The Utilization of Child Healthcare Services at the Ola during Children Hospital in Freetown

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***Abstract*-** Given the magnitude of utilization of child health care services and the interventions available, much has not been done, most of these problems are silent. There remain, to a large extent, uncounted and unreported cases. Child health program should focus on addressing these problems and identifying cost-effective health-related program interventions that are likely to reduce child morbidity and mortality. This work having perceived this resilient silent crisis will cover socio-cultural factors which are discovered to be influencing the utilization of child healthcare services in the Sierra Leone society using "Ola During Children's Hospital" as a case study and thus the research sought to assess the utilization of Child Health Care service at this Hospital in Freetown.

The research was a cross-sectional study; a combination of qualitative and quantitative data collection methods was used. In –depth interviews were conducted with 150 respondents of both child attendees and providers at the Ola During hospitals. The study findings on the availability and distances of child health care service revealed that women cover long distances to the health facility where child health care services are provided. This was expressed by respondents during questionnaire interviews, in depth interviews and focus group discussions.

The study revealed that majority; of 88.5% of the responses indicated that the respondents had knowledge about dangers a child might come across when attended hospital late during childhood illness. Most of the participants do not think it is necessary to bring their child for health service especially when the condition is not serious. The attitude of health care workers, the affordability, the satisfaction, and the distance are all factors contributing to the underutilization of the child health care. Most participants only visit when they are forced by relatives or when the condition goes worse. Thus in order to change the habit of those seeking alternatives, underutilization and attending child health care service late, the study recommended; making and disseminating appropriate policies, improving staffing and supervision in facilities and creating an enabling environment for community level care.

***Index Terms*-** ARI -Acute Respiratory Infections, ART- Anti Retroviral Therapy , AVD-Assisted Vaginal Delivery, MCH-Maternal and Child Health, MCHP-Maternal and Child Health Posts, MOHS-Ministry of Health and Sanitation, Ola During Children's Hospital

I. INTRODUCTION

1.1 GENERAL BACKGROUND INFORMATION: CONCEPT OF CHILD HEALTH CARE

The Government of Sierra Leone through Ministry of Health and Sanitation (MoHS) has developed ambition health policy and strategic plan to improve the health and wellbeing of Sierra Leoneans in the country. To effectively and efficiently implement the policy and strategy plan, the MoHS works with partners to invest in health inputs – from staff to supplies; from infrastructure to information systems. These inputs lead to immediate outputs, such as increasing the numbers of patients seen and treated, and these outputs lead to improved health outcomes in specific areas. The impact of Health service on the livelihood on the people indicates that all the different sub-sectors are performing. Reduced infant mortality is a performance indicator of not only on the quality of child health services at health facilities, but also performance across WASH, nutrition and malaria; and maternal mortality as well as maternity services, nutrition and HIV/AIDS services in terms of prevention of mother-to-child transmission.

According to WHO (2008),underutilization of maternal healthcare contributed to death and illness of women during pregnancy, childbirth and postnatal period. These have cost implications for family and the community because of high direct and indirect costs, the adverse impact on productivity and the tremendous human tragedy that every maternal or child death represents. It does not only contributed to the persistent poverty, lack of empowerment and loss of employment, leading to poor income among women of child bearing but also have huge costs impact on families in emotional, health and economic terms (Hauwa, 2011). The most tremendous impacts occur when a woman dies in childbirth, which can affect her children's well-being and schooling.

Sierra Leone has a population density of approximately seven (7) millions people in a geographical landscape of 7, 1740 square kilometre. From 1991 to 2001, the country suffered a severe brutal civil war which resulted into to the destruction of both human lives and infrastructures in the entire country. The Government of Sierra Leone developed ambition policies and programmes to addressing poverty in the country, including health services delivery initiatives commonly known as Free Health Care Services to most vulnerable group like Under Five children, pregnant women and lactating mothers with principal goal to reduce maternal, child and infant deaths.

On the 24th of May 2014, the director of disease control declared an outbreak of the world worst deadly and notorious Ebola virus of haemorrhagic genus in Sierra Leone which spread geometrically in the entire country. Prior to the epidemic of Ebola Disease in Sierra Leone, the country has been characterised by weak and fragile health system in term of man power, logistic and finance. A major focus after the outbreak was reducing child and maternal mortality and morbidity, for which the Expanded Programme on Immunization continued to be a backbone and an important entry point for broader integrated primary health care. In the same development platform, WHO and other health-related partners have supported the MoHS in rolling out the Integrated Management of Newborn and Childhood Illness (IMCI) programme as well as conducting pilot Emergency Obstetric and Newborn Care (EmONC) training sessions, and the national program of Nutrition has also been of critical importance.

In most developing countries like Sierra Leone, access to and utilization of Child health care services in rural areas is more limited than in urban areas. In Sierra Leone, the government has put in place health centers equipped with Community Health workers, trained nurse and mid-wives in all chiefdoms. Maternal and child healthcare system is an important segment of medical system in every society. This is as a result of large number of human population involved in this health sector, coupled with the significance of this group to the overall sustenance of the human population. It is also noticed that this sector of medical system is affected by less difficult health problems, which are usually preventable. Similarly, the increasing wave of gender equality has significantly stimulated attention towards the study of women and children . It is in the light of these, that this sector has attracted overwhelming attention especially from health related researchers, health providers, and health implementers (Kerber***et al.***, 2007).

Maternal health is the health of women during pregnancy, childbirth, and postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2008). Maternal health (MH) is important to communities, families and the nation due to its profound effects on the health of women, immediate survival of the newborn and long term well-being of children, particularly girls and the well-being of families. The improvement in maternal health has become a long term effect on creating healthy generation because women have a key role in the rearing of children and the management of family and community affairs (WHO, 2008). According to World Bank, 2009 maternal health indicators reflect not only how well the health system is functioning, but also the degree of equity in public service delivery, utilization of services, and the social status of women.

In industrialized countries of the world, an appreciable success has been attained in reduction of morbidity and mortality affecting the lives of both the mother and the child (Price, 1994). Whereas in less industrialized countries of the world, despite all the attempts to reduce the severity of child healthcare problems, it still remains a scourge which continues to claim the lives of a large percentage of their populations.

More than 150 million women become pregnant in developing countries each year and an estimated 500,000 of them die from pregnancy-related causes. Utilization of Child Health Care is also the causes for more than seven million under-fives or infant deaths within the first week of life. Lack of proper Child Health Care has a further impact by causing grave economic and social hardship for family and community. Other than their health problems most children in the developing countries like Sierra Leone lack access to so many other facilities/services and increase the magnitude of death from preventable problems.

The major determinants of utilization of Child Health Care and mortality include pregnancy, the development of pregnancy-related complications, including complications from abortion and, the management of pregnancy, delivery, and the postpartum period. However, a lot of factors contribute to the low health status of under-fives children in the developing countries including Sierra Leone. These factors include: Socio economic development of the country has serious Impact on morbidity and mortality. Infant death often has a number of interlined causes, which may start as early as birth or in early childhood.

Lack of access to modern health care services has great impact on increasing death rate among children.

Culture, belief systems and economic conditions are vital factors in determining health utilization services which can form the major concern of those who formulate and implement government health policies. The role which belief system, understanding the concept of disease, illness and health, improvement in the socio-economic status of the people and well planned education can all help in ensuring maximum and most efficient utilization of the health services. Communities on their own part should encourage their members to appreciate health facilities, provided by the government and utilize them. In order to combat the problem of child mortality and morbidity, the standard of living of the Sierra Leonean populace must be raised. Extreme poverty is not only the source of disease and mortality, but it is also one of the chief causes of bottleneck in public health delivery in Sierra Leone.

Performance across key maternal health indicators such as coverage of antenatal care and postnatal care services remains strong, though with a slight fall from 2015 and marked variability across districts. Family planning coverage has improved, and following a dip in performance in 2015, immunisation coverage rates have once again increased in 2016. However, the key story for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) is that despite excellent coverage rates, particularly compared to its peers, Sierra Leone continues to lag far, far behind in maternal, infant, and child mortality. This points to an issue of poor quality service delivery, and this needs to be the focus of attention for the MoHS going forwards (MOHS, 2016).

Additionally, viewing RMNCAH outcomes as a consequence of not only service delivery but also key preventative interventions such as nutrition, water, sanitation, and hygiene (WASH), and malaria prevention will be key to developing the joined-up strategic planning necessary to reduce the number of maternal and child deaths in the country. Given this background, this study focused on the perception of child health care services utilization and the factors that influence the utilization of child health care services.

1.2 STATEMENT OF RESEARCH PROBLEM

The persistent high occurrence of child morbidity and mortality especially in Sub-Saharan African societies still reflects that much ground is yet to be covered on child healthcare. The study therefore, investigates the socio-cultural factors that influence the utilization of Child Health Care Services. Many Sierra Leoneans especially indigenes and residents of rural communities survived to adulthood, while on the average, fifteen pregnancies for a Sierra Leonean woman would produce seven normal deliveries. Some of them, who managed to survive, had abnormal growth due to inadequate nutrition which results to failure to thrive and stunted growth. Their health ecology was too disturbing to the overall health development. This situation was as a result of inadequate knowledge of maternal and child health care, which ushered in various controllable infectious diseases.

There is a great need for revitalization of Primary Health Care (PHC) in Sierra Leone. PHC is a fundamental means of responding to the community's need for health services. It ensures community participation in planning and implementing their own healthcare, generating health awareness, mobilizing the community and preventing infections. This integrated approach is a deserving solution to child health problems in the slum communities in Sierra Leone. Sierra Leone is facing serious challenges in delivering health care services. In 2008, the life expectancy was 48 years, infant mortality rate 89 per 1000 live births, "under five" mortality rate 140 per 1000 live births and maternal mortality ratio 857 per 100,000 live births.

The country has a poor health status mainly due to a high disease burden caused by environment related communicable diseases and aggravated by poor nutrition. Malaria (38%), acute respiratory infection (16.9%) and watery & bloody diarrhoea (9.7%) are the top most causes of outpatient attendance, together accounting for about 65%. Although stunting prevalence in under-fives has decreased from 40% in 2005 to 36.4% in 2018 and 37.7% in 2014, poor nutritional status is still a public health problem (MOHS, 2016). .

The above-mentioned three diseases together with malnutrition account for about 70% of under– five consultations. Although the under–fives constitute about 17% of the population, they make up 49% of consultations at peripheral health units (PHUs). Malaria is endemic in the Sierra Leone and affects the whole population, but children under five years and pregnant women are most vulnerable with high morbidity and mortality rates. The country also, from time to time, experiences outbreaks of the following epidemic prone diseases: Cholera, Yellow fever, Shigellosis, Lassa fever, Measles and Meningitis, (MOHS, 2016).

An effective evaluation system has not been institutionalized till today. From this backdrop some questions may subsequently arise in the mind of a health practitioner-: Does the existing decision making not promote Child Health Care? Does the development project undertaken ignore promoting quality health service delivery to the more vulnerable? What are the factors that affect these? The present study is an endeavor to look through these pertinent questions.

1.3 JUSTIFICATIONS OF THE STUDY

Why should the care of children needs major consideration and be part of every program that is taking care of people's health? Children make up over 2/3 of the whole population, 4.5%. Most children in the developing countries like Sierra Leone receive insufficient or no health and are believed to result in to health problems subsequently it leads to death.
Between 1993 and 1999 when the country faced serious economic decline and political, coupled up with the Ebola epidemic in 2014 destabilized micro-economic policies. Under-five mortality rate moved from 130-194 deaths per 1000 live births. All these affected under five children (WHO, 2007 and The World Fact Book, 2010). Therefore, this work having perceived this resilient silent crisis will cover socio-cultural factors which are discovered to be influencing the utilization of child healthcare services in the Sierra Leone society using Ola During Children's Hospital as a case study.

Given the magnitude of these problems and the interventions available, much has not been done. Most of these problems are silent. They remain, to a large extent, uncounted and unreported. Child health program should focus on addressing these problems, clarifying policy and program alternatives and identifying cost-effective health-related program interventions that are likely to reduce child morbidity and mortality.

These outlined issues do not only show the importance of Child health care to the immediate problems. Rather, they show the role and it necessity in the welfare of the family, the community and the country as a whole.

1.4 AIM AND OBJECTIVES OF STUDY

1.4.1 Aim of Study

The ultimate goal of this study is to assess the utilization of Child Health Care service at the Ola During Children Hospital in Freetown.

1.4.2 Objectives of Study

i. Examine the socio-demographic characteristics of the respondents;
ii. Highlight the socio-cultural factors influencing the utilization of child health care services in the study area;
iii. Assess the level of the quality of health care delivery and free treatment to the less privileged neonatal (zero to twenty-eight days old babies) and the Under-Fives (twenty-eight days to five years old);
iv. Identify the major issues and causes that affect the free health care delivery;
v. To determine the health service impact in terms of preventing child morbidity and mortality.

1.5 SIGNIFICANCE OF THE STUDY

The government through MOHS and its partners has invested huge amount of money in order to improve health service delivery in post-war and post-Ebola. Health service initiatives which have high impact and cost effective, including primary care service delivery mechanism aimed to scale up health services rapidly, sexual and reproductive and child health services, water and sanitation, utilization of treated bed nets and promotion of early and exclusive breastfeeding; family planning

to address problems of teenage pregnancies and child marriage; essential and emergency obstetric care, including prenatal, delivery and post-natal services; integrated management of neonatal and childhood illnesses; preventive services, including immunization and school health; and promotion of hygiene practices and further reduce high child and maternal mortality and morbidity in the country.

Despite these ambition interventions, there has been high increase in the morbidity and mortality trends of many diseases. Against this background, the report of this research will be significant to MOHS, partners, private and other health-research demanded persons and institutions to fully understand the predisposing factors which are undermining beneath development of Sierra Leone health service delivery performance. It will be useful as a good document, reference, for libraries, researchers, and other related learning institution as a basic for literature review reference.

1.6 ORGANIZATION OF THE STUDY

Ministry of Health and Sanitation is the government leading agency responsible for health service delivery in Sierra Leone**.** During the course of the study, literature regarding health service delivering, operation tools and document, qualification of staff and quantity and quality of health commodities supply to the health facility will be reviewed, while the perception of health workers and beneficiaries will be assess to help improve the study.

II. 2.0 LITERATUREREVIEWS

2.1 INTRODUCTION

The Centre objective of this chapter is to review relevant literature laying premium on the utilization of Child Health Care. This work aims to strengthen the realization and utilization of Child Health Care in Sierra Leone with specific reference to Fourah Bay Community as case study. It has become necessary to examine Child Health Care within Sierra Leone's socio-cultural milieu and to observe how these are affecting the overall development process. The government's initiative to provide free quality health care to all under-fives all over Sierra Leone falls within government's overall development plan for the nation. The research has found that recent efforts to promote this through policy and targeted programs for women/children at the grass roots has been thwarted by a severe deficiency in financial and human resources, poor communication network, high illiteracy rate among, corruption, politics of ethno-regional segregation and the lack of a mechanism for enforcing legislation.

Child health care is one such service and despite its health worker plays a key role in delivering the services. Health workers are expected to make regular examination and monitor various aspects of the health of women and children, provide information related to health and deliver other selected services.

The reason for concern becomes evident when we consider the results of a study by Bloom ***et al***. (1999) in the urban areas of the state of Uttar Pradesh which showed that women with a high level of antenatal care had four times higher estimated odds of using trained assistance at deliveries than that for women with lower levels of care. In context of the policy change mentioned earlier, there is little policy focus on how to target secluded women; health workers are not well-informed about reproductive morbidity, and they are unaware of the many perceptions, beliefs and attitudes that need to be addressed in order to improve the compliance from and confidence of their clients. Thus, health workers seem not to be asking the right questions, and fail to recognize symptoms (Jejeebhoy***et al***., 1999). Finally, women are sometimes hesitant to use public health facilities because of absence of lady doctors and female attendants. Yet other studies indicate that while women indeed prefer lady doctors, they are not rigid about these preferences (Sharma, 2003).

The unhygienic conditions in which rural deliveries often occur lead to infection in many mothers and newborns (World Bank, 1996). Many women do not go to health facilities because they feel that it is unnecessary or their socio-economic status is a hindrance. However, in many cases it is the lack of appropriate facilities which is a hindrance. In the India Facility Survey (2003), it was found that in UP, Rajasthan and Orissa, a labor room was available in less than half the Primary Health Centers (PHCs) surveyed, and emergency drugs (that should be available) for managing labor were available in less than 5% of the PHCs (Das, 2006).

2.2 HIGHLIGHT THE SOCIO-CULTURAL FACTORS INFLUENCING THE UTILIZATION OF CHILD HEALTH CARE SERVICES

One of the most disturbing child health components in India is low and falling child immunization levels. While few studies have attempted to explain this in a systematic way (Audinarayana, 1987), many children do not receive full immunization because of socio economic barriers and supply side factors. We should be concerned at the low adoption rates of family planning methods. Immunization of children in India declined sharply from an already low 52% in 1998-99 to 44.6% in 2002-03 (Patnaik, 2006). Beyond population control, we must remember that there is a strong link between immunization and adoption of a family planning method since parents who expect that their children will be healthy, and live longer, are also more likely to adopt family planning methods (Bai***et al***., 1978).

We now turn to the more common explanations for low Child health care services utilization which fall under the domain of socio-economic factors. Majority of Sierra Leonean women are illiterate, poor, and live in rural areas and this has a negative impact on demand for Child health care services. In addition, women have little decision-making power. Various studies also show that the attitude of men, especially husbands in the case of married women, can be critical; and, husbands are usually found wanting when it comes to supporting their wives (Singh ***et al***., 1998). A study in Tamil Nadu by Kavitha and Audinarayana (1997) revealed that controlling for other variables, respondents education exhibited significant positive effect on the use of ante-natal and natal health care services. The same study also revealed that higher caste women were more likely to use antenatal and post-natal check-ups compared to lower caste women. The results from the study by Kavitha and Audinarayana have also been validated by other studies. Govindasamy and Ramesh (1997) found that benefits of maternal education persist even after accounting for other socioeconomic factors (income, rural/urban, North India/South India).

This research has thus revealed the gap between policy and implementation at the grass root level. Healthcare is the maintenance or improvement of health via the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Healthcare is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physicians, physician associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions. It includes the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

2.3 THE QUALITY OF HEALTH CARE DELIVERY AND FREE TREATMENT TO THE LESS PRIVILEGED NEONATAL (ZERO TO TWENTY-EIGHT DAYS OLD BABIES) AND THE UNDER-FIVES (TWENTY-EIGHT DAYS TO FIVE YEARS OLD)

Access to health care may vary across countries, groups, and individuals, largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans in relation to the personal and population-based health care goals within their societies. Healthcare systems are organizations established to meet the health needs of target populations. Their exact configuration varies between national and sub national entities. In some countries and jurisdictions, health care planning is distributed among market participants, whereas in others, planning occurs more centrally among governments or other coordinating bodies. In all cases, according to the World Health Organization (WHO), a well-functioning healthcare system requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; and well maintained health facilities and logistics to deliver quality medicines and technologies.

Neonatal care is receiving more attention as greater progress is made in reducing the burden of disease among older children and as more information is available on the burden of neonatal disease and interventions that can effectively reduce this burden. Most, interventions aimed at decreasing neonatal mortality are linked to prenatal and maternal care intervention.The interventions that are aimed at reducing childhood mortality beyond the neonatal period are typically delivered via public health programs that we generally think of as more classic public health delivery methods for instance immunization.

Causes of death also vary from region to region, district to district, for example, Malaria is responsible for 7% of childhood deaths globally, however, it can be the leading cause of childhood death in some endemic Africa countries like Sierra Leone. Proportional mortality data can be misleading if caution is not used in interpretation. We often use pie chart to visually display causes of death as percentages meaning proportional mortality. Remember proportional mortality only tells you what percent of deaths are due to a certain cause, it does not tell you about disease incidence or prevalence and it is not the same as cause specific mortality rates. A disease can kill as many people, but may result in a lower proportional mortality rate because there are so many death dues to other causes. Children are always among the most heavily affected by armed conflict either directly or indirectly. Even if they survive the bullets, they are often subject to violence or being orphaned. The destruction wrought by war disrupts social services such as education and health care. In the eleven years rebel war coupled with the Ebola and mudslide disaster in Sierra Leone the “under Five” mortality rate increased by 13% and adult mortality by even more, the aftermath is still evident after they ended; during the first five years of peace, the average “under Five” mortality rate remains 11% higher than it corresponding level before the conflict. Lack of access to modern health care services has great impact on increasing death rate among children within the ages of 0-11 years old. Most children do not receive postnatal care; etc. Less than 10% of children in Sierra Leone get less food that contains all the six classes of food for healthy living of a child.

Health care is conventionally regarded as an important determinant in promoting the general physical and mental health and well-being of people around the world. An example of this was the worldwide eradication of smallpox in 1980, declared by the WHO as the first disease in human history to be completely eliminated by deliberate health care interventions. The delivery of modern health care depends on groups of trained professionals and paraprofessionals coming together as interdisciplinary teams. This includes professionals in medicine, psychology, physiotherapy, nursing, dentistry, midwifery and allied health, plus many others such as public health practitioners, community health workers and assistive personnel, who systematically provide personal and population-based preventive, curative and rehabilitative care services.

2.4 CHILD HEALTH CARE SERVICESIDENTIFY THE MAJOR ISSUES AND CAUSES THAT AFFECT THE FREE HEALTH CARE DELIVERY

Children differ from adults in at least four important ways: 1) developmental change; 2) dependency on parents and other caregivers; 3) differential epidemiology (e.g. different health, illness and disabilities); and 4) demographic patterns (e.g. socio-economic determinants) (Forrest ***et al***., 1997). Children’s use of health services is different to other age groups, for example the rate of acute, short-stay hospital admissions in children is higher, and rising (Saxena***et al***., 2009). Children may need to be transitioned from paediatric to adult services, and have constantly changing needs in relation to their developmental stage and age (Wolfe and McKee, 2013). Education is especially important, rather than social care, and there is a greater dependence on the family than social care, compared to adults (Wolfe ***et al***., 2016). There is an opportunity to prevent physical and mental ill health in adult life by improving the health (Marmot, 2010)

The 2015 Quality Watch Annual Statement (Health Foundation and Nuffield Trust, 2015) summarized the state of quality of care for children based on a number of indicators that can be monitored over time, including health promotion/prevention, and care for children with acute, chronic and mental health conditions. It found that there has been improvement in some areas that are affected by broader societal trends (for example the conception rate for under 18-year-olds or the proportion of women who smoke at birth). However, in 2014/15 nearly 22 per cent of children in reception class (aged 4–5 years) and one in three children in year 6 (aged 10–11 years)

were overweight or obese. Between 2006/07 and 2014/15 the proportion of children in reception who were obese declined from 9.9 per cent to 9.1 per cent, but the proportion of children in year 6 who were obese increased by 1.6 per cent (Health and Social Care Information Centre, 2015a). Unplanned hospitalizations for long-term conditions (diabetes, asthma, epilepsy and convulsions) in people under 20 declined between 2003/04 and 2013/14, suggesting better management of these children in the community, as highlighted by epilepsy and diabetes audits (Royal College of Paediatrics and Child Health, 2014 and 2015). However, the rise in emergency admissions for children with lower respiratory tract infections, as well as unplanned hospital admissions for children due to ear, nose and throat infections, is of particular concern. These trends suggest a need to better understand how acute conditions are managed in primary and secondary care.

With respect to morbidity as measured by disability-adjusted life years (DALYs) 1 per 100,000, based on data from the Global Burden of Disease study (Institute for Health Metrics and Evaluation, 2013), for children under the age of five, the UK continues to perform poorly compared to similar countries. However, in the older age groups, where there is also less variation between countries, the UK does well and has the lowest DALYs per 100,000. In 2013, in the UK, the largest burden of disease for children under the age of five was due to preterm birth complications (26 per cent) and congenital anomalies (22 per cent). For children aged 5–14 the largest burden of disease was due to mental health conditions (19 per cent) and nutritional deficiencies (19 per cent), and for the older children (aged 15–19) it was again due to mental health conditions (31 per cent), followed by back and neck pain

2.4.1 Kinds of Health Care Services: The emergency room is often a frontline venue for the delivery of primary medical care.

2.4.2 Primary care: Refers to the work of health professionals who act as a first point of consultation for all patients within the health care system. Such a professional would usually be a primary care physician, such as a general practitioner or family physician, a licensed independent practitioner such as a physiotherapist, or a non-physician primary care provider (mid-level provider) such as a physician assistant or nurse practitioner. Depending on the locality, health system organization, and sometimes at the patient's discretion, they may see another health care professional first, such as a pharmacist, a nurse, a clinical officer (such as in parts of Africa), or or other traditional medicine professional. Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

Primary care is often used as the term for the health care services which play a role in the local community. It can be provided in different settings, such as Urgent carecentres which provide services to patients same day with the appointment or walk-in basis.

Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem. The International Classification of Primary Care (ICPC) is a standardized tool for understanding and analyzing information on interventions in primary care by the reason for the patient visit.

Common chronic illnesses usually treated in primary care may include, for example: hypertension, diabetes, asthma, COPD, depression and anxiety, back pain, arthritis or thyroid dysfunction. Primary care also includes many basic maternal and child health care services, such as family planning services and vaccinations. In the United States, the 2013 National Health Interview Survey found that skin disorders (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), disorders of lipid metabolism (22.4%), and upper respiratory tract disease (22.1%, excluding asthma) were the most common reasons for accessing a physician.

In Sierra Leone, primary care physicians have begun to deliver primary care outside of the managed care (insurance-billing) system through direct primary care which is a subset of the more familiar concierge medicine. Physicians in this model bill patients directly for services, either on a pre-paid monthly, quarterly, or annual basis, or bill for each service in the office. Examples of direct primary care practices include Free Health Care System.

In context of global population aging, with increasing numbers of older adults at greater risk of chronic non-communicable diseases, rapidly increasing demand for primary care services is expected in both developed and developing countries. The World Health Organization attributes the provision of essential primary care as an integral component of an inclusive primary health care strategy.

2.4.3 Secondary care: includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.

The term "secondary care" is sometimes used synonymously with "hospital care". However, many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists, most dental specialties or physiotherapists (physiotherapists are also primary care providers, and a referral is not required to see a physiotherapist), and some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care.

For example, in Sierra Leone, which operates under a mixed market health care system, some physicians might voluntarily limit their practice to secondary care by requiring patients to see a primary care provider first, or this restriction may be imposed under the terms of the payment agreements in private or group health insurance plans. In other cases, medical specialists may see patients without a referral, and patients may decide whether self-referral is preferred.

2.4.4 Tertiary care: is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.

Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

2.4.5 Quaternary care: is sometimes used as an extension of tertiary care in reference to advanced levels of medicine which are highly specialized and not widely accessed. Experimental medicine and some types of uncommon diagnostic or surgical procedures are considered quaternary care. These services are usually only offered in a limited number of regional or national health care centers. This term is more prevalent in the United Kingdom, but just as applicable in the United States. A quaternary care hospital may have virtually any procedure available, whereas a tertiary care facility may not offer a sub-specialist with that training.

2.5 HOME AND COMMUNITY CARE

Many types of health care interventions are delivered outside of health facilities. They include many interventions of public health interest, such as food safety surveillance, distribution of condoms and needle-exchange programs for the prevention of transmissible diseases.They also include the services of professionals in residential and community settings in support of self-care, home care, long-term care, assisted living and treatment for substance use disorders and other types of health and social care services.Community rehabilitation services can assist with mobility and independence after loss of limbs or loss of function. This can include prosthesis, orthotics or wheelchairs.With obesity in children rapidly becoming a major concern, health services often set up programs in schools aimed at educating children in good eating habits; making physical education compulsory in school; and teaching young adolescents to have positive self-image.

Many countries, especially in the west are dealing with aging populations, and one of the priorities of the health care system is to help seniors live full, independent lives in the comfort of their own homes. There is an entire section of health care geared to providing seniors with help in day-to-day activities at home, transporting them to doctor's appointments, and many other activities that are so essential for their health and well-being.

Culture, belief systems and economic conditions are vital factors in determining health utilization services which can form the major concern of those who formulate and implement government health policies. The role which belief system, understanding the concept of disease, illness and health, improvement in the socio-economic status of the people and well planned education can all help in ensuring maximum and most efficient utilization of the health services cannot be over emphasized. Communities on their own part should encourage their members to appreciate health facilities, provided by the government and utilize them. As observed in all cultures, each society has its peculiar way of dealing with bio-cultural problems affecting its human population. Responses to various interventions seem to differ considering the peculiar knowledge displayed by the population in each society. Environmental factors also play considerable role on the health seeking strategies, thereby making the health interventions and responses greatly different across the culture (Jegede, 1999).

In order to combat the problem of maternal and child mortality and morbidity, the standard of living of the Sierra Leonean populace must be raised. Extreme poverty is not only the source of disease and mortality, but it is also one of the chief causes of bottleneck in public health delivery in Sierra Leone. In industrialized countries of the world; an appreciable success has been attained in reduction of morbidity and mortality affecting the lives of both the mother and the child (Price, 1994). Whereas in less industrialized countries of the world, despite all the attempts to reduce the severity of maternal and child healthcare problems, it still remains a scourge which continues to claim the lives of a large percentage of their populations (WHO, 2007 and 2010; and The World Fact Book, 2010).

2.6 EXPLORING THE BUSINESS CASE FOR IMPROVING THE QUALITY OF HEALTH FOR CHILDRENE EXAMINE THE SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Until recently, support from the Commonwealth Fund, members of the Child Health Business Case Working Group considered the unique features of children's health care in their article, (*Health Affairs,* 2004).In many cases, improvements to health care yield benefits to society. Financial benefits, however, have been difficult to demonstrate for the organization investing resources. In examining five hypothetical quality improvement programs aimed at children's health care, the authors find that many of the same impediments to securing a financial return on investment lack of quality-based provider incentives and "displacement" of payoffs in time or place, for example affect quality improvement in similar ways for both adults' and children's care. But other barriers are unique to care for children, they say. These additional obstacles must be overcome, the authors argue, to clear the way for broad-based improvements in the care provided to children and adolescents.

A significant amount of literature talks about the influence of, and what shapes, attitudes and awareness. Rani and Bonu (2003) identify religion as a potential influence on seeking care. However, the effects of religion may be difficult to establish as religion and economic status often go together. Irrespective of religion or caste issues, pregnancy is often not considered as a problem that is worth seeking care for. Thus, pregnant women receive little additional food and often no medical attention, even when complications arise (World Bank, 1996). While the socio-economic factors still have an important role in explaining low Child Health services utilization, studies are now indicating that people in general, and mothers in particular have been coming forward to utilize the child health care services irrespective of their socioeconomic background (Audinarayana, 1987). This is also reflected in the increasing involvement of the private sector as indicated in a study by Rani and Bonu (2003) which reveals that though socially disadvantaged women are less likely to consult private providers, majority of the poorest, uneducated

and lower caste women will consult private providers (which are usually more expensive than government facilities).

Previous research indicates that investing in supply-increasing interventions such as expanded service delivery does not necessarily increase use of services (Hjortsberg, 2003; Thaddeus and Maine, 1994; Ahmed ***et al***., 2000). Instead, it is suggested that policies aiming at increasing access and utilization should take on both a supply and demand side approach. Empirical research shows that when ill, a variety of factors influence whether the individual seeks health care or not. These factors include socio-economic status, cultural beliefs, geographical accessibility, disease pattern, etc (Shaikh and Hatcher, 2004; Ahmed ***et al***,. 2000; Ahmed ***et al***., 2006).

The decision to seek care in Sierra Leone also incorporates the decision of what kind of care to utilize. The myriad of available health care options includes not only formal governmental providers but also village doctors, who often do not have any formal training, as well as traditional faith-healers (Ahmed ***et al***., 2000). This diversity of the health care sector should also be taken into account when studying the decision-making process of health service utilization.

The ANC Programs implemented in Sierra Leone needs to cost and to assess the effect of the ANC service package in terms of its content, coverage, affordability, and sustainability of services over time. The challenge to in Sierra Leone is to formulate application of the WHO FANC model within the needs and resources and identify the best approaches to deliver effective and sustainable ANC. The available literature shows that there has been less attention to the role and content of antenatal care and thus indicate to monitor progress in ANC and measured; the presence of skilled personnel during child birth, antenatal and postpartum care coverage, and deliveries at health facilities. The world health organization estimates that there are 5.1 million deaths in the new born period; that is before the baby is one month old. Almost 3.4 million of these occur during the first week of life, while 4.3 million fetal deaths are estimated to take place before or during delivery. These 7.6 million prenatal deaths are largely consequences of poorly managed pregnancies and deliveries or the result of inadequate care of neonate during the first critical hours of life.

2.7 BARRIERS TO UTILIZATION OF CHILD HEALTH CARE SERVICES IDENTIFY THE MAJOR ISSUES AND CAUSES THAT AFFECT THE FREE HEALTH CARE DELIVERY;

The challenges to implementation of minimum child health services include inequality due to inefficient allocation of available resources within the sector, poor distributions of human resources, low staff morale resulting from poor remuneration and over dependence on untrained personnel in primary health facilities. Generally, many factors contribute to less utilization and access to child care services; high rates of teenage pregnancy, low perception of pregnancy related risks, low level of female involvement in reproductive health and rights, harmful and negative culture on children, gender relations, and health seeking behavior as well as poor infrastructure.

A good deal of literature has identified a number of barriers faced in seeking professional health care, particularly for child health services. Studies have shown that there are many missed opportunities for care, both because of client- and health system-related factors. Mothers and children may face risks because of limited or late-term ANC visits, low-quality care during visits due to poor provider training, infrastructure and administrative weakness at facilities (Armar, 2006). Education provides the consumer with the basis for evaluating whether they require treatment. While it is sometimes suggested that individuals are unable to assimilate information on treatment options, this assumption is challenged by Leonard‘s recent work in Tanzania (Leonard, 2002). These studies suggest that, far from being passive consumers, patients actively seek out not only the best-known provider but the best facility for a particular illness. Thus, Perceptions of quality do, in fact, accord quite well with technical evaluations.

Location and distance costs are often seen to negatively impact service utilization. A study in Vietnam found that distance is a principle determinant of how long patients delay before seeking care (Ensor, 1996). Another, in Zimbabwe, suggested that up to 50% of maternal deaths from hemorrhage could be attributed to the absence of emergency transport. At the same time, distance is also cited as a reason why women choose to deliver at home rather than at a health facility in many rural areas in central and western Uganda (Nuwaha, 2000). In relation to the above, location of health centers and facilities is another important dimension of the cost of care. A study in Burkina Faso, for example, suggested that transport costs accounted for 28% of the total costs of using hospital services (Sauerborn, 1994).

The Uganda Demographic and Health Survey (UDHS) 2007 findings indicate disparities in utilization of health services, with rich, urban and more educated people more likely to use health services than the poor less educated rural residents. This trend was attributed to better economic and physical access to services among the former but also to attitudes influenced by religion, culture and limited understanding of disease causation among the latter. The reason why the poor do not make more use of public services is driven by both supply and demand factors (Ensor, 2004). Cultural and socio-economic factors such as the low status of the female in society, limited decision making powers, social immaturity and financial limitations might contribute to poor utilization of ANC services, resulting in an increased incidence of pregnancy and obstetric complications.

Many cultural, religious, or social factors may impede the demand for health care. In communities where women are not expected to mix freely, particularly with men, utilization of health services from static facilities may be impeded. Cultural conventions about propercultural norms, restrictions, can prevent women from seeking health care outside the home for themselves and their children. This barrier is often raised still further when men provide services, and has been offered as one reason why Asian women living in Western countries often make little use of health services. Another example of culture as a barrier to using health services is the perception and unacceptability of modern contraception among men in parts of many rural areas of Uganda including Kisoro. Shaffer in his study suggest that cultural issues relating to language and staff insensitivity are important and deter some women from accessing antenatal care early and regularly (Shaffer, 2002). These kinds of cultural oversights may

be viewed as disrespectful by women from various ethnic groups and generate feelings of frustration and further marginalization.

In general most specifications do not include interaction variables between demand-side barriers and income. As a consequence, most literature indicates the specific contribution of economic status on demand for services rather than indicating whether barrier-elasticity differ by economic status. The evidence certainly provides some support for the intuitive hypothesis that barriers are more important for the poor. Financial barriers may also interact with other demand barriers. One study in Kazakhstan, for example, found that the education of the household head or the care-seeker was an important determinant of the willingness to travel long distances to obtain treatment.

In practice, supply and demand side issues are not so easily separated. If the available health care is of poor quality, it is not surprising to find there is little demand for it. There is evidence that demand does react to quality. Poor quality of health services is a major problem in many, but not all, developing countries (World Bank Report, 2004). However, facilities open and close irregularly; absenteeism rates of doctors and nurses can be very high; staff can be hostile, even violent to patients; misdiagnosis is not uncommon, medicines are all too often unavailable, sometimes due to staff pilfering for use in private practice; and there is inappropriate prescribing and treatment. Deficiencies in quality have direct implications for access to effective health care. Further, one expects that demand will diminish in response to the poor quality of the care offered. This confirmed by the example of Ghana where a decline in quality of public health care was associated with 40% fall in utilization within only five years (1979-1983).

A second problem is that the available resources are not allocated to the most effective interventions, are geographically concentrated in large cities, and do not reach the poor. Despite the WHO Alma Ata Declaration, the bulk of public health expenditure continues to be absorbed by hospital based care delivered at some distance from poor rural populations. Shifting the balance of resources further toward primary care would not necessarily have the desired impact on the level and distribution of population health. However, there are major deficiencies in the quality of primary care delivered in many developing countries.

Other studies provide ―harder evidence of change in behavior. Education and information campaigns in Nigeria, Sierra Leone, and Ghana all led to significant reported increases in attendance at normal and complicated deliveries as a result of the intervention (Nwokobya, 1997). In Malawi, health information improved women‘s knowledge of the need for antenatal care, complications, and post-delivery care and increased the use of services (Gennaro, 2001),

A multivariate analysis of 40 low-income countries found that government health expenditure as a percentage of total health expenditure was significantly associated with utilization of skilled birth attendants and caesarean section rates, but not antenatal care, allowing for factors such as per capita health expenditure (Kruk, 2007). This supports the view that public subsidies of various sorts are likely to be necessary to improve access and skilled attendance.

Delivery of essential services concentrates on improving the quality of staff skills, protocols of treatment, availability of supplies and environment of health facilities. Yet while these interventions are important, they do not address many of the barriers to accessing services faced by a patient in a low-income country like Sierra Leone.

III. 3.0 RESEARCH METHODOLOGY

3.1PREAMBLE

This chapter presents an interview of methodology and procedures applied in this study. It describes the process that was employed to collect and analyze data in order to explore and measure the level of utilization of Child Health Care. This section gives information about research design, description of area of study, population of study; sample size, sample selection, methods of data collection, data analysis techniques, procedure, data collection instrument, validation, problems that the researcher encountered and limitation and constraints during the study.

3.2 RESEARCH DESIGN

The research was a cross-sectional study. A combination of qualitative and quantitative data collection methods was used. In –depth interviews were conducted to both child attendees and providers at the Ola During hospitals. The researcher and the interviewee agreed to sit in a private place and conduct the interview. The interview was conducted in Creole language that was convenient for the interviewees. Survey questionnaires were administered to child attendees on exit after receiving child health care services and health care providers at the Hospital. Some variables were quantified and others explored in depth, thus generating description. The general methodology adopted was a descriptive study. The qualitative method used involves the use of informal interview, observation and discussions. The use of qualitative method involves the administration of questionnaires out of which the large portions of the facts are obtained**.**

3.3 DESCRITION OF THE STUDY AREA

The study was carried out in Freetown covering one hospital- the children’s referral hospital. The researcher wanted to get a clear picture of child health care utilization in the area of study. Ola During Children’s Hospital which is housed in the compound with Princess’s Children Maternity Hospital, the country’s major referral maternity, in the Western Urban (Freetown) is the study area. Ola During Children’s Hospital is located in the Fourah Bay Community and along the main Fourah Bay Road and , off the left wing of the country’s major sea port, Queen Elizabeth II and the west wing of the country’s biggest market, Dove Cot/Moa market in Freetown. The research area, nevertheless, is characterized by all tribes in Sierra Leone plus foreigners from other countries which are working towards development of the country.

In 1792, Freetown became one of Britain’s first colonies in West Africa. It is the largest city and also capital of Sierra Leone lying on the peninsula near the Atlantic coast and hosts the third largest natural harbour in the world – Elizabeth II Quay. The landscape in Freetown is very hilly which were named Serra

Leôa ("Lion Mountains") by the Portuguese navigator Pedro de Sintra when he explored the West African coast in 1462 and I've heard it described as looking similar to other great landscapes for example the San Francisco Bay Area. In Freetown, you can see the sea from almost any point in the city and you are never far away from the beach! Today, Freetown is a buzzing capital and is lively by day or by night. On a busy day, Freetown echoes with the sound of hooting cars, local traders and passers-by. The west of Freetown is mainly residential and further west (South-West) you will find some of the country's most beautiful beaches.

There are dozens of Hospitals in Freetown and each certainly one of them is often counted on to treat typical troubles and more severe complications like surgeries and long term treatments. If you suffer from a heart condition or other dangerous conditions it's significant to know exactly where the nearest Freetown Hospital is in your area. Ola During children's hospital is on the street of "Fourah Bay Road" that is located in the north of Western Area Urban with the zip code of 00232. It is about 18.231 meters long. Ola During children's hospital is next to devastation Bay and is located in Western Area, Sierra Leone. As the name implies the hospital is specialized to treat all ailment of children in the city and serves as the centre for children's referrals.

3.4 POPULATION OF STUDY

The study population comprised of mothers and or caregivers seeking Child health care services at Ola During hospital. This hospital was selected because it is the main referral hospitals in the country. Although the study focused on mothers and or caregivers seeking Child health care services in Ola During hospital an informal interview, observation and discussions were conducted with the health care providers.

3.5 SAMPLE SIZE AND SELECTION PROCEDURES

The population of the study area is estimated for caregivers per annum **seeking Child health care services at the facility.** The study population particularly is focused on staff and **mothers and or caregivers seeking Child health care services at Ola during hospital** since August 2017 to August 2018 irrespective of the health. Twenty (20) sample respondents were selected from among the staff, fifty (50) neonate caregivers/mothers and eighty (80) under Five (5) caregivers/mothers served as a sample size. This was done using the stratified random sampling method. This was because the population from which the sample was to be drawn does not constitute a homogenous group. The technique applied was that the population was first stratified in to a number of non-overlapping sub population or strata.

The second stage involved the selection of sample items from each stratum as each stratum had more than the required sample size. This was done using the simple random sampling, where each and every member has an equal chance of being selected. The names of all members were written on slips of papers folded and placed in a plastic bag and properly shaken to conduct a lottery for each stratum. A total of one hundred and fifty (150) papers were removed at random, one after the other without replacement. All the One hundred and fifty (150) eligible participants in the selected catchment health facilities were interviewed using equal proportionate probability sampling giving a respond rate of 100% of staff and **mothers and or caregivers seeking Child health care services** who responded to questions pertaining to child health care service utilization.

3.6 DATA COLLECTION INSTRUMENT AND VALIDATION

The collected data was accumulated, categorized and analyzed keeping in mind the objectives of the study. The analysis of quantitative data was done with the help of statistical tools like MS Excel etc., and interpretation of data were based on statistical generalization. The data were first summarized to obtain raw scores some of which were converted in to percentages, while others were presented in the form of tables and charts. The qualitative method was used to explain the significant phenomenon, causalities, social realities, and experiences.

In this study, data were collected by questionnaire survey. Interview method was also followed. The combination of these two methods (Quantitative and Qualitative) therefore, helped to collect reliable and valid data.

The findings of the study from one type of method were used to check against the findings derived from the other type. Furthermore, it is mentionable that the researcher visited the field and administered the questionnaires with the respondents personally. Interviews and discussions were conducted by the researcher as well. In case of content analysis, principle of authenticity and objectivity has been maintained. So data are credible and reliable as much as possible.

3.7 LIMITATIONS AND CONSTRAINTS OF THE STUDY

Participants were asked for their consent to participate in structured questionnaire. But most importantly, the values and norms of the local people were studied well and respected to avoid any misconception and all the necessary permission from the university and the hospital authorities where the research was carried out.

All research conducted are prone to limitations and constraints. Collecting primary data from an area in Sierra Leone is not an easy task. Other factors are likely to limit the research are scope of the study, time and resources, access to **Child Health Caregivers**; and inadequate funding.

3.7.1 Scope of the Study

The major limitation of this study was its scope. The researcher only investigated the utilization of child health care with specific reference to the Ola During Children Hospital in Freetown. Other areas were excluded, due to funding and adequate human resource.

3.7.2 Inadequate Time and Resources

Time and resource constraints always pain the researcher. Limited time and resources have been allotted for the completion of this study**.**

3.7.3 Access to Child Health Caregivers/Respondents

Access to respondents has always been difficult in Sierra Leone. Collecting data from a particular segment of the

population of which vast majority is illiterate proved to be very difficult for the researcher. Many denied giving in to any interviews and those who were not reluctant were found shaky in their responses. It was not easy to get them persuaded to respond to my questions.

3.7.4 Inadequate Funding

For a work like this to be done completely and successfully without many problems, there must be enough available resources to cover certain cost such as: internet browsing, transportation, printing etc. These were not very easy to go through. In fact, this was one of the major causes to the delay of the work to a large extend.

The foregoing is a description of the methodology of the study. That is, how sample were selected and how data were collected and analyzed. The next chapter is concerned with data presentation, analysis and interpretation of result findings.

3.8 ETHICAL CONSIDERATION/ISSUES

Ahead of the commencement of this investigation, a research proposal and protocol was designed and submitted to the research supervisor who is attached to the Department of Environmental Health Sciences for approval. The permission to carry out the study was granted by the Medical Superintendent at Ola During Government Hospital. To ensure accuracy, the self-administered questionnaire was edited by my supervisor and pretested before used. This is to ensure consistency. Study subjects were requested to fill an informed consent form before they were recruitment into the study. Study subjects were given the options to withdraw from the study at any time if they so desire and that they were not being coerced for taking part in the study.

IV. 4.0 DATA PRESENTATION, ANALYSES AND DISCUSSIONS

4.1 INTRODUCTION

This chapter presents the study finding as obtained from the field by the researcher. The study was guided by five research objectives; to determine the utilization of Child Health Care service at the Ola During Children Hospital in Freetown.

The study covered a population of 150 respondents. To obtain data from the field a total of Twenty (20) sample respondents were selected from among the staff, fifty (50) neonate Caregivers and eighty (80) under Five (5) Caregivers, these serve as a sample size. The questionnaire was administered to respondents to assess the utilization of Child Health Care service at the Ola During Children Hospital in Freetown. The ANC and service provided; the practices accessibility and affordability, the demographic and factors influencing utilization were examined for easy analysis and interpretation of data collected from the field, the data was captured in the different responses and categorized into different themes.

For easy analysis and interpretation of data collected from the field, the researcher captured the different responses and categorized them into different themes and tabulations were calculated as demonstrated in the following sections of this chapter.

4.1 RESPONDENTS PERSONAL AND SOCIAL DEMOGRAPHIC CHARACTERISTICS

This section focuses on both Care givers and staff as the study set out to establish in terms of educational status, marital status, age, occupation and economic status.

Table 1: Respondents personal and social demographic characteristics

Category	Staff (n=20)	%	Under Five Care givers (n=80)	%	Neo natal Care givers (n=50)	%	Total (n-150)	%
Educational status								
No Formal Education	0	0	13	34.2	25	65.8	38	25.3
Primary School	0	0	22	55.0	18	45.0	40	26.7
Secondary Education	0	0	42	95.5	2	4.5	44	29.3
Tertiary Education	20	71.4	3	10.7	5	17.9	28	18.7
Marital status								
Single	6	11.8	15	29.4	30	58.8	51	34.0
Marriage	8	12.7	43	68.3	12	19.0	63	42.0
Devoiced	5	16.1	18	58.1	8	25.8	31	20.7
Widow	1	20.0	4	80.0	0	0.0	5	3.3
Age								

12-18 years	6	24.0	12	48.0	7	28.0	25	16.7
19- 35 year	9	13.0	32	46.4	28	40.6	69	46.0
36-45 year	3	7.0	28	65.1	12	27.9	43	28.7
46+	2	15.4	8	61.5	3	23.1	13	8.7
Occupation								
Trader	0	0.0	34	50.7	33	49.3	67	44.7
Housewife	0	0.0	16	66.7	8	33.3	24	16.0
Student	0	0.0	25	80.6	6	19.4	31	20.7
Office Worker	20	71.4	5	17.9	3	10.7	28	18.7
Monthly income								
Below SLL 50,000	0	0.0	58	87.9	8	12.1	66	44.0
Between SLL 50,000 and SLL 100,000	0	0.0	8	22.2	28	77.8	36	24.0
Above SLL 100,000 but Below SLL 500,000	2	8.7	9	39.1	12	52.2	23	15.3
Above SLL 500,000	18	72.0	5	20.0	2	8.0	25	16.7

Source: Author's Research data, 2018

Table 1 above demonstrates the respondents personal and demographic characteristics of the staff, parents of neonate and under Five (5) respondents. In terms of Educational status, the all the staff had attained Tertiary Education but there was a shift in the parents/care takers who took the children for child health care service as 95.5 % of those who attained secondary education were parents/care takers of under five (5) and the least of 4.5 who attained secondary education for parents/care takers who brought in neonatal. The study findings revealed that, the low levels of education had significantly influenced the timing and utilization of child health care facilities.

The findings in Table 1 further portrays that, majority of the respondents (42%) were married, although the widows were 3.3% they were in the majority among the parents /caretakers of under five (5) that were brought to the Hospital. The study revealed that marital status plays a significant role in determining women's utilization of child health care service. It was discovered that most married women go for child health care service early than single, widowed and divorced mothers.

The field results show that majority of the respondents were in the age bracket of 19 – 35 years (46%). Comparison of age groups (15-29 and 30-49) in all three category; showed that there is no significant difference for the age bracket of 19 – 35 years indicating the highest for all the age groups.

The field results show that majority of the women 44.7 % were traders (mainly practicing petty trading) and their level of income was low. Level of income at a household was defined on the basis of one member having permanent job, engaged in small scale business and subsistence farming. Households with a reasonable source of income were categorized as having fairly high income. Low –income level households were those that depended on petty trading for their living. The overall level of income of the participants was low below SLL 50,000 (44%).This means that there are high poverty levels among respondents in the area of study which in one way or the other affects their ability to access and utilize child health care facilities that are in most cases located kilometers away from their area of residence.

A critical analysis of the field results in Table 1 indicates that, most of the mothers were young, and had not attended school. All these contribute to limited ability to utilize child health care services and therefore poor care seeking behavior. Education of the mother and that of members of the household were found to be significantly associated with the levels of utilization of child health care services.

The reasons some respondents gave for underutilization were: child had a mild fever only and therefore no need to visit the clinic; a long distance to travel from home to the clinic,

avoiding making many trips to the health facilities for minor illness, and thinking they were able to treat the child with minor pills from drug stores or native herbs.

4.2 CHARACTERISTICS OF ANC PROVIDERS

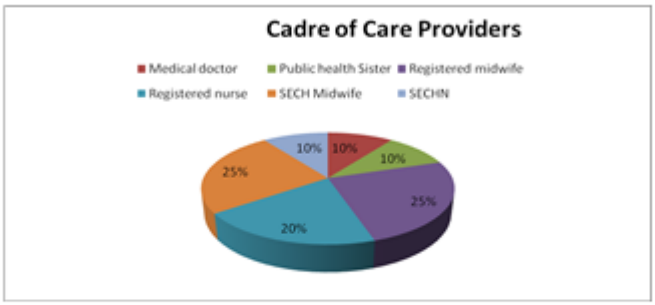

Figure 1: Care Providers of Respondents by Cadre. Source: Author's Research Data, 2018

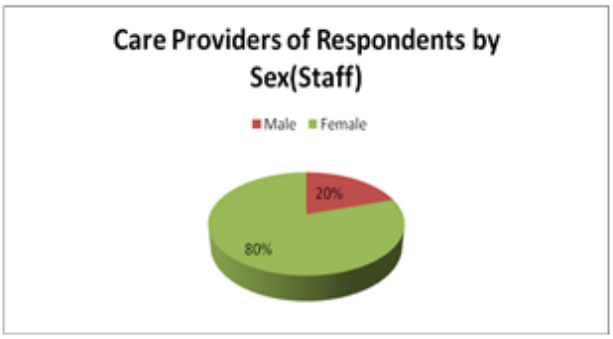

Figure 2: Care Providers of Respondents by Sex. Source: Author's Research Data, 2018

According to the study findings, majority of the care providers were females (80%) in the age group of 19-35years. The health care providers had a positive perception towards child health care and were helping parents/caretakers obtain the necessary services. However, the providers identified challenges of shortage of personnel and equipments necessary for the services.

Table 2: Care Providers of Respondents by Sex and Cadre.

Variable	Male	Female	Total
Sex	4	16	**20**
Cadre			
Medical doctor	**2**		
Public health Sister	**2**		
Registered midwife	**5**		
Registered nurse	**4**		
SECH Midwife	**5**		
SECHN	**2**		
Total	**20**		

Source: Author's Research Data, 2018

Twenty care providers were contacted during this study. These included the medical officer, senior nursing officers, nurses and midwives from the hospitals.

4.3 FACTORS INFLUENCING UTILIZATION OF CHILD HEALTH CARE

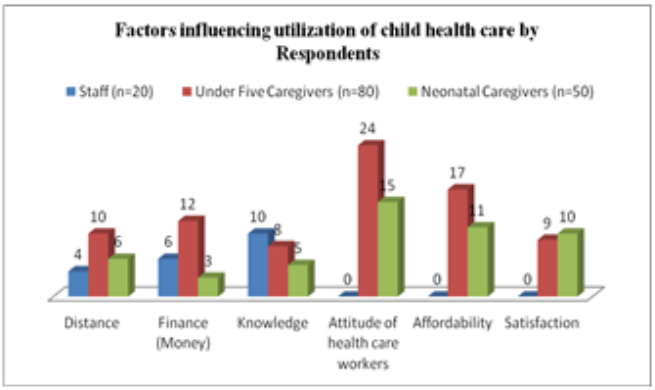

Figure 3: Factors influencing utilization of child health care by Respondents. Source: Author's Research Data, 2018

One of the objectives of the study was to determine the factors influencing child health care services in "Ola During" Children Hospital. Through exit interviews with child health care attendees, participants from each group (Under five and Neonatal) were asked to mention some factors influencing utilization of child health care. Responses from each group were summarized thus: majority of the respondents 13% travel 8 – 11 miles from home and most of them are attended to by other health practitioners and not medical doctors. Therefore many 55% prefer to be attending private facilities or rather come to the hospital only when the conditions are really serious. Majority of the participants said they don't attend the child health care because of lack of money for transport or to pay for services although there is a policy on free health care for all pregnant women, lactating mothers and children under the age of five. Most of the participants do not think it is necessary to bring their child for health service especially when the condition is not serious and so they chose to attend at their own time or when the condition is serious. The attitude of health care workers, the affordability, the satisfaction, and the distance are all factors contributing to the underutilization of the child health care. Most participants only visit when they are forced by relatives or when the condition goes worse.

4.3.1 Poor Quality of Care

Poor quality care at the health facility was mentioned by the respondents. The type and quality of child health care services that the women reported receiving were inconsistent and inadequate, and differed greatly from health workers. In this regard one woman mentioned that, the reputation of nurses and midwives regarding care for children was not good and as a result many women were scared of their bad behavior. A second woman echoed ―nurses are particularly strict on attendees who bring in their sick child and most women prefer to postpone their visits to health facilities for child health care services and even sometimes buy drugs over the counter or use herbs."

Another significant finding from the study in relation to poor quality care was mistreatment by health care providers. One respondent stressed that sometimes parent bring their sick child in hospitals and the nurses are not bothered and don't treat them because they did not give them money.

4.3.2 Accessibility to the hospital

With respect to delivery care, nearly most of the respondents were not satisfied with the care they received at the hospital, because they reported health providers were rude and not treated well or were not treated in a timely manner. Mothers who were satisfied reported that the facility had saved their baby's life or because staff identified the problem they were experiencing. In addition, nearly all of the women believed that the causes of infant mortality at health facilities were providers 'mistakes or hospital procedures whiles health provider thought it was the late arrival.

The above findings contravene the fact that; every child has the right to access high quality child health services that in turn must be accessible, affordable, effective, appropriate and acceptable to them in order to avoid preventable morbidity and mortality. Many complications of childhood illness that lead to mortality can be prevented by providing quality care that involves early detection of problems and appropriate timely interventions.

4.3.3 Myths and misconceptions

The knowledge, perceptions and attitudes of child attendees were assessed. The study established that participants had myths and misconceptions about seeking Child health early and in health units. The main reasons cited for failure to attend early were based on the woman's own beliefs and attitude that the facilities would provide quality care, or on the advice given by family members. All of the attendees pointed out that the government facility health care providers are not polite in handling patients. They do not explain when doing procedures; misplace records and reject most referrals.

However, the negative experiences of women regarding the care they received and the belief among many participants that late attendance was caused by providers requires a thorough investigation into the quality of child health care services.

4.3.4 Traditional Beliefs and Practices

The study demonstrates that many participants are still engulfed in the traditional past. The respondents' views revealed that many attendees seek ANC services late. The attendees reported that community norms were significant constraints in planning for early Child health care service. A nursing aid also described that attendees in general are reluctant to go for health services unless they suspect a problem with their child is serious. She elaborated that ―the influence of culture is deeply rooted in the society, which makes utilization of health services generally low among caregivers. Others even have the false belief that medical officials harass them. The researcher established that the status of women in the area of study was still low and they cannot make independent decisions about their child's health even when they have money.

4.3.5 Financial Difficulties

As established by the study, the level of income of the respondents based on their economic activities was so low. As a result their utilization of child health care services was reported to be minimal. It was established that, perceived expense of the child health hinder early attendance, the respondents stressed that transport costs, physical inability to travel long distances

make many attendee utilize the available alternatives and visit health units late.

In this study, majority of attendees complained of poverty and sometimes their finances being in the hands of their husbands while the widowed lacked control of property left to them. This reflects the real situation in the area of study.

4.3.6. Alternatives to Child health care service

The health care providers indicated that some mothers undertake other alternatives in early phases of childhood illness. As a result substantial proportions of women bring in their children when the conditions are very serious. It is clear that child mortality from within and without the health care system is not well addressed. The low child health care rate found in this survey is inconsistent even though many strategies have been laid by the government like the free health care initiative. There is also need to focus on women with no formal education and particularly those who have already had lost a newborn or young infant. To encourage earlier child health care attendance, service delivery must be improved and messages that aim at removing barriers to child health care utilization should be increased.

4.3.6. Ignorance

The study established that, the majority of the respondents had less education levels which was also a reflection of the entire study population. In this regard some health care providers revealed that most of the women access the hospital late because of ignorance. Many mothers do not want to make many visits to the hospital/clinics. Because of the high illiteracy levels among women interviewed in the survey and generally among attendees, there is need for outreach efforts by employing community engagement strategies, and counseling and educational materials used needs to be audiovisual, interactive and pictorial. This will enable the health providers to reach the uneducated women.

Due to the fact that many women are illiterate, they also have limited information on the dangers related to late entry to the hospital. The main purposes of early arrival of child care are to prevent certain complications, such as anemia.

4.4 KNOWLEDGE OF MOTHERS ABOUT BENEFITS OF SEEKING CHILD HEALTH CARE EARLY

Data collected show high level of knowledge among child health care attendees. Through the study, the researcher established attendees'knowledge levels by asking women to mention likely consequences of attending ANC late. Majority, 88.5% of the responses indicated that the respondents had knowledge about dangers a child might come across when attended hospital late during childhood illness.

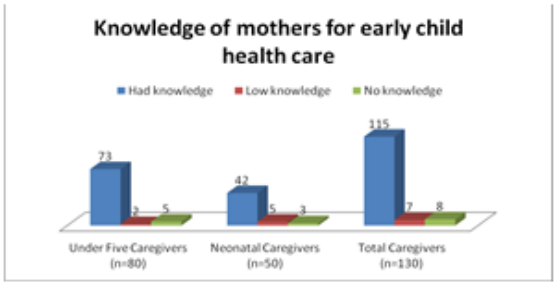

Figure 4: Knowledge of mothers for early child health care. Source: Author's Research Data, 2018

4.5 DISTANCES TO HEALTH FACILITIES.

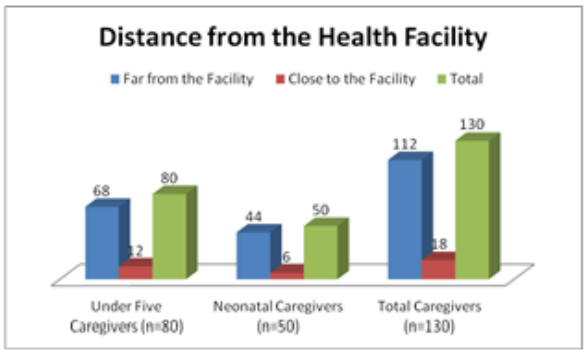

Figure 5: Distance from the Health Facility. Source: Author's Research Data, 2018

Seeking and utilization of child health care services by women and mothers is determined by a number of factors of which distance and mode of transport is one of them. To establish what influences women to seek alternatives and attend late, the researcher took the task of knowing how far the ANC attendees had traveled to the clinic/hospitals. The study findings on the availability and distances of child health care service revealed that women cover long distances to the health facility where child health care services are provided. This was expressed by respondents during questionnaire interviews, in depth interviews and focus group discussions.

4.6 DISCUSSIONS

4.6.1 Factors Influence the Free Health Care Initiative

The findings on the Sierra Leone Free Health Care Initiative, clearly state the need in Sierra Leone. However, its ambition was also a risk, and weaknesses in implementation have been evident in a number of core areas, such as drugs supply. It was noted that Sierra Leone Free Health Care Initiative was one important factor contributing to improvements in coverage and equity of coverage of essential services for mothers and children. The findings suggest that even-or perhaps especially-in a weak health system, a reform-like fee removal, if tackled in a systematic way, can bring about important health system gains that benefit vulnerable groups in particular. The findings highlight how a flagship policy, combined with high profile

support and financial and technical resources, can galvanize systemic changes. In this regard, the story of Sierra Leone differs from many countries introducing fee exemptions, where fee exemption has been a stand-alone program, unconnected to wider health system reforms. The challenge will be sustaining the momentum and the attention to delivering results as the Sierra Leone Free Health Care Initiative ceases to be an initiative and becomes just 'business as normal'. The health system in Sierra Leone was fragile and conflict-affected prior to the Free Health Care Initiative and still faces significant challenges, both in human resources for health and more widely, as vividly evidenced by the current Ebola crisis.

4.6.2 The Impact of Health Service in Preventing Child Death

Child health is a growing concern at the global level, as infectious diseases and preventable conditions claim hundreds of lives of children under the age of five in low-income countries like Sierra Leone. Approximately 7.6 million children under five years of age died in 2011, calculating to about 19 000 children each day and almost 800 every hour. About 80 percent of the world's under-five deaths in 2011 occurred in only 25 countries. This study reviews essential recommendations and interventions for improving child health, which if implemented properly and according to guidelines have been found to improve child health outcomes, as well as reduce morbidity and mortality rates. It also includes caregivers and delivery strategies for each intervention. Interventions that have been associated with a decrease in mortality and disease rates include exclusive breastfeeding, complementary feeding strategies, routine immunizations and vaccinations for children, preventative zinc supplementation in children, and vitamin A supplementation in vitamin A deficient populations.

4.6.3 Alternatives to Child Health Care in Freetown

The research findings show that; majority of the respondent who attends the Ola During Children's hospital had other alternatives to child health care. These included use of local herbs, over the counter drugs and traditional healers. This implies that, cultural beliefs are still a determining factor to the decision in seeking child health care services.

The study established ill treatment of child care takers from health care providers. Some health care providers are rude and sometimes abuse child care takers at that critical time when a mother brings in the child in a very sick condition. This demonstrated less ethical values among health providers. In addition research findings obtained, there was an observation some child care takers seek alternatives care because the husbands were refusing to accompany or even block them from attending.

4.6.4 Late Child Health Care Attendance

The study findings also illustrate that almost all of the respondents accessed child health care late in very critical condition. There is evidence to suggest that care takers seek child health care late because of poverty. The study findings show that many of the respondents' income is low, so mothers fail to raise money for transport, lunch during child health care visit and lack what to put on like dresses. Thus some mothers seek child health care late because the husbands cannot raise money for their child Hospitalization.

Ola During Children's Hospital is located in the Fourah Bay Community and along the main Fourah Bay Road off the left wing of the country's major sea port, Queen Elizabeth II and the west wing of the country's biggest market, Moa market in the Western Urban Freetown.

The data obtained from the study show that distances from the hospitals contribute to care takers to seeking child health care late. From data analyzed the biggest percentage of ANC attendees traveled longer distances to the hospital. Moreover Freetown is very congesting, with very high traffic stuff especially during the day making the major roads to the hospital impassable. This suggests lack of adequate means of transport in some parts of the area of study was a hindrance to accessing child health care services.

The findings indicated that care givers in the area of study are engaged in both in- home and tedious out-door trading activities for which they allocate little time for seeking medical care in general. Related to this; a study in Ethiopia, established that heavy workload, lack of access to health services, poverty, traditional practices, poor social status and decision-making power, and lack of access to education are among the highly prevalent socio-cultural factors that potentially affect the health of women (Marina and Mugoni:2005).

The findings also suggest that other factors, aside from service availability, may drive service utilization differentials between and among rural women. These factors include disparities in economic and cognitive access, perceived quality of child health care services, and differences in individual knowledge and attitudes towards child health care services. A comprehensive conceptual framework of how different dimensions of access to and quality of health services affect service utilization in Freetown. Such a framework should also take into account the emergence of non-public sectors that are increasingly involved in the provision of health services. A more comprehensive understanding of the service environment, consisting of all sectors and how different dimensions of service provision may affect utilization, will guide efforts to improve service utilization.

The study established that, late attendance was attributed to child health care takers seeking alternatives to child health care. This is a clear marker of how health and social systems threaten the capacity of child health care takers to seek medical attention promptly. While not attending child health care services as presented by the respondents, its true causes are grounded in child health care taker's acute socio-economic vulnerability which denies them access to timely and appropriate care. The severe shortage of qualified health workers, unavailability of transport to facilitate emergency referrals, searing poverty that denies people to afford health care; lack of education regarding basic reproductive health and the complications of childhood illness. More tragically, however, lack of adequate child health care services has contributed to the continuing and unabated acceptance that children naturally die during childhood illness, or are left with devastating disabilities.

Age was identified as a factor in child health care service late attendance, slightly more than half of the child health care takers in the study whose age was reported were 19- 35 year. It

also highlights the need for girls and young women to possess the fundamental rights to determine freely when they will marry and when they will begin having children. While it remains vital to recognize the severe impact of child health care service late attendance on young girls, the findings expand on the widely held assumption that ignorance on seeking proper and adequate child health care service predominantly affects very young women.

The findings of the study highlighted that those child health care takers who are slightly educated have maximally availed child health care service when compared to less educated and illiterate ones. Significant differences have been observed according to women's education in consulting a health professional. Attainment of education has a major influence on utilization of child health care service.

4.6.5 Respondents Recommendations on How to Improve Child Health Care Service Utilization

The study identified that it was significant to provide women with education and counseling on child health care. This means that Women in general should be encouraged strongly to take the sick child as early as possible to the hospital so they can receive emergency care promptly when needed.

Public education and programs to prevent child health care takers from seeking dangerous child health care service alternatives must therefore, target all women of reproductive age. In particular, maternal health services should provide accurate and timely counseling to women as well as key decision makers, such as husbands, mothers-in-law and parents on the importance of utilizing child health care service in early days of sign and symptoms, and encourage women and their families.

Training for health workers on clinical skills, as well as on client-provider interaction, was suggested as critical to ensure high quality, professional child health care service. Supplies and equipment must be available to health workers, and supportive supervision instituted to monitor service delivery standards. Health workers, in turn, need to be supported through training and supervision to provide essential, adequate, services to child health care attendees.

The Government should pursue its efforts to improve the availability of child health care service at existing and/or new health facilities, particularly those that are offering child health care service. Any interventions that aim to increase child health care service utilization should include efforts to target children of lower health status and educational achievements, as well as areas where women in general do not have high educational achievements.

Broad-based educational and advocacy programs are needed to dispel negative myths about seeking child health care service at Ola During hospitals as well as to encourage social support for child care takers. Consistent and reliable information on where and when services are available also needs to be disseminated to assist child health care takers to access treatment quickly. Radio programs and outreach through faith-based institutions may represent effective communication channels to reach them.

From the findings, it is clear that child health care service programs must address the reduction of infant and 'under five' mortality from within and without the health care system. The low child health care rate found in the survey is an indication that, there is need for community outreaches about the importance of child health care service to those most at risk for not being aware of or able to access appropriate care. In Freetown efforts need to be intensified and there is need to focus on care takers with no formal education and particularly those who have already had lost a newborn or young infant. Although the perceived expense of the child health care service may hinder attendance, it is uncertain that free health care initiative has increase coverage and a perceived negative attitude of health workers and poor quality of care would remain barriers.

V. 5.0 RESEARCH CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the conclusions and recommendations to the research findings in relation to the research objectives. The results were discussed in line with the research findings as presented in Chapter Four.

5.2 CONCLUSIONS

From the findings, it is clear that child health care service programs must address the reduction of infant and 'under five' mortality from within and without the health care system. The low child health care rate found in the survey is an indication that, there is need for community outreaches about the importance of child health care service to those most at risk for not being aware of or able to access appropriate care. In Freetown efforts need to be intensified and there is need to focus on care takers with no formal education and particularly those who have already had lost a newborn or young infant. Although the perceived expense of the child health care service may hinder attendance, it is uncertain that free health care initiative has increase coverage and a perceived negative attitude of health workers and poor quality of care would remain barriers.

The health and survival of Children in Freetown has gone unnoticed far too long. However, both immediate and long term opportunities exist to improve the situation at all levels. Sierra Leone has many policies in place but the utilization of child health care service illustrates a critical policy gap, especially in regard to the free health care initiative.

Existing policies and guidelines have not been fully disseminated, integrated or implemented by service providers, leading to poor and inconsistent utilization of child health care service especially in rural areas. There is an opportunity for policy makers to take a leading role to improve utilization of child health care service from the highest level in both public and private facilities. This can be achieved through making and disseminating appropriate policies, improving staffing and supervision in facilities and creating an enabling environment for community level care.

The study revealed that attitude of health care workers, the affordability, the satisfaction, and the distance are all factors contributing to the underutilization of the child health care. Another significant finding from the study in relation to poor quality care was mistreatment by health care providers.

The study established that participants had myths and misconceptions about seeking Child health early and in health

units. The study demonstrates that many participants are still engulfed in the traditional past.

The study revealed that late access to the hospital is because of ignorance and the high level of illiteracy among women interviewed in this study.

The researcher established that the status of women in the area of study was still low and they cannot make independent decisions about their child's health even when they have money.

It was established that, perceived expense of the child health hinder early attendance, the respondents stressed that transport costs, physical inability to travel long distances make many attendee utilize the available alternatives and visit health units late.

The study findings on the availability and distances of child health care service revealed that women cover long distances to the health facility where child health care services are provided.

The findings highlight how a flagship policy, combined with high profile support and financial and technical resources, can galvanize systemic changes. In this regard, the story of Sierra Leone differs from many countries introducing fee exemptions, where fee exemption has been a stand-alone program, unconnected to wider health system reforms.

The findings also suggest that other factors, aside from service availability, may drive service utilization differentials between and among rural women. These factors include disparities in economic and cognitive access, perceived quality of child health care services, and differences in individual knowledge and attitudes towards child health care services.

5.3 RECOMMENDATIONS

The study findings unveiled a number of gaps in the provision of child health care service; gaps in information dissemination systems and organizational barriers relating to accessibility and underutilization of child health care service. Thus in order to change the habit of those seeking alternatives, underutilization and attending child health care service late, the study recommended;

5.3.1. Health workers should be encouraged to take opportunity of the numbers of care takers that attend underutilization and educate them on the unpredictability of complications of childhood illness.

5.3.2. Having realized the weaknesses in the health service, there is a need to train health care workers in the concept of child health care service, with specific emphasis on ethics.

5.3.3. To improve access and utilization of child health care service, there is need to establish or strengthen national policies and locally adapted guidelines for evidence-based at the national level detailing the essential minimum components of child health care service, in line with the country epidemiological profile and country priorities and based on WHO guidelines and recommendations.

5.3.4. Considering the study findings, it is suggested that strategies should be developed for empowering communities to overcome obstacles to reach child health care service. These may include using community channels to identify childhood illness, targeting those more likely to be critical, and making the services more responsive to the needs of children.

5.3.5. Quality and performance improvement to mitigate factors affecting performance of child health care providers were identified as a way of ensuring quality of child health care service. This interdisciplinary approach should include key stakeholders, like the health management teams, to identify service gaps. Based on the gaps identified, priority interventions should be implemented focusing on a range of performance factors such as supervision, knowledge and skills; development, and availability of key resources, supplies and equipment to ensure sustainability and long-term results.

5.3.7. The study established that many of the medical personnel handle their clients in an inhuman manner a sign of poor client handling. Training for health workers on clinical skills, as well as on client-provider interaction, is critical to ensure high quality, professional child health care service.

5.3.8. The study recommends an improvement in health care systems at all levels and improving child survival and well-being, through improving physical infrastructure, essential drugs supplies, equipment to improve the extremely difficult working conditions for staff and enable providers to offer quality care.

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