

Evaluation
of the Intermittent Preventive Treatment component
of the Accelerated Child Survival and Development Project
in The Gambia



Draft Report

May 2005

Gates Malaria Partnership

&

DBL – Institute for Health Research and Development, Denmark

1. Executive summary

The Intermittent Preventive Treatment in pregnancy (IPTp) component of the Accelerated Child Survival and Development (ACSD) in Central River Division (CRD) and Lower River Division (LRD) in The Gambia was evaluated. The objectives were to: 1) provide information to guide policy decision-making in relation to IPTp scaling-up; 2) consolidate the current implementation process in the two project divisions and 3) inform the process of developing a full proposal to the Gates Malaria Partnership (GMP) for a project addressing the development and testing of a model and tools for scaling up of sustainable and integrated management of malaria in pregnancy interventions in The Gambia.

Implementation of ACSD in CRD and LRD commenced in September 2002. However, the IPTp component started with delay in September 2003. The evaluation was carried out in December 2004 to January 2005. The relatively short intervention period (of 16-17 months) was taken into consideration in the assessment of project efficiency, outcomes and impact.

Evaluation data comprised 1) pre- and post-intervention quantitative data extracted from various health facility registers and tally sheets, 2) semi-qualitative primary data collected through open-ended and semi-structured interviews with stakeholders at central, divisional and health facility level, 3) qualitative primary data from focus group discussions with pregnant women as they were leaving antenatal care (ANC) clinics and 4) information extracted from a wide range of documents on health policies, strategies, reports, action plans and guidelines.

The report presents a comprehensive number of *observations* which are analysed and used to define *strengths* and *weaknesses* of programmatic strategies, systems and processes related to IPTp services and the contextual framework within which they are provided. Presented *options for change* represent programmatic adjustments that are likely to improve the effectiveness of IPTp service provision under ideal conditions where human and financial resources do not comprise a major limiting factor. The *conclusions* relate to the relevance, efficiency, effectiveness, outcome, impact and sustainability of the project at the time of evaluation and, finally, the *recommendations* represent the evaluation team's opinions about changes that must be addressed in order to ensure a high degree of efficiency, effectiveness, impact and sustainability of future operations under (realistic) resource limited conditions where heavy donor input can not be taken for granted. The recommendations emphasise on the need to strengthen, intensify or establish:

- Community sensitisation efforts
- Involvement of community based groups and committees in health promotion
- Staff development programmes at health centres
- Rationalization schemes of IPTp service processes and procedures
- Integration of IPTp services in the health system
- Data handling capacity and capability of health officers
- Supervision and counselling capacities of health officers and service providers
- Monitoring skills of health officers
- Bi-directional flow of information across all levels of the health system
- Simplified, transparent and integrated registration system for ANC related recordings including IPTp
- Uniform and integrated system of project performance monitoring

The capacity of the health system in The Gambia is sufficiently high to handle a rolling out of IPTp services. However, current operations in CRD and LRD have been introduced without adequate consideration of structural integration at all levels of the health system. Implementation of the ACSD project appears to have favoured a donor-driven approach. Sustainability of operations will depend on the ability of DOSH to adjust and optimise programmatic procedures for complete integration of the IPTp project into routine services at all levels of the health system.

The present evaluation has combined an evaluation of a health project component with training in evaluation methodology for central level DOSH officers. This approach provides DOSH with a product (an evaluation report) for use in the further planning of appropriate health interventions and leaves behind increased capacity for conducting similar evaluation missions in the future.

2. List of content

1.	<u>Executive summary</u>	i
2.	<u>List of content</u>	ii
3.	<u>List of tables and figures</u>	iii
4.	<u>Acknowledgements</u>	iii
5.	<u>List of acronyms and abbreviations</u>	iii
6.	<u>Introduction and objectives</u>	1
	6.1. Introduction.....	1
	6.2. Objectives.....	2
7.	<u>Evaluation approach and methodology</u>	3
	7.1. The evaluation team.....	3
	7.2. Scope of evaluation.....	3
	7.3. Target area.....	3
	7.4. Methodology.....	3
	7.4.1. Data collection in relation to interviews and focus group discussions (Data Set 1).....	3
	7.4.2. Data collection from health facility records (Data Set 2).....	5
8.	<u>Findings and analysis</u>	6
	8.1. Key evaluation themes.....	6
	8.1.1. Structural framework, policies and plans.....	6
	8.1.2. Health promotion and service provision.....	9
	8.1.3. MCH related health care.....	15
	8.1.4. Health information system, monitoring and reporting.....	19
	8.2. Options for change by organisational level.....	22
	8.2.1. Central level.....	22
	8.2.2. Divisional level.....	23
	8.2.3. Health facility level.....	24
	8.2.4. Community level.....	24
	8.3. Options for change in relation to key cross-cutting themes.....	24
	8.3.1. Capacity building.....	25
	8.3.2. Supervision, monitoring and reporting.....	25
	8.3.3. Integration, participation and ownership.....	25
	8.3.4. Human, technical and financial support.....	26
	8.4. Outcomes and impacts.....	26
9.	<u>Conclusions</u>	29
	9.1. Relevance.....	29
	9.2. Efficiency.....	29
	9.3. Effectiveness.....	29
	9.4. Impact.....	30
	9.5. Sustainability.....	30
10.	<u>Recommendations</u>	31
	10.1. Human, technical and financial support.....	31
	10.2. Integration, participation and ownership.....	31
	10.3. Capacity building.....	31
	10.4. Supervision and monitoring.....	32
11.	<u>Annexes</u>	
	Terms of Reference.....	I
	Evaluation team members.....	II
	Map of target area.....	III
	List of places visited.....	IV
	Reference list.....	V
	List of informants interviewed.....	VI
	Health service provider questionnaire.....	VII
	Health service user questionnaire.....	VIII
	Focus group discussion guidelines.....	IX
	Organogram of DOSH.....	X
	Quantitative data from health registers.....	XI

3. List of tables and figures

Table 1	Level of satisfaction with divisional support as expressed by staff at health facilities (page 11)
Table 2	Possible effects to the pregnant woman of malaria in pregnancy as perceived by pregnant women (page 15)
Table 3	Possible effects to the unborn baby of malaria in pregnancy as perceived by pregnant women (page 16)
Table 4	Problems with ANC services as perceived by pregnant women (page 18)
Table 5	Measures for strengthening IPTp services as expressed by ANC staff (page 24)
Figure 1	Low birth weight deliveries by parity in Central River Division (page 27)
Figure 2	Low birth weight deliveries by parity in Lower River Division (page 28)

4. Acknowledgements

The evaluation team would like to express its gratitude to all officials and individuals met, in particular the pregnant women interviewed in CRD and LRD, for their openness, kind support and valuable information provided. To ensure a participatory approach to the finalization of the evaluation report the team will appreciate receiving any feedback that may improve the quality of the final report.

5. List of acronyms and abbreviations

ACSD	Accelerated Child Survival and Development
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BHS	Basic Health Services
CHN	Community Health Nurse
CIAM	Centre for Innovation Against Malaria
CIDA	Canadian International Development Agency
CRD	Central River Division
DBL	DBL – Institute for Health Research and Development
DCD	Department of Community Development
DHO	Divisional Health Officer
DHT	Divisional Health Team
DOSH	Department of State for Health & Social Welfare (the ministry of health)
DOT	Direct Observed Therapy
DPHN	Divisional Public Health Nurse
DPHO	Divisional Public Health Officer
EC	European Commission
EPI	Expanded Programme of Immunization
FGD	Focus Group Discussion
GMP	Gates Malaria Partnership
HMIS	Health Management Information System
IMCI	Integrated Management for Childhood Illnesses
IPTp	Intermittent Preventive Treatment in pregnancy
IT	Information Technology
ITN	Insecticide Treated Net
LBW	Low Birth Weight
LRD	Lower River Division
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MRC	Medical Research Council
MW	Midwife
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research

NMCP	National Malaria Control Programme
OIC	Officer-In-Charge
OPD	Outpatient Department
ORS	Oral Rehydration Salts
PHC	Primary Health Care
RBM	Roll Back Malaria
RCH	Reproductive and Child Health
RFH	Riders for Health
SAO	Senior Administrative Officer
SCHN	Senior Community Health Nurse
SEN	State Enrolled Nurse
SP	Sulphadoxine-Pyrimethamine
SRM	State Registered Midwife
SRN	State Registered Nurse
SWAp	Sector Wide Approach
TBA	Traditional Birth Attendants
TA	Technical Assistant
TC	Traditional Communicators
TOR	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollars
VHA	Village Health Agent
VHS	Village Health Services
VHW	Village Health Worker
WD	Western Division
WHO	World Health Organisation



6. Introduction and objectives

6.1. Introduction

As part of a sub-regional initiative to address maternal and child healthcare in West Africa, UNICEF, with funding from the Canadian International Development Agency (CIDA), developed the Accelerated Child Survival and Development (ACSD) project to assist selected countries in West and Central Africa with financial and technical support to intervene against the major causes of childhood mortality and morbidity.

The overall aim of ACSD is to reduce the mortality rate for children less than 5 years of age by 35% by the end of 2010 in its 12 target countries including The Gambia. This will be done through the strengthening of integrated services related to the Expanded Programme for Immunization (EPI), Integrated Management of Childhood Illnesses (IMCI) and Antenatal Care (ANC). In The Gambia the following three packages of interventions have been identified:

1. EPI Plus: Strengthening of delivery of immunization services to maintain a coverage of over 80% and strengthening of the community based Vitamin A supplementation programme.
2. IMCI Plus: Implementation of integrated management of childhood illnesses at facility and community levels for acute respiratory infections (ARI), diarrhoea, malaria, de-worming, monitoring and promotion of exclusive breastfeeding, hygiene, complementary feeding, iodised salt and increased access to insecticide treated nets (ITNs).
3. ANC Plus: Promotion of bed nets and insecticide for net impregnation (and re-impregnation), supplementation with iron/folic acid and provision of intermittent preventive treatment against malaria in pregnancy (IPTp) using sulphadoxine/pyrimethamine (SP).

The aim of the ANC Plus package is to reduce the burden of malaria among pregnant women. More specifically the objectives are 1) to increase the proportion of pregnant women sleeping under an ITN to 60% (from 35.5% coverage in Lower River Division (LRD) and an unknown coverage in Central River Division (CRD)) and 2) to increase the coverage of pregnant women receiving IPTp in antenatal clinics to 50%.

The ACSD target areas in The Gambia are LRD and CRD. These divisions constitute two out of six health divisions in the country and had a projected estimate (for 2003) of 13000 pregnant women potentially benefiting from the ANC Plus package annually. Implementation of ACSD in The Gambia commenced in September 2002 with EPI Plus, IMCI Plus and the ITN component of ANC Plus. Implementation of the IPTp component of ANC Plus started with delay in September 2003. The delay was caused by the need for a policy decision on the choice of anti-malarial drug to be used for IPTp. Funding from CIDA came to an end in December 2003. UNICEF in The Gambia continued funding the project at the same level up to the end of 2004. UNICEF has indicated that funding will continue during 2005 and 2006 but at a lower level. Furthermore, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria has committed funds to expand access to IPTp in Western Division of the country. Implementation in this division had not commenced when the present report was being prepared (i.e. April 2005).

The National Malaria Control Programme (NMCP) has spearheaded the development of national guidelines for the implementation of IPTp services. As part of the process of disseminating and applying these guidelines the Department of State for Health and Social Welfare (DOSH) has emphasised the need to evaluate and learn from the IPTp component of ACSD. Furthermore, the Maternal and Child Health (MCH) Unit in DOSH is taking the lead in the planning of scaling up access to IPTp nationally. It is therefore urgently needed to identify potential implementation gaps and assess programmatic effectiveness so as to inform the scaling up process. The present evaluation was commissioned to provide documentation on lessons learnt from current IPTp initiatives in The Gambia as well as much needed data informing and guiding the elaboration of a funding proposal to the Gates Malaria Partnership (GMP) aiming at developing and carefully testing a model and tools for integrated scaling-up of IPTp services in The Gambia.

6.2. Objectives

The objectives of the evaluation were to: 1) provide information to guide policy decision-making in relation to IPTp scaling-up; 2) consolidate the current implementation process in the two ACSD project divisions and 3) inform the process of developing a full proposal to the GMP for a project addressing the development and testing of a model and tools for scaling up of sustainable and integrated management of malaria in pregnancy interventions in The Gambia. Furthermore, it was agreed to strengthen the evaluation skills of selected and senior departmental officers at DOSH by providing a theoretical introduction to evaluation methodology and through participation in subsequent planning and implementation of a divisional field mission collecting both qualitative and quantitative primary information for the present evaluation report. The Terms of Reference (TOR) for the evaluation is attached in Annex I.



7. Evaluation approach and methodology

7.1. The evaluation team

The evaluation team comprised four international consultants. Three of these were from DBL – Institute for Health Research and Development (DBL) in Denmark and one was from National Institute for Medical Research (NIMR) in Tanzania. In addition, the evaluation team was supported by a field team comprising four senior officers from DOSH, two senior staff members from the Centre for Innovation Against Malaria (CIAM), and four field assistants recruited by CIAM to assist with data collection. All local team members participated as trainees in the theoretical and practical training component facilitated by the international team. For a list of members of the evaluation team, see Annex II.

7.2. Scope of evaluation

The scope of the evaluation was rather broad. Interviews were held with beneficiaries and stakeholders at central, divisional, health facility and community level. The beneficiaries comprised current and previous antenatal service users (i.e. pregnant women and mothers) and the stakeholders comprised service providers, supervisors, project managers, donors and decision-makers in the health and development sectors. Obviously, some of these interviewees had a more indirect role in relation to IPTp interventions than others. Nevertheless, they all provided relevant information about the context and (supportive) system within which IPTp services are carried out and therefore contributed to the fulfilment of the evaluation objectives as outlined in the TOR. Despite time constraints for data collection (two weeks were allocated in total) the evaluation also made some deeper explorations of relevant project features (such as those related to *training* and *health information*). Overall, the evaluation collected substantial amounts of qualitative and quantitative data providing important insights about the operational context of IPTp service provision from the perspective of both users and providers.

7.3. Target area

The evaluation was carried out in two divisions in The Gambia, namely Central River Division (CRD) and Lower River Division (LRD). CRD has 1 hospital, 3 health centres, 5 dispensaries, 638 villages, a population size of about 186,000 people (2003), an estimated 9,295 pregnant women (2003) and an estimated prevalence of low birth weight (LBW) deliveries of 15-24% (2000). Similarly, LRD has 4 health centres, 1 dispensary, 149 villages, a population size of about 72,546 people (2003), an estimated 3,630 pregnant women (2003), and an estimated prevalence of LBW deliveries of 8%. For a map of the target area, see Annex III. For more demographic data and health statistics from The Gambia, see the following WHO website: <http://www.who.int/countries/gmb/en/>

7.4. Methodology

Two different sets of data were collected for the evaluation: 1) Qualitative and semi-qualitative primary data obtained from semi-structured and open-ended interviews as well as focus group discussions (FGDs) with beneficiaries, service providers and other stakeholders in CRD, LRD and at central level and 2) quantitative data extracted from registers at health facility level in CRD and LRD. The data were collected in two different surveys. Qualitative data (Data Set 1) were collected during a one-week survey in January 2005 and quantitative data (Data Set 2) were collected during a one-week survey December 2004. For a list of places visited during the two surveys, see Annex IV. Furthermore, important information was obtained from examining a wide range of documents on health policies, strategies, donor reports, plans of action, divisional health reports, statistical reports, progress reports, meeting reports, guidelines, health registers, check lists and tally sheets. For a list of documents examined and informing the evaluation, see Annex V.

7.4.1. Data collection in relation to interviews and focus group discussions (Data Set 1)

Information about the nature and quality of services and support systems related to the IPTp component of ACSD was obtained through interviews and group meetings with major stakeholders (i.e. decision-makers, donors, implementers/providers and users) in the capital of Banjul and at divisional, health facility and

community level in CRD and LRD. A total of 10 health facilities were visited; 5 in CRD and 5 in LRD. Furthermore, 4 outreach (trekking) ANC/MCH clinics were visited in CRD and 3 in LRD.

Data collection methods included semi-structured interviews, open-ended interviews and FGDs. The below list relates the data collection methods with the different categories and numbers of informants as well as location. For a detailed list of informants interviewed, see Annex VI.

- Individual *open-ended* interviews at central level (in Banjul) with:
 - 13 senior directors and officers from DOSH and other state departments
 - 1 representative from the World Health Organisation (WHO) country office
 - 1 UNICEF programme officer
 - 1 representative from the European Commission (EC) delegation
 - 6 representatives from non-governmental organisations (NGOs)
- Individual *open-ended* interviews at divisional level with:
 - 9 members of Divisional Health Teams (DHTs)
- Individual *open-ended* interviews at health facility and ANC clinic level (at base and trekking stations) with:
 - 5 Officers-In-Charge (OIC) of public health facilities
 - 6 Community health nurses, midwives and nurse attendants
 - 2 Support staff (drivers etc) for ANC clinics and village volunteers
- Individual *semi-structured* interviews at health facility and ANC clinic level with:
 - 20 professional IPTp service providers at ANC clinics.
- Individual *semi-structured* exit interviews at ANC clinic level with:
 - 111 pregnant women as they were leaving ANC clinics.
- Group discussions at community level comprising:
 - 6 FGDs involving a mixture of pregnant women and mothers to children less than 5 years old

Open-ended interviews: A comprehensive non-prioritised checklist of topics for reference in open-ended interviews with stakeholders at central, divisional and health facility level were prepared in advance and used according to the specific interest/function of each person interviewed. The checklist was only used to allow for scrutiny of matters of particular relevance as uncovered in the course of discussion. Sufficient width and depth of collected information was obtained through three phases of exploration: 1) The first batch of interviews broadly addressed systemic and operational aspects of as many project features as possible, 2) the second batch deeply scrutinised a few important project features in an attempt to penetrate normal barriers of understanding of complex project issues, and 3) the last batch addressed recommendations for change as expressed by interviewees on the basis of both an *ideal* scenario and a *realistic* (and sustainable) scenario for systemic and operational project features.

Semi-structured interviews: Questionnaires for semi-structured interviews were developed and pre-tested (and subsequently adjusted) among ANC staff and pregnant women attending ANC clinics in Banjul in advance of their use at divisional level. The questionnaire for *health staff* addressed the nature and quality of support received from higher levels in the health system (including training, supervision and working conditions), the knowledge about, and services provided in, malaria prevention and treatment (including IPTp), and recommendations for improvement of ANC services. The questionnaires for *pregnant women* using ANC clinics addressed the nature and perceived quality of ANC services, costs associated with attending ANC clinics, health seeking behaviour, knowledge about malaria prevention and treatment (including IPTp), and recommendations for improvement of ANC services. For questionnaires used to interview health service providers and users, see Annex VII and VIII, respectively.

Focus group discussions: A guideline for FGDs was developed and pre-tested in advance. The guideline included topics for discussion and these related to the participants' views of ANC services, ANC attendance,

SP/fansidar, (direct and indirect) costs of ANC services and malaria preventive measures. For a guideline used to conduct the FGDs, see Annex IX.

The findings from the qualitative surveys are presented in sections 8.1 to 8.3 of the present report.

7.4.2. Data collection from health facility records (Data Set 2)

In order to carry out a preliminary assessment of achievements at outcome and impact level of the IPTp component of ACSD a set of quantitative data were collected from 9 public health facilities in CRD and 5 facilities in LRD all of which provide ANC and IPTp related services. The data were collected for a period of one year before (i.e. September 2002 – August 2003) to one year after (i.e. September 2003 – August 2004) commencement of IPTp services in September 2003. The sources of information (i.e. registers and tally sheets) and recorded indicators are listed in the following:

- *Delivery Register*
 - Number of recorded outcomes of delivery (i.e. live births, fresh stillbirths and macerated stillbirths) at facility level.
 - Number of low birth weight (LBW) newborns born to primigravidae, secundigravidae and multigravidae.
- *Antenatal Clinic Problem Tally Sheet; OPD Diagnosis*
 - Number of recorded clinical episodes of malaria in pregnancy at ANC clinics.
 - Number of recorded clinical episodes of anaemia in pregnancy at ANC clinics.
- *Antenatal Clinic Registers; OPD*
 - Number of recorded antenatal attendances at base and trekking (outreach) clinics and classified as “first” and “second or more” visit for CRD and as “first”, “second”, “third” and “fourth” for LRD.
- *IPT Register*
 - Number of recorded first dose treatments of IPTp (called IPTp-1) provided at ANC clinics (only post-September 2003 records existing).
 - Number of recorded second dose treatments of IPTp (called IPTp-2) provided at ANC clinics (only post-September 2003 records existing).

To optimise quality and standardisation of data collection, pre-defined summary forms were prepared and the field assistants properly trained and tested in their use before the survey was conducted.

Several limitations were observed in relation to the nature and quality of data recorded at health facility level. Most importantly for the assessment of achievements, it was not possible to directly relate IPTp services to birth outcome, malaria episodes and anaemia episodes due to incompatibility between the data sources (i.e. lack of personal identity indicators in the registers). Therefore, data were analysed with the health facility serving as the unit of sampling rather than the pregnant woman.

Following compilation and analysis of the data an assessment of achievements was carried out for each health facility and comparisons of findings were made between data recorded before and after the launching of the IPTp component of the ACSD project in September 2003. It was noted that the IPTp service implementation period had been relatively short at the time of data collection and that expectations about achievements would have to be adjusted accordingly. The findings are presented in the *Outcomes and impacts* section (section 8.4) of the present report.

8. Findings and analysis

The findings have been divided into four major sections: 1) Structural framework, policies and plans, 2) health promotion and service provision, 3) MCH related health care and 4) health information systems, monitoring and reporting. Section 2 takes a service provider perspective whereas section 3 takes a user perspective. For each section the observations, strengths and weaknesses are presented systematically. The chapter provides objective and descriptive summarised information about project mechanisms and processes as obtained through the written documentation, quantitative survey, interviews and FGDs. To the extent possible the observations are categorised according to organisational level (i.e. central, divisional, health facility and community). The *central level* comprises the national health management structure including all general health service and specific program departments and units, the *divisional level* comprises the Divisional Health Team, the *facility level* consists of the daily operative fixed facilities and the *community level* includes the village outreach (trekking) stations, village based staff and volunteers directly answerable to the Divisional Health Team as well as other community based health activities. *Strengths* and *weaknesses* add value to the observations as perceived by the evaluation team and/or interviewees. Project aspects considered relevant to highlight for either its strengths or weaknesses are presented.

Based on identified strengths and weaknesses the report presents the *options for change* referring to programmatic adjustments that are likely to improve the effectiveness of IPTp service provision under ideal conditions where human and financial resources do not comprise a major limiting factor. The options for change are presented in two sections of the report, one divided according to organisational level and the other divided according to the following four groups of cross-cutting themes: 1) Capacity building, 2) supervision, reporting and monitoring, 3) integration, participation and ownership, and 4) human, technical and financial support. It is believed that this structure for presenting the findings will most appropriately allow the reader to focus on sections of particular relevance and interest. Conclusions and recommendations are presented in chapters 9 and 10, respectively.

8.1. Key evaluation themes

8.1.1. Structural framework, policies and plans

Structures

Health services are three tiered consisting of hospitals, Basic Health Services (BHS; with daily services at a fixed facility) and Village Health Services (VHS; comprising most community level services). In the 2002 manual "Collecting data and using health indicators" a further subdivision includes central level managers, hospitals, DHTs, BHS and VHS.

Central level and divisional levels

DOSH has numerous service and disease specific departments and sections, some of which correspond to global initiatives and may overlap with those catering for broad health service areas. For DOSH organogram, see Annex X.

ACSD was initiated through UNICEF and CIDA in coordination with the DOSH MCH Unit, and is an example of a donor funded program, which at least initially establishes its own largely parallel structure for drug acquisition and distribution, as well as for supervision and reporting. .

Contracting out of transport services through "Riders for Health" (RFH), which amongst others have improved transport management for DOSH, though mainly for clinical and some outreach services. RFH has also provided the transport for ACSD. The central organization of RFH is ensuring a fleet of functional vehicles but also results in extra trips to the main workshop just for maintenance and repair. Interviews demonstrated disagreements whether RFH were charging government too much. However prices for the services are set to build up resources for purchase of a new vehicle about 5 years after acquisition, but according to interviews the salaries are higher for all RFH staff in relation to comparable positions in DOSH.

The maintenance and repair department indicated to be heavily overburdened with a very limited number of general maintenance and repair staff in each division mainly concerned with building repairs. The building of an increasing number of staff houses such as those for the Cuban doctors have not resulted in an increase of resources for maintenance. Simple jobs like replacement of a toilet cistern float valve must await supply from central level through the maintenance manager, who, in the stated instance, also had to travel to install it.

Hospitals are according to the DOSH organogram managed directly under the Director of Health Services and are not directly involved in preventive programs such as IPTp. Since the year 2000 one extra government hospital has been built and an NGO (mission) hospital has been taken over, raising questions concerning priorities for community based and preventive services.

Facility and community levels

According to the Second Strategy for Poverty alleviation (SPAII – 2000) major health centres by 2000 covered on average 185,000 persons (range 70,000 – 300,000) and minor health centres average 30,000 (range 30,000 – 60,000). This situation has been partly addressed through establishment of village level health services. However, these provide preventive and a limited range of curative services, the latter not being accessible every day. Coverage of facilities with daily availability of fully trained government health workers has been increased, partly by posting Cuban doctors to some village OPD clinics. Overall the structures for service provision differ for curative and preventive services as well as for facility and community based services so that the first point of contact for especially acute curative services still differs greatly between communities, though major investments and commitments of recurrent funds have been made available for hospital services.

Health in the national policy framework

The Second Strategy for Poverty Alleviation (SPAII – 2000) stipulates a number of targets for improved service quality and access to services, which will place increasing demands on the scarce financial, staff and other resources. Implications for a sustainable strengthening of existing and even more for introduction of new preventive programs are evident.

Decentralization of implementation of strategies and plans is an imperative from the overall government policy environment and will include transfer to Local Government of DHTs and all services supervised by them. Decentralization has been approved in the 2002 Local Government Act and facilitating legislation concerning financial regulations has recently been approved. Instruments for facilitating the decentralisation process are still to be developed.

The team saw no evidence of plans to guide and manage decentralization and no effective action to guide such major organizational change at divisional level was noted by the evaluation team. The interviews also made it clear that no one seemed to be responsible for progress in addressing critical issues such as also moving monetary and staffing resources to the divisions as well as providing adequate supervision and support to make them able to manage such increased responsibility. All relevant actors interviewed placed the responsibility for progress with on or more of the other actors. Interviews confirmed that divisions are still tied by support for activities through support for specific programme areas or by very limited budgets mainly earmarked for specific activities. DOSH is therefore not supporting DHTs for decentralization.

Health policies

The Health Policy “Changing for good” provides a comprehensive framework for health service and health status improvements. It refers strongly to health desires of the population and is to be the reference for a Health Development Plan. The need for donor coordination is underlined and plans and progress monitoring is to be closely linked to the routine health and health management information system.

The Health Policy and related programmatic policies such as the drug policy and the Malaria Control Policy are available on the DOSH website: http://www.dosh.gm/ggfpp/html/health_department.html. They provide a very good internationally recommendable guidance for the health sector. However it is not always clear

from what time they take effect, if they are time limited, which policy period they relate to or which previous policy they replace or supersede.

The Public Expenditure Review of 2001 in relation to the previous Health Policy of 1996-2000 provides a very comprehensive overview of the health sector performance at the time. Main conclusions were that spending was not guided by an explicit policy framework and that a strong bias towards curative and hospital care activities remains. Establishment of divisional cost centres was a key recommendation.

The policies often remain without a realistic link to existing realities and the resources and responsibility to implement them in practice are not defined. Where such policies have been translated into plans of action such as the malaria strategic plan of action 2002-2007, budgets are included, but do not provide support for already strained staffing and other resources for implementation. The team is not aware, how government ensures that the total resources needed to implement all programmatic and service plans does not exceed the overall health sector capacity.

Like other strategies in the Malaria Control Policy of January 2003, IPTp is guided by a national Task Force for implementation of Roll Back Malaria (RBM) interventions. The NMCP is responsible for overall coordination and implementation of RBM interventions including monitoring, evaluation and reporting (to the Task Force). NMCP is structurally placed under the Department of Disease Control in DOSH. Links to other sectors, NGO's, the private sector, civil society, communities, and multilateral and bilateral agencies are recommended in the strategy in order to ensure cooperation, support and sustainability.

The 2002-07 strategic plan of action for malaria control is mainly based on the RBM strategy; it sets up targets for a number of indicators. For 2005 it was expected that 60% of pregnant women would be receiving malaria chemoprophylaxis.

Chloroquine has been the first-line and SP the second-line drug for case management of malaria in The Gambia. However, in the light of increasing chloroquine resistance in The Gambia, the government the government has reconsidered its national drug policy for malaria case management and decided in January 2005 that the new first line drug for treatment of non-complicated malaria will be Coartem (Lumefantrine/Artemether). A strategy for implementing the new policy is not yet in place. The second-line drug (which is currently SP) is likely to change as well and will for some time remain to be the drug of choice for IPTp services in ANC clinics.

It was repeatedly brought up in interviews that supervision, even if planned, was very irregular from departments and special program units. There were competing commitments in the head offices as well as lack of transport and resources for subsistence. Monitoring was therefore mainly based on routine returns and supervision provided mainly on the basis request. The Health Education Unit stated to visit each division once every two to three months with a team of two and jointly with the DHTs to carry out Health Education in several of the villages in the division. The information and statistics division under the Director of Planning and Information was in the process of implementing a much improved health management information system and did indicate regular visits to divisions. However, it seemed that a quarterly calling of the key DHT staff was the preferred approach, which also provided opportunities for update for the divisions and programmes to convey new information and guidelines. During the visit a joint meeting of key DHT staff was in session.

The situation described in the Health Policy of 2000 is very explicit on the magnitude of health problems and on the service shortcomings. The team has observed that descriptions of the magnitude of problems in the overall problem statement and in the preamble to each management, financial, general service and specific program area sections are largely still unchanged and inadequately addressed.

The evaluation team did not observe the existence of a shared planning framework and accompanying guides for all parts of DOSH including central departments, programmes, units, DHTs, facilities and PHC circuits. Possibly the lack of such comprehensive planning framework has resulted in several of the concerns expressed about the efficiency and sustainability of IPTp as yet another programme, which have been expressed in general in some of the documents and more specifically in several of the interviews conducted.

On the basis of the above observations the following strengths and weaknesses have been identified:

Strengths

- Good coherent health policy and some departmental and programme policies exist.
- Evidence for development guidance is available from public expenditure reviews, monitoring of poverty reduction and from monitoring of Millennium Development Goals (MDG) indicators as well as from several bilateral and multilateral international reviews and strategic plans
- Mobility in the health sector has improved through outsourcing of transport functions related to drug delivery, ambulance services and outreach activities needs to be reviewed.
- Detailed programme documents are available for malaria interventions and several other related programme areas.

Weaknesses

- No overall national strategic plan and annual work-plan based on a shared uniform planning guideline were observed. Without such, DOSH programmes and DHTs will be hampered in setting coordinated priorities and defining output and activities within a given financial framework for achieving greater coordination and efficiency.
- The ACSD project was from its start implemented as a donor driven programme. This necessitates careful planning of post-project integration and sustained funding mechanisms.
- There is no clear division of responsibility for project implementation between donors, DOSH programmes at headquarters and divisional health services, which are already overburdened.
- The efficiency of the RFH in relation to its service output and resource use has been questioned and its current central organization may not be well suited to a decentralisation of DHT's.
- It is ineffective to apply two systems for procurement and distribution of drugs, i.e. one for ACSD and another for general government supplies.
- In the light of recent changes in antimalarial drug policy in The Gambia (identifying Coartem as the new first line drug for case management) first-line drug expenditures may increase excessively, stock levels may fluctuate significantly and periods of stock-outs may thus change unpredictably. This may negatively affect SP stock levels for use in IPTp and thus IPTp service provision.
- Drug accessibility, training and awareness creation have been identified as prime strategic components of ACSD rather than addressing systemic and mechanistic features from a more holistic perspective with the aim of ensuring integration and sustainability of provided health services.
- Supervision of health staff does not follow a systematic and structured approach
- None of the involved stakeholders for decentralization are taking charge of ensuring progress of the process.

8.1.2. Health promotion and service provision

Information for this chapter originates from open-ended and semi-structured interviews with central level, divisional and health facility-based stakeholders and focuses on the provision of IPTp services and integrated mechanisms and procedures supporting them such as training and supervision, supplies, health education and community sensitisation.

Central level

Training and supervision

DOSH has its own “educational department” in charge of the wider planning of in-service training activities within the domain of the health sector. However, apparently this training unit of the DOSH does not function well at present as indicated by several key informants at divisional level. There seems to be no criteria available for selection of candidates for training.

CIAM, the Malaria Unit and certain organizations (e.g. MRC, WHO) contribute to training activities at lower levels.

Drug supply

SP used in ACSD for IPTp is procured by UNICEF on the world market and shipped from the UNICEF store in Copenhagen to Banjul. The drug is brought to a medical drug store in Mansakonko falling under the Department of Community Development (DCD). From the drug store in Mansakonko SP for IPTp is either collected (by the OIC) or distributed (by the ACSD Technical Assistant, TA) to the health facilities in CRD and LRD. Release is based on request from the OIC using a requisition form. Documentation of SP stocks at health facility level using tally sheets determines the quantity released. Stocks for two months consumption are accepted. The system is generally appreciated by the OIC of the health facilities. SP for use in case management is procured by DOSH and stored at CMS in Banjul before being brought to the CMS stores at divisional level by RFH. The procurement and delivery system for SP for use in case management is thus different from the system used for SP for IPTp.

Divisional level

Training and supervision

The main responsibilities of the DHTs with respect to IPTp delivery relate to institutional support such as training and supervision. The DHTs do not have a special budget to cover for such activities.

ACSD has identified drug accessibility, training and awareness creation as key strategic project areas. The focus of training is on drug administration, data recording and referral. In relation to these disciplines It appears that the DPHN have not been formally trained or sensitized on the ASCD elements. The driving force in learning about the programme has been the interest shown by the DPHNs. Nevertheless, training was delivered to other levels and Village Health Agents (VHAs) thus received three days of training and Traditional Birth Attendants (TBAs) and Village Health Workers (VHWs) received two days of training in community health promotion, prevention and treatment at the early stages of ACSD implementation. A one day training of MCH workers in IPTp provision and recording was also provided in the early days of ACSD.

In this training, as well as in other trainings under ACSD, there was no practical component, no testing of acquired knowledge and skills, no written (but oral) evaluation and no feed-back from the facilitators who normally includes the TA and representative from DHT and DOSH. No refresher training has been provided in IPTp. Moreover, curricula's and training materials could not be presented in the two divisions.

Health facility staff was interviewed about the divisional level support. Answers to a question about institutional support such as training, regular supervision from superiors (higher authorities) in relation to staff duties, and supply of essential drugs and working materials, were obtained from 19 staff out of 20 interviewed. Of these respondents, **16 (84.2%)** admitted to have been receiving some kind of support at different degrees, while **3/19 (15.8%)** did not acknowledge to have received any kind of support from above. About half, **8 (42.1%)** of the respondents said that through the scheduled monthly supervision from the Division Health Team (DHT), they were being advised on how to, and the need for, providing good services including health education to patients and ANC/MCH clients and on how to use various registers.

Some other kinds of support stated are as outlined below (number of respondents and percentages shown in bold).

- Watching how the service to the antenatal clients were being provided and correcting/advising where the practice seems going wrong, and providing guidance on how to fill antenatal client registers, **12 (63.2%)**.
- Receiving basic materials- drugs, vaccines, registers, etc. to support ANC services, **6 (31.6%)**.
- Advising and sharing with us experience about job constraints and how to work in difficult environments, **3 (15.7%)**.
- In-service training to update my job skills to go with the any changes in the service delivery process e.g. training on IPTp, **1 (5.3%)**.

On a question concerning whether or not respondents have ever got an opportunity for training/orientation related to malaria prevention and management measures since posting to their current work stations, **12 (63.2%)** said “yes” and **7 (36.8%)** said “no”. Concerning which kind of training they were given for those who said yes in the previous question, **10/12 (83.3%)** respondents to this question reported to have been given a three days workshop orientation on IPTp. Health education and sensitization to pregnant women attending ANC clinics about environmental sanitation, use of ITN’s, and early diagnosis and prompt treatment procedures for malaria were mentioned by **3/12 (25%)**, each.

Table 1. Level of satisfaction with divisional support as expressed by staff at health facilities.

<i>Degree of satisfaction</i>	<i>Frequency</i>
High	3 (18.8%)
Moderate/fair	11 (68.8%)
Very low	3 (18.8%)

Further probes indicated that those who were dissatisfied or fairly satisfied pointed out the ‘irregular supervision’ they have been receiving from the DHTs. Of the **14/16 (87.5%)** respondents who were dissatisfied/fairly satisfied, 6 were from the LRD and 8 from CRD. As for those who were fairly satisfied, the following explanations were recorded:

“Apart from the DHT providing us with soap bleaches (e.g. OMO), there is no other hope for support. Even in the case of health promotion, people have been querying why it has taken so long that they have not been promoted” (a staff at one Health Centre, in the CRD).

“Sometimes drugs (e.g. antibiotics) and other materials are inadequately supplied. Sometimes supervision is not done as scheduled. I had never attended any training related to ANC” (a female, in the CRD). Other three community health nurses (two in the LRD and one in the CRD) shared the same point regarding training.

“Superiors do not come to assist us when the clinic is full. We work longer than necessary while there is no motivation for working overtime” (a female community health nurse, in the LRD).

At one Health Centre some staff argued that sometimes supervisors from the DHT do arrive late at the clinic after the official opening hours, so they can’t observe and certify whether or not health service personnel at the clinic adhere to the health service provision procedures.

In addition, the duration of training about malaria control for a few staff who remembered ranged between one day and several weeks. This length of time was seen to be too short to equip them with the full knowledge of what they were required to know.

Drug supply

The DHTs have experienced an improved availability of drugs at DHT level although some time lag in delivery of drugs especially to large districts has been recorded. Some general frustrations by the DHTs relate to maintaining the cold chain for vaccines and drugs due to poor and unstable electricity supply and equipment.

Health facility level

IPTp delivery

Since commencement of ACSD SP has been readily available at health facility level although short stock-out periods have occurred at the end of 2004. No major complaints about SP supplies were reported from beneficiaries or stakeholders from the health system. Inadequate supplies of other ACSD drugs (for community administration) were more frequently reported but not to any serious degree. SP supplies for IPTp and case management are kept physically separate at health facility level but its use in case

management is seen as a possibility depending on the availability of other antimalarials at health facility level.

SP is prescribed in accordance with WHO guidelines. These guidelines have been revised to fit into a Gambian context. National guidelines are available but these were not observed at health facility level. MCH teams at the health facilities coordinate the planning and implementation of their respective MCH services. At the routine ANC clinic the set sequence of events related to IPTp delivery is: 1) Registration of pregnant women in the Health Centre IPT file, 2) clinical examination on gestation age and Hb-measurement, 3) administering SP under direct observation and 4) providing health education to the pregnant mother on benefits, importance of e.g. early booking for second dose of SP and possible side-effects.

Interviews with OICs reveal that most ANC clinics do adhere to this procedure even though they have never received written operational guidelines. MCH teams at the health facilities coordinate the planning and implementation of their respective MCH services. There is no standard followed as to the information to be taken down in the IPT register (cf. Section 8.1.4). Almost all facilities do complain about lack of Hb-measurement equipment. The administration of drugs is supposed to be done under direct observation but not all facilities practise this. Women are given the drugs to take elsewhere for example because of lack of cups or because the pregnant women fear to use the same cup because of risk of catching an infection (e.g. tuberculosis) from somebody else. The availability of SP is usually satisfactory securing that women do not leave unattended.

Knowledge about the essence of the IPTp strategy

Following interviews with health facility staff it was recorded that knowledge about why the IPTp strategy was recommended in the country was not clear to all the 20 antenatal care staff respondents. Only (though the majority) **16 (80%)** respondents stated that the IPTp-SP strategy is intended to prevent pregnant women from malaria attacks. Others, **4 (20%)** could not state any reason why IPT is being implemented

It was furthermore noted that *malaria prevention methods* reported to be known and emphasized by staff to all the women attending antenatal and MCH clinics were the following (number of respondents for each method mentioned shown in parenthesis): Advising pregnant women on how to use SP for IPT and administering it to them, **14/18 (77.8%)**; providing health education about the importance of the use of ITNs by pregnant women, **9/18 (50%)**; and environmental sanitation, **9/18 (50%)**.

Perceptions about SP side effects if used during pregnancy

Of the 20 staff respondents, **15 (75%)** stated about side effects associated with the use of SP based on either their own experience with using SP or what they have been hearing from the members of the community including the pregnant women attending antenatal clinics. The rest (**25%**) of the respondents had no idea about SP side effects.

All the respondents who were able to identify the side effects testified to have been hearing complaints from some pregnant women attending the clinics and/or other people in the community setting they work. Whether or not they used to discuss about possible SP side effects with pregnant women, only **10/15 (66.7%)** respondents reported to have been doing so while the rest said they never did that, and one respondent could not say anything. Whether discussion about side effects is regularly/routinely done with pregnant women (by the staff respondents who reported to have been providing advice), **4/10 (40%)** and **6/10 (60%)** respondents reported to have been doing so always and sometimes (not often), respectively.

Staff motivation

In addition to limited opportunities for in-service training and inadequate supervision, generally most of the health staff was poorly motivated by the working conditions. The question concerning their satisfaction with their current job conditions was answered by 17 respondents, **11 (64.7%)** of which were fairly satisfied, while those who reported to be highly motivated accounted to **3/17 (17.6%)** each (Table 1). The reasons stated by those who were partly or not satisfied are as listed: Low salaries; lack of transport and communication facilities for the staff; lack of shortage of staff houses; untimely staff promotions; on-job

training especially for the low cadre personnel almost lacking; irregular supervision by superior staff and sometimes feedback, particularly from the DHT; and heavy workload to the existing staff due to shortage of staff at the facility level.

In addition, opportunity for career development was pointed out to be imperative, albeit rarely accessible, and most of the staff had little hope for securing such an opportunity.

Health facility staff and OICs as well as DHT members have not had any opportunity to influence the design and approach of ACSD adding to the feeling of lack of ownership to the project.

Community level

Community sensitization & participation

At the onset of the ACSD project, micro-planning meetings were held in all key villages at district level in CRD and LRD. Two representatives from each village within the catchment area of each district attended the meetings. The meetings were arranged by the TA. Resource persons from the DHT and nearby health facilities also attended. The purpose of the meetings was to provide information about the scope of the project, to hear the opinions from the participants and to modify their expectations if necessary. The communities have not had any opportunity to influence the design and approach of ACSD.

At the onset of the ACSD project and based on request by the TA, VHAs were identified in all non-Primary Health Care (PHC) villages in CRD and LRD. PHC villages already had VHWs and these were involved to cover similar duties as the VHAs. Both VHWs and VHAs were briefly trained in administration of three key drugs (chloroquine, septrin and ORS) and in reporting of their consumption using simple tally sheets. An additional role of these village volunteers is to participate in community sensitisation activities and announcing outreach clinic days and venue. CHNs (VHS) provide training and supervision to VHWs, VHAs and TBAs in relation to ACSD interventions at community level. Village volunteers have not had any opportunity to influence the design and approach of ACSD.

The CHNs (VHS) live in key villages that are centrally located, within a catchment area covering several villages. The number of villages in a catchment area ranges from 7-144 villages. CHNs (VHS) directly refer to three superiors: 1) The OIC of the health facility attached to, 2) the Divisional Public Health Nurse (DPHN) and 3) the TA of ACSD. In practice and generally the CHNs relate to the OIC by orally reporting at staff meetings on activities carried out. In relation to the DPHN the CHN is visited every quarter for supervision. More frequently (once or twice per month), the CHN interacts with the TA on matters related to (community) drug supply and (community) data reporting.

Although committed to do their job well many CHNs complain about limited supervision and training and poor working conditions and inadequate time to perform well. An example to illustrate this: CRD covers a total number of 640 villages and has 15 CHNs (VHS). Each CHN thereby covers an average of about 43 villages for monthly village visits or about two village visits per working day. During each visit the CHN is expected to supervise village health volunteers, facilitate information, education and communication (IEC) activities, inspect village health registers for inconsistencies and suggest and facilitate corrective actions. In addition to this, the CHNs are expected to attend staff meetings, outreach clinics, workshops etc. CHNs (VHS) have not had any opportunity to influence the design and approach of ACSD.

Late registration for ANC is a common problem with deep socio-cultural roots. It is not uncommon that registration takes place as late as in 6th or 7th month of pregnancy. Normally, a pregnant woman needs permission from the husband before she can register at an ANC clinic. Community sensitisation on the importance of early registration at ANC clinics are carried out occasionally and sporadically and can have different approaches. In the past UNFPA provided substantial financial support to "open field days" at community level. These were organised by the health facilities and mainly addressed MCH services through entertainment, open discussions, contests etc. without following a fixed agenda. ACSD related community sensitisations are arranged on request from the TA. The financial input comes from ACSD. The practical arrangements are prepared by the CHN with limited support from the health facility, DHT and ACSD. No

instructions or guidelines are provided as to how to plan and organise the activity nor is any training provided in sensitisation methodology.

Traditional communicators (TCs) are community members entertaining people at special events with drama, songs and jokes. TCs live in many communities in The Gambia and some of them have been trained by DOSH in health promotion skills. Community sensitisation campaigns of ACSD frequently involve TCs.

The above mentioned observations and characteristics of the IPTp service provision point to the following strengths and weaknesses of the service provision:

Strengths

- Training in IPTp has been provided to all relevant staff members at health facility and DHT level.
- Monthly and quarterly in-service meetings between health facility staff and DHT members form a major forum for exchange of information in both directions and are appreciated by both parties.
- There is a high level of willingness among health facility staff to work hard.
- The frequency of planned supervision of village volunteers is relatively high (i.e. monthly).
- MCH team meetings support the effective running of MCH base and trekking services
- There is an interest and willingness among most staff to improve service delivery and quality of care.
- Most clinic staffs are very loyal to the system in spite of difficult working conditions.
- Staff does recognize and appreciate the positive effects seen of the IPT in terms of its observed reduction in numbers of women complaining about malaria and increased birth weights.
- A well functioning requisition and distribution system for SP has been established.
- The IPT services are provided at an acceptable and affordable price (5 dalasis at registration only).
- Community meetings about ACSD took place at an early stage of project implementation. This may have left communities with a sensation of involvement in project planning.
- All communities were covered by the community meetings through participating community representatives.
- Joint activities by CHNs (VHS), village health volunteers and TCs may effectively mobilize communities in relation to health matters of significant importance to IPTp.

Weaknesses

- A rather high percentage of health staff is not fully aware of the content of the IPTp strategy and available malaria prevention methods.
- Drug accessibility, training and awareness creation have been identified as key strategic components of ACSD rather than addressing systemic and mechanistic features from a more holistic perspective with the aim of ensuring integration and sustainability of provided health services.
- Staff motivation (at both health facility and DHT level) is very low and working conditions are not satisfactory in relation to work load, salaries, career opportunities, allowances, housing, supervision, recognition, and technical and supervisory support.
- Supervision of health staff does not follow a systematic and structured approach.
- Guidelines and checklists for use in supervision and provision of IPTp are not available/used at health facility level.
- Supervision between DHT, OIC and health facility staff is generally insufficient in terms of quality, frequency and approach.
- Basic training in management skills and supervision has not been provided at health facility and DHT level.
- Training opportunities are not systematised and mechanisms for selection of trainees not transparent.
- Sharing of information between in-charges and staff at DHT level is inadequate.
- Clinic staff do not have available proper written guidelines and a uniform, standardized registration system for IPT
- Health facilities and ANC clinics do not receive requested amounts of equipment and supplies necessary for performance according to intention.
- Clinics are understaffed and staff is generally overworked and express frustration and lack of motivation.

- Most health centres and ANC clinics are in bad physical and hygienic state adding to the feeling of frustration and despair.
- The non-availability of secure cupboards with lockers for keeping of registers and records is considered a problem by staff.
- Availability of staff time per pregnant mother is not sufficient to cater for proper health education and counselling in connection with the registration and drug administration.
- The lack of guidelines in patient counselling and communication for use by IPT providers.
- The lack of proper written feedback by the DHT on the analysis of monthly returns makes it difficult for the clinic staff to follow the development of the malaria situation over time in pregnant women.
- The procurement and delivery system for SP for use in case management is different from the system used for SP for IPTp adding to the complexity of general SP provision.
- The DHTs are not able to meet requests for essential equipment (e.g. Hb metres), supply of utensils (e.g. drinking cups), and clinic furniture (e.g. cupboards with lockers), because of very low budgets (total of 5,000 dalasis/month/DHT) for the running costs of facility maintenance and improvements.
- Beneficiaries and stakeholders at community, health facility and divisional level have not had any opportunities to influence the design and approach of ACSD and ownership to the project therefore rests at central level.
- Community sensitisation activities are not planned systematically to ensure even, regular and high coverage.
- Many CHNs (VHS) are severely overburdened with work due to the large catchment area covered. Frequency, coverage and quality of sensitisation may be affected by this problem. Also, the degree to which sufficiently widespread announcements of time and venue of sensitisation activities may be affected.
- Without guidelines and instructions about when and how to plan and organise community sensitisation activities as well as training in how to implement such activities, the quality of performance will vary significantly from place to place and the overall effects on health seeking behaviour will be questionable.

8.1.3. MCH related health care

Information presented in this section originates from semi-structured interviews with 111 pregnant women as they were leaving ANC clinics as well as 6 community-based FGDs with pregnant women and mothers to children under 5 years of age (see section 7.4.1. for design details)

Malaria as a risk factor in pregnancy

FGDs: Malaria was commonly associated with the following signs and symptoms: Fever, general body malaise, loss of appetite, occasional vomiting, dizziness and joint pains.

Interviews: When asked about whether malaria may cause any *problems for a pregnant woman* **79 (71.2%)** of the interviewed pregnant women said “yes” and **15 (13.5%)** said “no”. The remaining respondents answered “don’t know”. For the women answering “yes” Table 2 shows the key problems for the woman associated with malaria in pregnancy as perceived by the respondents:

Table 2. Possible effects to the pregnant woman of malaria in pregnancy as perceived by pregnant women.

<i>Effect</i>	<i>Frequency</i>
General body malaise	24 (30.4%)
Anaemia	22 (27.8%)
Fever	20 (25.3%)
Stillbirth or abortion	17 (21.5%)
Headache	10 (12.7%)
Death	8 (10.1%)
Body Dehydration	8 (10.1%)
Prolonged Vomiting	4 (5.1%)

Interviews: When asked if malaria may cause *problems for an unborn baby* **70 (63.1%)** said “yes” and **34 (30.6%)** said “no”. The remaining respondents answered “don’t know”. For the women answering “yes” Table 3 shows the key problems for the unborn baby associated with malaria in pregnancy as perceived by the respondents:

Table 3. Possible effects to the unborn baby of malaria in pregnancy as perceived by pregnant women.

<i>Effect</i>	<i>Frequency</i>
Can die while in the body (fatal)	30 (42.9%)
Born with low-birth weight (low birth weight)	15 (21.4%)
Constant movement of the child in the stomach (<i>foetal unrest</i>)	11 (15.7%)
Can be born prematurely (premature delivery)	6 (8.6%)
Can get fever	5 (7.1%)

Knowledge about malaria preventive measures

FGDs: Attending ANC/MCH clinics as scheduled and sleeping under insecticide treated nets were most commonly mentioned at FGDs as preventive measures against malaria infection. Few participants were able to state directly that the use of SP/fansidar during pregnancy was a preventive method against malaria in pregnancy. Other malaria preventive methods mentioned include environmental sanitation with emphasis on destroying mosquito breeding sites and better feeding by pregnant women.

Interviews: Of the 111 pregnant women interviewed **42 (37.8%)** were aware that the three tablets prescribed at ANC clinics were for preventing malaria infection during pregnancy. Sleeping under an ITN was mentioned by **42 (37.8%)** of the respondents and environmental sanitation and cleanliness by **28 (25.2%)** of the respondents as preventive measures against malaria infection. Of all respondents **25 (22.5%)** could not mention any malaria preventive measures.

Knowledge about IPTp services at antenatal clinics

FGDs: The majority of the participants did not know why they were given “three white tablets” at ANC clinics. Only few participants in the FGD’s were able to identify and distinguish SP/fansidar tablets from paracetamol tablets. The majority of women were familiar with the name “paracetamol” but not “fansidar” or “SP”. The two kinds of tablets were considered very similar in size and colour. Additional probing suggested that health staff did not prioritise providing health education about prescribed drugs (and other services) at ANC clinics. When information was disseminated it was done swiftly and key messages were difficult for the pregnant women to fully understand and appreciate. Among those who knew about IPTp services one woman stated: “*Fansidar should be taken in the four months of pregnancy and the interval between the first and second doses is one month*” (at MCH trekking clinic in Jali village). Another woman said: “*The timing of the first dose is three months of pregnancy.....and the second dose one or two months later*” (at ANC clinic at Janjanbureh Dispensary). In Jarra-Sukuta village the majority of the FGD participants indicated that the second dose of SP/fansidar should be taken during the fourth month of pregnancy. The majority of the FGD participants at Bansang Hospital knew about the timing of the first and second dose of SP/fansidar.

Interviews: A total of **84 (75.7%)** of the interviewed pregnant women stated that, at some point during their pregnancy, they had received SP/fansidar to swallow under supervision of nursing staff at the ANC clinic. The tablets were commonly referred to as “white coloured” tablets of “paracetamol”. Only **12 (10.8%)** respondents knew the tablets by their real name. Of all respondents, **64 (57.7%)** had received IPTp on the day of the interview but only **31 (48.4%)** of these women were told what the treatment was for.

Attitudes towards and compliance with IPTp services

FGDs: SP/fansidar was generally considered effective in curing malaria infections. One woman at Jali dispensary testified, “*I am currently fine since previously I was experiencing backache and general body malaise. After having SP, I feel alright*”. An FGD participant at Brikama-Ba Dispensary argued that SP/fansidar “is not bad to the health, otherwise nurses would not dispense it to their clients”. Although some

of the participants had just received their first dose of SP/fansidar on the same day of the discussion it was generally acknowledged that many pregnant women receive the first dose of IPTp but not the second one. Several explanations were given for this observation: 1) Inadequate sensitisation by clinic staff, 2) other commitments such as farming and child caring, 3) shyness, 4) laziness and 5) illness. These factors could lead to registration late in pregnancy (or to no registration at all) and thus disqualification from receiving a second dose of SP/fansidar. In relation to these explanations one woman stated: *“It depends on the time of attending the clinic during one’s pregnancy. Sometimes after taking the first dose, a month later you enter into labour”*. Another woman argued: *“You know some of us after taking the first dose deliver before taking the second dose. Some of us do not join [the ANC clinic] until the pregnancy is six month old. This is because of the ignorance of the dangers of late booking”* (Bureng Health Centre). Finally, a woman said: *“Some women are single, so they feel shy being asked who gave them pregnancy”*.

Interviews: Of all pregnant women interviewed **51 (45.9%)** had a previous experience with SP/fansidar and **15 (29.4%)** of these women had experienced negative side-effects of treatment. The side-effects related to nausea, loss of appetite, vomiting, dizziness, shivering and tiredness. None of the respondents expressed any experience with or major concern about severe reactions to SP/fansidar or negative effects to the foetus. Moreover, none of the participants reported to stop visiting ANC clinics as a result of side effects. Of the 64 women who had received SP/fansidar on the day of the interview all **64 (100%)** swallowed the tablets in front of a nurse at clinic level as Direct Observed Therapy (DOT).

Perceived benefits of services at antenatal clinics

FGDs: ANC services were generally considered important for the health of pregnant women and unborn children. By attending ANC clinics a pregnant woman is helped to detect or prevent the risks factors in pregnancy that could lead to dangerous conditions to both the mother and the unborn child. One woman stated: *“When we come to the clinic, we are told about the position of the child in the womb and how to take care of the pregnancy”*. Vaccination/immunization services were also highly appreciated as disease preventive measures for pregnant women and children under five years of age. One respondents argued: *“Failure to attend clinics is up to one’s own will because we all know the importance of going to clinics to pregnant women”* (at MCH trekking clinic in Jali village). Another respondent stated: *“Regular attendance to ANC clinics is necessary because there are many illnesses apart from malaria that require immediate diagnosis and treatment at the clinic. For example, your blood can be measured and you get all the tetanus injections in time”* (at Bureng Health Centre). None of the participants had ever failed to attend a scheduled ANC clinic visit.

Accessibility (geographical and financial) to antenatal clinics

FGDs (accessibility of clinics): It was a common perception that the ANC clinics are relatively close to home and that only few users live far away. This is largely due to the existence of mobile (trekking) clinics operating in peripheral areas without physical health facilities. Several participants commended the Gambian government for ensuring that health facilities are within reach of the greatest proportion of the population in the country. Nevertheless, some people have to travel long distances using either horse carts or other means of transport. In Jarra Sukuta village (trekking station), it was reported that some pregnant women and mothers (with their children) travel 3-5 km or more to reach the nearest ANC clinic. It was proclaimed: *“We pay 5 Dalasis for one visit as a fare and we also buy food on the way. Sometimes we have to hire a horse cart and pay 10 Dalasis per person. A cart has a capacity of carrying eight passengers”*. At Bansang Hospital, FGD respondents reported that some women travel 7-8 km to reach the nearest ANC clinic; they pay a fare of 25 Dalasis for car transport per trip to and from the clinic. At Janjanbureh, one woman who came for the MCH clinic testified: *“I have paid 2 Dalasis at the ferry just to cross the river [River Gambia] and another 2 Dalasis for something to eat for my child.... but it is fine”*

Interviews: A total of **20 (18.0%)** respondents complained about walking long distances to reach an ANC clinic. The walking time of these respondents was between 2 and 3 hours each way. Besides compulsory payment for the ANC registration card (only paid once during a pregnancy) and (sometimes) laboratory services they reported to have spent money on transport (bus or horse cart) and food items (fruits and drinks) on their way to and from the clinic. The average transport cost per trip to the clinic on the day of the

interview for 12 respondents amounted to 13.33 Dalasis (1 USD = 29 Gambian Dalasis). The range of reported transport costs was 2 – 50 Dalasis.

Perceived quality of antenatal care

Many pregnant women participating in the FGDs and interviews explicitly expressed general satisfaction and appreciation with ANC services. This was more a rule than an exception. The present section emphasises on different (problematic) aspects of quality of care which were more specifically and elaborately discussed with or by the pregnant women.

FGDs (staffing and waiting time): The time spent waiting for services at the ANC clinics was raised as a major problem by some participants whereas others disagreed. Long waiting time was obviously associated with understaffing (especially of midwives) and a high degree of understanding of the immense work pressure of staff was commonly expressed and the problem (of understaffing) acknowledged everywhere. At Brikama-Ba Dispensary long waiting time was considered a problem. One participant said: “*We come at the ANC clinic early in the morning but leave at around five in the evening*”. It was added that due to the high attendance rates in some days, nurses get very tired. One nurse would typically attend to 30-40 pregnant women per day. At times this makes the service provider impolite or rude to the clients. Similar conditions and problems were reported from other sites. At Bureng Health Centre a pregnant women complained: “*It takes us 3-4 hours to wait for services at the clinic; this time is really too much!*” In Jarra Sukuta village a woman said: “*Sometimes we wait so long at the clinic due to the late coming of the clinic staff because they have no means of transport to come early*”. Complaints about long waiting time for the service were more commonly expressed by users of outreach (trekking) clinics. At Bansang Hospital a pregnant woman expressed dissatisfaction with the frequency of postponements of scheduled outreach clinics. She said: “*Although it is wise for us to attend to the clinics as scheduled, it is a shame that sometimes the clinic personnel never show up without notifying us, so we waste our time*”. In addition, it was reported that health staff occasionally come for outreach clinics without a weighing scale or all essential drugs. Long waiting time and understaffing would not stop the pregnant women from attending ANC clinics.

FGDs (staff behaviour): In five of the six FGDs the majority of the women appreciated the politeness of nurses at the ANC clinics. They were satisfied with the way nurses listened to them and talked to them at the clinics. One woman at Brikama-Ba Dispensary said: “*Nurses are generous and committed to their work. They are kind enough to assist us; there is no problem between them and us*”. A woman at Janjanbureh Dispensary stated: “*The nurses are neither harsh nor abusing when talking to us. They don’t shout at you*”. In the remaining FGD some complaints were raised about ANC staff behaviour. One participant at Jarra Sukuta trekking station stated: “*When things get out of hand, they [clinic staff] become harsh*”. Late arrival of health staff was also reported to discourage the participants. One participant stated: “*Nurses sometimes come late at around eleven. When they are asked about this, they complain of lack of transport*”.

Interviews: All 111 interviewees were asked about how they perceived the quality of ANC services and how services could be improved. From open-ended and probed questions some precision about the perceptions of quality of pregnant women was obtained. Table 4 summarises the frequencies of the most common problems of ANC services as presented by the pregnant women. The issues were articulated in different ways and either as problem statements or as measures for improvement of ANC services (or both).

Table 4. Problems with ANC services as perceived by pregnant women.

<i>Problem</i>	<i>Frequency</i>
Shortage of drugs (all drugs combined)	88 (79.3%)
Understaffing at the ANC clinic	47 (42.3%)
Inappropriate physical environment at the ANC clinic	41 (36.9%)
Long waiting time for ANC services	20 (18.0%)
Inappropriate Direct Observed Therapy arrangements	12 (10.8%)
Unpleasant staff behaviour	4 (3.6%)

Some additional issues were brought up by the pregnant women: 1) Provision of ITNs to pregnant women through ANC clinics were suggested as improvement by **9 (8.1%)** respondents and 2) intensifying health

education at clinic and/or community level was suggested by **9 (8.1%)** respondents. These issues are not included in the table as they, unlike those in the table, were not addressed through probing.

Of the 111 respondents **102 (91.9%)** indicated that they had never failed attending the ANC clinic on a scheduled clinic day.

Based on the above observations the following strengths and weaknesses have been identified:

Strengths

- Many pregnant women knew that malaria in pregnancy may be harmful to the pregnant woman and the newborn baby.
- Important malaria preventive measures were commonly known by pregnant women.
- The proportion of pregnant women who had received the first dose of IPTp was high.
- No serious side effects of SP/fansidar treatment were experienced by the pregnant women.
- No serious concerns were expressed about negative effects of treatment on the pregnant woman or child.
- The pregnant women confirmed that Direct Observed Therapy was consistently practised at all ANC clinics visited.
- ANC services were considered very important by most of the pregnant women and very few had ever failed to attend services on a scheduled clinic day
- The relatively close proximity to ANC clinics, mainly a result of outreach (trekking) stations, was generally acknowledged and appreciated by the pregnant women.
- The setup used to administer IPTp drugs using Direct Observed Therapy was generally accepted by the pregnant women.
- The behaviour and attitudes of ANC staff was highly appreciated by almost all pregnant women interviewed.

Weaknesses

- Few pregnant women knew the nature of negative effects on the pregnant woman and newborn child of malaria in pregnancy.
- The proportion of pregnant women who knew the most important malaria preventive measures was low.
- The knowledge about the name and type of the drug provided as IPTp at ANC clinics was very low.
- The knowledge about why IPTp drugs were provided at ANC clinics was low.
- The proportion of pregnant women who received the second dose of IPTp was low.
- Pregnant women living far way from ANC clinics spend substantial amounts of time and money on transport (directly or indirectly); this is extremely problematic at times when clinics (mainly trekking clinics) for any reason are cancelled without notice.
- Supplies of essential drugs at the ANC clinics were considered highly inadequate by most of the pregnant women.
- ANC clinics were considered understaffed and waiting times long by many of the pregnant women.
- The physical environment (space, facilities, benches, privacy etc) at the ANC clinics was not considered optimal by a substantial proportion of the pregnant women.

8.1.4. Health information system, monitoring and reporting

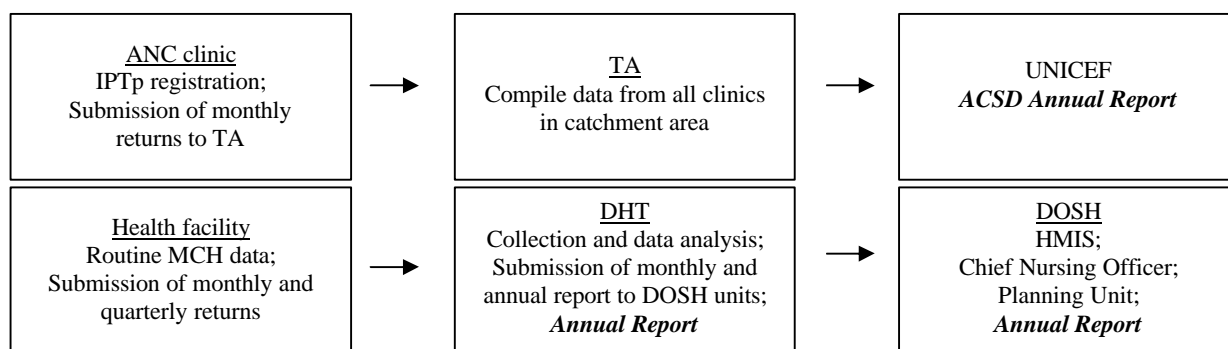
Health information management

The national Health Information System (HIS) and the more comprehensive Health Management Information System (HMIS) in the Directorate of Planning and Information are the overall responsible in collecting relevant health data from primary, secondary and tertiary levels. Data are supposed to be used partly to provide the nation with an up-to-date overview of the state of health and partly to be used in assessing staff and facility performance at all levels of the health system. The following relates to observations on the flow of data related to the return of IPTp information from ANC clinics:

On basis of the facility IPTp register the OIC will submit IPTp monthly return summary sheets to the TA, who forward data compilations to UNICEF. The IPTp register is not yet standardized. Each facility may decide which records to take. One example of an IPT registration form seen had the following items: Serial no.; ANC no.; Name; Address; Date of 1st dose; Hb-level after 1st dose; Date of 2nd dose; Hb-level after 2nd dose; Side effects; Birth weight; Remarks. There is never any oral or written feedback from TA to DHO or facility on the content and quality of the compiled data. The DHO strongly recommends that IPTp data are forwarded to the divisional health system for use. However, at present the system is not set up for this.

Parallel to this, the health facilities submit monthly and quarterly returns of MCH data to the DHT administrator, who will do general entry of data on computer and a rough analysis with subsequent oral feedback of results at DHO monthly and quarterly meetings with OICs (no written feed back to OICs). The DHT IT-data management system is not always functional due to shortages of electricity, hard-ware problems and lack of capability of solving even minor IT software problems. Furthermore, there are no internet or e-mail facilities.

The DHT forwards a copy of the summary data form on a monthly and quarterly basis to the HMIS office at Information and Statistics Division, the Chief Nursing Officer and the Planning Unit at DOSH headquarters. The DHO also prepares an Annual Report for the collective results of the divisional ACSD activities. The more or less parallel flow of health information is illustrated in the following illustration:



A compilation is done of IPT data and Annual Reports are prepared by UNICEF. DOSH prepares Annual Reports to satisfy the need for overviews of the state of health of the nation. There is considerable delay in the publication of the Annual Reports (latest available is from 2001). None of the reports are fed back to lower level facilities. When the TA (in LRD) left his position the IPTp information and data was apparently not left with the DHT (data could not be presented to the team).

The 2002 DOSH guide on “Collecting Data and Using Health Indicators” seemed not to be used at the divisional and health centre levels as a means to secure proper data handling and analysis. Generally, health registers and data at health centres and dispensaries are kept inappropriately with no secure filing system. Overall, staff expresses constraints and lack of skills related to data handling and management with implications for quality control and validation.

Project monitoring

As indicated earlier monitoring may be considered as part of the general HMIS performance evaluation system. The following observations seek to highlight monitoring related to the IPTp and are mainly focussing on processes, outcomes and impact of the IPT strategy at the central (including donors), divisional, health facility and community levels.

Central level (including donors)

The HMIS in DOSH receives copies of the monthly and quarterly returns submitted by the DHTs but not on IPTp. General ACSD monitoring (including IPTp) is done by a UNICEF Task Force together with the DHOs. The monitoring includes an assessment of the work of the TA and helps to assure quality. A report of

the monitoring activities is prepared prior to quarterly meetings at UNICEF. A plan of specific corrective actions is established.

Divisional level

There is a system at DHT level for monitoring although not clear in its scope. The purpose is bi-directional as the objective is to follow the progress of the project and to inform decision makers and donors at higher level as well as respond to issues related to project performance at lower levels. Monthly in-service meetings between health facility representatives and DHT are held to discuss performance and constraints. In addition, quarterly DHT in-service meetings including the OICs take place. Minutes are taken from these regular meetings and any requests made by the DHT are brought forward to DOSH for subsequent action. Generally requests for assistance and support are received positively at DOSH but requests are not always fully met due to lack of human and capital resources.

There is no written feedback from this level of the health system in terms of monthly, quarterly or annual reports sent to the OICs for information about overall project progress.

The DHTs also perform quality checks on the service delivery for example on the content of the health talks given to women at consultation for the IPTp. However, there seems to be no criteria given as to what should be covered in these specific talks. The result of monitoring of the service delivery turns into a form of on-the-job supervision for overall better performance and quality. Quality checks of data submitted by the health facilities take place occasionally and inconsistencies in data recording have been experienced by the DHTs.

Monitoring of staff performance is done by the DHT and OIC and the DHT has the power to have bad or non-performing staff transferred within the division. DHT has no mandate to hire or dismiss personnel. Work related poor practises or mismanagement may be taken up for discussion and correction at in-service meetings at health centre level.

Health facility level

At this level the OIC is in charge of monitoring the IPTp activities. Monthly staff meetings are conducted to review clinic functions. It appears that there are no specific guidelines or check lists to follow in the scrutiny of the IPTp service provision process and quality. As for disease indicators in some instances the OICs may do simple analysis of the monthly data at facility level with options for local, direct actions. This is only rarely taking place if at all. If done the DHT is informed about such local action taken.

Community level

Every three months the DHT joins the TA on a monitoring mission to all the health centres and communities in their catchment areas for inspection of work related to the implementation of IPT. The scope of work of the mission is not clear and the mission does not seem to follow set monitoring guidelines. Matters of concern are discussed with the OICs at the quarterly in-service meetings at the DHT office for possible corrective action. Village Health Registers (VHR), which in essence are tally sheets, are used in all villages in CRD and LRD. Recordings are monthly. Variables recorded by VHAs include malaria, ARI and diarrhoea cases. In addition to these variables, the VHWs record adult malaria, measles, family planning, referrals and home visits. TBAs record pregnancies, births, deaths and family planning. The use of the tally sheets in a concrete monitoring of ANC performance is not known. Although the VHWs are involved in the data recording it does not appear that they are participants in the monitoring process itself. The CHNs report to DHT from both PHC and non-PHC villages on a quarterly basis.

On the basis of the above observations the following strengths and weaknesses have been identified:

Strengths

- An HMIS is being established at department level.
- A DOSH Manual on “Collecting data and using health indicators” (2002) with core HMIS indicators and reporting formats is available.

- Structures, forms and procedures for monitoring health systems performance have been developed by the Department of Planning and Information.
- Awareness exists about the value of project monitoring as a tool for quality control and project adjustments.
- A formalised, functional data collection system is in place.
- The DHTs do quality control of data by regularly checking return forms for inconsistencies and errors.
- There is an interest and willingness to use time and efforts for personal career development by attending refresher courses and further education within data management.

Weaknesses

- There are no DHT plans to refer to and guidelines for use in monitoring of project processes and outcomes at all levels of project implementation.
- There is no mechanism in place for written feed back (monitoring reports) on monthly returns by the TA or DHT to the IPTp providers allowing the facility staff to follow trends and patterns in disease development over time and thereby results of their efforts.
- There is no standardized system for registration of IPTp services for pregnant women.
- The capability of ANC clinic staff to do proper data collection is weak as evidenced by reports by the DHT of data inconsistencies and data entry errors.
- The data management capability and capacity at DHT level is insufficient
- The DHTs do not share their respective annual report with the health centres by providing a copy to the H/C OICs.
- The Annual Reports by DOSH and UNICEF on ACSD and IPTp activities have not been provided to lower level health staff creating some frustration and uncertainty as to overall project performance and success.

8.2. Options for change by organisational level

The following options for change are defined on the basis of previously presented weaknesses and refer to programmatic adjustments or actions at central, divisional, health facility and community level which are likely to improve the effectiveness of IPTp service provision under ideal conditions where human and financial resources do not comprise a major limiting factor.

8.2.1. Central level

- To strengthen the divisional financial management competence in preparation for decentralisation.
- To review and strengthen planning procedures and formats for a national strategic planning framework with planning and monitoring guides for all levels including a review of divisional roles in programme planning and implementation.
- To strengthen the capacity and capability at DHT level to apply health planning tools for coordinated divisional service provision.
- To develop a strategy and a plan for the provision of long term technical and budget support to ensure sustainability of IPTp services and other priority interventions. Strengthening the system for Sector Wide Approach (SWAp) based donor and DOSH coordination could be explored.
- To develop a strategy and plan of action for long-term financing of SP for IPTp in sufficient quantities to cover national needs.
- To develop a strategy and plan of action for the antimalarial drug procurement, distribution and provision system which integrates procurement and distribution of SP for IPTp in the CMS based system used for governmental supplies and considers mechanisms for minimising the risk of SP leakage from IPTp provisions at divisional and health facility level.
- To assess the motivating and de-motivating factors among health staff and develop a long term plan aiming at increasing staff satisfaction and motivation.
- To develop a long term plan for training and refresher training based on an assessment of needs at health facility and DHT level.
- To develop a more structured approach to the planning and implementation of supervision, training, communication and reporting at health facility and DHT level.

- To introduce a more modern approach to training involving problem based approaches, practical work, group work, testing of acquired knowledge and skills, written evaluations and feed back.
- To introduce a procedure ensuring that training is always structured and standardised and based on a written curriculum and well tested and user friendly training materials (e.g. a resource package, guidelines, checklists, algorithms etc), the latter of which should always be provided to trainees as handouts.
- To introduce a system for training of trainers (TOT) to function in dissemination of knowledge and skills according to a cascade approach from central to peripheral levels of the health sector.
- To merge existing registers for ANC attendance (anonymous), ANC problems (anonymous) and IPT (non-anonymous) to allow for more comprehensive recordings at the level of the individual.
- To introduce a new integrated ANC register through thorough cascade-based training principles.
- To develop a new ANC registration card that has information on IPTp.
- To develop and make available material on counselling to be used by the IPTp providers.
- To reconsider the organisation of MCH clinics with a view to establish mechanisms ensuring optimal balance between preventive services and health promotion.
- To increase staff number at ANC clinics and provide proper accommodation for all staff.
- To prioritising the updating of the physical environment at the ANC clinics with emphasis on space, facilities, benches, privacy etc.
- To provide training in monitoring and communication as a means for improving the data quality and feedback to stakeholders.
- To develop monitoring guidelines for use by management at all levels to secure uniform criteria for assessing project development and performance.
- To put in place a uniform job performance monitoring system with a checklist of issues to be looked at to allow for proper feedback of both positive and negative findings. This will stimulate the sense of participation by the health staff leading to better staff job satisfaction.
- To more consistently use core HMIS indicators and reporting formats for providing support for development of shared planning guides.
- To establish a training programme in disease surveillance and data management meeting an expressed demand for more solid data handling skills among especially the DHT and OICs.
- To introduce a two-way communication system between all health system units by providing written feedback to units on monthly returns. This may be done on a monthly or quarterly basis and serves to enhance project ownership and staff satisfaction.
- To share the ACSO/UNICEF Annual Reports with stakeholders at all levels.
- To increase communication between relevant DOSH units and divisional health offices on issues pertinent to health information management, e.g. by sharing relevant project reports and guidelines.

8.2.2. Divisional level

- To advocate for increased divisional roles in programme planning and implementation.
- To provide support to staff satisfaction and motivation.
- To develop a long term divisional plan for training and refresher training based on an assessment of needs at DHT and health facility level.
- To develop a more structured approach to the planning and implementation of supervision, training, communication and reporting at DHT and health facility level.
- To introduce a system for dissemination of knowledge and skills according to a cascade approach from divisional to facility and community levels of the health sector.
- To reconsider the organisation of MCH clinics with a view to establish mechanisms ensuring optimal balance between preventive services and health promotion.
- To strengthen plans for coordinated divisional service provision.
- To put in place a uniform job performance monitoring system with a checklist of issues to be looked at to allow for proper feedback of both positive and negative findings. This will stimulate the sense of participation by the health staff leading to better staff job satisfaction.
- To train or sensitise ANC staff about good clinical practice with emphasis on information, education, communication, counselling, ethics, personal attitude etc.
- To train health facility staff in disease surveillance and data management.
- To more consistently use core HMIS indicators and reporting formats.
- To share DHTs Annual Reports as well as other relevant reports with their respective health centres.

8.2.3. Health facility level

- To support staff satisfaction and motivation.
- To review and as necessary address the balance between preventive services and health promotion.
- To improve the data quality and feedback to stakeholders.
- To strengthen the communication system between health facilities and community workers, e.g. by providing written feedback to them on monthly returns.
- To request DHTs Annual Reports as background for own service planning in collaboration with stakeholders at community levels and in other sectors.
- To intensify and systematise health education at ANC clinics on IPTp services, the positive effects of IPTp for the pregnant woman and the child, SP/fansidar treatment regimens, importance of full compliance to treatment, possible side effects etc.
- To request and adopt counselling guides for ANC staff.
- To establish mechanisms ensuring that the balance matches between the number of ANC staff and the expected number of pregnant women attending ANC clinics.
- To establish mechanisms ensuring that ANC clinics are always open as scheduled (in relation to day and time) and that sufficient drugs, materials and equipment are available.

8.2.4. Community level

- To intensify and systematise community sensitisation on the importance and nature of ANC and IPTp services, importance of early registration at ANC clinics, possible negative effects of malaria in pregnancy, malaria preventive measures etc.
- To participate in annual planning exercises.
- To regularly update supervisors on motivating and de-motivating factors for daily work.
- To request training necessary for improving performance.
- To increase communication with supervisors and request necessary support.
- To improve submission of data of better quality and share the information with community members.

8.3. Options for change in relation to key cross-cutting themes

A number of options exist for changing facility and working conditions in order to arrive at better IPT management and more competent and satisfied staff. The ANC facility staff had their opinions on this and as appears in Table 5 the staff had a number of suggestions as to what could be done to improve the implementation and effectiveness of the IPT strategy in country:

Table 5. Measures for strengthening IPTp services as expressed by ANC staff.

<i>Measure</i>	<i>Frequency (n=20)</i>
Regular, timely and adequate supply of basic drugs and materials to clinics	11 (55%)
Improve/Provide incentives to staff-salaries; houses; transport, etc.	6 (30%)
Increase the staff manning levels at all health facilities especially the cadre of nurse midwives	5 (25%)
Strengthen IEC material and community sensitization on malaria	5 (25%)
Training health service staff at health facility level on issues related to IPT	4 (20%)
Subsidising ITN's to ensure they are affordable to pregnant women	3 (15%)
Scale up the implementation of IPT to national level to avoid contradictions from different divisions	3 (15%)
Involving traditional birth attendants (TBAs) and village health workers (VHWs) on IPT related issues	1 (5%)
Extend outreach services to remote areas	1 (5%)

The above mentioned measures are also reflected in the overall options for change grouped according to major cross-cutting themes as follows:

8.3.1. Capacity building

- To increase communication and counselling skills of IPT providers by offering relevant on-the-job training and refresher courses accompanied by provision of appropriate teaching material.
- To develop and make available material on counselling to be used by the IPT providers.
- To introduce a new integrated ANC register through thorough training in its use by DHT staff.
- To strengthen the capacity and capability at DHT level to apply health planning tools for coordinated divisional service provision.
- To provide training in monitoring and communication as a means for improving the data quality and feedback to stakeholders.
- To establish a training programme in disease surveillance and data management meeting an expressed demand for more solid data handling skills among especially the DHT and OICs.
- To develop guidelines and instructions for (and provide training in) the planning, announcement, implementation, monitoring and evaluation of community sensitisation activities.
- To train or sensitise ANC staff about good clinical practice with emphasis on information, education, communication, counselling, ethics, personal attitude etc.

8.3.2. Supervision, monitoring and reporting

- To develop monitoring guidelines for use by management at all levels to secure uniform criteria for assessing project development and performance.
- To develop a new ANC registration card (for user) that has information on IPTp.
- To put in place a uniform job performance monitoring system with a checklist of issues to be looked at to allow for proper feedback of both positive and negative findings. This will stimulate the sense of participation by the health staff leading to better staff job satisfaction.
- To merge existing registers for ANC attendance (anonymous), ANC problems (anonymous) and IPT (non-anonymous) is suggested to allow for more comprehensive records of individuals – thereby make cross reference and comparisons possible.
- To intensify and organise the supervision and support of CHNs (VHS) from health facilities and DHT.
- To critically review the work burden, duties, lines of command, and sizes of catchment areas covered for all CHNs (VHS) with the purpose of improving their working environment and optimising the quality of performance.

8.3.3. Integration, participation and ownership

- To reconsider the organisation of MCH clinics with a view to establish mechanisms ensuring optimal balance between preventive services and health promotion.
- To increase staff motivation and job satisfaction by introducing e.g. a team bonus system in recognition and acknowledgement of good performance and results.
- To introduce a two-way communication system between all health system units by providing written feedback to units on monthly returns. This may be done on a monthly or quarterly basis and it will enhance the ownership and staff satisfaction.
- To share the DHTs Annual Reports with their respective health centres which will increase project ownership by health staff and improve staff satisfaction.
- To share the ACSD/UNICEF Annual Reports with stakeholders at all levels.
- To increase communication between relevant DOSH units and divisional health offices on issues pertinent to health information management, e.g. by sharing relevant project reports and guidelines.
- To intensify and systematically plan community sensitisation campaigns addressing the importance of attending antenatal care clinics early in pregnancy involving TCs and other community based groups and making a special effort also to invite men.

8.3.4. Human, technical and financial support

- To respond promptly and sufficiently to requests by the ANC clinics for needed equipment, drugs and utensils.
- To increase staff number at ANC clinics and provide proper accommodation for all staff.
- To develop by DOSH a new, standardized IPT register preferably integrated with ANC attendance register and ANC problem register, respectively.
- To carefully consider the degree of participation and sensation of ownership that decision-makers find it appropriate to provide to beneficiaries and all level stakeholders for use in future project planning.

8.4. Outcomes and impacts

This section summarises the quantitative outcomes and impacts of the ANC component of the ACSD project with emphasis on IPTp services. All data were obtained from the quantitative survey (i.e. Data Set 2, see Section 7.4.2.). The period of intervention (i.e. provision of IPTp services) of this specific project component was about one year at the time of data collection. Furthermore, where possible pre-intervention data for a one year period of time were collected for comparison. The term *outcome* refers to ANC clinic attendance and IPTp treatment rates whereas *impact* refers to health effects such as malaria and anaemia episodes as well as birth outcome. The data are summarised for all visited health facilities in each division. For health facility specific data, see Annex XI.

ANC attendances

There is some indication that the ANC attendance rates increased during the intervention period. Although the data varies substantially between health facilities and are of questionable accuracy here and there, CRD reported an overall increase of **37.5%** (from 4736 to 6511) in the number of first visits to an ANC clinic and an increase of **23.2%** (from 11442 to 14096) in the number of second or more visits between the pre- and post intervention data (Table 1a). For all visits, the increase was **27.4%**. For both pre- and post-intervention data first visits to ANC clinics comprise about **30%** of all visits.

LRD reported an overall increase of **29.2%** (from 2366 to 3057) in the number of first visits to an ANC clinic and an increase of **73.7%** (from 1519 to 2638) in the number of second or more visits (Table 1b). For all visits, the increase was **46.6%**. First visits to ANC clinics comprise about **60%** of all pre-intervention visits and about **50%** of all post-intervention visits.

Some identified inaccuracy related to the recording of visit number in the Antenatal Clinic Register (OPD) may question the validity of the number of first visits as a percentage of all visits for both CRD and LRD.

IPTp treatments and coverage

During the one year intervention period covered in this report the number of first (IPT-1) and second (IPT-2) doses of IPTp prescribed in CRD were about **7063** and **2699**, respectively (Table 2a; note that data from one health facility are missing). This suggests that **38.2%** (range for all facilities: **23.8% - 46.2%**) of the pregnant women who received the first dose also received the second dose. With a population size of about 186000 in CRD and an estimated 4-5% pregnant woman the IPT-1 coverage in the division is between **76.0% - 95.0%** and the IPT-2 coverage is between **29.0% - 36.3%**.

In LRD, the number of prescribed IPT-1 and IPT-2 doses were **2646** and **1160**, respectively, indicating a **43.8%** compliance to IPT-2 (range for all facilities: **12.0% - 65.6%**) and, with a population size of about 73000, an IPT-1 coverage of **72.9% - 91.2%** and an IPT-2 coverage of **32.0% - 40.0%** (Table 2b).

The number of IPTp-1 and IPT-2 treatments as a percentage of the total number of pregnant women attending ANC clinics for the first and second time, respectively, for the given pregnancy exceeds 100% in most health facilities (Table 2a and 2b; the last two columns). Apparently, this indicates weaknesses in the recording of visit number in the Antenatal Clinic Register (OPD).

Malaria and anaemia episodes

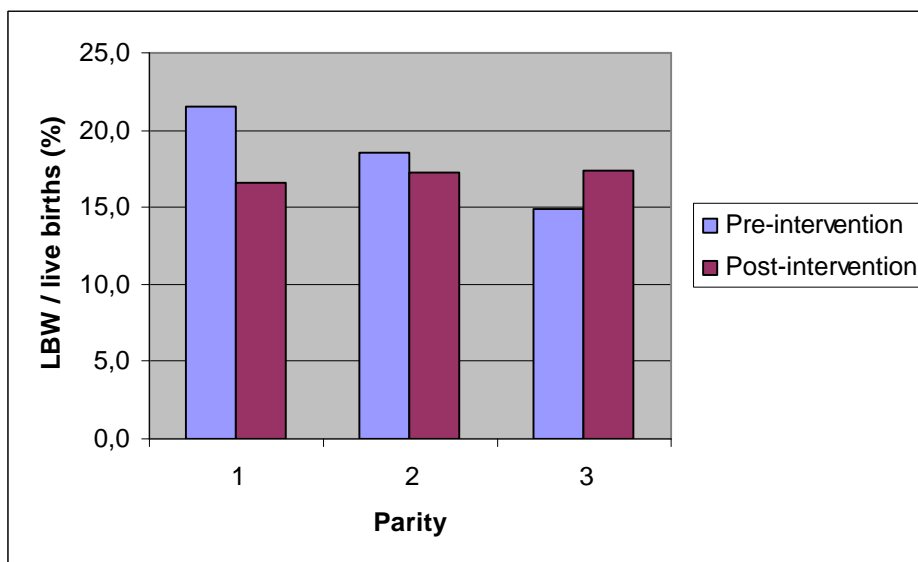
Between the pre- and post-intervention periods the number of anaemia episodes reported at the ANC clinics in CRD reduced by **23.5%** (from 1573 to 1204) whereas the number of reported malaria episodes increased by **9.2%** (from 4865 to 5312) (Table 3a). When related to all ANC visits for the same periods of time (i.e. pre-and post-intervention) the anaemia incidence reduced from **3.5%** to **2.7%** and the malaria incidence increased from **19.7%** to **23.4%**.

LRD reported a **27.9%** reduction in the number of anaemia episodes (from 839 to 656; note that Soma Health Centre underreported and the data were therefore excluded from the calculations) and a **19.5%** increase in the number of malaria episodes (from 1694 to 2105) between pre- and post-intervention (Table 3b). When related to ANC attendances the anaemia incidence reduced from **33.0** to **22.1%** (excluding Soma Health Centre) and the malaria incidence reduced from **43.6** to **37.0%**.

Birth outcome by parity

The percentage of low birth weight (LBW) deliveries in CRD reduced from **21.5%** to **16.6%** in primigravidae and from **18.5%** to **17.2%** in secundigravidae but increased from **14.9%** to **17.4%** in multigravidae between the pre- and post intervention periods (Table 4a and Figure 1).

Figure 1. Low birth weight deliveries by parity in Central River Division

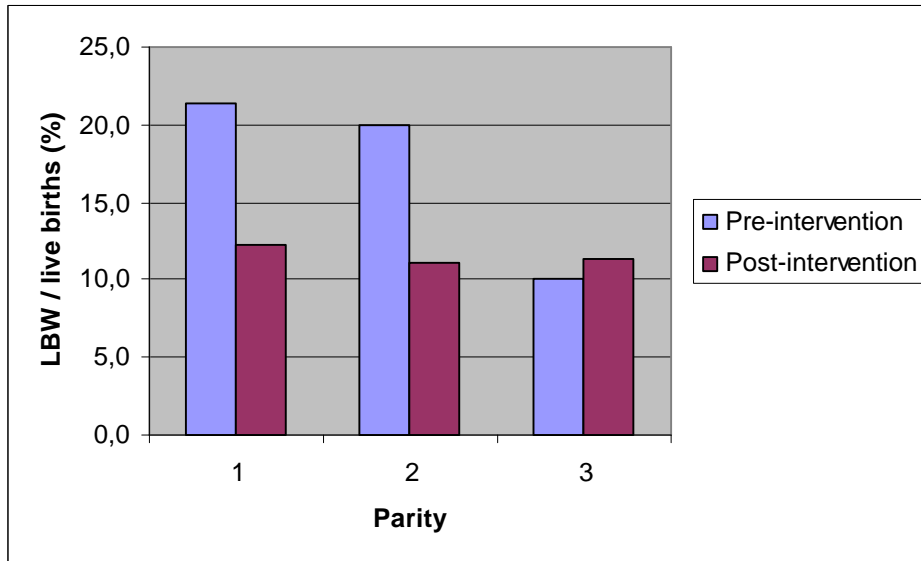


Similarly, in LRD the percentage of LBW deliveries reduced from **21.4%** to **12.2%** in primigravidae and from **20.0%** to **11.1%** in secundigravidae but increased from **10.0%** to **11.4%** in multigravidae between the pre- and post intervention periods (Table 4b and Figure 2).

The total numbers of births (live and stillbirths) during the pre- and post-intervention periods were 1429 and 1367, respectively. When related to the number of pregnant women who attended the first ANC visit during their pregnancy the health facility-based deliveries comprised **30.2%** pre-intervention and **21.0%** post-intervention (Tables 1a and 4a). When related to the total number of estimated pregnant women in the division the health facility delivery percentages comprised **15.4 - 19.2%** pre-intervention and **14.7 - 18.4%** post-intervention (Table 2a and 4a).

Similarly for LRD, the total numbers of births during the pre- and post-intervention periods were 720 and 820, respectively. When related to the number of pregnant women who attended the first ANC visit during their pregnancy the health facility-based deliveries comprised **30.4%** pre-intervention and **26.8%** post-intervention (Tables 1b and 4b). When related to the total number of estimated pregnant women in the division the health facility delivery percentages comprised **19.8 - 24.8%** pre-intervention and **22.6 - 28.3%** post-intervention (Table 2b and 4b).

Figure 2. Low birth weight deliveries by parity in Lower River Division



9. Conclusions

9.1. Relevance

In this report *relevance* addresses the extent to which the objectives of a project are consistent with decision-maker's policies as well as target group's priorities and needs. As such, an assessment of relevance does not relate to project design and approach.

IPTp is a key strategic intervention in the worldwide effort to control malaria. It is also a key strategic intervention in The Gambia together with case management and vector control as pointed out in the Malaria Strategic Plan of Action (2002-2007), NMCP, DOSH. Malaria is the leading public health problem in the country and accounts for about 78% of all outpatients, 58% of all inpatients and 40% of all visits to MCH clinics. In addition, 20% of all antenatal attendances and 18% of all maternal deaths are attributable to malaria and malaria related conditions due to limited access to preventive and curative measures. On this basis the relevance of the IPTp component of the ACSD project is unquestionable from an international and national perspective and it is furthermore the impression of the evaluation team, based on document review as well as interviews and group discussions with health staff and pregnant women, that malaria control, antenatal care and IPTp services are highly valued by beneficiaries.

9.2. Efficiency

In this report *efficiency* is defined a measure of the extent to which a project performs well or achieves results without wasting resources, effort, time or money. Greater efficiency is achieved where the same amount or standard of services are produced for a lower cost or in a shorter time, if a more useful activity is substituted for a less useful one at the same cost or time, or if needless activities are eliminated.

The strategic approach adopted by the ACSD project appears to be (and should be) based on pilot-testing of interventions in CRD and LRD; yet clear indicators and targets for a specified time frame are seemingly non-existing and mechanisms and procedures for learning from experience through systematic monitoring and definition of project milestones appears not to have been developed or implemented.

As a pilot project one target division would have been enough to inform post-project adjustments and subsequent rolling out of project interventions. The evaluation team is of the opinion that resources (though budgetary details are not known) could have been spent more appropriately if only targeting one (pilot) division and adopting a more holistic and process oriented perspective in defining the strategic approach of the project. Apart from the intervention itself (i.e. providing preventive treatment for malaria in pregnant women) the strategic approach would have benefited from inclusion of service provision support structures at higher levels, quality of care at ANC clinics, user concerns and attitudes, and community sensitisation, involvement and mobilisation.

9.3. Effectiveness

In this report *effectiveness* is defined as a measure of the extent to which a specific intervention, procedure or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population. In other words, it is a measure of the extent to which a project attains its objectives at the goal or purpose level. The term *outcome* is used to address the ultimate and direct effects or changes of a project. The changes may relate to knowledge, attitudes and practices in relation to health service attendances and treatment rates.

The stated aim of the ANC Plus package of ACSD is to reduce the burden of malaria among pregnant women. More specifically the objectives are 1) to increase the proportion of pregnant women sleeping under an ITN to 60% and 2) to increase the coverage of pregnant women receiving IPTp in antenatal clinics to 50%. More information about project objectives, indicators and targets was not made available to, or identified by, the evaluation team.

Although the apparent lack of indicators and targets makes it difficult to objectively assess the effectiveness of the IPTp component of the ACSD project, it is the opinion of the evaluation team, on the basis of documented project outcomes, that some of the achievements are impressive in consideration of the very short intervention period covered by the evaluation.

The coverage of (all estimated) pregnant women at divisional level who received the first dose of IPTp was very high (73-95%) but the coverage for the second dose much smaller (29-40%). Of the pregnant women who received the first dose 38-44% also received the second dose. During the intervention period there appears to have been some increase in ANC attendance rates (as compared to pre-intervention data) although data are not fully consistent in this regard. User satisfaction with ANC and IPTp services was very high despite very difficult working conditions for health staff in relation to the availability of time, space, staff, supervision, medical supplies and equipment.

9.4. Impact

In this report the term *impact* is used to address the overall and long-term positive or negative effects of an intervention such as the effects on health. The impact is normally affected by many factors of which some are not related to the intervention.

A stunning impact of the IPTp project is the reduction in the rate of LBW deliveries during the intervention period (when compared with pre-intervention baseline data). In just one year the LBW rate (as a percentage of all live births) among primigravidae reduced from 21.5% to 16.6% in CRD and from 21.4% to 12.2% in LRD. Reductions were also observed for secundigravidae whereas slight increases were observed for multigravidae; from 14.9% to 17.4% in CRD and from 10.0% to 11.4% in LRD.

Although data quality and statistical significances are questionable overall reductions were observed in the actual numbers and percentages (in relation to all ANC visits) of reported anaemia episodes among pregnant women attending ANC clinics. In contrast, no consistent patterns were observed in the changes in the reported numbers and percentages of malaria episodes among women attending ANC clinics.

9.5. Sustainability

In this report *sustainability* is defined as the ability of a project or programme to maintain its operations and continue to provide services to its clients within a realistic and long-term financial framework and an appropriate programmatic setup.

After initial CIDA support for the ACSD project in CRD and LRD funding came to an end in December 2003. UNICEF in The Gambia continued funding the project at the same level up to the end of 2004. As of late, UNICEF has indicated that funding will continue during 2005 and 2006 but at a lower level. Future budgetary and programmatic details are not known.

The Government of The Gambia is in the process of developing a programme for scaling up the provision of IPTp services in the nation as a whole. Substantial funding for this and other malaria control interventions has been obtained from, among other sources, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria for a five years period. Long-term financial support thereby seems to be available.

The capacity of the health system in The Gambia is sufficiently high to handle a rolling out of IPTp services. However, current operations in CRD and LRD have been introduced without adequate consideration of structural integration at all levels of the health system. Implementation of the ACSD project appears to have favoured a donor-driven approach. Sustainability of operations will depend on the ability of DOSH to adjust and optimise programmatic procedures for complete integration of the IPTp project into routine services at all levels of the health system.

10. Recommendations

The following recommendations represent the evaluation team's perceptions of changes that must be addressed in order to ensure a high degree of efficiency, effectiveness and sustainability of operations under (realistic) resource limited conditions where heavy donor input can not be taken for granted. Four main entry points for action-oriented recommendations relate to 1) supporting structures, 2) integration of project in stakeholder communities, 3) building relevant human capacity and 4) securing proper supervision and monitoring:

10.1. Human, technical and financial support

- To draw upon relevant, experienced, local resource persons (national or regional) in a scaling-up of IPTp services in The Gambia.
- To use the competencies of the evaluation field team (trained as part of this evaluation exercise) where appropriate.
- To utilize experiences and possible funding mechanisms available from local organizations (e.g. WHO country office, UNICEF country office, NGOs).
- To use the present evaluation report as an instrument in the ongoing process of project development and up-scaling.

10.2. Integration, participation and ownership

- To intensify interaction with various groups of community members (including men) with an emphasis on obtaining a higher degree of understanding of the knowledge, attitudes and practices related to health seeking behaviour of pregnant women.
- To intensify and systematise community sensitisation on the importance and nature of ANC and IPTp services, importance of early registration at ANC clinics, possible negative effects of malaria in pregnancy, malaria preventive measures etc.
- To intensify and systematise health education at ANC clinics on IPTp services, the positive effects of IPTp for the pregnant woman and the child, SP/fansidar treatment regimens, importance of full compliance to treatment, possible side effects etc.
- To consider rationalization schemes of processes and procedures to arrive at more balanced IPTp delivery in terms of more allocation of time for health education and counselling in general for ANC and specifically for IPTp.
- To review and as necessary strengthen routines for community consultations on health needs and demands including their key representatives, their selected voluntary workers and the community based extension workers in health and other sectors.
- To plan and implement staff development programmes at health centres with a view to enhance motivation, job satisfaction and commitment.
- To formulate strategic national and divisional health plans based on current policies with a view to integrate IPTp through wide consultations with all stakeholders from community to international levels.

10.3. Capacity building

- To enhance capacity and capability of DHTs and OICs to properly handle and analyse health data by setting up appropriate course programmes catering for needs.
- To develop further the competences for supervision and counselling by making available appropriate training opportunities in these areas.
- To strengthen DHT and OIC planning and monitoring skills in relation to needs and demands of users involving all relevant stakeholders for service provision.
- To further train or sensitise ANC health staff about good clinical practice with emphasis on information, education, communication, ethics, personal attitude etc.

10.4. Supervision and monitoring

- To ensure a bi-directional flow of information across the levels of the health system with focus on improved communication, supervision and support between DOSH, DHT and health facility based secondary and community based primary service providers.
- To simplify registration procedures and increasing transparency of information flows by introducing an integrated registration system for ANC related recordings including IPTp if decided to scale up to national level.
- To introduce a uniform system of project performance monitoring with clear indicators for use in the IPT scaling up process.
- To ensure a simple, transparent and timely flow of health information across the health system by introducing an integrated registration and reporting system with clear destination and wide reporting



11. Annexes

Annex I:	Terms of Reference
Annex II:	Evaluation team members
Annex III:	Map of target area
Annex IV:	List of places visited
Annex V:	Reference list
Annex VI:	List of informants interviewed
Annex VII:	Health service provider questionnaire
Annex VIII:	Health service user questionnaire
Annex IX:	Focus group discussion guidelines
Annex X:	Organogram of DOSH
Annex XI:	Quantitative data from health registers