

## **A rollercoaster of policy shifts: Global trends and reproductive health policy in The Gambia**

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Global trends influence strategies for health-care delivery in low- and middle-income countries. A drive towards uniformity in the design and delivery of healthcare interventions, rather than solid local adaptations, has come to dominate global health policies. This study is a participatory longitudinal study of how one country in West Africa, The Gambia, has responded to global health policy trends in maternal and reproductive health, based on the authors' experience working as a public health researcher within The Gambia over two decades. The paper demonstrates that though the health system is built largely upon the principles of a decentralised and governed primary care system, as delineated in the Alma-Ata Declaration, the more recent policies of The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria and the GAVI Alliance have had a major influence on local policies. Vertically designed health programmes have not been easily integrated with the existing system, and priorities have been shifted according to shifting donor streams. Local absorptive capacity has been undermined and inequalities exacerbated within the system. This paper problematises national actors' lack of ability to manoeuvre within this policy context. The authors' observations of the consequences in the field over time evoke many questions that warrant discussion, especially regarding the tension between local state autonomy and the donor-driven trend towards uniformity and top-down priority setting.

**Keywords:** global health policy; local health systems; donor driven; public/private

### **Introduction**

The ultimate goal of global health discourse, policy recommendations, negotiations and agreements should not simply be to achieve universal consensus on global agreements and declarations, but rather to prepare the ground for substantial change at the grassroots level or to improve population health and health-care delivery through a national health system (Barry, Diarra-Nama, Sambo, Kirigia, & Bakeera, 2009). Nevertheless, global health politics that evolve through the inputs of international agencies, meetings, conventions and reports sometimes fail to materialise into programmes initiated by decision makers at the state level. National-level stakeholders are important agents of change, needed to translate international directions in terms of local priorities and implementation challenges. There is considerable debate on this. President's Emergency Plan for Aids Relief, Global Fund and the GAVI (Global Alliance for Vaccines and Immunisation) Alliance have influenced governments to initiate disease-specific

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programmes, and the debate has centred around how useful this is in a framework that builds on a local, but weak health system. This paper is an attempt to review and exemplify some shifting priorities in one field of health, namely maternal and reproductive health, over time, as a case study from one specific country, The Gambia. I have been involved in reproductive and maternal/newborn research there for more than two decades. Countries are expected to also influence global policy, but many are too weak to have a major say in international fora where agendas are decided. It has even been demonstrated in previous studies that some countries, like my own, Norway, display a difference between national and international reproductive health policy (Austveg & Sundby, 2005).

This paper applies a historical perspective on the development of maternal and infant health care in The Gambia and tries to link some international trends to local-level policies and services. The purpose of the paper is to demonstrate how some channels of exchange may facilitate policy adaptation at country level, but also how inconsistent donors may push their agenda too hard in conflict with local priorities and local responses. I will show how shifting ideologies and changes in stakeholder ownership may prioritise different aspects of health, even within maternal health, over a period of time. This may have unforeseen effects on the health system as a whole and make systematic development of a better health service fragmented and unidirectional, even if the goal – better health for women – remains the same (Cham, Sundby, & Vangen, 2005; Cham, Vangen, & Sundby, 2007). The study is not a comprehensive and complete history of the health sector in The Gambia, but takes in some examples that illustrate the points made above. Key concepts that have emerged are national priorities, ownership, implementation capacity, resource constraints and the ‘ideal policy versus reality’ dilemma. It is important to expose country-level technical and political actors to important global health policy. They work within systems with many different challenges and may not have enough insight in all issues that may need reform. Countries do set priorities for themselves, even if they sometimes are unrealistic or based upon limited evidence. The Gambia has a health policy from 2012 (Ministry of Health & Social Welfare [MoH], 2012) which identifies the country’s health problems, and states:

General health systems challenges include the effects of previous high population growth rate, inadequate financial and logistic support, weak health information systems, uncoordinated donor support, shortage of adequately and appropriately trained health staff, high attrition rate, and lack of efficient and effective referral system.

The health systems framework here, as in other countries, relies on the financial commitment and preventive and curative services that are the responsibility of actors at country level, most often institutions run by the nation-state, sometimes supported by non-governmental institutions (Barry et al., 2009). In The Gambia, in 2004, only 24% of the spending on health and social welfare came from the national budget (MoH, 2012) and is spent mainly on salaries. The country is therefore highly donor dependent. Poorer countries with few well-educated and competent stakeholders may not have the level of capacity required to develop and run systems that fit their own targets and culture and will therefore tend to depend a lot on the advice and linked financial support given to them by global institutions, especially where these are also donors.

Historically, there have been many and changing internationally driven or internationally funded initiatives implemented in low- and middle-income countries. These range from the famous Alma-Ata Declaration of Primary Health Care and the ‘Health for

All' initiatives from 1978, and the World Bank's 'Investing in Health' initiative of 1993, through a series of Safe Motherhood and maternal and child health (MCH) initiatives in the time from 1987 through the 1990s, including the international conference on population and development (1994) and women (1995), and later the Millennium Development Goals (MDGs) and the GAVI (Global Vaccine Initiative) and Global Fund initiatives after the millennium. In addition, there are many smaller and larger initiatives including donor meetings and World Health Organization's (WHO) World Health Assemblies. Some of the drivers of these initiatives are public or semi-public, but private-sector actors have come to play a more prominent role. Some, if not most, of the recent ones are more disease or health problem specific and do not have broad health systems coverage goals, but rather limited disease reduction targets. In the past decade, international efforts and monitoring have to a large extent focussed on the UN MDGs, especially the three health-related ones on maternal and child, especially infant, mortality and HIV/AIDS. Thus, for countries that experience high maternal and child mortality, there has been an explicit drive towards health interventions that may have an impact on those parameters. This has indeed been a focus on The Gambian health sector as well (Jasseh et al., 2011). Nevertheless, recent estimates from an analysis of progress in MDG 5 and 4 published in *The Lancet* (Kassebaum et al., 2014) demonstrate that West African countries are less likely to reach these goals, and that countries that manage to reach their targets have had a more explicit and focussed development effort. The Gambia still experiences large challenges, high maternal and newborn mortality and shortcomings within health care for mothers and newborns, but according to the new draft 2013 DHS, The Gambia has in fact surpassed the MDG 4 target. Under-five mortality is 54 per 1000. This paper will exemplify some of these dilemmas, through a semi-chronological assessment of various international initiatives that have come and gone in the area of health. My last visit was in April 2014, and new discussions with previous informants confirm the main content of this review. One informant said: 'Now that some results of the new DHS [Demographic and Health Survey] is out, we see that there is still a decline in use of modern family planning and still high fertility and maternal mortality. It means that the focus and tools we had back in the nineties are not followed up by specific programmes. We have lost our chance'.

## **Methodology**

I did not start out my interaction with The Gambia with this paper in mind. The analysis has emerged from a longitudinal presence in the country, interaction with bureaus and technical people and field observations. The approach has also been fuelled by my presence in international fora. The paper therefore draws on my participation in a series of reproductive health research and evaluation projects in The Gambia since the early 1990s, as a professor of public health and a specialist in gynaecology and obstetrics. I first came to the country as part of a study within a World Bank-funded 'Women in Development' project in 1992 and have continued to work with The Gambian Ministry for Health over a period of more than 20 years. During this time, I have also participated actively as a scientist in several of the global movements relating to maternal health, including the 1994 UN International Conference on Population and Development (ICPD), concurrently as an adviser to WHO's reproductive health research programmes and an adviser to the Norwegian government's development cooperation and through visits to the World Bank, United Nations Population Fund (UNFPA) and several other international organisations.

This paper has also utilised a more systematic study. We conducted focus group discussions, longitudinal conversations and repeated formal interviews with five key stakeholders and policy-makers and substantial document review. I have repeatedly visited departments in the health ministry and UN agencies, especially UNFPA, which is the only larger donor for MCH in the most recent years. I have worked with core staff in the health sector and have supervised eight Gambian master students and two doctoral students in health over a period of 12 years. These students have also served as informants, through long-term interaction and discussions on local issues. Most of my students have received advanced training in international institutions and also worked at top positions in MCH in the country for long periods of time. Included in the time covered, there has been one state coup (1994), and later new elections. The leader of the coup has now become president and has been in power since 1994. Because of the current political and social situation in The Gambia, where there is a rapid turnover of technical staff inside the government structures, I have not included names of informants who still work within the system, if they did not wish to be named.

### **The national setting over time**

The Gambia is a small, relatively poor country in sub-Saharan Africa. The population is multi-ethnic, predominantly Muslim, with a plethora of local languages that also extend to the neighbouring countries of Senegal, Guinea Bissau, Mali and Guinea Conakry. Most of the population still lives in the rural areas, but there is a large net migration to the semi-urban coastal region. The country became independent in the 1965 after being a British colony for about 300 years.

The county's economy is based on subsistence agriculture, especially groundnut, maize, millet and rice production. Tourism provides substantial foreign exchange and employment, and to a certain extent, the seaport is important for continental trade. The gross national product is small and the country ranks low in the development index list. The country is poor and relatively small with a population of less than two million people. The low status of women in the country is also typical for the region. Fewer women than men are educated or have ever been to school. Polygamy is relatively common, and major household and family decisions are made by males. The social lives of women and men is fairly separated, though this is no longer always so in the semi-urban areas. At the national level, there have been strong women's institutions, working for the status of women and against harmful traditional practices, and they are still active, especially in trying to raise awareness on violence against women and female circumcision (Gambia, 1987).

When I first came to the country as a consultant for a 'Women in Development' study on infertility in the 1990s, there was a sense of optimism. The offices in the Ministry of Health headquarters were mostly found in a backyard in Banjul, and were not at all well equipped, but there were dedicated people working there. The health sector initiated several locally prioritised programmes to address the needs of women, such as 'baby-friendly communities', training of birth attendants, identification of problems with infertility and community-based contraception services. This was the immediate pre-ICPD 1994 period, and there was a lot of focus on women's health, Safe Motherhood, and family planning and community health initiatives (Sanyang, 1997; Sundby, 1997; Sundby, Mboge, & Sonko, 1998). But the main roles of women of being mothers, caretakers and meal makers in the household and agricultural workers in the rural farms were not really disputed.

Health indicators, and specifically maternal and child indicators, point to very many challenges, especially shortage of funding, weak institutions, shortage of health-care providers and lack of educational opportunities and very limited capacity to collect and analyse systematic health information, as expressed in both the health policy and in MCH field studies conducted (Palmer, Anya, & Bloch, 2009; Walker & Cham, 1981).

Much of the research on health in the country has been conducted by one specific institution, the British Medical Research Council Laboratories (MRC), which has run several field sites throughout The Gambia, generating important biomedical findings to the world at large focussing on child health and malaria (bij de Vaate, Coleman, Manneh, & Walraven, 2002; Fox-Rushby & Foord, 1996). The MRC also runs some clinical services in the country and has focussed a lot on nutrition, infections and hygiene. The MRC is an enclave of modern health research within a weak country system, and it has not run without some tension, at the same time as it has demonstrated important shortcomings in the health of the population that cannot be ignored. Gambian senior personnel in the health sector not only appreciate the high-level knowledge and services that have filtered into the country from MRC but also regret the lack of Gambian ownership in the institution, especially the inability to influence their research priorities.

The costing of health services in The Gambia is indeed an issue. In 1988, a cost recovery programme was initiated, bringing about user fees in the public services. The Gambia Health Policy specifically mentions the Bamako Initiative on user fees and cost recovery (1987) and Drug Revolving Fund as donor policies that had a positive impact. These were internationally launched initiatives that aimed at financing better services, by introducing predictable cost sharing via user payments for basic services and drugs in the public health sector (Standing, 2002).

However, these initiatives have not led to universal access, and The Gambia still allocates less than the Abuja-recommended 15% target of the national budget on health (MoH, 2012). The burden of out-of-pocket expenditure for services is as high as 80%, as there is no social health insurance. Local ownership is scarce: international donors' funds are channelled to Ministry of Health. They determine how funds are dispersed locally, to local governments (Conn, Jenkins, & Touray, 1996; Dixey & Njai, 2013). However, MCH care is offered free of charge over the past 5 years.

The Gambia has developed comprehensive health policies (Cole-Ceesay et al., 2010; MoH, 2012) and a national health system consisting of institutions, regions and service providers. On paper, the situation may look optimistic. The country started up its own training of medical doctors, with around six classes of doctors having graduated so far; most of them work in the urban coastal region (Chávez, Suárez, Del Rosario, Hechavarría, & Quiñones, 2012). But a large proportion of positions outside the urban area are held by expatriate doctors from elsewhere in Africa and from Taiwan and Cuba. The majority of health care at the field level is delivered by nurse-midwives and community health nurses, though there are three urban and two rural hospitals that can deliver comprehensive emergency obstetric care, sometimes with interruptions because of power breaks, lack of blood or lack of essential medicines. The number of private health institutions is less than 20 (MoH, 2012).

The country may seem small, but distance is a big challenge. Road conditions vary, with a 3-month rainy season being a major problem. This is especially problematic in this country as it is divided by a big river that is difficult to cross during floods. Nevertheless, The Gambia has had an explicit public health orientation and has since the 1980s established strong decentralised health divisions and a clear focus on primary health care

and preventive medicine. Recent studies in maternal and newborn health have demonstrated that a functioning health system has to be the key element in gaining control over the maternal and newborn disease burden, at the same time as focussed research on child survival has demonstrated that vertical target-oriented interventions against malaria may make a difference in child survival (Jasseh et al., 2011).

### **Health care in the late colonial era**

But let us go back to the introduction of modern health care. According to some of my key informants, in the colonial era the health care in the country was modelled on a common pattern: one very good, urban-based colonial hospital mainly run by expatriate doctors, also with good maternity services. This hospital was primarily intended to serve senior civil servants and urban dwellers, and as referral from rural areas could be difficult, some of the sick rural citizens that made it to this institution arrived in very poor conditions. There were also private traditional midwives, who went to homes and delivered babies. Their skills were said to be good, but they did not serve the rural population, whom we were informed suffered very high morbidity and mortality. In the late colonial era, the central administration also created an extension of services in the form of some health centres. There was a rigid posting system for these few rural enclaves. Often, senior hospital staff would go out on rotation and consult these services. A few national doctors trained abroad came to serve in their home country. A renowned female paediatrician started such a trekking service. This network of health centres in rural centres still exists, and some have been upgraded, even to maternities. A few of them, that I have visited over time, are like busy outpatient hospitals with a few beds for observation, and they do conduct deliveries and organise MCH outreach services on a regular schedule. The services are centred on basic primary care, antenatal care (ANC) and basic curative interventions for common ailments. Even back in the 1980s, these clinics checked pregnant women, provided advice and prophylaxis for anaemia and tetanus, weighed infants and young children and provided nutrition advice. The so-called tropical diseases were common: malaria was and is still endemic. But at that time the population was still small, less than one million people before 1990. Rural health care as a series of planned preventive activities was not really established until later.

In the 1970s the remains of the colonial ownership were diminished, and national stakeholders who had been educated outside the country, made a difference. The national doctor, Peter Ndow, the then Director of Health Services, publically advocated for a countrywide MCH plan. A very dynamic national nursing sister, Bertha Mboge, who later became the chief nursing officer, was appointed to head the newly established MCH Unit at Medical Headquarters, which she did until retirement. Mrs Mboge had earlier gone to USA to upgrade her knowledge at Johns Hopkins School of Public Health. At the same time, there were two OB/GYN doctors, one expatriate and one national, in the main hospital who were instrumental in addressing the emerging issue of MCH services there. A new maternity wing was opened in the hospital in Banjul (Royal Victoria Hospital) around 1975. Around that time there was also a yellow fever outbreak of some magnitude, and Dr Hatib Nije, one of the OB/GYNs, moved from the hospital to the medical headquarters in Banjul to launch a national immunisation campaign, and later became a public health leader. Most of these activities were funded by bilateral donors. The shift of focus initiated by the people with public health training made a breakthrough from only hospital services into a broader decentralised agenda that also covered other clinical as well as preventive services, making it possible to speed up the transition from

hospital and clinical service delivery to MCH in a public health framework. Dr Nije also later pursued a public health degree in London, in 1979.

At this time, complicated deliveries from rural areas would be referred to the main hospital, and they saw many extreme cases of obstetric complications. There was a blood bank established, though it did not function well, and the hospital had (mainly) expatriate specialists. In the rural area, a hospital had been established by the colonial administration (Bansang Hospital, still in operation today) and services here were on rotation, a rather disciplined system where staff stayed on duty, and did not leave for training or personal issues. Caesarean sections were performed, but mostly by general surgeons or medical officers. Still, modern health care was for the few, and mainly found in the urban area (Gambia, 1987).

### **The Alma-Ata breakthrough**

The Directorate of Health in The Gambia, which is one of five directorates under the Department (Ministry) of Medicine and Health, was in the late 1970s run by another prominent public health personality, later to be found in important positions in the AFRO region of WHO: Dr Ebrima M. Samba. Having led The Gambian delegation to the Alma-Ata Conference in 1978 (World Health Organization [WHO], 1978), Dr Samba was very inspired and influenced by the primary health-care message in the Alma-Ata Declaration and launched the national PHC programme in The Gambia. The programme plan was presented to a donor's meeting in Geneva and supported by the Dutch government, the Sassakawa Foundation, UNICEF, UNFPA and WHO and, later, by the UK (Save the Children Fund) and Germany (GTZ). Building a national health programme became an important issue in the post-colonial optimism.

This PHC programme brought about the first major reform of The Gambia's health sector. The primary health-care system, which was built entirely on a decentralised structure, was introduced in 1983 and consisted of PCH villages with more than 400 inhabitants, each staffed by a village health worker and a traditional birth attendant (TBA) trained by the government.

The more local District Health Teams transformed into the Regional Health Management Teams, where regional directors of health are responsible for coordination, planning, implementation and evaluation of health service delivery. The formation of district health teams was supported by medical officers, initially mainly expatriates. Unfortunately, only the administration was decentralised, not the budget and authority over personnel and posting. Posting has always been a 'headache' for the chief nursing officers, because many nurses do not want to be posted to rural areas for longer periods of time. But posting has been used, nevertheless, to cover the whole country with staff.

### **Nurses are core health workers in rural areas**

The core cadre of the new decentralised primary health-care system was the nurses. The training of nurses was mainly divided into the established 3-year hospital-based nursing education with an additional midwifery unit, and a shorter – 2-year – newly established community health nurse training school was located in the rural area. The nurses of all kinds could only be hired or moved by the chief nursing officer, and she/he would always be under immense pressure. The main shift, however, was the establishment of a basic rural health service, providing the poorer masses of the population with core services, supervising the village-based health workers (who were/are local people with

targeted short-course training), and running a PHC circuit of supervision from health teams. There was strong emphasis on gathering and training the numerous TBAs who used to serve the rural populations. TBAs were also locally based rural women with minimal formal schooling, but with focussed birth assistance training initiated by the Department of Health. The informants described the package as excellent. Reviews of the TBA training in The Gambia, which continued to at least 2007, demonstrated that they had a positive impact, and since most women delivered outside institutions, they were the only ones available and that there was no real alternative (bij de Vaate et al., 2002). This service is now phasing out, as more women prefer health service delivery. Many health-care seniors also received specific training: many nurses benefitted from a new comprehensive community health nursing training in Botswana, another country that bought into the Alma-Ata initiative. Health inspectors, mainly concerned with environmental health, like water and hygiene, were also trained under a Johns Hopkins initiative. Other donors that got involved were the British, Dutch and Japanese government-aid programmes, typically bilateral agencies that supported the reform. The MRC, already long in the country, agreed to assist in the MCH area, and a field station on the North Bank, Farafenni, was established. Farafenni became a pioneer in testing out new interventions in child health and family planning, like impregnated bed nets, intermittent malaria treatment for children and immunisation programmes, but also in monitoring of pregnancy.

The community health workers were actually doing exactly what they were asked to do, but their services were very basic. There was not much progress in maternal care, simply because access to more advanced obstetric clinical services was not a realistic part of the rural package. The health centres could not do much in this regard. The TBA training was thorough, and they were even taught to keep good records; however, the TBAs' work incentives were not really supported by the programme. They did get a certificate of training and were supplied with TBA kits, but were not paid by the system. There was also a problem with drugs: the supply chain was extremely centralised. During the 1990s, The Gambia's drug distribution system and essential drug lists and stores were developed, mainly because of the work of a returning graduate who had received a PhD in pharmacy in Norway. Maternal mortality, as demonstrated by the early stages of the 'sisterhood methods' and newer studies, remained huge (Cham, Sundby & Vangen, 2005), as did perinatal mortality (Jammeh, Sundby, & Vangen, 2011; Jammeh, Vangen, & Sundby, 2010). Family planning was an important part of the PHC programme, but did not really catch on in the population at large. China did for a period supply The Gambia with, among other things, several medical officers, and in the 1990s Chinese medicine, including acupuncture, grew in popularity even in the rural areas. But, as a system of care modelled on a primary care ideology adopted by local stakeholders, The Gambia, supported by some donors, had established their own structure that seemed a good backbone for further development.

### **Health and poverty**

The new country – although independent – was poor. Donor support for major investments was deeply needed. In the mid-1980s, the World Bank started and coordinated the National Health Development Program. Health sector development was co-financed by the governments of The Gambia, the Netherlands and Italy. The World Bank had several projects in The Gambia over time, including health components of the 'Women in Development' programme initiated in 1990. The World Bank programme



aims were to strengthen central and decentralised management; establish the Health Planning Unit; secure the supply chain management system including the establishment of a computerised drug management information system Gambia Drug Information System linked to the Swedish system and firmly establish the fee-for-service scheme and the Drug Revolving Fund. The project worked very much within and for the expansion of the health system.

The main focus of National Health Development Project 1 was improved MCH, with the creation of the Major Health Centre network, strengthened referral services with donkey carts, Community Health Nurse motor cycles, health centre-based ambulances and trekking vehicles, river ambulances, health radio network and solar telephone services, and staff development with training of 'at-risk nurses' to handle obstetric complications and nurse anaesthetists. It became more unclear who actually developed the agendas for inputs, and as many of the investments were on infrastructure, the decision makers were not only health professionals. But Gambian authorities had a long 'wish list', and also initiated and improved a new maternity unit at Bansang Hospital (rural) and a Senior Training School at Bansang and strengthened the Community Health Nursing School. Also constructed were a new Paediatric Ward in Banjul and a new central laboratory. All of these were strong health systems investments, meant to not only expand and improve what was already there but also introduce new elements. The MCH framework, however, varied with an increasing number of new initiatives, sometimes overlapping and sometimes only introducing new policies and alliances, but with no extra funding.

### **The World Bank health report and Population and Development Conferences**

I first came to The Gambia in 1992 on the midst of increased global-level attention to population issues and reproductive health, which culminated in the two conferences: the ICPD in Cairo in 1994 and the World Conference on Women in Beijing in 1995. These processes were seen by many as interactive and inclusive, as they involved stakeholders from governments, non-governmental organisations (NGO) and political voices. The programme of action from Cairo was very influential and played a role for The Gambia's position in its negotiations with the World Bank. The major shortcomings in addressing maternal mortality and fertility regulation and gender inequality were addressed internationally. The steps forward were not only to expand the menu of services for reproductive health but also to address it as a broad development agenda, with inputs outside the health sector like empowerment and education of women. In The Gambia, focussed rural family planning and infant feeding programmes were initiated, and on travelling through the country almost every local village reminds us of these efforts. They have large signboards with statements like, 'You are now entering Albreda, a baby friendly village'. In 1993 the World Bank had launched its development report, 'Investing in Health' (World Bank, 1993). The Bank had, as stated above, already started to fund health infrastructure strengthening in The Gambia, and this focus on health made it possible to ask for support in this sector specifically. The money was very welcome in a system that really needed upgrading and expansion, also due to the relatively rapid population growth. The key focus was on child health and nutrition, and on maternal health, through 'Women in Development' programmes. Female genital mutilation was addressed, but controversies like abortion and sexually transmitted diseases were not equally brought in as issues. The main effort was mainstream service delivery: to upgrade and equip major health centres, providing electricity, running water, operating theatres

and midwifery and anaesthetics competencies. Eleven young women were trained as ‘at-risk maternal health nurses’ in the central hospital, and anaesthetic nurses were also trained (Idriss et al., 2011). They were thereafter deployed, two for each health centre. The centres were given vehicles, solar power, and radio communication and were thus made operational.

Core managers in the system told me during interviews that the World Bank’s support was unfortunately terminated as it was found that some of the funds allocated to reconstruction and buildings could not properly be accounted for and the capacity to absorb funding was also limited. In 1998, the World Bank initiated a project called Improving Family Health, which was seen as a necessary starting point before one could embark on a broader sectorwide approach. Several promising programmes launched to support women – for example, a horse cart ambulance system and maternal waiting homes – did not function as expected and had to be phased out. Another possible reason for their failure was that there had been a slow shift in how agendas were set, from a local ownership and priority model to that of a more top-down implementation. The Gambia had lost some of its bilateral donors in health, both because of the decline in such assistance internationally and some donor fatigue, and because some donors withdrew after the state coup in 1994. The international community demanded that elections be held, and eventually the coup leader became an elected president. New international donors arrived, and in 2002 donors provided 66% of the health budget. Two of the main new actors after the turn of the millennium were the Global Fund and the GAVI Alliance (GAVI Alliance, 2014; The Global Fund, 2013)

### **New approaches, new funding channels**

In the years following the millennium, the focus changed somewhat. The reduced investment from the World Bank, and the decreasing power of WHO within policy-making at the global level (Lidén, 2014), plus the reduced health interest by bilateral donors and the establishment of large public/private disease-specific initiatives had important impacts at the country level. After 2000, there were not really any remaining national champions in the system in The Gambia to push the agenda on maternal health forward or participate in negotiations with the big funding agencies during the shift of the millennium. The next World Bank project addressing health was included within the Poverty Reduction Strategy framework: The Participatory Health, Population and Nutrition Project’. Important problems with these initiatives were that they were not really followed by any formalised evaluation and monitoring system, no baseline was established and the programmes were not followed-up regarding output and outcome. Nevertheless, the establishment of a community health training school in the rural town of Mansakonko contributed significantly to the strengthening of basic services, like ANC, which was found to cover almost 98% of eligible women. One reason for this was that this education was shorter than the general nursing degree, and students were recruited from and trained in the rural area. Deliveries still did not take place in the maternities to a large degree. Pregnant women wait until they are in labour, and then they consider coming to the maternity, but it may be difficult to get there in time, both for cases of maternal and newborn ill-health (Cham, Sundby, & Vangen, 2009a, 2009b).

The focus of some of the main donors was no longer health sector investments and strengthening, but more target oriented. The United Nations’ MDGs were indeed important for The Gambia, but the health goal for maternal mortality had no identifiable donor besides UNFPA. Child health was to a large extent targeted through the GAVI

initiatives, and when the Global Fund was introduced, there were financial streams going to the three domains of malaria, HIV and tuberculosis, also present in The Gambia. Paradoxically, the HIV epidemic was not really large in The Gambia, while maternal mortality remained high. The programmes were supposed to operate within the health system strengthening, and did strengthen some of those elements that related to these three diseases. But no funding agency paid more general attention to the whole system anymore. Typically, Global Fund health programmes enjoyed better quality support, larger offices and more vehicles than the rest of the health system. It was indeed visible. The old office structures in the backyards of Banjul were moved to much more modern buildings in Serrekunda, with highly improved infrastructure. It became an asset to be a public staff member of the offices of these disease control programmes, and they also reported both to the government and specifically to the donor, and staff had some room to manoeuvre because of more flexible funding.

The shift seems to have had some devastating consequences. Quality of care for less well-funded diseases was compromised; many health workers left the system, even if the health budget increased. Key people in the system that we worked with, like a statistician in the National Bureau of Statistics, got better-paid jobs in the NGO sector.

An example of how the vertical mode of operation worked locally was that although the Global Fund is technically accountable for maternal health, and must use its programmes as vehicles for initiatives like prevention of maternal-to-child transmission of HIV (PMTCT) in ANC programmes, maternal health seemed not to be a high priority. When I met with the county's reproductive health unit, they explained that they no longer had any specific large programme funders, but had to survive on mostly local funds, and some support from UNFPA only for family planning procurement. Their linkages to Global Fund programmes were weak. 'Achieving MDG 4 is possible in poor, rural areas of Africa through widespread deployment of relatively simple measures that improve child survival, such as immunization and effective malaria control,' Jasseh et al. (2011) said in a research paper. If the implications of this paper mean less support to health systems strengthening is needed for this specific goal, it will be necessary to make a special case for maternal survival, which is entirely dependent on a system that works.

When we visited the country programme for malaria – which also received Global Fund money – they demonstrated that they knew there were high levels of endemic malaria in the country, including among pregnant women and small children (Geissler, Kelly, Imoukhuede, & Pool, 2008). They also found an alarming prevalence of endemic anaemia, both findings that are important for strategies into MCH. But these issues were not addressed as cross-cutting. If service delivery was coordinated through a concerted effort, these issues could have been addressed as one. But as it is, these programmes only operate within their own mandate. Thus, the optimistic national health system thinking got somewhat distorted. Some programmes worked well, and some did not. The leadership and coordination that was clearly visible in the first period after independence lost its strong momentum. But comparatively, there was/is overall more funding coming into the health sector.

One informant claims: 'The reasons for the shift are clear: vertical projects, weak leadership resulting in poor coordination and weak absorptive capacity. Another reason is that compared to the well-seasoned and mature leadership in the first period after independence, which took years to cultivate and nurture, present day leadership make it too soon to the top with less managerial skills and lack overall confidence. Furthermore, the present leadership is also less motivated and cannot make independent decisions.'

### **Knowhow and expertise**

In the period 2000–2011 a large number of nurse-midwives were academically trained abroad and came home to work afterwards. The focus of training was research in MCH, at masters or PhD level. They brought with them substantial new knowledge of MCH issues. For a while some of them worked as top-level officers in the health system, and have informed me that they managed to revive the MCH programme implementation through a series of quality of care improvements, policy and guidelines work. Unfortunately, few of these remained in the same positions over long enough time to be able to take the programmes through major reforms. There have been improvements in the development and implementation of better skills training for emergency obstetric care, reporting systems and guidelines for referral and treatment. But some of the work slowed down considerably when core professionals were moved from this field to another before the agenda was accomplished. My main observation is that the situation improved in those institutions where there is committed leadership, but not all over the country. Estimates suggest that maternal mortality has decreased from 1050 maternal deaths per 100,000 live births in 1990, to 556 in 2007, but according to UNDP MDG 4, MDG 5, or global goals on gender equality are not on track (MoH, 2012). Perinatal mortality remains high. There are still some reproductive health challenges that have to be addressed in a concerted action by the health system and society at large, through education and empowerment of women. High fertility is still a goal for many women and families, and the total fertility rate remains high, at around five. Family planning awareness is high, but use is still low. Female genital mutilation has also been controversial in a political sense, and early marriage and large polygamous families with numerous children are very common, but slowly changing (WHO, 2013). Thus, the MDG 5b, on universal access to reproductive health, needs to be expanded and focussed in the future.

Increased technical and political emphasis on MCH resulted in some new frameworks. Trained, returning midwives have brought back many tools and situation analyses. The ideas come more from research evidence than from international donors. Maternal Death Audits as a quality improvement tool have been introduced and made mandatory in health facilities. The local nature of the audits has also led to immediate actions, and it looks as if this has managed to reduce case fatality rates dramatically at some of the rural institutions. A new reproductive health strategy is in the pipeline. A few facilities have been upgraded from maternities to fully equipped Comprehensive Obstetric Care Units. Lack of skilled personnel is still a major challenge: both doctors and trained midwives are too few, and seem not to prefer working in the periphery (Conn et al., 1996; MoH, 2012). As observed, people in charge of programmes move from one position to the next very rapidly and there is high turnover in decision-making positions. Unpredictable futures stop many competent people from being proactive.

The Gambian health policy addresses the instability and discontinuation problems in their document. A rapid turnover halts the development of change programmes – and undermines the anchoring of policies firmly in the national programme, as the successors may not fully understand why some choices were made and may opt for other alternatives. The officers are under a constant crossfire between doing what they feel are the right things to do and doing what is possible with the funding they are offered. One example is that a number of smaller donors currently want to fund ‘MCH skills upgrading training’ – but each programme follows its own curriculum and is implemented in specific geographical areas. Thus, programme managers at the central

level do not manage to follow what happens where, and planning and implementation becomes fragmented.

As is the case for many countries aiming to improve maternal health and achieve MDG 5, user fees for maternal care have recently been abandoned, and women now should not have to pay for services. However, the abolishment was implemented without any supplementary alternative funding for health staff, and it is unclear if some women still may have to pay for certain services in a less 'official' scheme. It is too early to really review if these financial changes have changed access to services, and no formal attempt to review it has been initiated in The Gambia. Again, it seems like the idea to abolish user fees was taken from global advice and implemented without local adaptation.

### **Remaining challenges**

In the rebuilding of a national system for delivery of services, there are still many challenges. Increasingly, health issues are invariably linked to poverty, and the surge of Poverty Reduction Strategy Programs focus the attention on the underserved. Skilled providers are indeed in shortage, and posting policies do *not* favour the rural poor. There is considerable need for focussed health promotion at the local level (Dixey & Njai, 2013). There is a very high turnover of staff in local health units, which makes any attempt of skills training somewhat unsustainable. The Gambia has seen a small development of a middle class demanding better privately funded services in the urban area, but the majority of the population still depends on government assistance in health care. As most of the funding for the health sector comes from donors, and many interventions must be paid for by users, the balance between local ownership and global agendas is difficult. The Gambia still depends too much on donor inputs for funding, including situation analysis and analytic capacity, even if there are a growing number of nationals with similar competencies. In such a context it is not easy to be an advocate for bottom-up decision-making. As fertility and maternal and newborn indicators show that there is still a long way to go, development assistance with a focus on such specific targets is still needed.

### **Conclusion**

It seems evident that shifting international priorities and funding policy has influenced local implementation of health care related to MCH to a large extent. Successful implementation seems to follow the logic of local exposure to the main principles through key local stakeholders, who buy into the ideas and have the influential power to make decisions, at the same time as they team up with dedicated and interested donors. Building a sustainable health system, however small and fragile to begin with, along with strengthening human capacity and addressing coverage of basic services and addressing major local diseases and health challenges seem to be a solid foundation ever since Alma-Ata. However, an integrated and prioritised plan for strengthening the whole system has not been an explicit policy in The Gambia since the turn of the century. We may see a shift now, with the National Health Policy being in place in 2012. Donor-driven programmes with large financial support, especially for construction activities or vertical programmes for some selected health issues, seem to have dominated in the last decade. This may yield less predictable long-term results on the total health picture. Remaining health challenges are identified – they include malaria, maternal and infant mortality,

pneumonia, malnutrition, tuberculosis and a growing burden of non-communicable diseases. Systems challenges are lack of adequate staff, regional and rural/urban inequity, lack of access to emergency care, unmet need for services, lack of supplies and a poor referral system. Structural factors like gender issues, high fertility and poverty play major roles for improvements in maternal health. Progress towards MDG 4 and 5 is slow (Countdown Secretariat, 2013), and interventions targeting maternal health have mainly been driven by dedicated individuals, not so much by the larger new MCH partnership agendas. Maternal and reproductive health have been long-term priorities in The Gambia, but the road to progress has been winding and not always clear, and there have been many obstacles and breaks. Some of these are indeed caused by shifting international priorities. The main challenges ahead seem to lie in human resource development and improved quality of care, and it has to be driven forward by a strong local commitment over time, and locally anchored health research and monitoring capacity building.

The new health policy is concerned with equitable access to a basic package of health-care services. Access to high-quality health care for all pregnant women and their children and the broader aim of reproductive health, remain a long way ahead. So despite global efforts around MDG 4 and 5, there is a knowhow and funding gap to be filled at the field level. In the future, the new era of the still negotiated post-MDG goals have incorporated health insurance and health financing issues as a key area to develop. It is an unresolved issue that national actors lack power to set their own agenda and secure funding for their own evidence-based, established priorities. The observations that I have made in the field over time evoke many questions that warrant further discussions, especially regarding the tension between local state autonomy and the donor-driven trend towards uniformity and top-down priority setting seconded by local people who seek opportunities inside well-funded options.

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