globally. This reform was set in enhancing Sierra Leone, achieving its maternal and child health target in reaching MDGs 4 & 5 as exemplified in the following quote,

"*Back then in terms of maternal and child health mortality, Sierra Leone was the third-highest globally, indicating that, we were losing our mothers and under-five children to preventable conditions that needed prompt action. As a result, the government decided to intervene in providing FHC for under-fives, pregnant women, and lactating mothers. These were the three categories of the FHC" KI.*

The reform was made in providing healthcare services free at the point of service delivery for pregnant women, lactating mothers, and children under five years, in exempting them from paying user fees (for drugs and consultation); at all public health facilities and also in increasing access to health care services by the target groups, as described in the following quote,

"*So the President by then thought it wise to introduce an initiative called the FHCI, for pregnant women, lactating mothers and children under five years, so they can access health care services at free cost without paying for anything. Before the launching of the FHCI, mostly it was difficult for these target groups to access healthcare services because they can't afford the healthcare bills, so the uptake of services by them was low as compared to after it was launched. The FHCI was of great help to the target beneficiaries" KI.*

It was targeted to treat 230,000 pregnant and lactating women and, one million children under five years which would enhance saving lives and improving health outcomes but the number keeps increasing as time proceeds (19) (62) (45). Abolishing user fees for the target beneficiaries at the point of service delivery was the immediate objective of this reform, with aim of providing long term universal access to all vulnerable groups (27) (63) (64) especially in removing barriers to accessing health care services by the poor population (45)

After the launch, the president appointed a working group and steering committee from MoHS, with the responsibility of forecasting the cost required in providing quality health care services for the utilization of health services by the target group and in driving the preparation of the FHCI (19) (27). Moreover, the six working group members were assigned five months to address the following themes of focus of the FHCI such as, increasing health financing, health infrastructural development, availability of continuous Drugs, and Medical Supplies, Comprehensive Monitoring and Evaluation, increasing the health workforce, and Communicating the reform to the public, strengthening governance structure. As a result of that, the working group that was responsible for the coordination of health financing included members from donor partners, Non-Governmental Organizations (NGOs); government and civil society groups. During the launching process, they used to meet regularly and report to the Health sector Steering Committee. Governance was responsible for oversight activities of the reform (27) (62).

During the proclamation, US$70.9m was pledged by the president and including a donation from various Donors like WHO, NGOs, Global Fund, Global Alliance for Vaccine Initiative (GAVI); Department for International Development (DFID), and UNICEF with a shortfall of US$20m as indicated in Table 1. However, DFID and UNICEF were two of the contributing partners in the provision of Drugs and Medical supplies for the FHCI, as they are one of the main implementing partners responsible for improving the healthcare services in the country (45) (63) The cost involved in running the FHCI is $91,000,000 in 2010 but keeps increasing in the following year (65), with a funding gap of US$20,000,000 which was twice MoHS Total Health Expenditure (THE) following the previous year of 2009.

Table 1: Estimated funding required for the first year of the FHCI (2010)

Cost Items	**US$ (millions)**	**Committed funding by implementing partners to RCH**	**US$ (millions)**
Government infrastructures put in place	2,000,000	GoSL	12.500,000
Human Resource (salaries and performance-based allowance scheme	38,000,000	GAVI	5.609,000
Logistic including drugs and medical supplies	44,000,000	Global Fund	12,000,000
Communications	3,000,000	Multilateral (World Bank, African Development Bank (AfDB)	12.800,000
M&E	4,000,000	Bilateral	10,000,000
		United Nations	6,000,000
		NGOs	12,000,000
Total	91,000,000	Total	71,000,000
Total funding gap US$ (million)			20,000,000

Source: Free healthcare services for pregnant and lactating women and young children in Sierra Leone (19).

The strategies put forward in achieving the reform were, the commitment of the government in increasing its health financing to enable achievement of the Abuja Declaration by 2012, strengthening the procurement and supply chain management in ensuring availability of adequate drugs and medical supplies, recruiting of more skilled health care providers and introduction of Performance-Base Financing (PBF) incentives with support from World Bank, to enable the promotion of quality healthcare services and increasing of salaries, strengthening of coordination and management, at all level of care and communication of the reform to the population, as corroborated in the quote,

"*Some of the key areas considered were, improving healthcare providers condition of services, capacity building and recruiting more staffs, monitoring, and Evaluation, improvement of infrastructure by upgrading and constructing more health facilities, constructing of medical stores and upgrading district stores, availability of drugs and medical supplies in ensuring that, all essential drugs and medical supplies were available in providing the right interventions for the target groups. Governance and accountability were also addressed in ensuring the target groups benefit from the services, they are not charged user fees and in improving partners collaboration" KI.*

In the area of Drugs and medical supplies, a commitment was made by the government in ensuring adequate drugs and equipment were available to deliver the interventions by designing an efficient and well achievable procurement and supply chain management system, harmonization of a parallel system of the supply chain to prevent duplication of drugs and medical supplies, establishment of a transparent procurement process that will be well monitored and supervised with a well reporting system for pharmaceuticals at all levels (19). Moreover, upgrading and constructing of well-structured warehousing for the storage and distribution of drugs and medical supplies from central to districts level in preventing stock out of quality essential drugs and medical supplies (19) (27). In collaboration with UNICEF, and UNFPA in providing technical support in developing a Logistic Management Information System (LMIS) to enhance the distribution of drugs and medical supplies from central to district levels. As supported by a participant,

"*UNFPA provides support in procuring maternal and child health commodities including contraceptives, oxytocin, and misoprostol, of late there has been a commitment by GoSL" KI*

Moreover, in providing equipment for all public health facilities to deliver quality health and emergency obstetric interventions, improving Standard Operating procedures, and in constructing and upgrading of facilities to be well capacitated in providing the interventions (19).

There was also a plan set by the government in training, employment, deployment, and retaining of human resources for health, improving conditions of services for staffs, the introduction of PBF allowances in replacement of user fees, and motivating staffs in providing services for the target groups (19) (27). Additionally, remote allowance was provided to attract and enhance retaining of health care providers in the rural areas. Increasing wages for health care providers, as corroborated by a key informant,

"The advent of the FHCI gave light to positive transformation to the health system. Nurses' wages were upgraded during the launching of the FHCI, though there were challenges experienced.

There were inadequate health workers required to meet the demand of the beneficiaries. This led to the training of more nurses and other health providers to meet the demand of providing the FHCI services, with salary increments and different incentives such as PBF" KI.

Moreover, a policy was developed in 2010, preventing Traditional Births Attendants (TBAs) from conducting deliveries and training more midwives (19) (66).

In the area of Monitoring and evaluation, a collection tool was designed to enable the availability of reliable and timely data on the health system performance, including the policy implementation, strengthening Health Management Information System (HMIS). Data collected will be used to provide oversight information on the evaluation of the policy (19) (27). Measures put in place include conducting periodic household and health facility surveys, reporting and review mechanisms to enhance strengthening of the management health services and governance system, conducting effective supervision and performance appraisal tools, and an audit system to ensure quality services are been provided. Finally, engaging the community participation in monitoring of the FHC services provided at the health facilities (19).

In addition, a plan to communicate the policy to the wider public and in allowing them to exercise their right in seeking health care services. Finally, there was a plan to strengthen the oversight, management, and coordination process of the FHCI. Ensuring effective coordination with the government sector and other stakeholders (19).

3.4 ACTORS

Sierra Leone's health system constitutes government public health services, donor partners, and a mix of private healthcare providers (48) (67)**.** Over a while, before and after launching the FHCI, the donor community in Sierra Leone has been contributing to the improvement of public health services. UNICEF, and WHO, provide supports for the improvement of maternal and child health and public health services, in collaboration with the Ministry of Health and Sanitation, GAVI, and Global Fund. DFID has been contributing immensely towards the Government of Sierra Leone's (GoSL) policies in improving health outcomes for the poor population in Sierra Leone. (31). World Bank focusing on strengthening the health infrastructure and National Health accounts, in addition, numerous NGOs and bilateral donor partners are actively involved in providing public health support to health care facilities, communities, and upgrading health facilities (22) (60).

Additionally, the majority of the funding provided by donors is earmarked for programs towards specific districts. The European Union (EU) is providing support in strengthening the health system while the African Development Bank and Islamic Development Banks are focus mainly on improving health infrastructures in the country. Other UN agencies such as United States Agency for International Development (USAID); provides funding for the provision of health services, and capacity building. This funding support is either provided via the MOHS to particular programs or directly to specific districts' activities (56).

3.4.1 Roles

1. President, Ministry of Health, Ministry of Finance and Economic Development, Civil Society Groups, and Donor partners

To understand the roles, influence, and power dynamics of different actors during the FHCI, this section offers insight into it. The involvement of stakeholders in designing policy reform is important in the success of health reform. In Sierra Leone, the action embarked on by the government in removing user fees in 2009, was having both national and international influence on the policy drive. After the proclamation of the FHCI by the president, a working group consisting of MoHS members, donor partners, and MOFED (26). They used to have weekly meetings and reports to the steering committee consisting of development partners, and members of other ministries of the government of Sierra Leone, and the Chief Medical Officer (CMO) was the chairman of the meeting (27). Moreover, a monthly progress report sent to the President, follow-up with challenges, and anticipated risks involved in preventing the progress of the policy. The steering committee meeting was chaired by the president, and embarked on several trips to different parts of the country in monitoring the progress of the policy, thereby leading to immense improvement to MoHS and the FHCI. The MoHS was responsible for the implementation of the FHCI (27) (54).

Actors like civil society groups including Health Alert and Health for all Coalition were all supportive of the FHCI in the area of conducting monitoring and supervision at various health facilities in ensuring the effective removal of user fees, availability of health care providers at their workplace, and in monitoring the distribution of drugs from central to the district or hospital level (63) (68).

3.4.2 Influence and power

1. Donors, United Nation Organizations, and Non-Governmental Organizations

At the international level, one of the main actors that were immensely supportive of the reform was the United Kingdom (UK) government, in which a letter was written by Gordon Brown to many African Head of States, including the president of Sierra Leone, committing to provide financial support if barriers to accessing health care services, like user fees were removed for the target beneficiaries in enhancing the country achieving it MDGs 4 & 5. The UK government provides technical and financial support of £10m for salaries of health care providers and political commitment towards the launching and implementation of the reform. The International Monitoring Fund was against the removal of user fees considering Sierra Leone was not well capacitated in financing the reform and was concern about its sustainability (27) (69).

Moreover, there was also support from other international partners like the World Health Organizations, Global Fund, UNICEF, CARE-SL, UNFPA, ADB, and International Rescue Committee with a focus on Maternal and Child Health in achieving the MDGs 4 & 5 in which the country was far behind in achieving these goals (27). The international non-governmental organizations in Sierra Leone were also in a position with strong advocacy interest for the removal of user fees by the government, for the target beneficiaries. There was strong financial support and interest by these international partners in influencing the reform in achieving the MDGs 4 & 5 (27).

Donors including ADB, DFID, World Bank, UNFPA, and UNICEF provided a sum of US$ 31, 016,801 towards the FHCI during the implementation process, however, DFID is the main funder of the FHCI committing around 50% during the implementation process in 2010, as supported by Key Informant,

"The donor partners were one of the key stakeholders, mostly the British government i.e. DFID by then which has transformed to Foreign Commonwealth Development Office (FCDO) and UN agencies including UNICEF, UNFPA, USAID, and WHO. Civil Society Groups e.g. Health for All Coalition are still active up to date, other women groups and other stakeholders" KI.

The World Bank provided support to Sierra Leone in the interest of improving Reproductive and Child Health (RCH) projects, with a focus on increasing service utilization for the FHCI target groups, and in providing additional financial support for PBF which is part of the RCH project to improve performance of health care providers service delivery (45) (39). Though, they were one of the critics of the FHCI proclamation in opposition that, the reform would result in more donor dependence with minimal ownership by the government as the country was not well capacitated to completely fund its health system, as corroborated by the following quote,

"*Government wasn't well capacitated in providing adequate funding to support FHC for the target groups, though their limited funds were used towards paying wages of healthcare providers, options were explored such as DFID, the main financing partners for FHCI, including other donors that contributed finance towards health infrastructures, and drugs and medical supplies" KI.*

Nevertheless, after the initiative was launched, there was a drop in funding to the country by the World Bank, after support by the UK Government (63).

2. Government, Civil Society Groups, and other stakeholders

At the national and local level, there was pressure from a national non-governmental organization like the civil society groups in advocating for the beneficiaries to the government for removal of user fees considering the high number of maternal and child mortality that was nothing good to write home about before the launching of the FHCI (27). Additionally, this was a strong presidential flagship program as there was a strong political will by the president of Sierra Leone towards the launching of the FHCI, with great expectations and strong public demand for it at both national and global levels, as validated by a key informant,

"*The government of Sierra Leone was strongly supportive of the initiative, as it was an initiative of the President, other stakeholders, including Civil Society, donors, and other well-wishers were all on board during the introduction of the FHCI" KI.*

The Decision of the FHCI was more centralized rather than decentralized. Additionally, other ministries including the Ministry of Labour, Ministry of Social Welfares and private health care providers, and other key stakeholders were not part of the initial working groups of the process, considering the aim of achieving the goals of the FHCI this was not taken into consideration. As was reported by a key informant,

"Health workers were not involved in the decision making as a result of that, immediately after the FHCI launching, there was nationwide strike by them, as they were not part of the initial planning process, and this was a situation where the health workers were moving from user fees to FHC. The health workers realized that there will be an increased workload with an increased influx of patients, with no additional benefit. It took some time before it was resolved by the government. There were some stakeholders that the government was supposed to be involved in the decision-making but were not, including community members and private health care providers" KI.

Added by a key informant,

"The planning process was mainly done by government and donor partners, for the private providers they only came on board when the process was in the implementation phase but was not involved in the initial phase" KI.

3.5. IMPLEMENTATION

During the implementation process, some positive improvements were highlighted, in which there was an increased uptake and accessibility of health care services by the target beneficiaries, as verified by a key informant,

"*FHCI enhances in improving access to healthcare services, whereby the beneficiaries have stopped using the unregulated birth delivery provided by TBAs that were contributing to high maternal mortality due to lack of skills in providing intervention during pregnancy. Currently, there is increased awareness by the target groups on attending health facilities which is a great milestone achieved so far by the FHCI. Though there is more to be done" KI.*

Added by KI,

"*Comparatively, before and after the launching of the FHCI, there has been a reduction in maternal and child health mortality, though it's still high. There has been a facelift of some health facilities including hospitals, PHUs, BEmOC facilities" KI.*

As indicated in (table 2); before the launching of the reform, the health indicators were worse but the improvement has been observed overtime during the implementation. In 2012, and 2014, the country faced cholera and Ebola outbreak respectively. This led to the devastation of the economy, loss of many lives, including the death of healthcare providers thereby leaving a gap in the human resource for health (70) (17).

Table 2: General trend of some health indicators in Sierra Leone-Changes over time according to DHS

Indicators	DHS 2008	DHS 2013	DHS 2019
Infant mortality rate (per 1,000 live births)	89/1,000	92/1000	75/1,000
Under-five mortality rate (per 1,000 live births)	140/1,000	156/1,000	122,1,000
Maternal mortality ratio (per 100,000 live births)	857/100,000	1,165/100,000	717/100,000
% of births attended by skilled providers (public and private)	42	60	87
% of women received ANC from skilled providers	87	97	98
DPT immunization (% children 12-23 months)	60	75	78
Measles immunization (% children 12-23 months)	60	68	75
prevalence of anemia (% among children age 6-59 months)	76	80	68
Insecticide Treated Bed net (ITN) use (% in under-five children)	26	49	59
Intermittent Preventive Treatment of malaria during pregnancy (IPTp) (% coverage in women 3 doses)	5	21	36
Fertility rate (birth per woman)	5.1	4.9	4.2
HIV prevalence (% population aged 15-49)	1.5	1.5	0.1
Use of contraceptive (% women aged 15-49)	14	16	21
Teenage pregnancy (%)	34	28	21

Source: DHS 2008, 2013 and 2019 (29)(30)(41)

3.5.1 Financing

In the area of finance, the committee members that were charged with the responsibilities in addressing finance required for the effective implementation of the FHCI came up with a total cost of US$91,000,000, and funding gaps of US20, 000,000 were identified as indicated in table 1 above. Additional salary increments requested by health providers during the implementation of the FHCI were not included in the 2010 budget which resulted in a deficit of healthcare providers' wages and was not addressed till the implementation process of the FHCI (27) (60).

In a month after the implementation process of the FHCI, health workers went on strike for better wages due to increase workload and loss of income from the beneficiaries. The wages of health care providers in Sierra Leone increased twofold in response to the strike, leading to an increase in wage bill from US$6m to US$19m, as validated by a key informant,

"*The challenges are numerous, firstly there was a nationwide strike by health workers, as they claimed their salary was small compared to the services rendered to patients. This resulted in increased spending by the government on salary increments during the FHCI. The cost was also involved in the construction and upgrading of more health facilities to enhance access to FHCI services by the communities. More drugs and medical supplies were procured to meet the demand of drugs needed for the target groups" KI.*

Additionally, the increment in wages in 2011 was also due to the additional employment (28) (52). There was resistance by donor partners in providing funds in filling the gap for wages of healthcare providers especially the issues like ghost workers which was yet to be addressed but due to the commitment of the government in increasing their funding for health, donors including DFID and Global Funds were convinced in investing their money to resolved the issues (39) (71).

Moreover, the government mobilized adequate funding from donor partners including DFID, and Global Fund during the implementation, for support to health care wages and drugs and medical supplies, this was supported by a key informant,

"*Donor partners committed a huge sum of money during the launching process, even though there were gaps in other areas, what they did was improving on the remuneration of healthcare providers, and putting some seed money into the procurement of drugs and medical supplies and also brought some technical expertise in strengthening the FHCI" KI.*

There was a Memorandum of Understanding (MOU) between DFID, MoHS, and Ministry of Finance and Economic Development (MOFED) towards the financial aid given in support of the FHCI, on the condition of improving performance indicators on human resources and maintaining the payroll clean, of late areas including human resource, that was improving have been deteriorating (60) (62) (71).

As documented by Budget Advocacy Network and anecdotally reported by many, disbursements of funds are most often delayed from the government through the MOFED to Local Councils also between Local Councils and District Health Management Teams (DHMTs); and hospitals, this has led to ineffective implementation accountability, coordination and fiscal sustainability of the FHCI

(45) (62). As a result of a delay in allocation of funding, hospital, and district staff have been limited in executing their outreach and supervision effectively, as verified by a key informant,

"*The government currently has constraints with financial resources in providing services required for the FHCI, funds disbursed to the council are untimely. Imagine we are in July that when we have received the first quarter funding from the government" KI*

There is weak accountability regarding effective planning and disbursement of funds from central to local councils, poor governance arrangements, and a more centralized decision-making process. (26) (72).

Additionally, considering the policy reform and the added strategies instituted, transformation in the health financing is expected through the disbursement of funds from central to the district level and collaboration between the different financing organizations, and monitoring of expenses (27).

During the FHCI, the proportion of household expenditure reduced from 83% in 2007 to 62% in 2013 as a result of donor funding replacing it, thereby decreasing out-of-pocket payments to 48% as of 2018 and catastrophic spending, however, though per capita and as a proportion of THE, household expenditure is still considered high in the context of 2010 report of World Health Organization which stated that, when direct payment is below 20% of THE, then the risk of catastrophic expenditure is much less (1)

Considering there was a loss of revenue from this target group and an increase in the utilization of health care services by the beneficiaries' thereby increasing pressure on the existing budget mainly on salaries of health care providers and procurement of drugs. The funding for the FHCI continues to dwindle (39). Alternative sources were therefore required for the effective implementation of the policy as well as new strategies put in place in providing cash at the facility level in ensuring their operations. As exemplified by this quote,

"*As time elapses, since 2010 till then, funding for the FHCI continues to reduce from donors, one key challenge for most health facilities currently is a shortage of quantity of drugs and medical supplies that used to be distributed to these health facilities has been decreasing by more than 50%, while the FHCI beneficiaries have increased with decrease in funding and supplies. Currently, patients visiting the hospitals don't get the required medications prescribed for them unless they ration the medications for the patients" KI.*

3.5.2 Drugs & Medical Supplies

A promise was made by the government in providing adequate drugs and medical supplies for the effective implementation of the FHCI, it on that note, funding was provided by donor partners in the procurement of drugs for the FHCI, and was given to UNICEF via DFID, in procuring drugs and medical supplies for distribution from government central warehouse to district logistic stores and health facilities, as validated by a key informant,

"*UNICEF is known very well for its procurement strengthen and ability, through donor partners, UNICEF was contracted to procure essential drugs and medical supplies for the FHCI. UNICEF supported the procurement and also under supply chain strengthening support process and recruited some staff to support logistics and supply chain at the district and regional level and*

they also provided other technical assistance and participated in several working groups committees to support the FHCI" KI.

Added by a key informant,

"*Moreover, DFID has been the main donor in providing funds for drugs specifically, and UNICEF has been handling the procurement of drugs and medical supplies for the FHCI, in 2019, DFID engaged the MoHS and the government of Sierra Leone to develop a strategy where they would be participating in a co-financing scheme, where the government will put funds aside in their annual budget in addition to what DFID will provide in enhancing the timely procurement of drugs and medical supplies" KI.*

Added by a key informant,

"The challenges remain as the release of funding from the government is delayed and accessing their funds is also challenging as years passes by. The established government procurement agency is responsible for procuring drugs and medical supplies on behalf of the government while UNICEF procured on behalf of DFID" KI.

An increase in the utilization of the health care services requires increasing the number of health workers and their wages, upgrading of health facilities, and financial increment in the procurement of free drugs for the target beneficiaries, as corroborated by a key informant,

"In the area of availability and access to drugs and medical supplies, the government has made some progress but a wide gap exists as funding allocated by the government is inadequate. E.g. if quantification is done and US$ 24m is required in procuring drugs and medical supplies for FHC, US$ 6m will be provided, leading to stock out of these commodities at health facilities, often these beneficiaries are given a prescription to buy drugs in the community pharmacies" KI.

Additionally, user fees on medications have been requested from patients especially when there is stock-out, albeit the drastic improvement in uptake of service delivery in reproductive and child health services, as validated by a key informant,

"*Currently there is donor fatigue been experienced, donors want the government to take responsibility of the FHCI and government is not understanding the full scope of what it takes to run the FHCI" KI.*

Added by a participant,

"Hitting the aim is kind of difficult year after year. For E.g. actual quantification for the year is 220 commodities, but funds are available to procure only 54 commodities, referred to as a prioritized list. This is one of the challenges faced in terms of implementation as the year goes by, there is persistence stock out of drugs and essential commodities, poor referral system in terms of ambulance services, lack of skilled expertise at the lowest level of service delivery all these keeps accumulating as the challenges of FHCI" KI.

Additionally, UNFPA provides intervention in the area of strengthening logistic system, human resource capacity building, construction and upgrading of health facilities, and procurement and distribution of drugs and medical supplies, as validated by a key informant,

UNFPA supported the construction and rehabilitation of health facilities. Additionally, they provided support with an inventory control system called CHANNEL to monitor the flow of drugs and they provide wages for District Information Officers but of late has stopped paying their wages as the former UNFPA Country Representative didn't see it realistic" KI.

3.5.3 Human Resources

As was stated by the government, in their commitment to improving conditions of services for healthcare providers through providing motivation package in replacement of user fees, and in increasing the health work force insight towards this direction throw a light on it (19). Since the development of the National Health Sector Strategic Plan (NHSSP) 2010-2015, many reforms have been instituted by the government in improving the health system such as increasing the human resource for health from 7,164 to 8,446 in 2009 and 2011 respectively. Health providers working in remote communities have been receiving remote allowances, though understaffing is still observed in the Peripheral Health Units (PHUs); and lacking basic facilities like water and power supply, and essential equipment (50). Additionally, the current Human Resources for health in Sierra Leone is below the required number, in 2010, WHO estimated the physician density at 0.0024 per 1000 population. According to Service Availability Readiness Report 2017, the estimated physician density is 0.05 per 1000 population which is still below the recommended WHO requirement of Physician to population density 1:1000 (73).

To compensate health care providers in improving services provided for the target beneficiaries and in replacement of funds loss from the income of the target beneficiaries, the World Bank provided a PBF support program for healthcare providers, under the phase 2 Reproductive and Child Health Programme (27). The program has been fruitful in providing independence to health facilities in managing their funds and in contributing to better hygiene, a good working environment, adequate supplies of services, and giving autonomy to facilities to provide incentives for Traditional birth attendants for referring patients to the health facilities, paying volunteers and in financing outreach programs (52). However, challenges exist with the PBF as the disbursement of the funding is often late, thereby leading to health providers not visioning the money as compensation for better performance, additionally, the funding for the PBF and remote allowance has not been forthcoming, as was substantiated by a participant,

"*The PBF and remote allowance has not been forthcoming as they used to during the initial process of the FHCI, the arrangement of the PBF was wrong as it was done based on quantitative analysis and not on quality services delivered by the health care providers. Based on the number of patients attended to, that how the funding was disbursed regardless of quality, at the end most heads of health facilities started manipulating the figures to present as if they have been attending to more patients. This was one of the reasons it's not forthcoming, also there is a delay in receiving the money from the government. It takes 6months before the funds can be transferred for payment" KI*

In addition, the FHCI enhance the monitoring of staff attendance and minimized staff absenteeism. However, this system that was in place has been ineffective of late. (27). Furthermore, TBAs have been part of the traditional birth delivery system of Sierra Leone health care, and have been receiving payment in kind including chicken or rice for child delivery (66). Since the establishment of the FHCI, their roles have been limited to persuading pregnant women to visit the health facilities which has been fruitful but in return for cash payment by the health care staff in the PHUs. The PBF has been a source of funding for the TBAs but considering it has not been forthcoming has been a challenge (74). Training schools for the training of more nurses and midwives were operated by the government to meet the demand of the FHCI. (52) (60). Retention of staff has been challenging (75), with frequent relocation of staff from one health facility to another, as was verified by a participant,

"*Staff deployment is inappropriately done, e.g. staffs are randomly transferred within a month from one PHUs to other which is affecting the intervention of health services" KI.*

There have been complaints by patients of ill-informed attitudes of healthcare workers providing FHCI services, particularly the nurses. Considering it's free, they sometimes shouted at patients hindering the quality of care provided and demand money for the FHCI services (27) (76). A study conducted by Cordaid's in 2014 indicated that 12% of FHCI beneficiaries still pay user fees at the initial phase of the launching of the FHCI, as was validated by a key informant,

"*The FHCI is currently facing challenges, to say the truth. Initially, when it was launched the target groups were supposed to access these services at free cost, of late we have been informed by them during supervision that, some healthcare providers have been requesting money around le 10,000 from them" KI.*

Added by a key informant,

"*Another challenge regarding services like counseling that should be provided for patients, we have been receiving complaints from patients regarding ill-informed attitudes of health workers towards patients as not welcoming considering the FHCI services are free of cost, in the area of quality of care perspective this is an issue" KI.*

However, recently the uptake of services by the target group has not been positive as it used to be during the launching process (45) (77).

3.5.4 Health Infrastructures

In the government agenda during the launching, a commitment was made to improving health facilities, however, there has been some improvement though challenges continue to exist in this area. Health facilities classified as Comprehensive Emergency Obstetric Care (CEmOC) or BEmOC are not according to the national standard (61) (50), there have been stock out of life-saving kits or drugs, inadequate blood collection equipment, and unavailability of basic amenities including regular water supply and electricity, confirmed by a key informant,

"In harmonization of infrastructures, all PHUs are supposed to have similar infrastructures with required staff and equipment, the lack of harmonization is a bit confusing. These are some of the challenges of the FHCI as it is not well supported by the government" KI.

Added by a key informant,

"The enthusiasm towards blood donation during the launching of the FHCI has been dwindling, as sometimes blood donors may not be available, except the patient relative is brought onboard to donate blood. Some hospitals have been short of blood collecting kits, shortage of water and electricity supply" KI.

3.5.5 Monitoring & Evaluation

However, though M&E was one of the key areas of focus of the FHCI, with improvement in data collection and supervision. Inadequate leadership and resources were not apportioned to M&E during the implementation process with limited follow-up on the activities to be executed efficiently (68). The ineffective engagement of the Civil Society groups, government, and communities on issues of the FHCI implementation process has not been realistic as it was during the launch (27) (78).

3.5.6 Governance

Nonetheless, the GAVI corruption scandal in 2013 worn out the staunch relationship between MoHS and donor partners. The decision on the FHCI process was top-down, the working group meetings consisting of MoHS, GoSL, Civil Society Groups, and donor partners that were well attended during the launching of the FHCI which used to be in place are no longer effective. In the main while, there is a lack of leadership direction on ownership of the FHCI, as it was a presidential decree and has been supported and guided by the Directorate of Reproductive and Child Health (RCH) in the MoHS till 2014. After the Ebola outbreak, ownership of the FHCI is unclear, as it is arguable by the then director that the FHCI cut across all sectors of the MoHS and ownership should be on all other directorates instead of specifically the Directorate of RCH. The lack of clear leadership of the FHCI tends to undermine its sustainability, as supported by a key informant,

"There is no explicit policy giving direction on how the FHCI should be rolled out and which directorate within MoHS should take ownership in terms of responsibilities of the FHCI. There is dwindling in donor funding as the year goes by, it has been challenging year after year" KI.

Added by a key informant,

"*Considering there is no clear policy giving direction on who is to benefit from the FHCI, during the launching, the beneficiaries were pregnant women, lactating mothers and children under five years, currently speaking four beneficiaries have been included such as Ebola survivors, people with disabilities, aged and school-going children" KI.*

3.5.7 Communication

During the launch, the reform was communicated to the beneficiaries before it was communicated to the healthcare providers, which was a mistake done on the side of the government, though the awareness-raising was done by CSOs through different media fora. After the launch, little attention has been given to this area due to the funding gap (27).

CHAPTER 4

4.0 DISCUSSION

The FHCI was a complex intervention, and it is difficult to determine what progress can be attributed to each of the components of the initiative, considering many things that happened at the same time, and overtime. Progress has been achieved in improving some indicators including ANC and immunization coverage, prevention of malaria during pregnancy and others as indicated in table 2, and in increasing access to healthcare services by the poor. The reform was initiated in the face of high maternal and child mortality, exempting the target groups from user fees in public facilities, and aiming to achieve MDG's progress towards UHC. Though there has been a reduction in maternal and child mortality, whether the reduction is attributable to this FHCI can not be concluded, as other health issues were also addressed during the period of this reform. Considering user fees were impeding access to seeking healthcare services by the beneficiaries, the abolition of user fees has contributed to increased uptake of healthcare services by the beneficiaries. This finding is consistent with studies reported in Ghana (79) (80), Burkina Fasso (81) (82), Nigeria (83) (84).

4.1 Financing

In the area of financing, the commitment made by the government towards increasing its domestic health financing was observed though more needs to be done in maintaining the sustainability of the reform. DFID was the main financial sponsor of the FHCI, with other donors also on board, but their funding support towards the policy has been dwindling over time. The sustainability of the policy is at stake which needs to be addressed by the government to ensure the efficient, sustainability of the FHCI. Improving Public Financial Management (PFM) may enhance the efficiency of spending from both on-budget donor funding and domestic allocations for the FHCI. In some African countries like Sierra Leone that have introduced user fee exemption in health facilities, sustainability is currently a critical issue with their policy (85) (86).

In the future, inadequate funding for the FHCI may lead to the termination of the FHCI, as was observed in the Democratic Republic of Congo (87) and Nigeria (84). In Sierra Leone, OOPS as a proportion of THE is high compared to the 20% benchmark proposed in the WHO report 2010, reducing OOPS when seeking healthcare is essential, avoids putting the population at risk of catastrophic expenditure.

Delay in the allocation of funding to the local councils, for the implementation of FHCI activities, can be attributed to a shortage of cash management, weak planning, centralized decision-making, overall health financing issues faced by the government. Countries like Rwanda, and Costa Rica, expand insurance coverage for their population through public pooled funds and funding arrangements and is essential in enhancing the sustainability of health reform, which Sierra Leone should consider implementing in the future, through either contributory or non-contributory (tax-funded) arrangements. This would enhance coverage for a wider group of the population with not only the original FHCI beneficiaries (88)

4.2 Drugs and Medical Supplies

Improvement in the area of procurement and distribution of drugs and medical supplies, access to drugs, improved storage facilities, and LMIS were observed as progress in the context of the FHCI. Results show that constant stockouts of pharmaceuticals are an issue faced by the reform due to funding challenges. Hindrance to progress made in this area towards providing drugs and medical supplies for the beneficiaries will result in them incurring the cost of drugs from community pharmacies, buying drugs from peddlers, and reducing the uptake of healthcare services.

Other studies have also documented, ways of improving quality of care through the availability of drugs for beneficiaries, after the introduction of fee exemption for maternal and child healthcare including studies in Uganda (89), like raising domestic revenue through different tax systems, flexibility in funding allocation for cost-effective interventions, preferentially targeting the poor population that carries the highest burden of diseases. Sustainable funding replacement is of importance in user fees exemption policies. Countries like Senegal, and Burkina Faso are using domestic funding to finance their fee exemption policies, while a country like Nepal depends on external funding. On other hand, Ghana relied on a mixed funding system comprising MoHS funding from general revenues and health insurance which itself is mainly funded through a Value Added Tax.

4.3 Governance

The JPWF document enhanced coordination between donors and the government. The lack of clear governance of the FHCI is critical in strengthening PFM. The GAVI corruption scandal by the government might lead to a weakening of donor confidence, the unpredictability of donor funding support. This has led to weakness in PFM with possible consequences of the uncertainty of funding support from donors towards the FHCI.

Delays in the allocation of funds from the government are caused at least in part by a lack of resources, although administrative procedures and accountability requirements may also have caused delays, both in the disbursement of government allocations or those from donors. Other studies (80) (90) (91) (92), have reported similar findings as an impediment to the success of their fee exemption policies. Timely allocation of funds will prevent healthcare providers from rationing drugs and other free services including requesting informal charges from patients. In the area of lack of leadership of the FHCI, our study observed challenges in this area considering it was a presidential decree, which is similar to the FHC implemented in Ghana (93).

4.4 Actors

In improving governance and accountability of a policy, wide stakeholders involvement is key in its agenda-setting, design, effective implementation, and monitoring of the policy. Our findings regarding the introduction of FHCI showed limited stakeholders consultation, and was having high political influence with a top-down approach, as not all relevant stakeholders including health workers, community leaders, and others were involved during the design of the policy, which may lead to lack of ownership. This is in agreement with other studies, where inadequate consultation of key stakeholders jeopardized the objectives of the Free health program (79) (80) (94) (95).

4.5 Health Infrastructures

Progress has been seen in this area over the ten years but challenges continue to exist, health facilities' preparedness for BEmONC and CEmONC has been facing challenges regarding the shortage of basic equipment, stock out of life-saving kits or drugs, inadequate blood collection equipment may have resulted in poor quality of care rendered by these facilities. A study (96) reported that poor quality of care as a result of people not receiving appropriate care due to undercoverge and lacking basic equipment and supplies may lead to high mortality and decreased access to care. Underperforming health systems, with inadequate water and power supply, lack of adequate drugs and medical supplies, derail the progress made towards UHC.

4.6 Human Resources

Human Resources for Health (HRH) issues have been improved since the launch of the reform, with increased recruitment and wages of healthcare workers, cleaning of payroll, and motivation packages provided, including PBF and remote allowances, in response to increasing workload, and replacement of loss of user fees to provide autonomy and motivation for health workers. A monitoring system on staff absenteeism was also put in place, with immediate action taken for absenteeism from work, like withholding of staff salary. Additionally, training schools were operated by the government to enhance the training of more skilled health workers. In response to the Ebola outbreak, which exposed our weak health system and resulted in the death of an increased number of HRH, strives achieved in the past in this area have eroded.

Delay in the disbursement of PBF, might be due to donor funding unpredictability considering World Bank was the donor providing PBF support, and also due to poor reporting system and data manipulation, these findings are consistent with other studies where PBF is implemented (52) (97). This have consequences on the motivation of health workers and autonomy in providing some needed requirements for facilities. Additionally, an impediment to this funding source may jeopardize the inputs of healthcare providers towards providing services to the beneficiaries, thereby resulting in a poor attitude of the healthcare providers and in requesting informal charges from patients, resulting in beneficiaries incurring the OOPS.

Poor attitude of healthcare providers towards patients and collection of informal charges has been cited in our study. This may reduce uptake of healthcare services in the future leading to the jeopardy of strives that have been achieved by the government in reducing maternal and child mortality and progress towards UHC. Other studies have reported similar challenges during the exemption of user fees policy, in which exempted beneficiaries still experience OOPS, the ill attitude of health workers, and informal charges for services that should be free for maternal and child healthcare, thereby limiting progress on increased access to healthcare services by the target beneficiaries (70)(81) (90) (98). This usually occurred due to underfunding of the healthcare facilities by the government

The exemption of user fees improved access for the lower socioeconomic groups, especially those in the rural areas which were previously using the TBAs for deliveries. Some studies have reported inequalities in healthcare services where user fees exemption was introduced (99) (100).

4.7 Monitoring and Evaluation

The health M&E system before the launch of the FHCI was underperforming, but with the introduction of the reform, progress was made through improvement in data collection and supervision. Due to funding challenges, there is an ineffective M&E of the FHCI activities. This is consistent with findings in Burkina Fasso where ineffective M&E was observed due to funding issues (84).

It is always important to adapt successful policies where needed; to keep donors on board through accountability of progress made using the HMIS data. However, though M&E was an area of focus of the FHCI, with improvement in data collection and supervision made in the past, inadequate leadership and resources were not apportioned to M&E during the implementation process with limited follow-up on the activities to be executed efficiently

4.8 Communication

During the launch of the FHCI, the reform was communicated to the beneficiaries before it was communicated to the healthcare workers which was a mistake on the side of the government. While this area was considered as one that needed improvement according to the initial budget of the FHCI, funding challenges continued to derail the effective implementation of communication activities of the reform.

CHAPTER 5
5.0. CONCLUSIONS AND RECOMMENDATIONS
5.1. CONCLUSION

In conclusion, the FHCI was a reform that enhanced improvement of health coverage and in reducing equity for the target beneficiaries The Ebola outbreak in 2014, eroded progress made earlier. However, challenges continue to exist and need to be overcome, especially in the area of funding, drugs and medical supplies, human resources, M&E, health infrastructures, governance, and quality of care. This has consequences in the future for the sustainability of the policy and needs to be addressed by policymakers. Moreover, the current funding problems faced by the reform, might leads to underfunding of the health system, and more particularly of the primary care system. “Free” healthcare in such circumstances leads to people needing to go to pharmacies to buy their prescriptions, health workers getting demotivated and offering a low quality of care, and asking informal charges for health services. Health workers preferring to work in urban places where they can practice opportunities for moonlighting; lack of supplies, supervision, etc, or healthcare workers abandoning the facilities. The only alternative then for the beneficiaries is to go to informal providers, like the traditional practitioners, drug sellers, etc, resulting in bad quality of services. This may eventually lead to an increase in maternal and child mortality, that the country was preventing during the introduction of the FHCI. Health facilities should have an adequate replacement of lost user fees, that would serve as motivation towards increased patient influx and in improving the health facilities, as was reported in Ghana (80)

With the current funding issues and added to other shortcomings of the policy, achieving Universal Health Coverage for the target beneficiaries and additional exempted groups will be challenging. Meaning Sierra Leone needs to move towards pooled financing arrangements, from preferably domestic resources, that can offer the entire population a basic package of services (evolving gradually over time, when the country can afford more) and that goes beyond only maternal and child health services. It is of importance for the government to develop strategies in preventing informal charges collected from beneficiaries, motivating health providers, and ensuring timely disbursement of funds for the effective implementation of the policy, and establishing ownership of the policy.

Due to limited data availability, a detailed analysis of actors/stakeholders’ involvement during the FHCI was not addressed which future studies should consider. This was a complex policy with aim of exempting few target groups from user fees but was a broad set of health system strengthening components, and the reform has adapted over the ten years, partly in response to enormous challenges to the health system, notably cholera, then the Ebola, and recently the corona epidemics. In such a complex policy environment and context, it is quite challenging to make a comprehensive analysis.

5.2. RECOMMENDATIONS

5.2.1. POLICYMAKERS

1. In the area of increasing health financing, the government should develop strategies in raising sufficient domestic funding in increasing fiscal space for health, for the sustainability of the policy, and in meeting the increasing demand for health services. This can only be achieved, by a comprehensive financing policy that includes overall economic growth, improving general fiscal space, risk pooling, strategic purchasing, improving PFM, improving tax collection system, prioritizing the share of health within the general fiscal space, introducing earmarked and innovative taxes that would then be reserved for health, increased donor funding, eliminating wasteful expenditure by using the money efficiently, prioritizing the most cost-effective services by designing a realistic benefit package.
2. Strengthening accountability and transparency of the government in enhancing donor support towards health improvement.
3. Strengthening inclusive stakeholders' participation, ownership and consultation are essential for the success of the policy.
4. Strengthening M&E system, in improving availability of quality and reliable data in enhancing effective tracking of the policy.
5. Strengthening HRH systems at both central and district levels, in providing sustainable remote and PBF allowances for health workers on time would motivate them, and enhance their retention at the workplace.
6. Ensured health facilities are provided with the requisite medical equipment and supplies, availability of sustainable water and power supply to provide the needed quality of care for the beneficiaries.
7. Allocation of fixed budget and disbursement of funds for the procurement of drugs and medical supplies to prevent frequent stock out.
8. Integrating communication across all sectors of the health system is essential for the success of reform in the future, in ensuring the flow of information across all sectors regarding the success and challenges observed, and in providing solutions through the involvement of different stakeholders.

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APPENDICES

APPENDIX 1- Information sheet

INFORMATION SHEET AND INFORMED CONSENT FORM

INFORMATION SHEET AND INFORMED CONSENT FORM FOR KEY INFORMANT POLICYMAKERS IN SIERRA LEONE

RESEARCH TITLE: ANALYSIS OF FACTORS INFLUENCING THE EFFECTIVENESS OF THE FREE HEALTH CARE INITIATIVE POLICY IN SIERRA LEONE

This Informed Consent Form has two parts:
Information Sheet (to share information about the study with you)
Certificate of consent (for signatures if you choose to participate)
You will be given a copy of the full Informed Consent Form (ICF)

Part 1: Information Sheet

Good morning /afternoon. My name is Halimatu Kamara a Master of Public Health student at KIT, Royal Tropical Institute, Amsterdam. I am conducting research on the "Analysis of factors influencing the effectiveness of the Free Health Care Initiative policy in Sierra Leone". You have been identified as someone that could make a valuable contribution to this study that why you have been sent this form via email. I hope you will be willing to participate. Please take time to read the following information carefully and feel free to ask any questions you may have regarding it.

PURPOSE OF THE STUDY: This research aims to understand challenges faced by the Free Health Care Initiative (FHCI) Policy on factors influencing its effectiveness, in which not enough is known about, where these challenges originate in the policy formulation, process, and implementation, and the information that would be obtained will be used to inform policymakers in addressing barriers to its effectiveness. Your professional view is important in informing this research. Therefore, I will be grateful for your support, if you agree to participate in the research. I will have a short interview with you on questions relating to your professional capacity on the content, context, actors, and process of the FHCI.

DISCOMFORT AND RISK: All of the questions I will be asking will relate to your professional view to validate study results. No questions related to your personal life and views will be asked. Your permission to participate in this study is completely voluntary. You have the right to stop the discussion if you are uncomfortable.

DURATION OF PARTICIPATION: The interview will last about one hour and will also depend on your willingness to participate. Your participation in this research is entirely voluntary. You do not have to participate if you do not want to. If at any time you do not want to answer a question or discuss an issue, you are free not to do so. You are also free to withdraw from the study at any time. The decision about whether or not to participate in this study or to answer any specific question will not have any impact on you, your work, or your family. Whatever you decide is up

to you and you will not get into any trouble if you decide to stop or not talk with me. If you decide to participate, an informed consent form will be obtained from you.

CONFIDENTIALITY: The interview with you will be strictly confidential. The responses will not be shared with anyone. Your name will only be recorded on the consent form, which will be kept separate from the interviews. Your interview responses will be combined with responses from other policymakers and no one will be able to identify your responses. The information gathered will only be used for the stated purpose. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is and your information will be kept under lock and key with password protected. It will not be shared with or given to anyone.

BENEFIT AND COMPENSATION: There is no direct benefit to you, but your participation will help to find out more about understanding factors influencing the effectiveness of the Free Health Care Initiative.

SHARING THE RESULT: The result from this study will be shared with policymakers to inform the decision on addressing barriers to the effective implementation of the Free Health Care Initiative. Nothing that you will tell me during the study will be used to identify you.

WHO TO CALL IN CASE OF A NEED: If any problem arises, or if you have any questions, please contact Halimatu Kamara, telephone number +23278801421

I will answer truthfully any questions you may have. If I don't have the information you require, I will tell you so and if you wish, I will try to get an answer for you.

Do you have any questions? (If yes, note that questions) 1. Yes 2 No

Key Informants Interview Declaration form: I will require you to write your name and approval for your participation in the study by signing or writing your name in the spaces provided below:

I have been allowed to ask questions, I may have, and all such questions or inquires have been answered to my satisfaction. I have been informed orally and in writing of whom to contact in case I have questions. I hereby consent to this study.

Name of participant:……
Date……

Interviewer's Declaration:
I Halimatu Kamara hereby declare that I have explained clearly to the participant the objectives, benefits, and risks of involving in the research. I have received his/her consent.
Date: 1/07/2021

APPENDIX-2

PART II: CERTIFICATE OF CONSENT

I have been invited to participate in research about "Analysis of factors influencing the effectiveness of the Free Health Care Initiative policy in Sierra Leone"
I have read the information. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.

Name of Participants……
Signature of Participant……
Date…….

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been forced into giving consent, and the consent has sent been given freely and voluntarily.

A copy of this ICF has been provided to the participant.
Name of Researcher: Halimatu Kamara

Signature of Researcher
Date: 1/07/2021

APPENDIX-3

STUDY GUIDE FOR KEY INFORMANTS

1. What was the context of the FHCI Policy:
    a. Socio-economic
    b. Socio-political, historical, Socio-cultural
    c. Health system
    d. situational, structural, and exogenous
    e. Others, specify
2. Who were the actors involved in the formulation of the FHCI policy? Who were the key groups/actors that were influencing the policy formulation?
    a. Different government actors-Ministry of Finance, Ministry of Health, President, Parliamentarians, Civil Society groups, and Community leaders
    b. Donors
    c. Non Governmental Organizations
    d. Local government actors
    e. Health Providers, Professional groups
    f. Others, specify

2.1 What were their interest, values, and ideas

2.2 Were there any key actors not included while they should have been?

3. Content
    a. What were the objectives of the FHCI policy
    b. Which key thematic areas were addressed by the FHCI
    c. Were there any gaps observed in the content of the FHCI
    d. What were the implementation plans and strategies put in place for the FHCI
4. Process
    a. What was the status of the Health system before the launch of the FHCI policy
    b. Were there any challenges experienced during the implementation phase of the FHCI in terms of cost, technical feasibility, acceptability of the policy among the target groups
    c. Is there any current challenges been faced by the policy, if yes what measures have been put in place to overcome them
    d. What are some of the current successes of the FHCI policy?
    e. What are the expected results of the FHCI based on the objectives of the reform?
    f. Were the expected results of the FHCI achieved? Yes or No
    g. If yes how were they achieved?
    h. If no, why were they not achieved?
5. Are there any recommendations you would like to give on how the FHCI results could be better improved?

APPENDIX-4: Coding Framework

Coding framework for analysis of the semi-structured interviews with key informants

THEMES	SUB-THEMES/CODE
Context	Socio-economic Socio-political Historical Socio-cultural Health system Global context
Actors	President Ministry of Health Ministry of Finance and Economic Development Civil Society Groups Donor partners Non-Governmental Organizations Private Health Workers Beneficiaries Public Health Workers Role in the FHCI Influence and power Actors not included in the process
Content	Objectives of the FHCI policy Key thematic areas addressed by the FHCI policy Gaps experienced in the content of the FHCI policy Implementation plans and strategies put in place for the FHCI policy
Process	Challenges in the health system before the launch of the FHCI policy Successes of the FHCI policy Challenges experienced during the implementation phase of the FHCI policy Current challenges of the FHCI policy Recommendations from Key informants