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Maternal and Child Nutrition and Health Results Project

Technical Brief: The Gambia

December 2015

Health, Nutrition, and Population Global Practice

Impact Evaluation Baseline Report: Health System

Key Messages:

- Inadequate infrastructure, combined with laboratory, drug, and equipment shortages, undermined health workers' capacity to provide services.
- Health worker density varied from a high of 1.4 health workers per 1,000 population in North Bank Region-West (NBR-W), to a low of 0.5 health workers per 1,000 population in the Central River Region (CRR).
- Insufficient staffing, poor resourcing, and low salaries contributed to high levels of dissatisfaction and absenteeism among health workers.
- Relationships among staff, as well as those between providers and patients, were strong and an important driver of health worker motivation.
- More than 25 percent of staff were less than satisfied with the quality of management and nearly 20 percent expressed some degree of dissatisfaction with opportunities to discuss work with their immediate supervisor.
- Most regional health directorates (RHDs) and health facilities reported an acute shortfall in funding that limited their ability to operate.

Introduction

The government of The Gambia is implementing the Maternal and Child Nutrition and Health Results Project (MCNHRP) to increase the use of community nutrition and primary maternal and child health services. In collaboration with the government, the World Bank is conducting an impact evaluation to assess the project's impact on key aspects of maternal and child nutrition and health. The MCNHRP baseline evaluation was conducted between November 2014 and February 2015.

Quantitative and qualitative data were collected on three regions: CRR, NBR-W, and Upper River Region (URR). Its purpose was to establish a baseline against which project performance will be assessed in the future. This technical brief summarizes the baseline report findings related to the health system.

Health Facility Infrastructure

Acute infrastructure challenges exist across the three regions, especially at major and minor health centers. The main inadequacies

This series of policy briefs was produced in direct response to a request from the government of The Gambia to share the findings of the Maternal and Child Nutrition and Health Results Project Impact Evaluation Baseline Survey.

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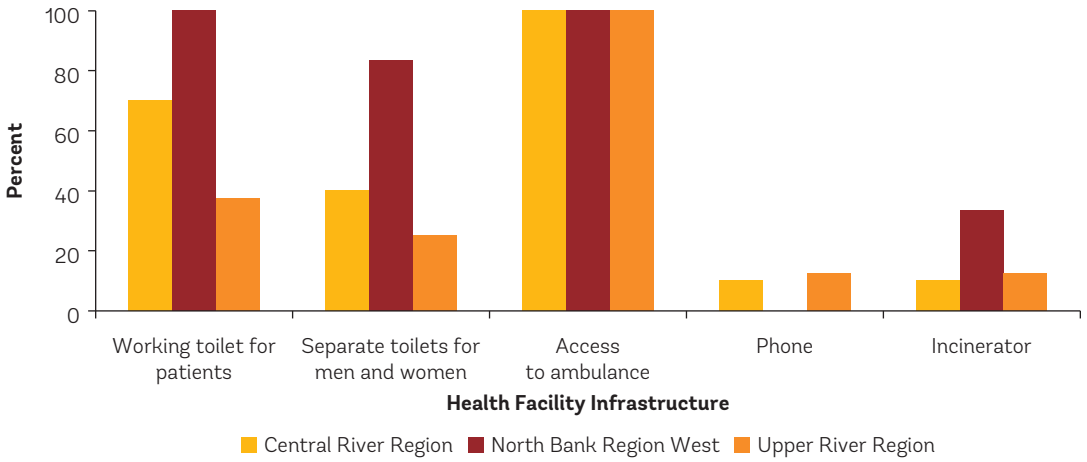
This brief was prepared by a core team comprising Laura Ferguson (Principal Investigator, University of Southern California), Rifat Hasan (co-Principal Investigator, Health Specialist, World Bank), and Chantelle Boudreaux based on the Impact Evaluation Baseline Report produced by Laura Ferguson, Rifat Hasan, Guenther Fink, Yaya Jallow, and Chantelle Boudreaux. The Impact Evaluation Baseline Report benefited from substantial inputs from the Gambia Bureau of Statistics, Mariama Dibba, Halimatou Bah, Momodou Conteh, Sering Fye, Alexandra Nicholson, Hannah Thomas, and Steven Strogga. The team benefited from the general guidance of Vera Songwe (former Country Director), Louise Cord (Country Director), and Trina Haque (HNP Practice Manager). Helpful comments were received from the Project Implementation Committee led by Modou Cheyassin Phall (Executive Director, The Gambia National Nutrition Agency) and comprised of Haddy Badjie, Abdou Aziz Ceesay, Ousman Ceesay, Modou Lamin Darboe, Malang Fofana, Catherine Gibba, Bakary Jallow, Musa Loum, Lamin Njie, and Matty Njie and Menno Mulder-Sibanda (Senior Nutrition Specialist, World Bank). The work was made possible by support from the Health Results Innovation Trust Fund.

Figure 1. Health Facility Infrastructure by Region in The Gambia



mentioned by health workers were: insufficient ward space and consultation rooms, lack of basic drugs and equipment, inadequate electricity supply, lack of incinerators, poor staff quarters, inadequate waiting areas, and insufficient vehicles. There was wide concurrence from clients, among whom the most often reported shortcomings were: lack of basic drugs and equipment, inadequate electricity supply, inadequate waiting areas, and insufficient vehicles for evacuations and referrals.

While all facilities had access to an ambulance, availability of other basic amenities was much lower (figure 1). More than half of the 24 health facilities reported a power outage in the seven days preceding the survey and almost two-fifths of the facilities had water outages over the same time. Qualitative data highlighted the effects of limited hours of electricity as well as shortages of the necessary equipment and staff, which restricted the availability of laboratory and other services.

Chronic underinvestment in maintenance, overcrowding, poor sanitation, and a lack of space were complaints among health staff and clients alike. This situation compromised privacy and other aspects of the quality of care. Nearly half of health workers reported feeling that the quality of care was constrained by the facility's working conditions.

"For us, lack of materials is our problem. Sometimes when you need to do something the materials are not available and some of these materials patients cannot buy them especially if we have an emergency case like Hydralazine [drug used to treat hypertension in pregnancy] is not available, catheter is not available. Sometimes it's just crazy, to be candid enough, this is just crazy. Cord scissors, no not available. We ask the women to go and buy razor blades. It's just crazy actually... it's crazy... if I want to work, I want the materials."
– Health worker, URR

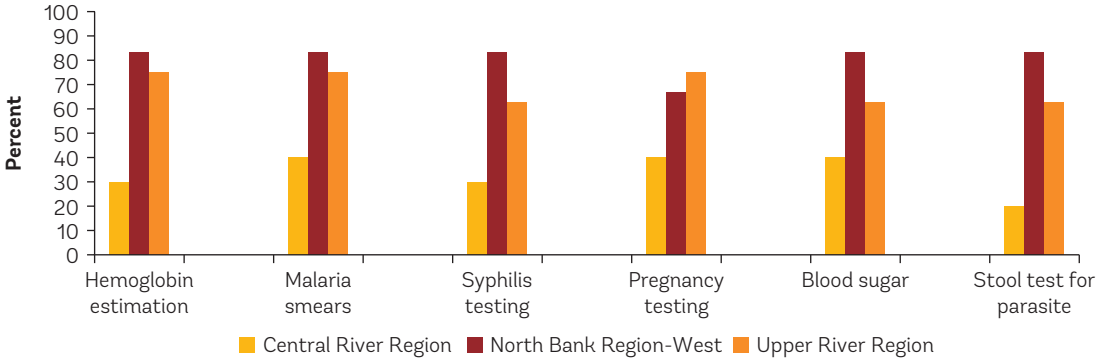
Availability of Supplies, Drugs, Equipment, and Services

While the drugs Paracetemol, Fansidar, and Coartem were generally available, stockouts of other drugs were widespread and, despite the existence of guidelines on essential drugs for health facilities, insufficient resources left many health managers unable to meet minimum standards. The tuberculosis drug Rifampin and the antibiotic Amoxicillin, in particular, were frequently unavailable. There was significant regional variation in supply, with stockouts least common in NBR-W.

Health facilities in CRR were the least able to perform basic laboratory services while facilities in NBR-W reported the best equipped laboratories (figure 2).

"I always go with the expectation that I will get some medicine like even Paracetamol but it doesn't materialize. The last time I went with my son who was having chest pain, but there was no medicine available. I was referred to [a different] health center to buy the drugs, what a waste of time!"
– A woman who had delivered in the previous six months, CRR

Figure 2. Laboratory Test Availability by Region



Human Resources for Health

Insufficient staffing has important implications for the provision of care. While the government has formally increased the quota of health worker spaces available, a substantial proportion of positions remain unfilled, resulting in a very low health worker density. Estimates vary from a high of 1.4 health workers (defined as doctors, clinical officers, or nurses) per 1,000 population in NBR-W, to a low of 0.5 health workers per 1,000 population in CRR.

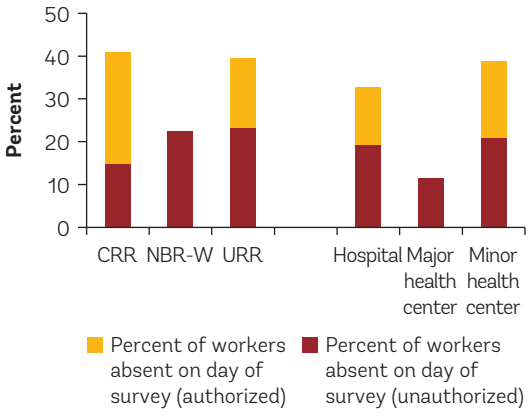
Shortages cut across all cadres including doctors, nurses, lab technicians, pharmacists, and data clerks. Many health workers noted that this labor gap created day-to-day challenges and had an impact on the availability of services. Health information activities and the quality of data collected may have been particularly affected by these shortages, as data was rarely used for internal planning or performance assessments. Qualitative data suggests that data recording is a particularly marginalized task and that quality is compromised when staff are busy.

Some health workers considered time constraints to be a barrier to consistent and appropriate client care—nearly 20 percent of health workers reported not having time to appropriately deal with clients. Community members' perceptions of health worker attitudes were mixed, with some describing positive experiences and others citing poor attitudes and neglect of patients as problems in some health facilities.

The generalized staff shortage is exacerbated by high rates of absenteeism, both sanctioned and not. Although self-reported absenteeism was low, the percentage of workers absent on the day of the survey was high (figure 3). In URR, where there was only one health worker for every 1,000 population, nearly one in four staff was absent without permission. When authorized absences are also considered, only approximately six out of every ten health staff were on duty in CRR and URR on the day of the survey.

Some authorized absences are unavoidable. For example, in-service training is a critical part of ensuring that the health system remains responsive in a dynamic environment. Of the 94 staff participating in the survey, 85 (90 percent) perceived a need for additional training, with training related to the integrated management of childhood illnesses (IMCI), tuberculosis, postnatal care, and nutrition being the most in demand. Perceived need varied greatly by facility type—while only 9 percent of major health center staff reported a need for training in antenatal care, twice this proportion requested training at hospitals. Focus group discussions highlighted a broader range of training needs, including communication, data management, financial management, fundraising, information technology, management, monitoring and evaluation, and results-based financing.

Figure 3. Absenteeism at Health Facilities



Health Worker Satisfaction

Health workers reported generally high satisfaction with specific components of their job (for example, 97 percent stated that their job made them feel good about themselves and 80 percent were satisfied with the available opportunities to use their skills on the job). Relationships at health facilities—both intra-facility and facility-community—are strong. Health workers also emphasized a client-oriented approach, including being friendly and polite to all clients and allowing clients to ask them questions.

At the same time, however, many health workers reported high levels of frustration with their work. Satisfaction with remuneration and benefits was particularly low, as 81 percent reported dissatisfaction with their salary and 77 percent were dissatisfied with their benefits. Overall, 65 percent of health workers reported that they would prefer to work at a different facility.

Leadership and Management

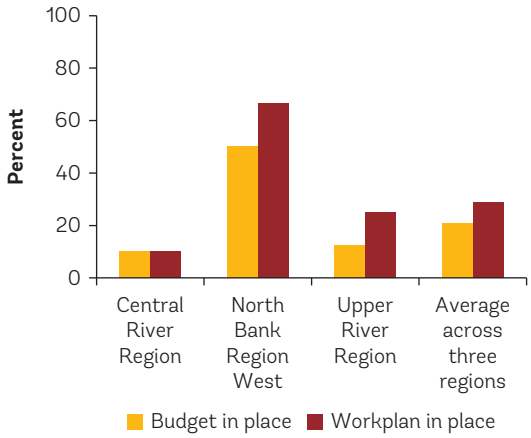
There was relatively little formal supervision at health facilities, limiting the opportunity for feedback to staff. In the six months preceding the survey, two-thirds and three-quarters of staff had spoken about their performance to an internal or external supervisor, respectively. Nearly one-quarter were less than satisfied with the quality of internal supervision, and 41 percent were less than satisfied with the

65%

of health workers interviewed would prefer to work at another health facility

"We don't procure because we don't have any money to procure."
– Officer-in-charge, CRR

Figure 4. Budgets and Workplans at Health Facilities by Region



quality of external supervision. More than 25 percent of staff were less than satisfied with the quality of management, and nearly 20 percent expressed some degree of dissatisfaction with opportunities to discuss work with their immediate supervisor.

Budgeting and planning were generally weak across health facilities. With substantial regional variation, only 21 percent of facilities reported having a budget in place and just 30 percent reported having a workplan (figure 4). Notably, even when budgets were compiled, formal tracking of budgets remained weak. Few major health centers and no minor health centers were able to provide official reports on financing.

At the levels of both the RHD and health facility, respondents articulated a desire for budgetary autonomy, explaining that they were best situated to understand their own needs and as such should be able to act accordingly. While most administrators reported being able to assign tasks and activities to staff, a substantial number reported not having sufficient authority to obtain the resources needed in their facility and not being able to choose which health services are provided at facilities.

Health Care Financing

Most RHDs and health facilities reported an acute funding shortfall that limited their ability to operate. Some health facilities reported having no ability to procure needed items due to a near total lack of funds.

User fees are among the few revenue-generating options open to facilities, and most facilities reported using the government-sanctioned fees for services. Some facilities appeared to be charging higher fees as a way of increasing their income. Fees were generally coupled with exemption policies (especially for children under the age of five and pregnant women). However, despite the availability of these waivers, approximately 20 percent of households reported having a significant health expense—defined as one higher than could be afforded with the household's usual income—in the previous 12 months.

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