

Technical Brief: The Gambia

December 2015

Health, Nutrition, and
Population Global Practice

Impact Evaluation Baseline Report: Maternal Health and Nutrition

Key Messages

- Only 8 percent of women scheduled their first antenatal care (ANC) visit within the first 12 weeks of pregnancy.
- Less than half of deliveries were carried out by a skilled attendant.
- Barriers to accessing skilled delivery included delays in deciding to seek care, reaching the health facility, and receiving appropriate treatment at the health facility.
- Traditional birth attendants (TBAs) play an important role in delivery care, treatment for complications, and postnatal care (PNC).
- Only 7 percent of women received the three recommended PNC visits.
- Frequent stockouts in supplies negatively impacted the quality of ANC, skilled delivery, and PNC visits.
- Women were generally satisfied with services at health facilities, but some felt certain staff lacked thoroughness and attentiveness.

Introduction

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

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

Pregnancy Outcomes

The baseline evaluation found that rates of stillbirth were low, but more than 10 percent of babies were born with low birth weight. Across the three regions, there was an average

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

of 3.8 neonatal deaths and 1.8 maternal deaths per facility, with significantly more deaths occurring in CRR than in the other regions.

Antenatal Care

Uptake of ANC Services

Increasing uptake of ANC and skilled delivery services can improve pregnancy outcomes. National guidelines recommend four ANC visits, with one visit in the first 12 weeks of pregnancy. Receiving ANC at least once during pregnancy was nearly universal, and 68 percent of women received at least four visits. However, only 8 percent of women scheduled their first appointment within the first 12 weeks of pregnancy (figure 1).

ANC Services, Supplies, and Equipment

The provision of adequate information and services is necessary to ensure an effective ANC visit. Provision of information and services recommended in the Focused ANC (FANC) guidelines was low, with only 21 percent of women reporting having received syphilis testing and 19 percent reporting having had their blood type and Rhesus factor assessed (figure 2).

Figure 1. ANC Uptake in CRR, NBR-W, and URR

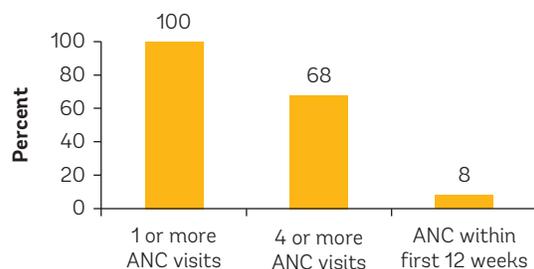
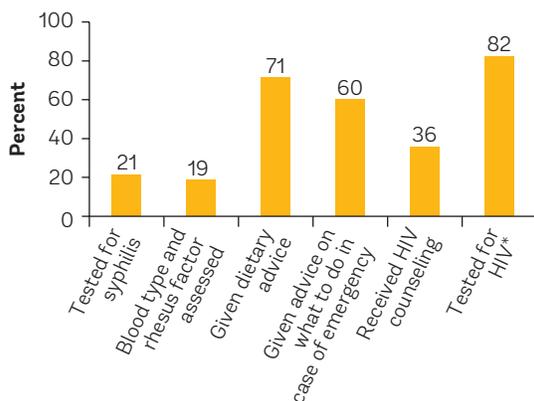


Figure 2. Services Provided during ANC Visits in CRR, NBR-W, and URR



*Based on 788 women who reported receiving HIV counseling.

Reported receipt of antenatal supplements was also low, with only 48 percent of women in their first pregnancy receiving two doses of tetanus toxoid, 26 percent receiving at least 90 days' supply of iron supplements, and 63 percent receiving at least two doses of intermittent preventive treatment for malaria.

Unavailability of necessary supplies could explain, in part, why not all women received the services and supplements recommended in the FANC guidelines. Although the guidelines indicate that all pregnant women should receive syphilis and urine tests, these services were rare at the facilities visited. Only 55 syphilis tests had been given across URR in the three months before the survey, and only 83 urine tests had been given in CRR. In the 30 days before the survey, more than 90 percent of health facilities reported stockouts of syphilis and urine protein tests.

Health Workers' Knowledge of ANC

Service provision was also affected by the knowledge and actions of health workers. When asked which follow-up services they would provide, health worker responses indicated that while 68 percent of workers knew to complete the antenatal card, only 54 percent would schedule another ANC visit and 25 percent knew to schedule the institutional delivery. Failure to perform these recommended actions not only contributes to poor quality of care but also discourages uptake of ANC and subsequent maternal and child health services.

Furthermore, many health workers did not provide the recommended advice to clients, which could negatively impact pregnancy outcomes. Although 68 percent of workers reported providing information on nutrition, less than 10 percent reported providing information on breastfeeding or contraception (figure 3).

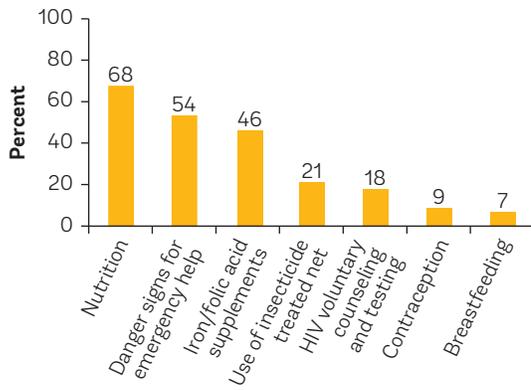
Reasons for Not Using ANC Services

Difficulties accessing the health facility (such as cost, time, and transportation) impeded uptake of ANC services. Although most health facilities reported fee waivers for pregnant women, some women reported paying for ANC services with a high reliance on out-of-pocket payments. Women reported that the reproductive and child health outreach services to the community greatly improved the accessibility and use of these services. However, health workers reported that fuel shortages often hampered these outreach activities.

"In local communities men have to decide what the women should or should not do. The husband will tell you to wait because it is very early to go [to ANC] and women cannot force themselves to go without seeking and getting permission. Some men are very aggressive."

– Community Health Nurse, CRR

Figure 3. Health Worker Knowledge (Advice) in CRR, NBR-W, and URR



Most women believed that the first ANC visit should take place in the second trimester of pregnancy, and many believed that ANC attendance was necessary every month after the first visit, which discouraged early attendance because it would imply a higher total number of visits. About half of the women interviewed agreed that ANC was useful in preventing problems during pregnancy, whereas the other half disagreed.

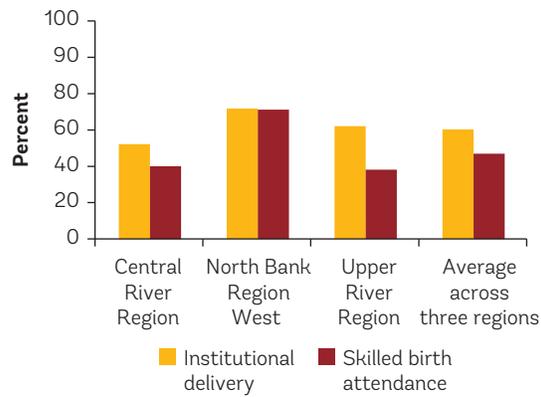
Traditional beliefs around pregnancy appear to have affected women’s willingness to attend ANC during the first trimester of pregnancy. Some women described how revealing a pregnancy early can lead to miscarriage or becoming bewitched, while unmarried women and recent mothers reported wanting to hide their pregnancies out of shame.

Nutrition during Pregnancy

A balanced diet including sufficient iron intake is an important component of a healthy pregnancy. The national prevalence of anemia among pregnant women is 68 percent (Gambia Bureau of Statistics 2014), and a high prevalence of anemia was also noted by health workers in this survey.

Health workers, village development committees, and village support groups described providing pregnant women with information on an appropriate diet based on locally available foods. Several traditional beliefs were mentioned that could negatively affect pregnant women’s nutrition. However, some respondents said that these beliefs were declining because of activities to raise awareness and because most women strive to eat a balanced diet when pregnant.

Figure 4. Skilled Birth Attendance, by Region



Skilled Attendance at Birth Uptake of Delivery Services

Using skilled delivery services at a health facility can reduce complications and improve pregnancy outcomes. Approximately 61 percent of women reported delivering in a health facility, and 47 percent were delivered by a skilled attendant (figure 4). Nurses or midwives were the most common delivery assistants (44 percent of all deliveries), followed by TBAs (40 percent of deliveries). Whereas 60 percent of women in the wealthiest socioeconomic quintile had skilled attendance at delivery, only 36 percent of women in the lowest quintile reported skilled assistance.

Referral by a health care provider to a health facility can improve health outcomes if complications occur. While 71 percent of women reported at least one postpartum complication (abdominal pain, bleeding, or headache), fewer than 20 percent of these women were referred.

Reasons for Not Delivering at a Health Facility

Most women believed that it was safer to deliver at a health facility and that the level of support received from health facility staff was higher than that received in the community. However, barriers to institutional delivery persist.

Women were often slow to make the decision to seek care at a health facility due to a lack of knowledge or decision-making power. Respondents often believed a woman was unable to tell her expected due date. When women did not know when they were due to deliver, it took many of them a long time to realize when they were in active labor.

The decision to seek care was usually made by the head of the household, which

47%

of women were delivered by a skilled attendant

40%

of births across CRR, NBR-W, and URR were attended by TBAs

7%

of women received the recommended three PNC visits

<2%

of women reported receiving the full dose of postpartum iron supplementation

often led to delays if the household head was unavailable or unwilling to allow seeking care.

Once the decision to attend a health facility was made, delays often occurred in reaching the facility. The most frequently mentioned barrier was difficulty getting to the health facility due to long distances and inadequate transport options. Particularly challenging was ensuring access at night and during the rainy season. Many women preferred home delivery because delivery en route to the health facility was common. The availability of a small vehicle at some health facilities to transport women in labor was gratefully acknowledged.

Delivery Services, Supplies, and Equipment

Many health facilities reported shortages in drugs and supplies, with only 25 percent of facilities having newborn resuscitation kits, 29 percent having tape measures, and 38 percent having delivery lights. No health facilities in URR reported having a newborn resuscitation kit. All facilities had at least one dose of diazepam, with only 4 percent of health facilities having had a stockout within the past 30 days. The opposite was true for oxytocin, with no health facility having it on hand at the time of the survey.

Role of TBAs

TBAs played an important role in delivery care, treatment for complications, and PNC. TBAs were held in high esteem by health workers and community members. Some respondents noted that many of the TBAs are very old and that a problem of succession is emerging.

Across all three regions, 37 percent of women reported preferring to deliver with a TBA. In NBR-W, TBAs reportedly referred and escorted women to health facilities for delivery whenever time allowed and referred women for pre- and postpartum complications. In CRR and URR, TBAs reportedly referred some women while delivering those with no complications at home. Across the three regions, they often assisted in deliveries at health facilities. Most TBAs appeared to embrace the idea of referring all women to the health facility for

delivery, and they did not see their role as being diminished by this process.

Postnatal Care

Uptake of PNC Services

A woman should receive her first PNC visit within 24 hours of delivery, her second visit within one week, and her third visit within six weeks. While 72 percent of women reported having at least one PNC visit, only 37 percent received PNC within 24 hours, and only 7 percent received the recommended three visits.

Although 95 percent of health workers reported knowledge of when to prescribe iron, only 1.6 percent of women reported receiving the recommended 90+ days of postpartum iron supplements. No women in NBR-W reported receiving the full dose.

Reasons for Not Attending PNC

Across all regions, qualitative data suggest awareness of the importance of PNC was very low. TBAs played a critical role in providing PNC during home visits; however, low use of facility-based PNC services remains a concern. Cost, time, and transportation difficulties deterred uptake of PNC services, particularly when women did not feel sick at the time of scheduled visits.

Satisfaction with Maternal Health Services

Women were generally satisfied with maternal health services; however, some reported that certain staff lacked thoroughness and attentiveness. They reported receiving good quality care during ANC and delivery. Almost all women would return for ANC and would recommend the facility to a friend. Some women stated a preference for female health workers because they felt ashamed to have male health workers see their body. Of concern were instances of reported health worker negligence.

Reference

Gambia Bureau of Statistics (GBOS) and ICF International. 2014. *The Gambia Demographic and Health Survey 2013*. Banjul, The Gambia, and Rockville, MD: GBOS and ICF International.



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