A Rapid Assessment of the Gambia PHC and Community Health & Nutrition Structures: A Mixed-methods approach

FINAL REPORT

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Contents

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ACRONYMS

BCC	Behaviour Change Communication
BJL	Banjul
CAC	Catchment Area Committee
CBO	Community Based Organization
CHW	Community Health Worker
CRR	Central River Region
FGD	Focus Group Discussion
GBOS	Gambia Bureau of Statistics
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IDI	In-depth Interview
IEC	Information, Education and Communication
IMNCI	Integrated Management of Neonatal & Childhood Illnesses
IMR	Infant Mortality Rate
KM	Kanifing Municipality
LRR	Lower River Region
MCNHRP	Maternal and Child Nutrition and Health Results Project
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NaNA	National Nutrition Agency
NBR	North Bank Region
NGO	Non-governmental organisation
PHC	Primary Health Care
RBF	Results-Based Financing
RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Test
RHT	Regional Health Teams
TBA	Traditional Birth Attendant
TCs	Traditional Communicators
URR	Upper River Region
VDC	Village Development Committee
VHW	Village Health Worker
VSG	Village Support Group
WCR	West Coast Region

EXECUTIVE SUMMARY

Introduction

The Gambia is a small country with a population of 1.9 million. Current life expectancy is 58 years, infant mortality rate (IMR) is estimated at 34 per 1000 live births, according to The Gambia Demographic and Health Survey 2013; and MMR is at 360 per 100,000 live births, according to World Bank estimates. About 25% of children are chronically malnourished or stunted. The country's progress towards the attainment of Millennium Development Goals (MDGs) (MDG 1c, 4 and 5) has been considered slower than expected. Therefore, the government of The Gambia has embarked on new initiatives to make structural changes, especially to improve the status of the primary health care system and nutrition structures. The objective of this study was a rapid assessment of the PHC system and community health and nutrition structures using a mixed-methods approach (i.e.a combination of quantitative and qualitative methods).

Methodology

Twenty-one health facilities were surveyed from among the public, NGO and private-for-profit sector. The qualitative study involved 23 FGDs (for VSGs and CBOs) and 24 in-depth interviews with health workers (Heads of health facilities, RHTs and RCH teams).

Results

Health Facility Survey

Among the 21 health facilities surveyed 13 (61.9%) were government owned. Two-thirds (14) of the facilities were in the rural area and 7 in the urban area. The majority of the facilities depended on the national grid for electricity, though a few had access to multiple sources of electricity. All of them had safe source of water supply. However, there existed a shortage of electricity and water supply for more than 10 hours in a week, adversely affecting their routine functioning, especially in the public facilities of rural areas.

No substantial difference was found in the infrastructural status between private and public facilities and those in the rural and urban areas. Admission beds were available in all health facilities, except one. All public facilities were open 24 hours a day and only 2 public health facilities did not provide any outreach clinics. Two private facilities provided surgery service in the urban area. Most referrals were for surgery, specialised care, radiology and in-patient services.Haemoglobin estimation and rapid diagnostic test (RDT) for malaria were the twomain laboratory services available, for both rural and public facilities. Many public health facilities reported more stock-out of essential medicines in the past 30 days. Coartem and Fansidar were not available in 3 (21.4%) and 2 (15.4%) public health facilities respectively. HMIS and IMNCI protocols were more available in the facilities of rural areas.

Focus Group Discussions (FGDs)

FGDs were conducted with Village Support Groups (VSGs), and Community Based Organizations (CBOs). VSGs and CBOs had a common understanding of the health and nutrition issues in their communities. They provided health and nutrition related services to their communities, even including the purchase of medicines for the VHW. VSGs also participated in various health and nutrition talks. VSG members were supervised by the CHN in managing malnourished children in their communities and they were often satisfied with the supervision they received from the CHNs. The recording of data at the community level is not regular and often this irregularity is due to lack of record books. Challenges faced by VSGs were related to limited technical capacity of their members, IEC/BCC materials, medicines and medical equipment, the referral system and cultural issues. Many of them seemed to know the importance of data and how to use it. The linkage of VSGs with the minor health facilities was found out to be well defined and cordial. They have demanded for additional training for CHWs and their other members, and the provision of adequate supplies of medicines, delivery kits, cooking utensils, data recording books and IEC/BCC materials. TBAs were actively involved in catering to pregnant women; further training is needed to improve their capacity. CBOs were actively engaged in community health and nutrition activities, especially with VSGs. VSGs also required external technical and managerial strategies to improve community health and mobilizing community members for local development. Their current understanding of the local issues,

experience in collaborating with CBOs and trust among the community members will be relevant for mainstreaming the CBOs in health and nutrition activities.

In-depth Interviews (IDIs)

IDIs were conducted among 24 health staff in the Regional Health Teams (RHTs) and health facilities. Health facilities are engaged in both "preventive services" and "curative services" at the community and health facility levels. The majority of them were performing the tasks they were mandated to do. Staffing and medicines are the key challenges for the public health facilities. The referral system seemed to be functioning well with ambulances available for patient evacuation, except when fuel is in shortage. The current supervision of health facility staff from the higher levels is inadequate. Data are recorded routinely on papers and sent to higher levels. Providers in public facilities and nutrition structures are overburdened with workload, though they receive limited incentives. The public facilities depended on government funding and user fees for revenue, while the private sector depended on donations and user fees. Both sectors demanded for additional financial resources to improve their infrastructural status. Many NGO facilities faced financial constraints as they provide free services to poor patients. Staff shortage was a constraint in the private facilities as well, however most of them were able to provide incentives to staff. They have solicited adequate financial resources to incentivise health and nutrition actors, implement the various training, ensure adequate supply of medicines and equipment for both the health facilities, and provide village health services and transports.

Discussions

The current evidence on the status of the Primary Health Care system in the country, especially the community health and nutrition structure is limited. Therefore, the findings from this rapid assessment will be a strong foundation to further explore the various needs for improving the Primary Health Care system in the country. The findings reinforce the need to improve the building blocks of the PHC system (e.g. availability of staff, medicines, equipment and linkages with the community). This revelation also establishes an already known fact that the current weak status of the primary care system is a major impediment to meet MDGs. In short, the study findings reiterate the need to prioritize the various mandates of the National Health Policy 2011-2015.

Conclusion

The basic structures of the PHC system in The Gambia hasalready beenlaid. There exists the village health service staffed by volunteer CHWs supported by VSGs, VDCs and other CBOs. Public health facilities are delivering services with the constraints of financial, technical and managerial capacities. The status of NGO facilities is not substantially better than that of the public facilities. Health facilities need a major structural improvement and the availability of skilled staff to enable them to provide the Essential Service Package, envisaged in the National Health Policy 2011-2015.

Recommendations

The recommendations centre around making health facilities functional through the provision of equipment, medicines, other supplies, financial and logistical support; availability and appropriate remuneration of trained health staff; supporting the training of health personnel; support to community nutrition and health actors; engaging NGO and private health facilities to provide RCH and other health services. Other recommendations are to improve the data recording system and creating mechanisms for the timely evacuation of patients from the community to the health facility level.

1 INTRODUCTION

1.1. An overview of the Gambian Health System

The Gambia is a small country in West Africa with a population of approximately 1.9 million (GBOS, 2013).On average, the population of The Gambia has been growing at the rate of 3.3 per cent annually during the period 2003 to 2013 (GBOS, 2013a). At this rate, the current population size is expected to double in the next 21 years. According to the 2003 census[1], the population of The Gambia is mainly young with more than half (63.55%) below 25 years. Elderly persons of 65 years and above account for 2.8% of the population. Women in the reproductive age group constitute around 25% of the population, while infants and under-fivesconstitute 2.1% and 14.3% of the population, respectively. More than half of the population live in urban areas.

The Gambia adopted the Primary Health Care (PHC) Strategy in delivering health services in 1979. It envisages for basic health services being universally accessible to the population. PHC is delivered through three levels of care; 1) the primary level provides the preventive and curative action through a network of village health posts consisting of volunteer Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs), who are supervised by trained Community Health Nurses (CHNs), 2) the secondary level provides procedures less complicated than the tertiary and has a network of major and minor health centres, and clinics with more specialised staff and equipment and 3) the tertiary level provides more specialised services and interventions and is intended to function as a referral service for the secondary level.

Despite a long history of having a PHC strategy, when it comes to health status indicators, the current life expectancy at birth is 58 years. As per GBOS 2013b, the current infant and under-5 mortality rates are estimated at 34 and 50 per 1,000, live births, respectively. Neonatal mortality contributes to 65% of total infant deaths. Around 25% of children were chronically malnourished

[1]The 2013 provisional census report does not have the population by rural/urban and age group breakdown. Hence the 2003 census figures are used.

or stunted (height-for-age below –2 SD), and 8% was severely stunted. According to a World Bank report published in 2012, the maternal mortality ratio is still high at 360 per 100,000 live births in 2010. This figure is a modelled estimate using information on fertility, birth attendants, and HIV prevalence[2]. With regard to utilization of family planning services, 9% of currently married women use a contraceptive method of any kind, and 8% of them use a modern method.

As per the current evidence, there exists inequalities in the utilization of health services between rural and urban areas and different socio-economic groups (DHS 2013). For instance, the prevalence of any contraceptive method is three times higher in urban areas (12%) than in rural areas (4%). Women with secondary or higher education are more likely to use a modern Contraceptive method (15 %) compared to less educated women (6%). The percentage of children who were fully immunized was higher in rural areas than in urban areas (84% vs. 67%).

As explained above, The Gambia's slow progress towards health- and nutrition-related MDGs can be largely attributed to five main but interrelated factors:

1. *Neglect of the primary care:*Half of the national budget remains at the tertiary level, while only 20% goes to the decentralized level.As a result, many public subsidies for health frequently benefit the rich more than the poor.
2. *Inadequate availability of* maternal and child health and nutrition services. The healthcare delivery system is weak with poor quality of care.
3. An absence of a comprehensive *human resource* strategy that enables recruiting, training, deploying, maintaining and monitoring sufficient numbers of providers in health facilities and communities. As a result, the health sector is experiencing high rates of attrition of skilled workers and inequitable distribution of providers.
4. *Inadequate (or inconsistent) supplies* of equipment, medicines, fuel and commodities in both health facilities and in communities, including electricity, clean water, cold storage capacity for blood; delivery kits; new growth reference charts; service manuals;

[2] Source: http://www.tradingeconomics.com/gambia/maternal-mortality-ratio-modeled-estimate-per-100-000-live-births-wb-data.html

consumables including birth control; transportation means for supervision as well as emergency evacuation; and needs forecasting.

5. *Socio-cultural barriers and limited community mobilization:* The prevailing cultural practices result in a plethora of harmful practices, delayed treatment seeking and ineffective first contact with health personnel at the community level. However, community structures are not full-fledged to enhance community level mobilization.

6. *Uneven access to and utilization of nutrition and health services* by socioeconomic status and by geographic region, with urban and coastal regions faring much better than rural and more remote regions, and underutilization of services by adolescents.

These factors point to an operationally weakened and under-funded PHC system and inadequate linkages between communities and or health sector. The Gambia relies on external aid for health sector financing with 67% coming from donors and 21% from the Government. The out of pocket expenditure constitutes 12% of overall health expenditures according to the 2007 National Health Accounts. Verticalization of externally financed programs and a decline in government financing of PHC has contributed to a gradually under-performing PHC system, whose structures are not well positioned to provide preventive or curative care.

1.2. Rationale

Given the unmet health related MDGs (1c, 4 and 5) and the weak health care delivery system, the Government is committed to improving the primary healthcare system and nutrition structures. The proposed Results-Based Financing (RBF) project expects to improve the health facilities, service availability, human resource performance, data management and financial sustainability. Further, the project envisages improving the community nutrition structures and linkages between various primary health structures. However, currently, the availability of basic information on the infrastructure status, functioning of health facilities and their linkage with community health structures is limited. These basic details are necessary to design the proposed project attuned to the contextual needs appropriately.

The rapid assessment will: (a) inform overall design of incentives for the project on both the demand and supply sides; (b) inform how best to address supply-side bottlenecks to service provision and utilization; and (c) inform how best to capitalize on and strengthen existing inter-linkages between the PHC system and community-based structures using RBF.

1.3. Objectives

The main objective of this consultancy was:

- To conduct a rapid assessment of the PHC system and community health and nutrition structures using quantitative and qualitative methods.
    - At the health facility level, this assessment explored the infrastructure and service delivery status.
    - At the community level, the functioning and status of community health and nutrition structures were assessed.

Further, it explored the challenges and opportunities in service delivery at health facilities and community health and nutrition structures.

The quantitative component used a health facility survey and community questionnaire (administered to community level providers) to yield an overview of infrastructure, human resources and management capacity, equipment, material, medicines, quality of data, knowledge of health and community workers and quality of service provision. The qualitative component used key-informant interviews and focus group discussions to provide a snapshot of the strengths and challenges of the existing structures including inter-linkages between the PHC system and community health and nutrition structures (e.g. coordination and referral systems); supervision and monitoring processes, reporting and management of data, and accountability and feedback mechanism.

2 METHODOLOGY

This study was a rapid assessment of the PHC system and community health and nutrition structures. It was conducted by using a mixed-methods approach (i.e. a combination of quantitative and qualitative study design). This was a nation-wide study conducted in all the regions and municipalities of The Gambia.

2.1 Quantitative survey

A total of 21 health facilities were surveyed from among the public, NGO and private-for-profit sector. The sample of health facilities include 5 major public health centres, 8 minor public health centres, 6 NGO health centres (including 1 Faith-Based facility), and 2 private-for-profit health facilities (see Table 1).

Table 1: Distribution of sample health facilities, by type and region/municipality

Facility Type	URR	CRR	LRR	NBR	WCR (Fonis)	WCR (Kombos)	KM	BJL	TOTAL
Public	2	2	2	2	1	2	1	1	**13**
NGO	0	0	1	1	1	1	2	0	**6**
Private	0	0	0	0	0	0	1	1	**2**
Total	**2**	**2**	**3**	**3**	**2**	**3**	**4**	**2**	**21**

Since there are only 6 major public health centres, the 5 included in the sample were purposively selected. The other minor public, NGO and private health facilities were randomly selected in each region/municipality. Private-for-profit health facilities are only found in the Greater Banjul Area. Hospitals have not been included in the assessment.

The health facility survey questionnaire was adapted from the World Bank RBF Toolkit, which provides a set of assessment tools for RBF.

2.2 Qualitative study

The qualitative study involved conducting focus group discussions (FGDs) and in-depth interviews (IDIs).

Two groups were identified for theFGDs as follows; i) Village Support Groups (VSGs) and ii) Community Based Organizations (CBOs). The participants for the FGDs with VSGs and CBOs belonged to the same catchment area of the health facilities in the sample.

The respondents forIDIswere as follows; i) Health facility staff, ii) Heads of major and minor health centres, iii) Regional Directors of Health Services and iv) Heads of Reproductive and Child Health (RCH) Teams

Table 2: Distribution of FGD participants and IDI respondents, by type and region/municipality

Participant	URR	CRR	LRR	NBR	WCR (Fonis)	WCR (Kombos)	KM	BJL	TOTAL
VSG FGD	1	1	1	1	1	1	0	0	**6**
CBO FGDs	2	2	2	2	2	2	3	2	**17**
Total FGDs	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**23**
Health worker IDIs	3	3	3	4	2	3	4	2	**24**

The guidelines for both FGDs and IDIs were developed to suit the needs of the RBF project.

2.3 Training of Fieldworkers and Pre-Testing of Tools

Four teams comprising 3 persons each were trained for 3 days on the draft tools. The training covered background information on the assessment, which was delivered by the Executive Director ofNaNA;the study methodology, techniques for interviewing and recording by the Sahel Group. This was followed by a review of all the tools and translating them into the 3 main local languagesMandinka, Wolof and Fula.

Both the qualitative and quantitative tools were pretested over a one-day period. Based on the pre-test some sections of the health facility questionnaire were deleted from the finalised version. These included sections on administration and management, staff roster, referrals, parts of HMIS; and some direct observation questions. It was felt that these were too detailed for a rapid assessment as specified in the Terms of Reference.

2.4 Data collection

Data collection started on Sunday 10th November 2013 and lasted approximately for 5 weeks. There were challenges getting the cooperation of private health facilities and 1 NGO facility. Moving the teams from one health facility to another and from one FGD or IDI to another proved challenging, especially in the rural areas. Transportation was not readily available and assembling the groups for an FGD session sometimes took more time than expected.

Informed consent was obtained from respondents of both the quantitative and qualitative studies. All FGD sessions were conducted in the local languagesof the participants. The health worker IDIs were conducted in English. Some of the health workers did not want to be recorded. In these cases fieldworkers were asked to take detailed notes of their responses.

2.5 Data entry and analysis

Data entry clerks and data entry supervisor for the Quantitative survey data were recruited and trained. Data was entered into CSpro 5 and exported into SPSS and Epi Info 7 for analysis.

The qualitative data from FGDs and IDIs were transcribed verbatim on each day of the interviews. The transcribed data from FGDs were later translated into English (IDIswere recorded in English). Later, the transcribed data were coded by keeping the anonymity of the respondents to some extent (e.g. name). Coded data were manually analyzed in an inductive manner, based on various themes. A two-day workshop was conducted with the fieldworkers to review and summarize the thematic findings of FGDs and IDIs.

3 RESULTS

The Results are presented in 2 sections. Section 3.1 presents the results of the quantitative survey in which a pre-tested questionnaire was used to collect data from public, NGO and private-for-profit health facilities. Section 3.2 describes the qualitative results from the focus group discussions (FGDs) and in-depth interviews (IDIs).

3.1 Health Facility Survey

3.1.1 Basic profile of health facilities

A total of 21 health facilities were surveyed. Among them, the majority, 13(61.9%),were Government owned facilities, either minor or major health centres, (referred to as public health facilities), see Table 3. There were 19.0% private NGO facilities and 14.3% private-for-profit facilities. According to the Health Policy Framework – "Health is Wealth", the minor health centre is the unit for the delivery of basic health services. The national standard is 15,000 population for a minor health centre. The minor health centre is to provide up to 70 percent of the Basic Health Care Package need of the population. The major health centre, on the other hand, serves as the referral point for minor health centres for such services like obstetric emergencies, essential surgical services, and further medical care. Bed capacity of a major health centre is up to 100 and, in addition, to serve as blood transfusion points for the area. Two-thirds (14) of the facilities were in the rural area and 7 in the urban area.

Table 3: Profile of health facilities

Characteristics	No of facilities (%)
Type of facility	
Major health centre	6 (28.6%)
Minor health centre	9 (42.9%)
Village clinic	4 (19.0%)
Other,	2 (9.5%)
Ownership of facility	
Government	13 (61.9%)
Private-for-profit entity	3 (14.3%)
Private NGO	4 (19.0%)
Mission/Faith-based organization	1 (4.8%)
Primary sources of electricity	
Electrical mains/grid	14 (66.7%)
Generator	12 (57.1%)
Solar	10 (47.6%)
No source of electricity	0 (0.0%)
Primary source of water	
Piped into facility	16 (76.2%)
Piped into yard/plot	1 (4.8%)
Public tap/standpipe	1 (4.8%)
Protected well	2 (9.5%)
Other	1 (4.8%)
Facilities with working computer	14 (66.7)
Facilities with internet connection	7 (33.3)
Total	**21 (100%)**

3.1.2 Infrastructure of health facilities

The primary source of electricity was the national grid, with stand by generator and solar plants serving as back-ups. However, 8 facilities reported not having electricity for more than 10 hours in the past week before the interview. Rural and public health facilities were affected more by power outages than urban and private facilities[3], see Table 4. All health facilities had safe sources of water, with most (76%) having pipe borne water into the facility. Three health facilities, all rural and public, reported working without water supply for more than 10 hours in

[3]Private facilities used in tables refer to private-for-profit, NGO and FBO facilities

the previous week before the survey. Fourteen (66.7%) health facilities had working computers and 7 (33.3%) had Internet connection.

Table 4: Infrastructure status in Health Facilities

Infrastructure status in health facilities	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
Having 10 or more beds	8 (57.1%)	4 (57.1%)	7 (53.8%)	5 (62.5%)
Having more than 2 beds in maternity ward	8 (57.1%)	4 (57.1%)	8 (61.5%)	4 (50.0%)
Having no bed in maternity ward	3 (21.4%)	1 (14.3%)	3 (23.1%)	1 (12.5%)
Having more than 2 beds in paediatric ward	6 (42.9%)	1 (14.3%)	6 (46.2%)	1 (12.5%)
Having no bed in paediatric ward	7 (50.0%)	5 (71.4%)	6 (46.2%)	6 (75.0%)
Having a reception room	8 (57.1%)	6 (85.7%)	7 (53.8%)	7 (87.5%)
Having a waiting room	9 (64.3%)	6 (85.7%)	7 (53.8%)	8 (100%)
Having a separate waiting room for women	4 (28.6%)	3 (42.9%)	5 (38.5%)	2 (25.0%)
Having a functional toilet for patients	12 (85.7%)	7 (100%)	11 (84.6%)	8 (100%)
Having an accommodation arrangement for health workers	6 (42.9%)	5 (71.4%)	6 (46.2%)	5 (62.5%)
Facilities worked without electricity for more than 10 hrs in the last week	6 (42.9%)	2 (28.6%)	6 (46.2%)	2 (25.0%)
Facilities worked without water supply for more than 10 hrs in the last week	3 (21.4%)	0 (0.0%)	3 (23.1%)	0 (0.0%)
Facilities not having any type of telephone connection	9 (64.3%)	1 (14.3%)	8 (61.5%)	2 (25.0%)
Facilities not owning any vehicle	1 (7.1%)	1 (14.3%)	1 (7.7%)	1 (12.5%)

Admissions beds are available in all health facilities, except one. Twelve of the facilities have 10 or more beds in total. The public health facilities in Brikama, Basse, Soma and Essau, all major health centres have the most number of beds, 86, 83, 67 and 48 respectively. Four of the facilities did not have a maternity ward; whilst 12 did not have a paediatric ward.The majority of them had a reception and waiting rooms, and functional toilets for patients. A few had a separate waiting room for females. Urban facilities were reported to have better accommodation arrangements for staff. Ten facilities did not have any telephone connection; whilst 2 facilities (1 public and 1 private) did not own a vehicle (see Table 4).

Table 5: Availability of protocols in Health Facilities

Availability of protocols	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
Having protocols for IMNCI	10 (71.4%)	3 (42.9%)	11 (84.6%)	2 (25.0%)
Having protocols on HMIS	5 (35.7%)	0 (0.0%)	3 (23.1%)	2 (25.0%)

As can be seen in Table 5, 13 health facilities out of the 21 have protocols for Integrated Management of Childhood and Neo-natal Illnesses (IMNCI). More rural facilities (71.4%) were reported to have IMNCI protocols compared to urban facilities (42.9%). Similarly more public than private facilities have IMNCI protocols, 84.6% and 25.0%, respectively. Only 5 out of the 21 facilities reported having protocols on Health Management Information System (HMIS).

3.1.3 Health Services

Table 6: Services in Health Facilities

Services in health facilities	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
Facilities providing 24 hour services	13 (92.9%)	6 (85.7%)	13 (100%)	6 (75.0%)
Facilities with 2 or more days of ante natal clinics in a week	4 (28.6%)	7 (100%)	7 (53.8%)	4 (50.0%)
Facilities with 2 or more days of under-5 clinics in a week	3 (21.4%)	5 (71.4%)	6 (46.2%)	4 (50.0%)
Facilities with 2 or more outreach clinics in a week	12 (85.7%)	1 (14.3%)	11 (84.6%)	2 (25.0%)
Facilities not providing any outreach services	2 (14.3%)	5 (71.4%)	2 (15.4%)	5 (62.5%)
No. of outreach services in a month (mean; SD)	7.0 (SD 4.350)	2.43 (SD 5.996)	8.08 (SD 4.890)	1.25 (SD 2.435)
Facilities with 1 or more days of surgery services in a week	0 (0.0%)	2 (28.6%)	0 (0.0%)	2 (25.0%)

Table 6shows a sample of services offered by the health facilities. All public facilities were providing services 24 hours a day. Urban facilities conduct more antenatal and under-five clinics at base; whilst rural facilities had more outreach clinics. Only 2 public health facilities did not

provide any outreach clinics. They were Serrekunda Health Centre and Banjul Polyclinic, all in the urban area. Surgery services were not provided in any rural health facilities, while two private facilities provide surgery services in the urban areas.

Nearly all the facilities had referral arrangements. Most referrals were for surgery, specialised care, radiology and in-patient services. All rural facilities referred patients for specialised care and surgery. Most facilities seemed to be able to handle uncomplicated delivery, as only 8 out of the 21 would refer such cases, see Table 7.

Table 7: Facilities that would refer for laboratory, radiology, in-patient and other services

Referral services	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
Lab tests	7 (50.0%)	2 (28.6%)	7 (53.8%)	2 (25.0%)
Radiology	12 (85.7%)	5 (71.4%)	12 (92.3%)	5 (62.5%)
In-patient	9 (64.3%)	3 (42.9%)	8 (61.5%)	4 (50%)
Specialized care	14 (100.0%)	4 (57.1%)	12 (92.3%)	6 (75.0%)
Surgery	14 (100.0%)	5 (71.4%)	13 (100%)	6 (75.0%)
Uncomplicated delivery	5 (35.7%)	3 (42.9%)	5 (38.5%)	3 (37.5%)

According to Table 7, there were more referrals from rural health facilities compared to urban facilities; and similarly more referrals from public health facilities compared to private facilities.

3.1.4 Laboratory services

Table 8: Availability of laboratory tests on the day of survey

Laboratory test	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
HIV testing	7 (50%)	5 (71.4%)	7 (53.8%)	5 (62.5%)
Malaria smears (thick and thin)/ Rapid diagnostic test	12 (85.7%)	7 (100%)	12 (92.3%)	7 (87.5%)
Syphilis testing (RPR Test)	6 (42.9%)	5 (71.4%)	7 (53.8%)	4 (50.0%)
Haemoglobin estimation	11 (78.6%)	6 (85.7%)	10 (76.9%)	7 (87.5%)
Urine protein	8 (57.1%)	5 (71.4%)	6 (46.2%)	7 (87.5%)

Urine glucose test	6 (42.9%)	5 (71.4%)	5 (38.5%)	6 (75.0%)
Gram stains	3 (21.4%)	3 (42.9%)	3 (23.1%)	3 (37.5%)
Pregnancy testing	9 (64.3%)	5 (71.4%)	7 (53.8%)	7 (87.5%)
Blood sugar	9 (64.3%)	5 (71.4%)	7 (53.8%)	7 (87.5%)

All the 21 facilities were asked about which laboratory tests they were able to perform on the day of the survey. Haemoglobin estimation and rapid diagnostic test (RDT) for malaria were the 2 main laboratory services available, for both rural and public facilities. Otherwise, laboratory services were available more in urban and private facilities. Pregnancy test was available in 7 public and private facilities each. Malaria smear/RDT was more available in urban areas and private facilities. HIV testing was available in 12 of the facilities. Gram staining was the least available laboratory test on the day of the survey, see Table 8.

Table 9: Availability of equipment for antenatal care

Antenatal Care Equipment	Health facilities with at least one functional equipment (%)
Examination table/bed	20 (95.2%)
Fetoscope	20 (95.2%)
Blood pressure instrument	20 (95.2%)
Tape measure	20 (95.2%)
Adult weighing scale	20 (95.2%)

NjabaKunda HC was the only health facility without any available and functioning antenatal care equipment from the list in Table 9. All the other 20 facilities visited had at least 1 functioning examination table/bed, fetoscope, blood pressure machine and an adult weighing scale.

Table 10: Reported Drug Stock-outs during previous 30 days

Medicines and vaccines	No. of health facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
General Medicines				
Tetracycline ophthalmic ointment	6 (42.9%)	1 (14.3%)	6 (42.6%)	1 (12.5%)
Paracetamol (Panadol) tabs_Adult	6 (42.9%)	1 (14.3%)	6 (42.6%)	1 (12.5%)
Paracetamol (Panadol) tabs_Paediatric	5 (35.7%)	2 (28.6%)	6 (42.6%)	1 (12.5%)
Paracetamol (Panadol) Syrup	8 (57.1%)	2 (28.6%)	9 (69.2%)	1 (12.5%)
Amoxicillin (tabs or capsule)	6 (42.9%)	1 (14.3%)	7 (53.8%)	0 (0.0%)
Amoxicillin (syrup)	8 (57.1%)	2 (28.6%)	9 (69.2%)	1 (12.5%)
Ampicillin caps	7 (50.0%)	1 (14.3%)	8 (61.5%)	0 (0.0%)
Ampicillin syrup	10 (71.4%)	3 (42.9%)	11 (84.6%)	2 (25.0%)
Ampicillin injection	5 (35.7%)	1 (14.3%)	5 (38.5%)	1 (12.5%)
Oral Rehydration Solution (ORS) packets	9 (64.3%)	1 (14.3%)	8 (61.5%)	2 (25.0%)
Iron tabs (with or without folic acid)	4 (28.6%)	0 (0.0%)	4 (30.8%)	0 (0.0%)
Folic acid tabs	6 (42.9%)	1 (14.3%)	7 (53.8%)	0 (0.0%)
Other antibiotics besides Amoxicillin	4 (28.6%)	1 (14.3%)	5 (38.5%)	0 (0.0%)
Vitamin A_100,000IU	3 (21.4%)	1 (14.3%)	4 (30.8%)	0 (0.0%)
Vitamin A_200,000IU	3 (21.4%)	0 (0.0%)	2 (15.4%)	1 (12.5%)
Mebendazole	3 (21.4%)	1 (14.3%)	4 (30.8%)	0 (0.0%)
Family planning commodities				
Male Condoms (1 unit)	3 (21.4%)	0 (0.0%)	1 (7.7%)	2 (25.0%)
Female Condoms (1 unit)	4 (28.6%)	2 (28.6%)	5 (38.5%)	1 (12.5%)
Microgynon (28-day cycle)	6 (42.9%)	0 (0.0%)	5 (38.5%)	1 (12.5%)
Microlut (28-day cycle)	7 (50.0%)	0 (0.0%)	7 (53.8%)	0 (0.0%)
Injectable _1 month dose	3 (21.4%)	1 (14.3%)	4 (30.8%)	0 (0.0%)
Injectable _3 month-dose	4 (28.6%)	0 (0.0%)	4 (30.8%)	0 (0.0%)
Emergency FP Pill	4 (28.6%)	1 (14.3%)	5 (38.5%)	0 (0.0%)
Implant jadelle (1 unit)	5 (35.7%)	1 (14.3%)	6 (46.2%)	0 (0.0%)
Intrauterine Device (IUD) (1 unit)	5 (35.7%)	1 (14.3%)	6 (46.2%)	0 (0.0%)
Malaria medicines				
Quinine (1 tab)	5 (35.7%)	2 (28.6%)	6 (46.2%)	1 (12.5%)
Fansidar / Sulphadoxine-Pyrimethamine (SP) (1 tab)	2 (14.3%)	0 (0.0%)	2 (15.4%)	0 (0.0%)
Artemisinin-Based Combination Therapy ACT (Fansidar + Artesunate) / Coartem (1 tab)	3 (21.4%)	1 (14.3%)	3 (23.1%)	1 (12.5%)

The availability of medicines was also assessed. As can be seen in Table 10 many public health facilities reported the most stock-out of essential medicines in the past 30 days. Among the general medicines, the least stock-out was for Vitamin A-2000,000 IU in 15.4% of facilities. Seven of the general medicines were not available in the past 30 days for over half of the public health facilities. Among the family planning (FP) commodities, the male condom was more widely available. For anti-malaria medicines, Coartem and Fansidar were not available in 3 (21.4%) and 2 (15.4%) public health facilities, respectively.

3.1.5 Funding and Incentives

The three main sources of funding or income for rural and public health facilities were Ministry of Health, user fees and donors, see Table 11. Urban facilities, on the other hand were mainly funded through user fees, government, and lab/radiology fees. For private facilities their main source of funding was from user fees, followed to a lesser extent from government, lab/radiology fees and donors.

Table 11: Sources of funding and Incentives

Major sources of revenue	No. of facilities (%)			
	Rural (N=14)	Urban (N=7)	Public (N=13)	Private (N=8)
Ministry of Health	10 (71.4%)	3 (42.9%)	10 (76.9%)	3 (37.5%)
User fees	7 (50.0%)	5 (71.4%)	7 (53.8%)	5 (62.5%)
Lab. / radiology fees	1 (7.1%)	3 (42.9%)	1 (7.7%)	3 (37.5%)
Faith based organizations	1 (7.1%)	1 (14.3%)	0 (0.0%)	2 (25.0%)
Private company	0 (0.0%)	2 (28.6%)	0 (0.0%)	2 (25.0%)
Donor	6 (42.9%)	1 (14.3%)	4 (30.8%)	3 (37.5%)
Facilities providing any staff incentive or salary top ups in the last quarter	5 (35.7%)	1 (14.3%)	4 (30.8%)	2 (25.0%)

Table 12: Training needs expressed by Health Workers

Services in health facilities	No. of facilities (%)
Labour and Delivery	11(52.4%)
Mental Health	11 (52.4%)
IDD Control and Prevention	16 (76.2%)
Management of Sexually Transmitted Infections (STI)	21 (100%)

Health workers from more than 50% of the facilities demanded for training in Labour and Delivery and Mental Health. Staff from three-quarters($^3/_4$) of the facilities needed training in IDD control and prevention.

Table 13: Distance to higher level of facility

Distance	No. of facilities (%)			
	Rural	**Urban**	**Public**	**Private**
Less than 10 KMs	1 (7.1%)	3 (42.9%)	2 (15.4%)	2 (25.0%)
10-19 KMs	4 (28.6%)	3 (42.9%)	3 (23.1%)	4 (50.0%)
20-29 KMs	4 (28.6%)	0 (0.0%)	4 (30.8%)	0 (0.0%)
30-39 KMs	3 (21.4%)	1 (14.3%)	3 (23.1%)	1 (12.5%)
40-49 KMs	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
50+ KMs	2 (14.3%)	0 (0.0%)	1 (7.7%)	1 (12.5%)

Table 13 shows the distance from the health facility to the referral facility, which was estimated based on responses from health workers. Most of the urban facilities referred to places within less than 20 kilometres distance. In the rural areas the opposite prevailed, most referred to other higher level facilities more than 20 kilometres away.

Referrals were evacuated using ambulances. Elevenof the public health facilities had ambulances. Only Banjul Polyclinic, in the urban area and NjabaKunda Health Centre in North Bank in the rural area, did not have any functional ambulance.

3.2 Focus Group Discussions

Information from the FGDs complemented the health facility survey. They were held in order to explore particular issues in greater depth. Participants were encouraged to express their views freely. This added to the quantitative information obtained and facilitates a greater understanding of the situation in the Primary Health Care (PHC) system and the communities.

3.2.1 Characteristics of FGD participants

The FGDs were conducted with 7 Village Support Groups (VSGs) and 16 other Community Based Organizations (CBOs). The CBOs were from 10 Village Development Committees (VDCs), 2 Traditional Communicatorgroups (TCs), 2 health centre Catchment Area Committees (CACs), and 2 other local community groups.

The standard VSG membership is 8, usually 3males and 5 females, comprising the Village Health Worker (VHW), Traditional Birth Attendant (TBA), and 6 other members selected by the community. Most of the VSG members and CBOs who participated in the FGDs were elderly, between the ages of 30 and late 70s. Many have little or no formal education. The few who had formal education stopped at the primary (Lower Basic) or junior secondary (Upper Basic) level. Among the VSG members, however, many have received training within the past 1 year and some of them in the past 6 months or less.

3.2.2 Common health and nutrition related issues in the Community

Box 1: Commonly reported health and nutrition issues by the community groups (VSGs and CBOs)	
General health and related issues	➢ Malaria, diarrhoea, hypertension, diabetes, anaemia, stomach pain, chest pain and coughing. ➢ Socio-cultural beliefs and assumptions: Some women still approach traditional healers for abortion and infant care. ➢ Limited access to health messages, lack of medicines, limited Coartem with VHW also affect access to community level care. ➢ Bad harvest and food shortage in the rainy season affect nutritional

	status. ➢ Not having transportation arrangements in the community delays timely care. ➢ Unsanitary environment and poverty also limits healthy living.
Issues of under-5	Malaria, diarrhoea, pneumonia and malnutrition
Issues of pregnant women	➢ Malaria, fever, anaemia, bleeding in pregnancy, stomach pain, lower abdominal pain and cough. ➢ Other issues are difficult labour leading to caesarean section, late booking for antenatal care, poor diet and poverty.
Issues of adolescents	Stomach pain, lower abdominal pain, smoking and limited access to health messages

VSGs and CBOs have a common understanding of the health and nutrition issues in their communities. In Box 1 above these have been broken down into general conditions and conditions that affect children under-5, pregnant women and adolescents. A few have said they have noticed an increase in pneumonia this year, referring to 2013.

*"As for pneumonia, it is very common this year."*VSG member, Mandinari

3.2.3 Health and nutrition services provided by VSGs and CBOs

Box 2: VSGs
➢ Environmental sanitation ➢ Procurement of medicines for VHW ➢ Nutrition education to mothers, pregnant and lactatingwomen ➢ Promote use of locally available foods ➢ Educate mothers on exclusive breastfeeding, and complementaryfeeding after 6 months ➢ Advice women to go to clinic within the 1st 3 months of pregnancy ➢ Advice mothers to take their infants to clinic after the naming ceremony ➢ Assist the CHN in conducting the twice yearly nutrition surveillance ➢ CHNs supply "plumpy'nuts" and "BP-100" through the VSGs ➢ Promote family planning

CBOs
➢ Environmental sanitation ➢ Assist the CHN in conducting nutrition surveillance ➢ Promote exclusive breastfeeding for the 1st 6 months ➢ Disseminate health messages

VSGs and CBOs provide health and nutrition related services to their communities, which they view as part of their mandate. Box 2 lists a comprehensive range of services that VSGs and CBOs are involved in within their communities. Environmental sanitation refers to cleansing exercises that the communities would conduct. VSGs help to organise these village cleansing exercises, known locally as "set settal".

> *"We organise "set-settal", but lack of cleaning materials is a major challenge."*VSG member Mandinari

One VSG participant said they have bought medicinesfor the VHW.

*"We do buy medicines for the VHW in case of emergency."*VSG member, Diabugu

VSGs also participate in various health and nutrition talks, including advising pregnant women to attend clinic during the first trimester. A VSG member from Diabugu health centre catchment area sums it nicely:

> *"We sensitise women on exclusive breastfeeding, how to take care of their children and on environmental sanitation and personal hygiene."* VSG member, Diabugu

VSGs also work with the CHN supervisor to manage malnourished children in their communities.

> *"We work with the CHN and conduct nutrition surveillance and we use the results to educate mothers on the dangers of malnutrition."* VSG member, Diabugu.

3.2.4 Major challenges and opportunities in delivering responsibilities by VSGs and CBOs

Box 3: Major challenges and opportunities of VSGs

Challenges of VSGs

- Limited capacity and awareness on community health and nutrition management. VSG members are not fully equipped to manage community health and nutrition issues.
- Some TBAs are not trained in managing pregnancy care.
- Lack of medicines and RDTs with VHWs limits timely management of health issues. This reduces the community's confidence on VHWs.
- Some TBAs manage with limited equipment in their delivery kit.
- VSGs face shortage of sanitary materials and equipment (e.g. metallic weighting scale)
- The IEC programs are not regular and well organized as VSGs face shortage of IEC materials such as posters and loud speakers.
- Cooking demonstrations are irregular due to inadequacy of cooking utensils.
- VSGs face challenges in evacuating patients from the community to the nearest health centre due to distance factor and limited transportation arrangements. These issues are more chronic at night and in ferry crossing points.
- VSGs also have constraints in community mobilization for health education, especially to gather women.
- VHWs, TBAs and VSGs are currently de-motivated to perform mainly due to limited financial incentives.
- Current data recording is irregular, mainly due to shortage of record books.

Opportunities for VSGs

- Training conducted by NaNA increases knowledge and awareness of VSG members.
- Sometimes they are able to borrow utensils for cooking demonstrations
- The outreach clinics in the village provide VSGs a linking platform to the Community. The CHN weighs the children monthly and reports to VSGs the details of those whose weights are low and those not attending clinic regularly. This enables VSGs to follow up with those children.
- CHWs (VHWs and TBAs) are very cooperative with other VSG members.

- Role of the Alkalo as adviser to the VDC. The Alkalo is the head of the village. His involvement with the VDC as adviser gives recognition and respect for the VDC.

Scope of CBOs in Community Health and Nutrition activities

- CBOs work with VSGs and CHNs and have understanding of the community health and nutrition issues.
- Lack of resources, and community mobilization skills limit the effectiveness of CBOs in community health and nutrition activities
- There is cordial relationship between health staff and CBOs, which gives courage to CBOs to engage themselves more in community health.

Box 3 describes the major challenges and opportunities that VSGs face. The challenges are related to availability and accessibility of services, IEC/BCC materials, medicines and medical equipment, the referral system, cultural issues, and capacity of VSG members. These difficulties constrain VSGs in executing their functions.

*"The VSG needs more training."*VSG member, KaniKunda

"We are weak due to inadequate refresher training." VSG member Sintet

As well as shortage of medicines in the health centres, most VSGs mentioned the shortage of medicines and delivery items for the VHW and TBA.

*"Our VHW does not have medicines and we are poor."*VSG member Basori

*"There are no medicines for malaria, diarrhoea and pneumonia with our VHW."*VSG member, Essau

As a VHW, the lack of RDTs to diagnose [malaria] and medicines such as Coartem and paracetamol to treat [malaria] is a major challenge." VSG member, Madinari

"Some items are missing [from the delivery kit], only the box and the [weighing] scale." VSG member, KaniKunda

*"We have been functioning without Coarterm for the last three years", VSG*member, KaniKunda

Sanitary equipment and materials are used in cleansing exercise referred to as "sett-settal" exercises. These include wheel barrows, rakes, cutlasses, etc. VSGs would use these items during village cleaning exercises, and to mobilise community members to come out and join in the village cleaning.

> *"We organise "set-settal", but lack of cleaning materials is a major challenge."*VSG member Mandinari

IEC/BCC materials help the VSGs disseminate health and nutrition messages. These materials include posters, flyers, T-shirts with health or nutrition messages printed on them, loud speakers, etc.

> *"Posters will also help us in our campaigns and cooking demonstrations."*VSG member, Essau

VSGs use cooking demonstrations to teach mothers the kinds of foods to prepare for children, especially malnourished ones. The unavailability of utensils to use for these occasions would limit the VSGs ability to demonstrate how to prepare nutritious foods for malnourished children.

> *"For cooking utensils, we provide that ourselves. We want partners to help us with our own cooking utensils."* VSG member, Essau

Some villages are quite far from the nearest health centre. In case of emergencies there can be delay in reaching the health centre, which can be fatal, especially for a pregnant woman. In some instances the distance can be short but because there is a river crossing involved, it becomes more challenging.

> *"When we have referrals we encounter ferry crossing problems [between Barra and Banjul], then we refer the patient to Farafenni [over 100 KM from Essau]; and sometimes our patient dies before reaching the referral point."*VSG member, Essau

In spite of the challenges, there are opportunities available to VSGs. For example, the training programmes organized by NaNA are seen as an opportunity to improve their knowledge on health and nutrition issues; and the outreach clinic in the village is an opportunity to know who

among the under 5 children have low weight-for-age, whose mothers are targeted; and being able to borrow utensils to conduct cooking demonstrations within the community.

> *"Since we had training with NaNA, [we] relate the information to the people and they are followed; we have seen great improvement in our children's growth."*VSG member, Mandinari
>
> *"The coming of Jarjusey [referring to the CHN Supervisor] to weigh our children on a monthly basis is a big opportunity. We always work very closely with him and we tell him to alert us with any child whose weight is low or who has not been attending clinic regularly so we can follow them up and give advice."*VDC member, Mandinari

The CHWs (VHWs and TBAs) are part of the VSG and they cooperate and work well with other VSG members.

> *"The TBA informs me of all the births in the community and I visit the mother to educate her on breastfeeding."*VSG member, Basori

VSGs also appreciate the support from health facility staff:

> *"We have lesser constraints because we are getting support from health staff."*VSG member, Sintet

3.2.5 Current mechanisms of data recording and management

Box 4: Mechanisms of data recording and management

- VHWs and TBAs use tally sheets to record their data and give it to the CHN at the end of the month.
- The data helps VSGs know the common illnesses in the month so they can focus their health talks appropriately.
- During meetings CHWs and VSGs can tell the number and types of illnesses
- Village deliveries are recorded in a book. This keeps VSGs updated on newly delivered women in the communities to target them for exclusive breastfeeding, clinic attendance, etc.
- TBAs record all births and deaths in the village.
- Minutes of meetings are not recorded.

- VSG members expressed their concern on the current data recording practices. Often, due to limited record books and pens, they do not record data timely.
- Some VSG members were aware of the importance of data recording, while the situation was reverse for a few others.
- Sometimes illiteracy forces them to depend on school children for data recording.

At community level data is managed by each actor. As many of them are not literate they resort to using school children in the community to record data for them.

> *"I use tally sheets to record data and at the end of the month I give it to the CHN."* VSG member, Mandinari
>
> *"The TBA records all the births and deaths in the community. [She] informs the VSG of all the births and deaths."* VSG member, Basori
>
> *"One thing I forgot, since we cannot write we plead with the youths who can write to record such data and we give them some money."* VSG member, Mandinari

Many of them seem to know and understand the importance of data and how to use it.

> *"It helps me know the most common illnesses in the month and [helps me] focus my health talks on those illnesses."* VSG member, Mandinari
>
> *"As soon as we know someone has delivered we record it. They become a target for advice on breastfeeding."* VSG member, Mandinari

Some VSG members do not understand anything about data management.

> *[I have] no idea [about] data management at the community level."* VSG member, Essau

3.2.6 Current mechanisms for supervision, monitoring, and feedback between a community health/nutrition structure and the basic health facilities

Box 5: Mechanisms for supervision, monitoring, and feedback
➢ VSGs are supervised by the CHN of the area ➢ The CHN gives feedback to the VSGs, especially about malnourished children ➢ Feedback is used by CHWs and VSGs to make follow-ups on children, mothers and pregnant women. ➢ None of the VSGs reported any issue with the current reporting supervision and reporting mechanism

The CHN supervisor is a key person in the monitoring and supervision of CHWs and their VSGs and CBOs. The CHN involves them in the health and nutrition activities conducted at village level.

"We are only supervised by the CHN of the area." VSG member, Sintet

"We conduct nutrition surveillance with the CHN." VSG member, Basori

*"Whenever he [the CHN] comes, he makes sure that we sit together and gives us feedback on the children's weight, immunization status and other related issues."*VSG member, Mandinari

3.2.7 How do Community Health and Nutrition Structures/Actors relate to other CBOs?

Box 6: Relationship with other CBOs
➢ VSGs and VSDs work with CBOs during village cleaning exercises. They fix nutrition days and other activities together with CBOs. ➢ VSGs, CBOs and traditional communicators (TCs) jointly organize cooking demonstrations in the villages ➢ VSGs, CBOS and traditional communicators (TCs) collaborate to pass on health and nutrition information.

CHWs and VSGs understand they need to collaborate with other groups and agencies in the community on activities/programmes related to health and nutrition.

> *"We all come together and discuss on issues and work together. Even set-settal, we choose a date together and work together. We don't do things in isolation."* VSG member, Mandinari
>
> *"We collaborate with the traditional communicators in our programmes."*VSG member, Essau

3.2.8 Making the health and nutrition structures/services more effective and acceptable

Box 7: Making VSGs and CBOs more effective and acceptable

- Support from the Ministry of Health and NaNA is required, especially in training and increasing the skills and knowledge of VSG and CBO
- TBAs to be trained and given well equipped delivery kits
- VHWs need to have adequate supplies of medicines
- Provide weighing scales to VSGs to monitor weight of children in the villages
- Provide vegetable gardening materials and equipment
- Provide IEC materials such as posters, T-shirts and loud speakers
- Provide cooking utensils
- Assist with funds to procure food supplies for cooking demonstrations
- Improve communication between VSGs/CBOs with MoH to solve problems more effectively
- Provision of environmental sanitation equipment and materials
- Provide medicines to health centres so that pregnant women and mothers are treated appropriately**.**

When VSGs were asked what can be done to make them more effective and acceptable in their work, the responses were linked to the challenges they mentioned earlier, see Box 3. VSGs expressed the need for training for CHWs and their other members, and the provision of adequate supplies of medicines, delivery kits, IEC/BCC materials.

> *"We need more training to refresh ourselves."*VSG member, Sintet

"Please provide more capacity building for us." VSG member Basori

*Having materials such as rakes, wheelbarrows, loud speakers, posters, and delivery kits will also be very helpful."*VSG member, Mandinari

"We need more [vegetable] garden inputs." VSG member, Sintet

"We want to know how to monitor the children's growth and do the [nutrition] surveillance ourselves." VSG member, KaniKunda

"Medicines should be available at the health facilities rather than referring patients to the [commercial] pharmacies." VSG member, Diabugu

"[we need] starting capital to buy eggs, groundnut paste, maize, etc. for our cooking demonstrations." VSG member, Essau

The need to improve communication with the Ministry of Health (MoH) was also highlighted as an issue that can make VSGs more effective.

"Better communication between us and those at the MoH in order to relate and solve problems more effectively." VSG member, Mandinari

3.3 In-depth Interviews

Information from the IDI also complemented the health facility survey and the FGDs. The IDIs explored particular issues in greater depth from the health workers' perspective. This added to the information obtained from the FGDs and the health facility survey and enabled a greater understanding of the situation in the Primary Health Care (PHC) system and the communities.

3.3.1 Characteristics of the IDI participants

The IDIs were conducted among 24 health staff in the Regional Health Teams (RHTs) and health facilities. Six Regional Health Directors (in their absence the next in-charge) were interviewed. In addition, heads of health facilities, and Reproductive and Child Health (RCH) team leaders or their representatives, in public, NGO and private health facilities were also interviewed. Most of the health workers interviewed were between the ages of 26 and 55 (mean 38 years), with most being males. Their cadres included Public Health Officers (PHOs), State Registered Nurse Midwives, State Enrolled Nurse Midwives and Community Health Nurse and Midwives. There

were no Medical Doctors among the health workers interviewed. Seven of the 24 interviewed were health workers from the private health facilities.

3.3.2 Services provided by health facilities at the health facility and community level

Box 8: Services provided by health facilities

Health facility level services

- Outpatient services
- RCH services, including immunization against childhood diseases, growth monitoring for children under 5 years (including screening and management of malnourished children), vitamin A supplementation, family planning, intermittent preventive treatment during pregnancy (IPTp) for malaria, antenatal services, etc.
- Health promotion and nutrition education
- Delivery and postnatal care
- Provision of food for children
- Inpatient services, offered by those facilities with capacity to admit patients
- HIV and AIDS services such as voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), treatment, care and support for people living with HIV
- Laboratory services
- Surgery

Community level services

- Outreach Reproductive and Child Health services (RCH), including immunization against childhood diseases, growth monitoring for children under 5 years (including screening and management of malnourished children), vitamin A supplementation, family planning, intermittent preventive treatment during pregnancy (IPTp) for malaria, antenatal services, etc.
- Screening and management of malnourished children
- Health promotion and nutrition education
- Supervision
- Surveillance

- Food hygiene
- Cooking demonstration
- Environmental sanitation
- Vegetable gardening

Health workers at the facility level were all asked what services their health facilities were providing at the community and health facility level. Box 8 lists the services mentioned by most of the respondents. A few mentioned broadly "preventive services" and "curative services" as the services provided at the community and health facility levels. Some health workers listed additional details such as immunization, family planning, treatment of malaria, Intermittent Preventive Treatment of malaria in pregnancy (IPTp), and Vitamin A supplementation.

Some of the health facility services listed under Box 8 are not performed by all facilities. For example, surgery was mentioned in only one instance. Most of the private health facilities are not involved in any community level services. Most of the public health facilities have some community level services.

3.3.3 Services officially mandated to be delivered but are not being provided

Box 9: Services that are not being delivered in a few of the facilities interviewed

- Family planning
- Prevention of mother-to-child transmission (PMTCT) of HIV
- Postnatal care
- Caesarean section
- Emergency obstetric care (EmOC)
- Surgery
- Scanning
- Microscopic services
- Some deliveries are being referred
- Assisting women deliver at community level
- Inspection of meat

All the health workers were asked about services that they are mandated to deliver but are not being provided by them at community and health facility level. Several services were mentioned, most of them being health facility services, see Box 9. The most common reason for not being able to provide services is the shortage of qualified staff. Other reasons mentioned include lack of electricity, lack of water supply, and inadequate spacing.

"Family planning could not be provided because of limited manpower."

EmOC, scanning, operations, and microscopic services are not done due to lack of materials and erratic electricity."

"Some deliveries are being referred [to another health facility] because of inadequate staff."

One public health worker said postnatal care is not conducted in their health facility.

"Postnatal care is not available."

3.3.4 Status of Health Facilities

Box 10: Status of Health Facilities	
Medicines	Inadequate in all public facilities unlike in any private facility.
Quality of care	➢ Lack of blood supply is a major issue leading to maternal deaths in public facilities. ➢ Shortage of RDT kits
Staff availability, skills and motivation	➢ Inadequate number of trained staff ➢ Limited incentives and low salary affect motivation of staff in public facilities. ➢ Incentives from Global Fund programmes paid to some public health facility staff ➢ In some public facilities, one staff caters to 150 patients a day.
Infrastructure	➢ Inadequate in all public facilities and a few NGO private facilities. ➢ Dilapidated PHC infrastructure ➢ Inadequate accommodation for health workers in rural areas ➢ Many public facilities were not able to provide the essential services they were supposed to offer, as per the National Health Policy 2011-

	2015.
Funds	➢ Funds are limited for constructing buildings and purchasing other supplies in public facilities. ➢ Lack of funds for maintenance and repair of infrastructure
Transport and referral	➢ Transport is always available for outreach clinics ➢ The referral system is 24/7. Ambulance available in most facilities. ➢ Non-availability of fuel affects timely referral in public facilities. ➢ One private facility did not have ambulance and hence use a doctor's vehicle.
Leadership and management	➢ Delay in taking decisions affect procurement of supplies and medicines in public facilities ➢ Private-for-profit facilities are keen to collaborate with Govt. programs as they are not involved in government run PMTCT, Nutrition and LLIN service provision.
Monitoring, supervision and feedback mechanisms	➢ Doctors monitor the staff in private facilities ➢ In public facilities, Officer –in-charge monitors daily and RHTs monitor monthly. ➢ Though staff report to RHTs, they do not receive any feedback from RHTs
Health Education (BCC)	➢ Talk shows, TV shows and community BCC activities exist, but they are not regular
Incentives	➢ Providers in Private facilities receive 500 Dalasis per delivery or some other annual incentives. ➢ Some NGO facilities could not pay the promised incentives to staff due to financial constraints. ➢ Government facilities do provide some incentives, but health facility staff and VSG members demanded more incentives to increase their work motivation.

Box 10 shows the status of health facilities, based on the in-depth interviews with health workers. It shows several challenges faced, especially by public health workers. The shortage of

medicines was found to be a problem in all public health facilities. Shortages of other supplies such as RDTs and blood, which affect the quality of care, are also experienced.

"… erratic supply of medicines especially Coartem and RDTs."

"People should be aware that blood is not manufactured and most maternal deaths are caused by lack of blood."

Staffing is another major challenge in public health facilities. One health worker mentioned that they do not offer FP services because of shortage of staff. The limited qualified staff are overworked and poorly paid. In public health facilities, a midwife sometimes caters to 70- 150 patients for outpatient services in a day. Though the number of patients per staff in an NGO facility is less, they have also demanded for having more staff. While some health workers complained of lack of incentives, others acknowledged that they receive incentives from Global Fund programmes, such as TB, Malaria and HIV/AIDS; and the Global Alliance for Vaccines and Immunization (GAVI) for the immunization services. In one private facility D500 is paid as an incentive for each delivery, and in another one they provide annual bonuses equivalent to the monthly salary of the health worker. Training workshops organised for health workers help boost their capacity for better service delivery.

Infrastructure is another major challenge in all public and a few NGO private facilities. In addition, the village health service (VHS) health posts are dilapidated and without funds to maintain or repair them.

"All PHC infrastructures are dilapidated and abandoned due to lack of funds to maintain and repair them"

The referral system seems to be functioning well with ambulances available for patient evacuation.

"The road is good and the ambulance is always available."

However, it was stated that the non-availability of fuel affects timely referral in public facilities.

"Ambulance is available, challenge is fuel."

Monitoring and supervision is reported to be conducted routinely. One health worker said VHS CHNs supervise PHC villages 4 times a month; whilst RHTs supervise health facilities once a month. There is cordial relationship between the RHTs and the health facilities. However, there is little or limited feedback, and no feedback on referrals.

3.3.5 Making health and nutrition actors/services more effective and acceptable by the community

Box 11: Making health and nutrition actors/services more effective and acceptable

- Provide adequate funds, medicines and supplies. They require continuous and adequate supply of medicines and equipment.
- Motivation and incentives for health and nutrition actors
- Train community members on nutrition and community participation
- Fund for training of VHW and TBA
- Provision of reliable transports/ motorcycles for supervision
- Establish VSGs in those communities which currently do not have a VSG
- Strengthen supervision and data recording at the community level
- Identify and report malnourished children, as quickly as possible, to the health facility
- Construct nutrition centres in communities
- Address common diseases/infections
- Involve the private sector in GFATM and nutrition activities

Health workers have given their suggestions in Box 11 on how to make health and nutrition actors more effective and acceptable. Adequate financial resources is required to incentivise health and nutrition actors, implement the various trainings, provide adequate supply of medicines and equipment for both the health facilities and the village health services, provide transports/motorcycles.

"If you want people to deliver you must give them resources and supplies"

4 DISCUSSION

This study explored the status of the primary healthcare system including community health and nutrition structures in The Gambia. It specifically explored the status of service provision at health facilities (both public and private) and by the community health and nutrition structures. The linkage between the community health and nutrition structures and other higher levels of facility, monitoring and supervision of primary healthcare structures, data management and incentives of staff were also specific aspects of exploration in this study. It included only the health facilities and structures which provided the primary and secondary levels of care.

The study found out that a primary healthcare delivery system has been already laid in the country. However, its current status limits its ability to offer the Essential Service Package, mandated by the National Health Policy: 2011-2015. The major limitations of the health facilities were limited number of skilled staff, work motivation, infrastructure, supplies and medicines. The community health and nutrition structures also had more or less similar status with shortage of skilled health workers and supplies. The Management of the health facilities also needed improvement, especially the supervision of staff and data recording and utilization.

Infrastructure and services

During the health facility surveys both minor and major health centres were visited. Most of the facilities had a very basic infrastructure for the delivery of health services. These included reception room and a waiting room. A few had a separate waiting room for females. However, this infrastructure status is not adequate to meet the mandates of the National Health Policy, specifically to meet the related MDGs. Some rural public health facilities did not have any functional toilets for patients. Health facilities are part of the community and hence, they should promote health and sanitation and safety of patients. The first programme in delivering the Basic Package of services within the Health Policy is environmental health and safety, which include "proper management of solid, gaseous and liquid wastes". The 2 rural public health facilities without functional toilets may not be able to promote the use of toilets in their communities and for their patients.

All the facilities had electricity and a safe source of drinking water. However, prolonged hours of power and water shortages did adversely affect the proper functioning of many public facilities in the rural areas.

Nearly all health facilities had in-patient services, with 12 (57.1%) having 10 or more beds. The major health centres all have fewer number of beds than what is recommended in the health policy: "The standards for bed capacity for major health centres range from110-150 beds per 150,000 - 200,000 population." Brikama Health Centre had the most number of beds, 86.

We did not find any substantial difference in the infrastructural status between public and private facilities and those in rural and urban areas.

Funding and incentives

Public health facilities mostly depended on government funding and user fees. Private facilities, on the other hand, mainly relied on user fees and donations. User fees in public facilities are regulated by the MoHSW. In a public facility services are free for maternal care and for under-five children. A caesarean section in a major health centre, if it were to be done, would be free; whilst in a private facility it may cost from D10, 000 upwards. Though in principle, RCH services are free, shortage of medicines and laboratory services do force pregnant women to incur out-of-pocket expenses. Some of the NGO facilities in rural areas also did not charge substantially for RCH care (except fee for medicines and a nominal consultation fee). However urban private facilities operate differently with much more higher charges for their services.

Staff in private health facilities received much better salary and incentive packages than their counterparts in the public sector. They also have relatively lesser workload. Consequently they may most likely be better motivated and may have a more positive attitude to work and patients. However, it is true that financial sustainability is a concern for private facilities and hence often they were not able to pay the promised incentives to staff.

It is worth noting here that one of the guiding principles in the health policy is about skilled staff retention and circulation. It talks about attractive service conditions (package); and job satisfaction to encourage a net inflow of skills.

Human resources

At the public health facility level, there were shortages of qualified personnel. No Medical Officers were seen in the public health facilities. In their absence, the most qualified would be the SRN Midwife or SRN without additional midwifery training. In 2 major health centres the head of the RCH teams were CHN Midwives. This is an indication that staff attrition among the SRN category is high. According to the Policy on Human Resources for Health (2005-2009) "the attrition rate among health professionals in general, is estimated at between 30 – 50 per cent. The rates are higher for some cadres, including the State Registered Nurses, Medical Doctors, Public Health Officers and Laboratory Technicians. More than 50 per cent of PHOs who qualified in the past ten years have already been lost. Poor conditions of service and work environment are among factors leading to such high attrition."

Other challenges that have a direct impact on Human Resources for Health (HRH) and the performance of health system included inadequate management capacities at all levels, communication difficulties between various levels of the health system and inadequate supervision (National Health Policy 2011-2015). This study finding also reiterates the above shortcomings pointed out by the National Health Policy.

At the community level, there are VHWs and TBAs. These two, in Gambian terminology are called Community Health Workers (CHWs). According to the FGDs there are some untrained TBAs. Deliveries conducted by TBAs are not regarded under the MDG5 indicator as "skilled attendant at birth". TBAs, however, conduct home deliveries, which make up approximately one-third of all deliveries (GBoS, 2013b); and refer pregnant women for facility delivery. TBAs are part of the VSGs and together promote health and nutrition in their communities. Their training may contribute to improved maternal care in the community and greater timely referral for institutional delivery.

Health and nutrition actors

In the community, the health and nutrition actors are the VSGs (including the CHWs), and all other CBOs, including the VDCs. These are supported by the CHN Supervisor, who is also part of the MDFT of the area. The VSGs clearly associate themselves with NaNA. They have received training and sanitation materials and equipment from NaNA. They participate in promoting village environmental sanitation, exclusive breastfeeding, advising on child feeding and childcare, antenatal women to report to clinic in their first trimester. They support the CHN Supervisor in conducting the six-monthly nutritional surveillance for the under-fives, and follow-up of the identified malnourished children. VSGs work with other CBOs such as the TCs in community health and nutrition activities and programmes. VSGs and CBOs expressed the need for training and refresher training. Training is a form of motivation and can boost their morale and participation in health and nutrition promotion activities.

Medicines and other medical supplies

Curative services are seen as an important and critical part of the health services at both community and health facility levels. It is a basic element within the minimum package "Out-patient services". Throughout interviews with public health workers, and FGDs with VSGs and CBOs, shortage of medicines both at community and health facility levels came as major concerns and challenges. Some of the VSGs even mentioned that the availability of medicines at these 2 levels will make them more effective and acceptable in their roles and functions. Coartem and RDTs for malaria, one of the leading killer diseases in The Gambia, was frequently mentioned during the FGDs to be in short supply. On the day of the health facility survey, RDTs were not available in one-fourth of the health facilities surveyed, especially Coartem and Fansidar in the past 30 days. The assured availability of medicines and diagnostics in health facilities would build confidence in the communities and contribute to the desired quality of care. Without these, many patients may resort to alternative treatment behaviours, such as going to the traditional healers and/or self-medication.

Referral services

There were improvements in the referral services due to the availability of ambulances in nearly all health facilities. At the health facility, the ambulance is available 24/7. Most health workers

agreed that the referral service from the minor health facility to the major health facility was good. However, occasionally there was non-availability of fuel resulting in another delay. For those facilities in the north bank of the river going to the next level of care on the south bank of the river, there comes a much more serious challenge – ferry crossing. VSG members also described the challenges of pregnant women to reach out to the first level of care, as the transportation facilities were not adequately available in many communities. According to the NBR FGD team, the waiting time for a ferry can take up to between 6-8 hours. Whilst this may not be an average waiting time for a ferry, it shows the difficulties health workers and patients can encounter during referrals from one bank to the other side.

Data management, monitoring and supervision

At the community level, CHWs and VSGs record and use data. Some do not understand the importance and use of data. The shortage of record books limits the scope of daily data recording at the community level. CHWs and VSGs were reported to have a good and strong relationship with their CHNs. The monitoring and supervision role of the CHN is viewed positively. CHNs visit their village up to 4 times in a month. To be able to do this CHNs must have access to motorcycles and adequate fuel and maintenance.

At the health facility level, the staff were routinely monitored in-house. However, the supervision by the RHTs was not reported to be adequate.

5 CONCLUSION

The basic structures of the PHC system in The Gambia have been laid. There exists the village health service staffed by volunteer CHWs supported by VSGs, VDCs and other CBOs. The CHN, who is an extension worker of the MoHSW, supervises and connects this level with the network of health facilities. The CHWs and VSG participate in health and nutrition activities. They are the primary health and nutrition actors at the community level. However, many CHWs are not functional due to the lack of medicines, delivery equipment and other medical supplies. Sanitation and IEC/BCC materials to support village cleaning exercises and the dissemination of information are lacking, weakening the functionality of the VSGs and other CBOs in the respective communities. Many TBAs are currently mainstreamed into the primary care system without proper training.

Public health facilities deliver services under difficult conditions and amidst several challenges. There is inadequacy of skilled staff, medicines and other medical supplies. Staffs in public facilities arereported to be less paid, overworked and poorly motivated, with little or no incentives. Their counterparts in the private sector, however, are better remunerated, better stockedwith medicines and supplies, and better incentivised and more motivated. This study has found out that no public health facility meets the standards and norms in staffing, equipment and supplies according to the current health policy. It is mainly in the areas of patient evacuation and conducting outreach clinics that public health facilities seem to be doing well – there is an ambulance in all public health facilities (except Banjul Polyclinic). The Polyclinic does not conduct any outreach or do referrals.

6 RECOMMENDATIONS

- It is essential to equip the health centres considerably to enable them to offer the essential service package, entitled for the Gambians by the National Health Policy 2011.
- Provide financial and logistics support to public health facilities and community structures to have minimum requirements in terms ofinfrastructure, supplies and skilled staff.
- Initiate for capacity development programs and hands on training for health facility staffs and community health and nutrition structures.
- Engage NGO/private facilities to provide RCH services, as they are willing to collaborate with Government run health programs.
- Support the training of nurses and other health workers at the pre-service stage by increasing the annual intake for the nursing and other health schools.
- Increase the work motivation of health facility staff and community health and nutrition service providers by reducing their work load, providing better working environment and adequate remuneration.
- The management of the health facilities also needs improvement, especially the supervision of staff and data recording and utilization.
- Improve the data recording system at the community level.
- Upgrade RCH outreach clinics in big communities to health centres
- Provide sanitation and IEC/BCC materials and equipment for CHWs and VSGs
- Support VSGs and other CBOs to engage in vegetable gardening schemes
- Provide motorcycles to CHNs to improve the supervision of VSGs
- TBAs appeared to have a considerable role in sensitizing mothers and providing maternal care. With more capacity development initiatives, they may be able to better support other members of the VSGs.
- Create mechanism for the timely evacuation of patients from the community to health facility level.

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