Jordan Engler

PIM 62

August 2004

In Partial Fulfillment of the Requirements for a Master of Arts in Sustainable Development

at

The School for International Training,

Brattleboro, VT August 2004

Practicum Final Report

SUMMARY OF PRACTICUM

As stated in my Learning Contract, my primary post is at the Divisional Health Team/Upper River Division. My responsibilities continued to evolve along with the needs of the office and community. Although it was initially hoped that I would assist staff in computer training and data analysis to improve management of health indicators and make adjustments to the overall surveillance system, this has been difficult due to bureaucratic barriers within the national health system and resource shortages in the division. Throughout the entire practicum period, my responsibilities at the DHT/URD are more directed towards community outreach, although I have worked with a few key staff members on formatting annual reports and data entry procedures. After facilitating a successful in-service training for community health nurses and public health officers in the Upper River Division, the DHT has asked me to continue to provide relevant staff development trainings for the remainder of my service (approximately ten months) and designing in-service trainings for health workers in the division.

During the second half of the practicum period, I continued to teach the students at the Basse Skills Centre for a short time until the school year closed. As stated in the mid-term report, the Skills Centre is a small alternative school for about 35 girls in the Basse area. The girls attend this non-traditional skills-based institution for about two years. Students pursue one of three different vocational tracks (home science, secretarial, and accounting) and receive some general academic instruction (English language and math) in addition to skills based practice.

The philosophy of the school is to empower girls to participate in community income generation projects for self-sufficiency and family contribution. However, the school has historically defined *skills* in a narrow sense of technical skills and hands-on practice. After meeting with faculty, I was able to show them that *life skills* is a more general philosophy towards healthy living that would broaden the current curriculum and provide the girls with the opportunity to develop socially. The *life skills* philosophy holds that people generally have sufficient knowledge on how to stay healthy in today's world. Worldwide, people are becoming aware of the threat of HIV/AIDS and have the basic knowledge on how to protect

themselves. Still, unhealthy behaviors persist. *Life skills* allow students the opportunity to develop relevant skills and attitude changes that will allow them to put knowledge to use in their own societies. This process is difficult, therefore trust and sensitivity between group facilitators and students is important.

A few times a week, I bring all the girls together for sessions on a variety of topics including emotional management, relationship building, communication skills, HIV/AIDS, public speaking, peer education, communication skills, gender empowerment activities, etc. A variety of interactive teaching techniques are used so that students have the opportunity to engage in the material presented. Not only are the students able to confront difficult and serious health issues directly and in a safe space, teachers are also able to learn a new teaching techniques that differ from the lecture approach that is prevalent in the Gambia. Teachers are able to see that facilitating discussions, which allows students to confer among themselves, actually is a viable educational approach that students benefit from. During the summer months when school sessions were officially closed, the students still requested some trainings from myself. Because these sessions were not mandatory and attendance was lower than during the academic year, we focused instructions on income generating activities in which the girls could engage. Students received instruction on soap-making, fabric dying, and making body creams from local low cost.

PROGRESS TOWARDS OBJECTIVES

I. Increase knowledge of the health care system in the Gambia

As noted in the Learning Contract, three primary learning methods continue to assist in the achievement of this objective. At the mid-term point of my practicum, I have utilized all three learning methods. Institutional issues such as staff transfers, lack of vehicles, long-term absenteeism on the part of staff, technical difficulties, and lack of medical resources, have prevented large scale/DHT sponsored public health strategies during the practicum period. Therefore, my assistance in terms of capacity building at the DHT continues to be been limited, yet I have integrated into the workplace enough to being planning campaigns and learn a good deal about the reality of primary health care in the Gambia. Although the practicum period is over, my Peace Corps service continues until June or July of 2004. During the next few months, it is expected that a major project initiative will receive funding and I will be able to work directly with DHT staff in order to provide trainings to community health workers in the region.

In order to gain a comprehensive understanding of the Gambian health care system, I continued to engaged in dialogues with my cohorts at the DHT/URD, as well as other civil servants in the Basse-Mansajang area. Two key DHT staff members were transferred since the mid-term report was submitted. One man was a key collaborator with me in terms of planning reproductive health activities. Because of this, I worked more directly with the Acting Public Health Officer for the URD. He is in charge of the entire staff of the division and oversees all activities, and it has proved difficult to obtain the necessary support from him.

Attendance of monthly in-service meetings for community health nurses at the DHT has also provided me with a deeper understanding of the role of the community health nurse in the primary health care system. It has been interesting to see points of tension that have arisen

due to resource constraints and managerial issues, between community health nurses and the managerial staff at the DHT. Other DHT meetings on a variety of public health topics (usually referred to locally as *sensitizations*) have allowed me to build relationships with local stakeholders, which will also me to have support for some upcoming campaigns.

Unfortunately, the DHT/URD continues to struggle with major managerial issues. Classes at SIT, specifically Organizational Behavior I and II provided me with some valuable background information. Leadership styles employed by the Department of State for Health and Social Welfare (top-down and hierarchical) are not conducive for high staff output at the DHT (middle government) level. These managerial tendencies are exacerbated among key DHT staff and this affects staff output at the field level (community health nurses, maternal and child health workers, etc.). Key staff at the DHT is oftentimes unaware of the activities of fieldworkers, who in turn, scoff at managerial demands. Because of institutional constraints on resources, DHT staff is not able to actively supervise field workers, ensure timely submission of reports, and provide much needed feedback on performance. Because of this, fieldworkers feel little connection and loyalty to the DHT. This problem is compounded by the fact that both DHT staff and fieldworkers are not working in their home communities, instead subject to placement demands by DoSH. This is no small issue in this culture, where family and community play an important role in one's life. Since health workers are civil servants who are posted in a new community, transferred at whim, and oftentimes paid unfairly, they usually do not build strong relationships with patients, complete returns on time, nor do adequate community outreach.

During the second half of the practicum period, the issue of institutional memory became more apparent when two key DHT staff members were transferred to DHTs in other divisions. The DHT/URD was especially affected when the Divisional Public Health Nurse was transfered. He was one of the few staff members who executed his duties with passion, empathy and complete professionalism. His work ethic was unique in the office and before his replacement arrived the office was unable to complete routine field supervisions. Last month the Community Health Nurse Tutor, a basic liaison and mentor to community health nurses in the field returned from studies in Cameroon. He was been eager to apply his learnings on development and nursing in the context of West Africa in the Gambia.

Since the Gambian Government completely decentralized the health system less than a decade ago, DHTs have continually been unsupported by the central level. Because they are unsupported and do not have complete control over their own funds, they have been unable to sufficiently support their own health workers in the field. Unfortunately, the state of health of the community is what suffers the most.

Please see Appendix A for an overview of the Gambian health care system.

Please see Appendix B for a case study on pathways to care in the Gambia.

II. Improve skills in the area of intercultural project design and management (program monitoring and evaluation, program/project design, etc.)

I again followed all three Learning Objectives as presented in my Learning Contract. Training of Trainers with the Skills Centre students and staff has provided me with valuable skills in project design and implementation.

Unfortunately, at the close of my practicum period (but not yet my Peace Corps service) I cannot report on the outcomes of my project proposal attached regarding interpersonal communication skills for health workers, as funding has not been secured. I was pleased with the writing phases of the project and am anxious to begin the implementation phase.

I completed a substantial proposal that will address interpersonal communication skills for health workers, specifically focused on women's/reproductive health. The initiative is exciting and has been submitted to DoSH and will were asked to present the proposal in-person in Banjul. Participants in the communication workshop will be community health nurses in the URD, but we have already made plans for extending the project to the national level. Depending on the level of success of the project and based on participant feedback, we hope to make some permanent adjustments to the national nursing curriculum. These efforts have been difficult once again due to the high staff turnover at the DHT.

Please see Appendix C for a copy of a project proposal for the DHT/URD.

I have learned a great deal from working at the community level. The nature of my work differs in my primary and secondary projects, but the skills gained from one, benefit the other. The realities of my student's lives and their state of health allow me to provide "voice" to the sometimes faceless "communities" that are referred in planning sessions at the DHT. What I able to see on campaign treks into remote villages allows me to contexualize life skills material in a manner consistent with my students' culture and society. The community groups (kafoos) in Mansajang have allowed me to expand my basic program planning skills. Although no formal proposals were written consistent with the format preferred by S.I.T., myself and kafoo presidents have secured funding for various trainings and programs through the Gambian National AIDS Secretariat's process.

III. Increase skills in effective coalition building for social change

This Learning Objective and methods for achieving it have continued to be somewhat difficult. Establishing formal links between the Skills Centre and other community groups has been limited to informal partnerships and joint training sessions. This has been due to limited resources, and staff discouragement. Throughout the Gambia, informal inter-organizational relationships are prevalent and work to the advantage of many, except when funding for projects is necessary. Funding sources are limited in the Gambia and many donors hold strict limitations to what activities funds can be used for. This is especially prevalent in the health sector. The World Health Organization, United Nations, and other health focused NGOs control much of the health policy planning on a state level due to large donations and partnerships, but this can be detrimental for community organizations who then find it difficult to coalesce under strict funding guidelines.

Compiliation of a resource directory of NGOs, CBOs in the Basse-Mansajgang area was not completed due to the inappropriateness as a goal. As I became comfortable in the community, it became apparent that everyone involved in development work or civil service, knows of everyone else at least in the Upper River Division. The Gambia is a small nation, with an even smaller percentage of the population being literate and employed in the formal economic sector. Ordinarily anyone in the division beginning a project would know exactly who potential collaborators would be. Contacting them would not be difficult either and would likely involve stopping by the person's office for tea or their family compound for dinner. Partnerships in the workplace begin with friendships outside of work. The directory, it

seemed, would only benefit transient and foreign workers (such as *new* Peace Corps volunteers, VSOs, UN volunteers, etc.) unfamiliar with this social network. Through casual and friendly conversations with community members I have become fully aware of whom I would need to contact for support on a project. My host family is also well connected and has assisted me in locating the right person. Coalition building in the Gambia is really an informal process centered on friendship and community integration.

Because compiling the resource directory was irrelevant, I instead worked more directly to establish relationships among community groups called *kafoos*. During the second half of the practicum period, I began actively working with two kafoos in the Mansajang area. One such kafoo is composed of about thirty women in Mansajang. Many women are prominent in the village (the Imam's wife, mayor's wife, and wives of CBO workers) and very driven to increase their economic status. Activities with this group have been primarily directed towards income-generation activities, but some basic women's health information has been presented to them. Because many NGOs are located in the capital region, it can be difficult to host trainings in Basse. However, during recent months a partnership between this kafoo and an NGO called The Nova Scotia Gambia Association (NSGA) has been solidified. NSGA traditionally has focused on training Gambian youth on the importance of peer education, but has since initiated a community outreach component. Discovering this, I made contact with the organization and they have provided the kafoo with numerous trainings free of charge and in Basse. The women have been receptive and requested more collaboration with NSGA. The kafoo has also met the members of another women's group in the North Bank Division (NBD). The kafoo in NBD maintains a community center that was established last year. The women meet there on a weekly basis to engage in income-generating activities and trainings on health, micro finance, and alternative agricultural techniques. URD kafoo members benefited from seeing the efforts of another community group and in the next few months will collaborate on some activities.

IV. Reevaluate beliefs about *sustainable development, capacity building,* and *medical anthropology*

It is imperative that I meet this Learning Objective during my service in the Gambia. Living with a Gambian family and working with many civil servants and NGO workers has provided me with valuable insight into international development work. I feel fortunate that many of the people with whom I come into regular contact are willing to engage in conversations about development and grassroots initiatives. The Gambia is an interesting place in terms of development work. At times there seem to be more foreign aid workers in a setting than Gambians and it has been this way for decades. This creates an interesting dynamic when trying to discuss *capacity building* and *grassroots mobilization*. I have already come to some conclusions about work in the field of *development*. I began formulating some of these ideas while on campus last spring (particularly in James Breeden's "Leadership, Community and Coalition Building" class) and navigating the complex web here has solidified some of these thoughts.

The Gambia achieved independence from Great Britain in 1965 and at that time international organizations rushed to the "aid" of the people of the tiny new nation. Peace Corps began sending volunteers to the Gambia as early as 1967 and has continued to send volunteers without interruption. Due to the political nature of the country, which has been relatively stable and non-violent, many NGOs have maintained programming and aid since 1965.

The overwhelming presence of NGOs has affected post-colonialism in the Gambia. Once independent, Gambian society changed little in terms of distribution of power, access to education and wealth. NGOs have basically taken the role of England and dominate the Gambian economy, culture and society. There is an interesting phenomenon to note about social change in the Gambia—there are no social movements calling for change and an end to governmental exploitation. Many people are complacent and somewhat unmotivated to work for change. I believe this is due to the fact that foreign aid flooded into the country immediately after independence and affected the way citizens viewed their personal and social agency. Gambians continue to be caught in a web of dependence, although now not under the rule of one specific country but NGOs. Citizens themselves have had little opportunity to work for change and therefore cannot conceptualize the possibilities of grassroots mobilization against a corrupt political regime. Many Gambians are unhappy with the state, the economy, market for goods, etc. but maintain apathy for change. I have seen this over and over in the community and it can also be attributed to a fatalistic religious ideology. I have heard time and time again, that suffering must be the will of God or Allah.

NGOs have consistently not held the Gambian government accountable. At times, I have wondered if they are perpetuating repression because they continue to give aid. I have also struggled personally with the ethics of my being a volunteer in the country. Sometimes, it feels like we are doing more harm than good, perpetuating the view of the northerner as the carrier of knowledge and money. Although I have come to the personal conclusion that my work for social change must be domestic upon completion of my service, due to personal ethics and view on sustainability and the role of community and culture, I believe that completing my service in the Gambia will continue to provide me with perspective.

Development as it has progressed in the Gambia is not sustainable as the citizens of the country continue to be caught in a web of dependence in the name of foreign aid. Development workers have exercised hegemony so that Gambians have little opportunity to create their own visions for a post-colonial society. What grassroots initiatives that have started in the last few decades continue to struggle under repressive governments.

<u>Please see Appendix D for a summary of these ideas as presented in the mid-term.</u>

V. Identify a research question for capstone proposal

Since arriving at my placement site in September, I compiled a list of possible research topics and questions. Co-workers at the DHT have provided continual feedback on some ideas and guided me to new directions when my questions went too far off track and would be unachievable. Although I began my work at the office fuelled by medical anthropological theories, ethnobotany and traditional medicine, daily work at the DHT has not been focused on this. I have instead become more interested in health systems management and other managerial issues. I am somewhat hesitant to present a research proposal of this nature because it is more removed from the local community, but am comforted by the fact that I would have a plethora on which to base my study.

At the close of the practicum period, I have not completed my capstone proposal. At this time, I am drafting the proposal. I will examine the socio-cultural, political, and economic factors that impact the Gambian health care system. I will examine how the Gambia has fared in "providing health care for all" and whether or not PHC strategies are still adhered to since adopting the Primary Health Care strategy in 1980. In questioning the roles of NGOs in

health finance, I will investigate whether or not Gambians are provided with the highest quality of care possible in terms of reproductive health care. Consistent with their roles at a macro level, NGOs have seriously undermined the comprehensive nature of PHC and perpetuated "campaign" driven care and funding that has negatively impacted the health of Gambians. I will look specifically at reproductive health care in the Upper River Division to provide context to a more lofty discussion of the role of NGOs in health policy planning in the Gambia.

VI. Become competent in one local Gambian language

PST (Pre Service Training) lasted three months (July-September) and during that time I was trained in a local language called Pulaar. I scored high on my PST language assessments. As repored at mid-term, volunteers are normally placed in a village that speaks the language in which they were trained during PST. In this way, the volunteer continues to learn the local language and community integration is easier. I, however, was placed with a Mandinka family. Mandinka is the prominent local language in the Gambia and if official meetings are not conducted in English, they are conducted in Mandinka. My host family speaks fluent English (even the young children) so my Pulaar level has stagnated. As with all adult learning, though, I have to make an extra effort to keep up on my Pulaar because of my host family's English fluency and the fact that the civil servants all conduct business in English as well.

ANALYSIS OF LEARNINGS

Coursework at S.I.T was definitely valuable throughout my practicum experience. I have drawn upon my learnings in numerous conversations with Gambians and other volunteers. I believe that my S.I.T classmates and teachers prepared me well for this experience. Because of the knowledge I gained from S.I.T, I feel confident to engage my fellow volunteers in discussions about development, sustainability, and capacity building.

Since beginning my practicum, I have further developed skills in program design and project planning, qualitative research methods, group facilitation, intercultural communication, and lobbying for support.

Reviewing my professional goal statement, I remain committed to work in cross-cultural health in the United States. The health needs of many immigrants, migrants, and marginalized groups in the United States are similar to the needs of the majority of Gambians. The skills that I continue to build on here will ultimately assist me in developing a career in public/cross cultural health when I return home.

FINAL ANALYSIS

What did you learn during the practicum that you did not plan for in the learning contract?
Perhaps the most critical learning I achieved during the practicum was recognizing the importance of the social in Gambian workplaces. Engaging in any sort of work with another organization or individual without adequate social networking and casual conversation about is inappropriate in this culture. If an outsider wishes to involve a community in a program or project, they will fail if they separate "work" from "community and family." This ultimately gives Peace Corps volunteers an advantage in community development over other international organizations. Because Peace Corps volunteers live with host families, are

competent in local languages and work in the communities in where they live, mobilizing community members is easier. I have learned to conceptualize "work" in a completely different manner here in the Gambia. Work in this culture, sometimes means hours of tea brewing and chatting underneath a grass porch.

I also learned just how much high staff turnover and transfer rates affect institutional memory in every institution. Staff here are transferred regularly and at the will of those at the central level. When Peace Corps volunteers work with a counterpart to implement change at the community level or at an office, and that person is transferred before work is completed, there are difficulties maintaining the initiatives. It is ultimately hoped that when the person is transferred to a new post, they will take the knowledge with them there, but in actuality this is rare.

How would you assess your performance as a professional in the field, specifically in the practicum organization?

As a Peace Corps volunteer my performance has been good. I have successfully integrated into my primary and secondary worksites and host community. I have become proficient in a local language and am able to engage people in dialogues about global development. The nature of work for a Peace Corps volunteer is somewhat ambiguous. Mostly we are forced to navigate our own work plans and the measurement of progress can be difficult. However, I believe based on feedback from Peace Corps administration and my counterparts in the field, that my performance is benefiting the community in which I live. My placement at a government office has provided some professional structure that other volunteers oftentimes lack. The fact that I go to an office daily to work with other civil servants is quite different from most volunteers in the Gambia. My placement site was a result of my being a Master's International student and the requirements of the PIM practicum.

What competencies (skills, knowledge, self-awareness) will you develop in future work?

I will continue to develop my skills in program planning and project design. I am more confident in grant/proposal writing and multi-dimensional program design, however I have not had an experience with monitoring and evaluation. I also would like to gain more knowledge and skills regarding the establishment of a 501-C3 non-profit organization in the United States. Although I remain professionally committed to coalition building among organizations back in the states, it would be beneficial to have this knowledge if program planning went to the level of founding a new organization.

Given the aspirations of the PIM program and PIM participants to contribute to intercultural understanding and global development, how would you describe the contributions you have made through the practicum?

In terms of intercultural understanding, I believe Peace Corps volunteers can have a large impact in their host countries. I do not believe that any sort of sustainable changes or "development" can occur without community support. Whether or not my work in Basse will greatly impact the socio-economic status of community members in the long run, the fact that we have strong relationships and I am considered a real member of the community, I have been able to have an impact during the last year. Intercultural understanding and development is an on-going process for a Peace Corps volunteer, as work environments are often informal and at the grassroots level. Due to the nature of Peace Corps work, it is doubtful that any sort of quantitative measurement of impact could be made. However, impacts can be measured in terms of person-to-person relationships.

In terms of global development, my role during the practicum has been primarily through capacity building of Gambian nationals. Because of my training at S.I.T. and Peace Corps, I have been mindful of sustainability issues, institutional memory, and the cultural appropriateness of activities when engaging in work. I believe the largest and most measurable impact of my practicum/ Peace Corps work has been with students at the Skills Centre. When students learn new ideas and engage in critical thinking in the classroom, they carry those ideas directly home and into the community. Topics covered in the classroom spark discussions in the home. As young people become empowered with new ideas, social change begins.

Appendix A

Primary Health Care in the Gambia

Introduction

Compared to health care in the United States, which is largely based on institutions and the provision of treatment, the Gambia maintains a system of Primary Health Care (PHC). The PHC system was adopted in the Gambia in 1979, and is more a system of health promotion, disease prevention, and education. PHC consists of a referral system from the village level to one of the nation's four hospitals. PHC aims to ensure that patients have access to affordable and acceptable care.

The Government of the Gambia trains health care providers and the Department of State for Health and Social Welfare (DoSH) subsidizes most of the health care system. Since decentralization, various government offices at the regional and state levels are responsible for health care delivery and each maintains a specific function. Decentralization has had its difficulties, but DoSH is working to give villages and regional offices more autonomy in service delivery.

PHC Staff

Community Health Nurses (CHN) are trained by the Government of the Gambia in a two-year program. The main focus of study are the health issues that will arise at the community/village level. Most CHNs are placed in rural Primary Health Care villages and a few are posted at health centers.

State Enrolled Nurses (SEN) are also trained by the Government of the Gambia and are usually placed at village dispensaries and health centers. SEN training is also two years and generally focuses on more clinical and bedside care compared to CHN training at the community level.

State Registered Nurses (SRN) are trained in Banjul, the capital for three years. They are clinically trained and placed at health centers and hospitals. SRNs have more formal training and sometimes work at higher government offices and hospitals at the administrative level. It is not uncommon for SENs and CHNs to apply to the SRN school to receive further training after some time in the field.

Village Health Workers (VHW) village members selected by their community to undergo eight weeks of government sponsored training. VHWs provide very basic services and are not paid by DoSH. Usually VHWs receive payment in-kind from community members.

Traditional Birth Attendants (TBA) are also selected by village members and historically have been older women who acted as prominent village midwives. TBAs are trained by the government in safe motherhood and birthing practices for six weeks. TBAs work with CHNs and also do not receive payment from the government.

Since the Gambia has no medical school and few Gambian nationals return to the country with medical degrees, the government relies on doctors on contract from Cuba. Cuban

doctors are posted at health centers and also PHC levels to provide more specialized and clinical care.

DoSH and PHC Structures

The Department of State for Health and Social Welfare (DoSH) is the governing body of the health care system in the Gambia. Various units in the department have different tasks, i.e. the Maternal/Child Health Program manages campaigns to reduce childhood and maternal mortality and morbidity and the Health Information Systems Management team ensures that statistical data is submitted to the central level for national anaylsis.

The Divisional Health Team (DHT) is an administrative office that handles all health care aspects for each of the Gambia's division. The Gambia's six DHTs report directly to DoSH and coordinate the activities of all health centers, dispensaries and NGOs within its catchement area. The office is responsible for the planning, implementation, and evaluation of public health initiatives in their regions. The office is also responsible for the collection of epidemiological data to be used in divisional health planning and submitted to DoSH to ascertain national health status. DHT staff also supervises all health workers in their respective divisions, in addition to providing trainings and education programs.

Primary Health Care Villages are villages in the divisions that are key points for the PHC system and where patients begin treatment. Whether or not a certain village is considered a PHC village depends on its population—a village with a population of at least 400 is considered a PHC village. PHC villages house a community health nurse (CHN) station. Non-PHC villages are considered to be part of the PHC circuit and the CHN treks to each of these non-PHC villages to handle health care aspects. Within a circuit there are usually 7 to 8 villages. Recently, DoSH began to station Cuban doctors in some PHC villages. If the CHN or doctor cannot treat an ailment at this level, the patient is referred to the nearest dispensary or health center.

If a patient requires more care than a CHN can offer in the catchment area, s/he is referred to the secondary level, comprised of health centers and dispensaries. Health Centers and Dispensaries are basically small hospitals, albeit with vary few resources. Dispensaries offer limited services and make referrals to health centers. Health centers provide more services that dispensaries and therefore are the main referral points in a division from the community level. Health centers have neonatal wards, small surgical theaters, and limited laboratory services. Dispensaries and health centers provide outreach services to the community level. Outreach treks include weekly maternal/child health clinics and immunization services.

In cases that require advanced or emergency care, patients are referred to the tertiary level. Rural health centers maintain ambulances to transport patients. This level does incur some cost, so it is the aim of health workers in the lower two levels to provide optimum care so as to avoid burdening the patient and hospitals with unnecessary costs. The Gambia has four hospitals that are completely autonomous from the supervision of the DHTs. Hospitals maintain their own board of directors and executive committees. The major hospital is Royal Victoria Teaching Hospital in Banjul and the newest semi-functioning hospital in the Western Division (Bwiam). There are two "up-country" hospitals; in Farafenni and Bansang. Not all hospitals are equipped with the same resources and depending on location, staff and bed shortages continue to be major problems. Bansang Hospital in the Central River Division,

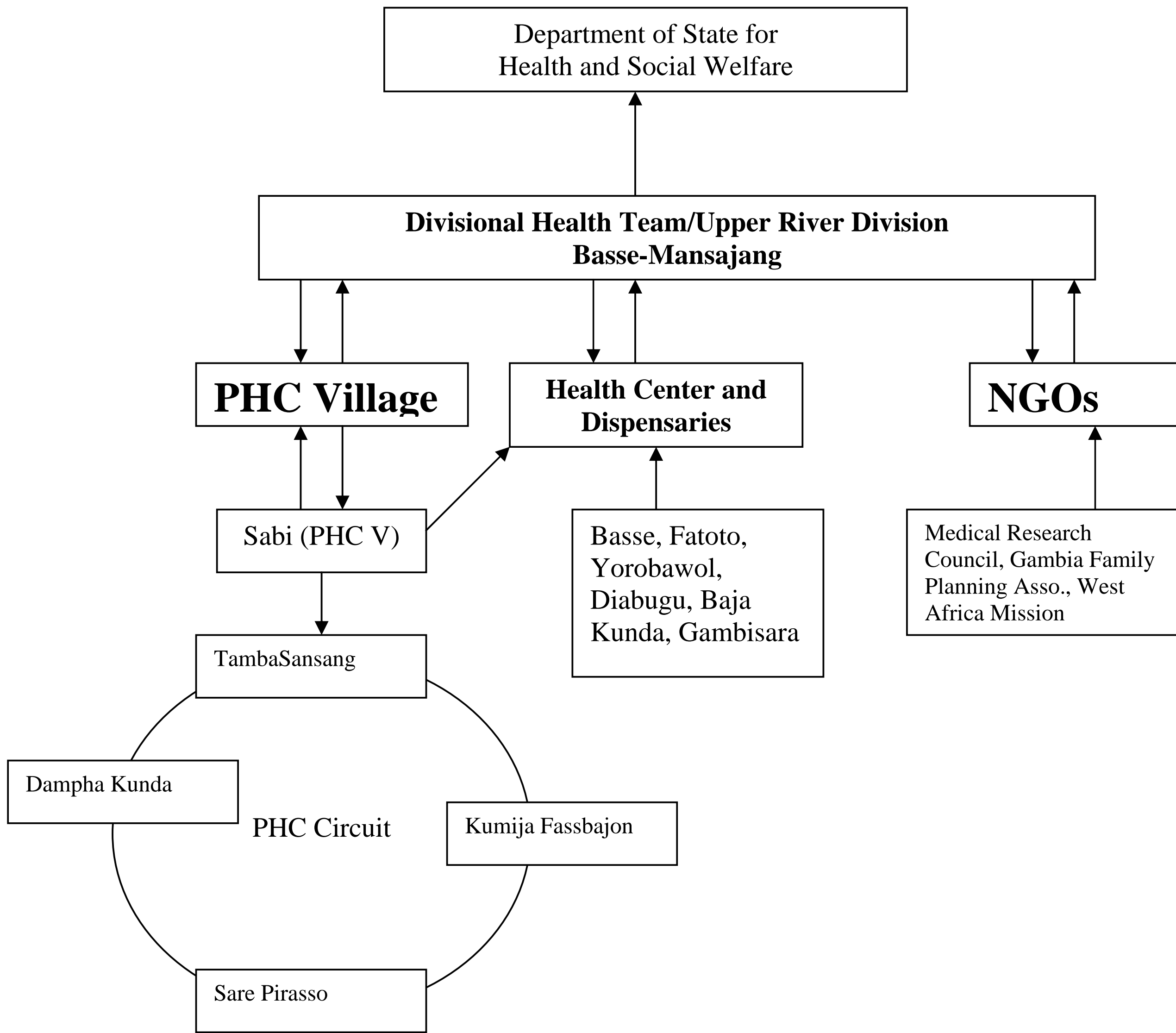
the most rural hospital, is currently experiencing major budget shortfalls, lack of essential medications and suffers from high staff turnover.

Non-governmental organizations provide secondary support to DoSH and the Government of the Gambia in health care and service delivery. Most NGOs focus on education and advocacy. Gambia Family Planning Association (GFPA), an International Planned Parenthood Federation subsidiary provides high quality reproductive health care to women, men and adolescents. Other education and advocacy organizations include the Child Protection Alliance (CPA), the Foundation for Research on Women's Health, Productivity, and the Environment (BAFROW) and the Medical Research Council (MRC).

Conclusion

What makes Primary Health Care unique is that it includes three levels of care and support, so as to maximize the use of limited government resources. The first level begins at home, where the family is encouraged by health professionals to maintain their own personal health (and ideally given the skills to do so). The community is the second level of support. Community health nurses assist in education and provision of treatment. Institutions function at the third level of care.

Primary Health Care Structure for Upper River Division



Hospitals

Royal Victoria

Farafenni

Bansang

Bwiam

Appendix B

Navigating Mental Health Care in The Gambia, a Case Study

Introduction

During my practicum, I became friends with a thirteen-year-old orphan named Omar (for confidentiality pseudonyms will be used in this report). After speaking with Omar and other Peace Corps Volunteers in the area, I learned that he was not an orphan per say, but was forced to care for himself and his mentally ill mother, who is unable care for herself or him. This short case study will illustrate many issues that Gambians face when seeking clinical care in rural areas, far from the country's capital, but will focus on mental health care. While many government and global initiatives have been devoted to eradication of diseases such as tuberculosis and malaria, in addition to safe motherhood and mass immunization campaigns, HIV/AIDS prevention, and proper nutrition, little funds have been funneled into the Gambia for adequate mental health care. The national infrastructure is unable to support even the most basic initiatives that have been implemented in accordance with World Health Organization standards on treatment for the mentally ill, primarily using the rhetoric of a human being's right to a healthy mental and emotional state.

The Primary Health Care system determines how patients with mental and emotional illnesses seek and receive care. Omar and his mother live in the Upper River Division of the Gambia, the easternmost division in the country, and in a village called Fatoto, approximately 42 kilometers from the divisional capital of Basse. The road connecting Basse and Fatoto is unpaved and becomes increasingly difficult to travel on during the rainy months. Fatoto has a small health center that provides secondary-level care to the surrounding villages and is staffed with state-enrolled nurses and two Cuban doctors.

Omar and Binta Sowe

Presently Omar's mother, Binta Sowe, is in her mid 30s. According to Omar, Binta developed her "sickness" in her 20s, around the time he was born. He says she becomes "wild," complains and talks about "strangers and strange things," shouts verbal insults, hears voices, and hallucinates. She has harmed herself in the past usually due to negligence, but Omar says that this is infrequent, and she has never harmed him or anyone else. About one-quarter of the time, she is "normal," but at any moment, she can slip into scattered, confused and incomplete thoughts and speech and erratic behavior.

Until about three years ago, Omar and his mother (he never has known his father) lived with distant maternal relatives in a rented hut in Fatoto. His older sister, he has said, lives with her husband and children in Senegal, and is all but removed from the lives of her brother and mother. As Binta's outbursts occurred more frequently, her relatives became ashamed of her. She did not dress appropriately, according to Omar, and the village started to gossip about her and her son. Binta became sicker-- she started to shout insults at community members, which did little to draw empathy and support. Finally, her family cast her and Omar out of the compound and they were forced to seek shelter in public areas in the community. In a culture where homelessness is almost unheard of because of vast familial and communal support networks, I was shocked to hear that Omar and Binta slept under verandas in their own community without anyone offering to take them in. After a few months a Peace Corps Volunteer posted in Fatoto noticed the mother and son. She and Omar became friends and she

cooked for him and Binta because they were not eating regularly. The volunteer also re-enrolled Omar in school. After a few months, the volunteer was reassigned to Bass and she took Omar with her. She found a host family for him near her new home and paid his school fees. When the volunteer returned to the United States at the close of her service, another volunteer in the Basse area took responsibility for Omar's care and began to inquire about the treatment options for Binta.

Mental Illness and PHC

The pathway to care for mental illness is the same for any illness in the Gambia. A sick person first must go to the primary level to be referred onwards. If the person lives in a Primary Health Care village, they must visit the *village health worker*, who then refers him/her to the *community health nurse* for the catchement area. The community health nurse will make an initial diagnosis and treat any physical symptoms that they are able. Omar is unsure whether or not he and Binta sought help at this primary level of the health system. Before long, Binta was seen at the Fatoto Health Center where staff was unable to make an accurate diagnosis of her illness, saying only that she was "deranged." The health staff did not explain any treatment options to Omar.

When Omar became settled in the Basse area and his studies improved, he became increasingly driven to secure adequate care for his mother. He worked with local Peace Corps volunteers for assistance in this process as he and his mother had been continually discriminated against within the formal health system. The Peace Corps Volunteer who was assisting Omar in his studies and school fees at this point made efforts to contact the national hospital for the mentally ill in Banjul, Campama, to see whether Binta fit criteria for admission, as she was still without a regular residence and therefore deteriorating rapidly. Omar and the volunteer estimate that over ten phone calls were made to the hospital without a successful outcome. Staff was rude, short, and unhelpful to Omar's questions according to the volunteer, and when she herself, went to the capital to meet with doctors, they canceled.

It is not surprising that Omar became disillusioned with the formal health system. He, like many Gambians, is not treated fairly when he made efforts to seek care. Time and time again during my service I have asked rural people how often they visit the hospital or health center for treatment and I have repeatedly heard, "never" or "I never go there." When I have probed exactly into why there is such a strong avoidance to seek care in the formal sector, I am told that health workers in the Gambia "do not care about patients" or "drop babies on their heads, while yelling at mothers," "are immature and badly trained," that health centers are "dirty," and that nurses "do not take care of their uniforms." Families of patients, like Omar, feel that their loved ones are ignored when they finally are seen by a health worker or admitted. From the perspective of the ministry of health office where I am posted, I can understand why people feel this way about the system. Severe staff shortages do not allow for adequate "bedside" communication and relationships, which is very important in this culture. Adding to communication difficulties is the fact that the only medical doctors in the Gambia are from Cuba. The Cuban doctors do not know local languages and little English. Patients, therefore, are afraid of the care they receive because they do not understand it. Budget and resource shortfalls make hospital maintenance difficult to impossible. There are bed shortages and available beds are often dirty or stained. Staff are continually transferred within the country and therefore do not feel a loyalty to the community in which they work. Because people avoid or delay seeking care until absolutely necessary (labor emergencies, hemorrhages, etc.), when they finally do reach the dispensary, health center or hospital, their cases are so

advanced that staff is able to do little and the patient dies. This does little to instill confidence in the patient's family. The cycle will continue to be difficult to break unless the Government of the Gambia allots more financial resources to the Department of State for Health and Social Welfare, who then must ensure that money is used appropriately and corruption is minimized.

Traditional Remedies for Mental Health

When Omar, the primary caretaker of Binta, was failed by formal health system, he turned to traditional medicine for help. Like many Gambians, Omar was comforted by the idea of traditional remedies for health problems. Traditional practitioners continue to be respected, longtime residents of their communities. Oftentimes, the practitioner knows the ill person and their family on a personal level, so the trust between provider and patient that is so difficult to establish, is already present. Omar was comforted by the idea of traditional medicine for these reasons and also because it was available close to where he resides. In a country with one main and partially paved road, and an unsafe and unpredictable public transportation system, treatment close to one's home is ideal.

Omar and the Peace Corps volunteer visited a traditional healer, or marabout, in their community for a diagnosis for Binta. Healers use combinations of local medicinal plants, trees, teas, charms, and versus from holy Koranic scriptures to heal. Many do not require cash payment until the patient is cured. Even then, a gift of a goat, sheep or cow is accepted. The local healer was unable to successfully treat Binta and Omar was again disillusioned.

One day, Omar was talking to some elder friends about the dilemma of his mother and one man said he had an acquaintance who might be able to help Binta. He agreed to set up a meeting between Omar and this man. Omar was willing to try anything at this point, so he agreed to meet the stranger. During the meeting Omar learned that this man too, had suffered from a mental illness or "derangement" similar to Binta's in the past. He said he was cured by a well-known marabout in the neighboring country of Guinea-Bissau. This man seemed trustworthy as he was a friend of a friend, and Omar agreed to negotiations with him regarding Binta's treatment. As the meetings progressed, this man was to act as a liaison between the marabout and the Sowes. Since Omar was a student, this man would travel with Binta to visit the marabout, hold the funds, and oversee the treatment at the marabout's residence in Bissau. But he needed the money up-front, Omar told me. The costs of this care were high, Omar said, and he definitely needed the help of his Peace Corps friend. He arranged for her to meet the middleman in Basse and she agreed that, yes, the treatment was expensive, but that a cure seemed possible and considering their past failures with the hospitals, worth a try. Omar agreed to raise half of the money on his own and the volunteer fronted over one hundred dollars to the middleman for Binta's lodging, transport, and medicine in Guinea-Bissau. Omar bought food supplies for the man to take with him on the journey. In all almost two hundred dollars was given to this man to pay for treatment.

Omar and the man traveled with Binta to Guinea-Bissau and when there appeared to be no problems, Omar returned to the Gambia to continue with studies. After almost one month, Binta was sighted in Basse, ragged, dirty and scared. Omar rushed to her and realized that the man who had agreed to help them, had not. He took all of the money Omar had given him, along with the food for Binta, and left Bissau. Binta was then stranded with the marabout's family, who in the end gave her money and helped her escape from the middleman and Bissau. The marabout was unable to treat Binta, as she had no way of paying, but the

kindness of him and his family did enable her to return to the Gambia. Binta said the middleman “did things to her” and she did not want to see him again.

Conclusion

Omar continues to be optimistic about traditional medicine even after this setback. He says now that he will not trust go-betweens and never again will make payment before care is given. He remains dedicated to finding a cure for Binta’s “sickness” and has located a traditional healer in the Basse area who specializes in mental health issues.

Binta is schizophrenic. While traditional medicine may help her symptoms, biomedical care will help minimize her outbursts and help her lead a more normal life. Quarterly up-country mental health treks from the Banjul area offer diagnosis and the provision of medication, sometimes for schizophrenia. I have offered to help Omar negotiate this pathway to care, along with my Divisional Health Team counterparts, but he would like to exhaust traditional means before returning to the formal health system that failed his mother in the past. Last month Omar completed his seventh grade year with high marks considering that he was absent for almost two months of the term due to the Guinea-Bissau situation. He plans to spend the summer months mending relationships with his maternal relatives in Fatoto, in hopes that they will agree to care for Binta again. Omar is also actively fundraising in Basse, hosting parties and selling wares, to raise money for the traditional healer he will soon visit with Binta. He agreed to consider biomedical treatment maybe next fall if I agreed to network with my co-workers.

Binta is living in a family compound in downtown Basse. Her outbursts and hallucinations have become more frequent, but she has recently decided to start selling embroidered skirts. She wants Omar to locate extra money, in the form a micro-loan, so that she can produce the skirts on a larger scale and help contribute to her own care.

Appendix C

Background

Needs Assessment:

Due to barriers (cultural, social, economic and infrastructural) in reproductive health care, women in the Upper River Division of the Gambia are not receiving the highest quality health care possible. Health workers in the division need to acquire the necessary communication skills so that they are empowered to assist women to achieve this type of care. When women are able to obtain reproductive health care, the entire family unit benefits from a higher status of health.

The proposed training meets community needs on two levels. First, the training addresses the fact that health workers do not receive sufficient training on the importance of strong communication skills during their clinical training at SEN, SRN, and CHN schools. There are references to the importance of strong communication skills in some courses, but the information it is not explicit, nor is it stressed. Therefore, this training is an important in-service component to continuing education for health workers in the Gambia. Secondly, the proposed training assumes that if health workers are better equipped to communicate with their patients, they will provide better care, and in turn, the state of women's health will improve.

Because women in most communities do not necessarily receive the most quality care possible, their reproductive health suffers, as indicated by the statistics below[1]:

- In the first and second quarters of 2003, over 1383 pregnant women in the URD suffered from clinical malaria. In the same quarters of 2002, over 3000 women suffered from clinical malaria.
- In January and February 2004, almost 400 women were diagnosed by facility staff as having clinical malaria.
- In the first and second quarters of 2003, facility returns indicated that 255 women were suffering from sexually transmitted infections. More complete data from 2002 indicated that nearly 700 STI cases were seen at the facility level.
- Anaemia continues to be a problem for many pregnant women in the URD. In the first two quarters of 2003, 252 women were diagnosed with anaemia at the facility level. In the month of January 2004, 52 cases were noted. More complete data from 2002 indicated that there were a minimum of 1187 anaemia cases in the URD.

Current gaps in service and certain health trends can be attributed to the obstacles and barriers women face when seeking reproductive health care in the Gambia and how health workers struggle to recognize them in a timely manner. In order to provide more comprehensive care to women, health workers must recognize these barriers and adjust their service accordingly.

[1] These statistics were gathered by the DHT/URD in 2003. Due to resource constraints and other issues, data is not complete. However, it is useful when beginning an assessment of the state of women's health in the Upper River Division. In reality, the numbers of women suffering from illnesses and infections is much higher.

Barriers and obstacles to care may be the result of a client's orientation to service, i.e. the client may lack the knowledge, desire, or skills necessary to seek treatment or prevent a problem. Other times, barriers to care are more social in that a client may hold attitudes or beliefs that are not compatible with seeking certain types of services. Often, however, barriers are created by the service providers themselves or through faulty program design. This training will allow health workers the opportunity to critically investigate common barriers to women's reproductive health care in their communities. When health workers become aware of obstacles that a woman faces, they will be better able to support her in her care and treatment.

Current barriers to *quality* women's reproductive health care can be assessed by health workers in five domains (Coley and Scheinberg, 2000, p. 24):

***Availability**:* Services may not be provided in the community, or the costs may be prohibitive. Health workers must ascertain to what extent they work together as a team with other professionals concerned with reproductive health (e.g. social workers, teachers, government and non-government officials, etc.).

***Accessibility**:* Health workers need to question whether or not the client can reach the site of service. Are the hours of operation convenient for the client? Is transportation reliable and safe? To what extent are multiple services provided at a convenient single location?

***Acceptability**:* Health workers must also consider whether or not the services are pleasing to the client. Are the health workers perceived as friendly, professional, competent and helpful? Are the services in the client's language and sensitive to cultural issues? Are the client's physical needs taken into consideration?

***Appropriateness**:* Health workers must ask if the reproductive services they are providing in their communities are right. Also, are the services within the scope of the provider's ability and/or range of practice (or does the health worker need other clinical support)?

***Adequacy**:* Is the service sufficient in amount to meet the needs of the community? Are the services as comprehensive as possible?

This training focuses on women's health for two reasons: 1) most health services in the region focus on curative care or child survival; while these are vitally important, *women's* health is often overlooked; and 2) as child-bearers and primary care-takers of the family, women's health is critical for the well-being of the entire family.

To help *women*, however, health workers must be aware of the need to communicate with the *men* who are important in women's lives (i.e. husbands, brothers, relatives, son, community and religious leaders). During this training, health workers will develop such communication skills through the use of case studies, role-plays, and problem solving sessions. Such interactive activities provide trainees with the opportunity to practice new skills with their professional peers.[2] With practice, the ideas and skills at he core of this training can easily be used to communicate the importance of women's health with all members of the family and community.

---

[2] Please see Appendix B for select case study and role-play narratives and description of activities.

The training also focuses on women's reproductive health because childbearing and the complications that arise from it continue to be major causes of illness and death for women in most developing countries. Other reproductive health problems, such as sexually transmitted infections (STIs) and HIV/AIDS are growing, but underreported problems. While many STIs are treatable, if neglected they can cause serious pain, long-terms illness, infertility, and even death.

International efforts towards patient-centred care have helped health workers and service providers recognize the importance of educating and establishing good relations with patients. Nevertheless, research and evaluations in many countries have shown the quality of patient-provider communication and health education is often poor (Tabbutt, 1995, p. iv). This contributes to poor health because women are not provided with essential information on their own health issues in terms that are understandable to them (linguistically and culturally). Women often become disenfranchised. This distrust perpetuates the underutilization of health services in the formal health sector because of poor inter-personal relations between health workers, women, and their families (Tabbutt, 1995, p. iv).

Most maternal and child health/family planning (MCH/FP) workers in the field provide a range of maternal health services (i.e. antenatal care, supervised delivery, postpartum care, and family planning). This training is more comprehensive in its approaches to women's reproductive health as it also addresses pregnancy-related services, abortion, treatment of STIs, HIV/AIDS prevention as well as the needs of adolescents.

Designers of the proposed training program, **"Strengthening Communication Skills for Women's Health: A Training Guide"** have researched many of the obstacles that women face when trying to secure quality reproductive health care in their communities. They found that if health workers receive continuing education on how they can strengthen communication skills and attitudes, they are able to provide better care and build stronger rapport with patients and their families. Health workers will be better able to provide care and support to women because they will more effectively communicate with clients in order to assess barriers to care and how the health worker and women can try to overcome them in a realistic manner.

Since the late 1980s, the Government of the Gambia has initiated economic reforms aimed at reducing poverty. Changes in public expenditures for education and health have been made. In recent years, hospitals have received an increasing share of the national health budget, while many primary health care programs suffer from serious shortfalls in resources. This training is valuable because it recognizes limitations in monetary and medical resources and thus develops skills and fosters knowledge in human capacity, ultimately the most fundamental aspect of any program.

Project Description

Goal:

To improve the standard of women's reproductive health care in the Upper River Division, the Gambia by improving the communication skills of community health nurses and selected public health officers.

Purpose:

To help improve the quality of women's reproductive health services and to enhance the role of the health workers in preventing and treating reproductive health problems. This training specifically aims to improve the communication skills of nurses, midwives, and other clinically trained health workers[3]. Such skills empower not only the health worker in terms of service delivery, but also strengthen various service delivery functions (i.e. patient education, counselling, community education/outreach, staff training) and clinic management.

Methodology and Training Approach:

The learning objectives of this training are primarily oriented to change attitudes and to develop skills. The training team will utilize the manual, **"Strengthening Communication Skills for Women's Health: A Training Guide"** by Jill Tabbutt. The content focuses on principles of communication and steps for learning communication skills. Research on adult learning has shown that while a lecture approach, common in many workshops and trainings is most effective for imparting *new* information, it is not successful in changing the attitudes and skills of the learners (Tabbutt, 1995, p. vi). The training methods found to be most effective for attitude change and skills development are those that involve active participation of the learners. Therefore, this training relies heavily on the following training methodologies: brainstorming, discussion, small group work, large group exercises, demonstrations, case studies, role-plays, as well as lecture by the training team.

This programme is designed to last 4 ½ days, with an 8-hour working day—8:30 to 4:30. Breaks, lunch, participant feedback sessions, and wrap-ups are included in a sample schedule attached in Appendix A.

---

[3] This training is intended to act as an in-service education for Community Health Nurses (CHNs) senior community health nurse tutors, and public health officers. It will enhance the clinical training programmes that prepare health workers for service in the community, hospital, or clinic. It is assumed that participants already have sufficient *knowledge* of women's health issues, as they have all received clinical training. Therefore, this training concentrates on how health workers can apply what is learned and on the *attitudes* and *skills* that are necessary for strengthening communication with patients and their families.

Participants/Target Group:

Trainees (participants) are the 27 Community Health Nurses (CHNs) from Village Health Services and Maternal and Child Health and 3 selected public health officers (PHOs) from the Upper River Division.

Applicant/Training Team Capability:

The training team is comprised of three members:

Janko Jimbara, Acting Divisional Health Officer, DHT/URD
Babucarr Jammeh, Divisional Public Health Nurse, DHT/URD
Jordan Engler (Haddy Njie), Peace Corps Volunteer, DHT/URD

Objectives:

Objective 1
By the end of the training, participating health workers will have increased their knowledge regarding problems women and adolescents face when seeking reproductive health care in their catchment areas. To accomplish this objective, health workers will spend approximately **3 hours** working in different modules. Brainstorming, discussion, and small group work will allow trainees the opportunity to develop these skills. They will also have the opportunity to conduct a rapid needs and knowledge assessment for their female patients.

Objective 2
By the end of the training, participating health workers will demonstrate the ability to identify complex causes and factors that contribute to reproductive health problems in women and adolescents. To accomplish this objective, health workers will participate in a variety of training activities; extensive discussions, lectures, role-plays, and case studies to help them understand their own role in addressing non-medical factors (social, economic, educational, cultural) that impact reproductive health. Approximately **3 hours** of the total workshop schedule are directly devoted to this objective, although trainees must have a strong grasp of these ideas to move successfully through the remainder of the training.

Objective 3
By the end of the training, participating health workers will demonstrate the ability to recognize and use the 5 principles of effective communication. To accomplish this objective, health workers will again participate in a variety of interactive modules. As the development of communication skills is the foundation of this training, approximately **18 hours** of activities are devoted to meeting this objective. Trainees will engage in many interactive approaches to learning these skills to ensure a thorough understanding of communication skills and principles. They will use role-plays, listen to lectures by training team members, discuss, and complete realistic case studies to develop relevant skills in non-verbal and verbal communication. Health workers will also be able to determine common and simple words and health messages that can be used to explain complex medical problems to female patients.

Objective 4

By the end of the training, participating health workers will promote commonly held traditional beliefs/practices that are helpful to women's reproductive health and integrate these helpful traditional practices in their educational efforts upon returning to the community. Activities will allow health workers the opportunity to develop skills to more cooperatively work with traditional healers and community leaders to minimize the negative effects of harmful traditional beliefs, while reinforcing helpful ones. Approximately **3 total hours** of the training are devoted to this specific objective, through the use of discussion and small-group work. Trainees will increase their awareness of cultural issues and its effects on reproductive health throughout the remainder of workshop activities (i.e. when analyzing case studies or acting in role-plays).

Objective 5

By the end of the training, participating health workers will reduce the negative and biased effects of their own attitudes regarding reproductive health when providing care to women and adolescents. Approximately **3 hours** activity are dedicated to meeting this objective. Activities will be mainly small-group exercises and large-group discussion, as this objective seeks to increase personal awareness. Trainees will be able to reflect on their own attitudes and how they affect care given to female patients in the practicum activities of the training.

Objective 6

By the end of the training, participating health workers will demonstrate communication principles and skills in specific reproductive health topic areas such as STIs, HIV/AIDS, and adolescent care. Approximately **8 hours** of activities are allotted for meeting this objective. Activities are mainly applied (analytical case studies, small group work, etc.) in order to give trainees the opportunity to practice the skills and reflect on the principles they learned throughout the training. All trainees will develop action plans for facilitating quality reproductive health care upon returning to their communities and catchment areas.

Output:

1. 27 Community Health Nurses and 3 Public Health Officers in the URD will receive 40 hours of training on communication skills for reproductive health
2. 27 Community Health Nurses and 3 Public Health Officers will receive 8 hours of training specifically focused on prevention of HIV/AIDS
3. 30 Action Plans for ensuring adequate reproductive health in their catchment areas will be developed by each of the CHNs/URD

Evaluation:

Evaluation of the training is on going and relies heavily on qualitative evaluation and participant feedback given at the beginning and closing of each training day. Since the training is based on the acquisition of skills and attitude change, quantifiable evaluation is difficult. The interactive nature of the programme makes feedback sessions an important component to qualitative evaluation.

On the first day of the training, before any modules are completed, trainees will complete a pre-test to determine their knowledge of the principles of communication and factors affecting reproductive health. Again, after completion of the final module, trainees will complete a post-test to assess their knowledge and skills. Trainers will then be able to

determine the effectiveness of the training as a whole, identify weak areas, and make changes so that the training can be implemented with future groups, (i.e. other divisional CHNs, and step-down trainings with traditional birth attendants (TBAs), village health workers (VHWs)).

Trainees will complete an assessment on the effectiveness of each trainer's presentation style and the relevancy of the information presented in each module, at the closing of each day. The training team will meet at the end of each day to reflect on feedback from trainees, to assess their effectiveness as trainers, and to review plans for the following day. Flexibility is necessary to respond to the changing needs of trainees and should discuss any adjustments necessary to meet participant needs during these meetings. The training team will evaluate the progress of trainees through careful observation of activities. Final assessment of learning will be made when trainees complete an action/work plan during the last module.

Budget Request:

Training Supplies

Item	No. Units	Price/Unit	Cost
Flip chart paper	4	D 150.00	D 600.00
Markers (box)	3	D 125.00	D 375.00
Ballpoint pens	45	D 5.00	D 225.00
File folders	40	D 10.00	D 400.00
Note paper pads	40	D 15.00	D 600.00
Cello tape (roll)	3	D 25.00	D 75.00
Stapler	1	D 90.00	D 90.00
Staples (box)	1	D 15.00	D 15.00
Certificates	40	D 1.00	D 40.00
Information packets & photocopying fee	1200 pgs.	D 2.00	D 2400.00
Total Cost			D 4,820.00

Accommodation/Food

Item	No. Units	Price/Unit	Cost * 5 days
Accommodation (trainees)	33	D 50.00	D 1650.00 * 5 = 8250
Food/Beverage	40	D 100.00	D 4000.00 * 5 = 20,000
Per diem (support Staff)	3	D 100.00	D 300.00 * 5 = 1,500
Per diem (training team)	3	D 200.00	D 600.00 * 5 = 3,000
Per diem (trainees)	33	D 100.00	D 3300.00 * 5 = 16,500
Travel reimbursement	33	D 50.00	D 1650.00 * 5 = 8,250
Total Cost			D 11,500.00 * 5 = 57,500

Total Amount Requested: **D 62,320**

Future Funding Plans:

Continual evaluation of this training will allow the training team and the DHT/URD the opportunity to assess the transferability of the curriculum to other target groups, including outreach to the primary health care level (TBAs and VHWs). If the project is deemed successful with the selected CHNs and PHOs from the Upper River Division, it is very possible to implement similar initiatives with different health workers in the nation. Furthermore, the training team would welcome the opportunity to expand the training to other target groups. Below is a brief description of future funding plans and possible target groups.

Phase I: Current project proposal. Trainees are 27 CHNs and 3 PHOs from the Upper River Division, with facilitation by the aforementioned training team

Phase II: Future funding of this project would allow the training team to implement the workshop on a broader scale, after making appropriate modifications at the close of Phase I. Trainees in this phase would be Senior CHN Tutors from each of the nation's divisions, as well as 3 highly motivated CHNs from each division. The training would be held at a central location and facilitated by the same training team. Divisional trainees would be encouraged to work with cohorts in their divisions, including TBAs and VHWs upon completion of the workshop. It is assumed that the action plans drafted at the close of this workshop would include these cluster-training activities for each division.

Phase III: To ensure institutional sustainability of this curriculum and positively affect the status of women's health in the Gambia, a third phase of this project could be implemented. This phase would entail collaboration with the training team, DoSH and the Reproductive Health Unit, and the Gambia's three nursing schools to introduce curricular changes that address communication skills for health workers. A manual would be produced if necessary, or instructors would become versed in this training so that for a minimum one-week per term, nursing students could gain these skills while still in the classroom. Since students are a captive audience, costs for this phase would be minimal and primarily directed towards the training of faculty and possible production of manuals.

Appendix A: Sample Schedule

Day 3 Module IV: Communication Skills for Health Workers

Time	Session	Activity
8:30-8:45		Daily Greetings and Announcements
8:45- 10:00	**IV-1**	Communication Skills
10:00-10:15		Break
10:15-11:30	**IV-2**	Assessing Women's Needs and Knowledge: Asking the Right Questions
11:30-12:00	**IV-3**	The Big Picture: Using Visual Aids
12:00-1:00	**IV-4**	Keeping It Simple: Using Non-Medical Terminology
1:00-2:00		Lunch/ Prayers
2:00-3:00	**IV-5**	Keeping It Sensible: Adults Need Reasons
3:00-3:15		Break
3:15-4:00	**IV-6**	Role Play: Applying Communication Skills
4:00-4:30		Daily Wrap-up and Evaluation

Appendix B: Sample Case Study

Case Study #5: Adolescent Reproductive Health

Miss G is 17 and started having sex with a boy from school four months ago. She thought it would only happen once, but she has found it impossible to say no to this boy—he enjoys it so much and treats her better than anyone in her life ever has. Now she is starting to worry about the risk of getting pregnant. She has only a half-year left in senior secondary school and she definitely wants to go on to university. She summons her courage to go to the health centre and ask about family planning.

Case Study Questions

a) *What is the teenager's most important problem—from her perspective? From a medical perspective?*
b) *What specific questions should you ask to assess her needs and knowledge?*
c) *What information does she need? How should this be presented? What visual aids would be helpful?*
d) *What should the teenager do—either to stay healthy or to address her problem? What barriers might she face doing this? How can you help her (including providing health services)?*
e) *What follow-up is needed? (e.g. counselling, medical services, community outreach, family involvement).*

Appendix D

Ideas on Sustainable Development in The Gambia

The Gambia gained independence from England in 1965. Since then, the country has remained relatively peaceful. Peace Corps entered the Gambia in 1967 and has had a constant input of volunteers since that time. Because of the lack of civil unrest, many other NGOs have also had uninterrupted service. This has created an interesting phenomenon. With independence, many countries enter a new phase in social growth, usually difficult, but with great motivation towards social change. The Gambia never had this. Since independence international development agencies stripped the power from local people and created a strong web of dependence. The segment of society that should be most committed to driving social change and equality (the 20-50 year-olds) have a great complacency and apathy to confront injustice. They have never known a society without foreign aid and this affects how they view the global north and their own government. Also because of extreme poverty and somewhat fatalistic religious views, many are reluctant to confront political corruption. This could be the reason that there are no apparent social movements in the Gambia. I was reviewing a book that I read last year in James Breeden's "Leadership, Community, and Coalition Building" course titled *Grassroots Postmodernism: Remaking the Soil of Cultures*. The material in this book affected everyone in the class, as it called for a radical democracy and local based social change (instead of large global movements). Anyway, I was trying to relate some of my experiences here to what have observed in many Gambian communities thus far and I had difficulty. Then I realized that the authors of the book, Esteva and Prakesh, drew heavily on the idea of social movements as being the voice of local communities and shaping social change. The only entities dedicated to change, as I see it here, are non-governmental organizations, which arguably do not meet the real needs of communities since they are not born of the communities themselves. It is an interesting idea that I hope to relate to the state of the health system here for a possible capstone topic.