The call to action: health promotion in The Gambia – closing the implementation gap?

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Abstract: This paper discusses the difficulties facing the development of health promotion in The Gambia, and in ‘closing the implementation gap’ noted by the WHO 7th Global Conference on Health Promotion (2009, Nairobi). The Gambia has achieved a great deal so far, but health promotion as a discipline has not really informed the development of its approach to health. There is not a central concern with determinants of health and tackling health inequalities and there is no well-developed health promotion infrastructure. The difficulties facing sub-Saharan Africa generally can be extrapolated from the paper, with the conclusion that sub-Saharan Africa faces many health challenges not experienced by richer countries and thus not only does the discourse of health promotion need to take this into account, but also the basic needs of Africa need to be placed at the forefront. (Global Health Promotion, 2013; 20(2): 5–12)

Keywords: capacity building, development, health promotion, Sub-Saharan Africa, The Gambia

Introduction

This paper aims to discuss the difficulties facing the development of health promotion in The Gambia, and in closing the implementation gap noted by the 2009 Nairobi Conference, the 7th WHO Global Conference on health promotion. It uses the six points highlighted by Amunyunzu-Nyamongo and Nyamwaya (1) to frame the discussion of what The Gambia has achieved so far, but goes further to suggest that addressing these points doesn’t necessarily result in a healthy state of health promotion, if by that is meant the central concern with determinants of health and tackling health inequalities. The difficulties sub-Saharan Africa is facing generally can be extrapolated from the paper, with the conclusion that sub-Saharan Africa faces many health challenges not experienced by richer countries and thus the discourse of health promotion needs to take this into account, and the basic needs of Africa need to be placed at the forefront.

The Nairobi Conference, the first in the series of conferences to be organized in Africa, enabled more Africans than hitherto to participate. Catford’s conference reflections (2) describe Africa’s opportunity to light the way forward for health promotion, thus closing the obvious ‘implementation gap’ between the rhetoric and the reality; he comments: ‘we look in eager anticipation to see how Africa moves ahead in closing the implementation gap in health promotion’ (2:3). This paper will explore issues the development of health promotion in one African country, The Gambia, is facing.

Health promotion in Africa has been described as being in a poor state (3). Amunyunzu-Nyamongo et al. comment that: ‘the continent is characterised by a worrying disconnect between policy and implementation which remains one of the key challenges to the development of health promotion in the region’ (4:185). They point to six areas requiring attention if health promotion is to develop: (i) investment in health; (ii) development of more robust health systems; (iii) building capacity in health...
promotion; (iv) working within traditional and new settings; (v) cultivating political will; and (vi) generating evidence of health promotion effectiveness. These six areas are used to frame the discussion of health promotion in the smallest African nation, The Gambia. It is inevitably selective, intending to raise issues rather than aiming at a comprehensive sense of all that is happening in The Gambia.

The Gambia faces many of the problems other African nations are facing, such as lack of access to safe water and sanitation, serious communicable diseases, ‘tropical’ diseases such as malaria, and high rates of infant and maternal mortality. Globally, Africa experiences the highest rates of HIV. Bartram and Cairncross (5) suggest that diarrhoeal diseases claim more lives of children under the age of five in developing countries than the combination of malaria, tuberculosis and HIV/AIDS; 75% of mortality in poorer countries is associated with poor hygiene, water and sanitation. Poor roads and large distances affect access to basic preventive and curative services (6–8). Frontline health workers are often underpaid, work in poor conditions with chronic understaffing, and have low morale. The health workforce has been described as being in ‘crisis’ (9–11). Two Africans (Mary Amunynnzu-Nyamongo and David Nyamwaya), writing about health promotion (12:21) comment:

The most confounding factor to health promotion development in Africa emanates from the fact that health promotion activities are in most cases, planned, managed and controlled exclusively by health staff, mostly from within the ministry of health. The main actors are health workers whose concept of health is based on the conventional public health model and whose focus is on interventions revolving around curative services.

Nyamwaya (13:87) suggests that health promotion development has accelerated over the last twenty years, but there remains ‘an undeclared war for supremacy among different practitioners… health education practitioners, medical doctors, nurses and professionals from areas such as social mobilization, behaviour change communication and social marketing, who are jostling for niches’. Despite this pessimism, there are many examples of good practice from Africa, and significant health promotion-type activities take place undocumented as ‘health promotion’, including income generation, micro-finance, community-led projects, informal education activities, agricultural and food-related activities – all of which do tackle the determinants of health. There is also effective policy work in areas of women’s rights, land rights, and other areas impacting on health. These activities are often not well documented, reducing the evidence base.

The Gambia: introduction

The Gambia, with its bizarre shape carved out by the colonial powers, faces serious administrative and logistical problems; its very viability was called into question at independence. Surrounded on three sides by Senegal, and the ocean on the fourth side, it is split entirely in two by the river Gambia, which is ten miles across at its widest point. It ranks 151 out of 169 countries on the Human Development Index, with signs that it is becoming poorer. Its 1.36 million population grows 2.8% per year. GNP per capita is US$ 390 with 64% of the population living below the poverty line; 82.9% live on less than US$ 2 per day. Agriculture is the main occupation of 75% of the population, and of those below the poverty line, 91% work in agriculture (14).

Poverty in the eastern two thirds of the country generates high rural–urban migration, with 50% of the population now living in the western, coastal area. Migration has resulted in food insecurity in urban areas (15). It is politically stable, President Jammeh having been in power since 1994. Being 90% Muslim and with several main ethnic groups (chiefly Wolof, Mandinka, Fula), it prides itself on being a harmonious society. Dubbed the ‘Smiling Coast’, it has developed as a major package tourist destination for Europeans, leading to income but also to sex tourism and a charge that tourism does not benefit local people enough.

The Gambia faces serious challenges not faced by the global ‘North’, including many adults with no schooling, a large informal sector (where livelihoods are precarious), food insecurity and heavy reliance on street foods, poor levels of sanitation, inadequate access to safe water, lack of adequate solid waste management systems, high infant and maternal mortality, a tradition of not talking about sexual matters openly (resulting in a lack of sexual education), traditional practices harmful to women such as female genital mutilation and a lack of
gender equality. Gambia is ranked 24th of the 100 critical countries most vulnerable to global climate change, particularly sea level rise, floods, wind storms and drought (16). 60% of the population in some areas (e.g. Ebo Town) lives in precarious conditions already, being subjected to regular flooding (17).

This partial picture clouds the positive aspects of The Gambia, including relatively low levels of violence, low levels of alcohol problems, respect for elders, strong cohesive communities, and close contact between political leaders and the people.

How has The Gambia fared in the six areas where health promotion needs to develop?

**Investing in health**

The Gambia has worked steadily towards keeping its 2001 Abuja Declaration promise to allocate 15% of its national budget to improve health. In 1998, the Ministry of Health and Social Welfare obtained US$ 20 million for a five-year Participatory Health, Population and Nutrition Programme (PHPNP), to improve family health. The Project was designed to enhance the quality of, and facilitate access to, health services. It has four areas: Reproductive Health services, Integrated Management of Childhood Illness, Nutrition Policy and Service for Women of Reproductive Age, and Management and Implementation of a Family Programme. All four components addressed monitoring and evaluation, operations research, extensive training activities and Information, Education and Communication. The latter led to ‘Operation 2010’ with health promotion interventions at the community level using the ‘Bantaba Approach’ (described below). The PHPNP has left a legacy of health and extension workers using participatory approaches to disseminate health, nutrition, water and sanitation messages.

The World Health Report 2008 on Primary Health Care, suggested how to revitalize health systems: leadership in the health dimension of public policies; making health care universally accessible; making health care people-centred; and being fully accountable in the delivery of health care (18). The latter led to ‘Operation 2010’ with health promotion interventions at the community level using the ‘Bantaba Approach’ (described below). The PHPNP has left a legacy of health and extension workers using participatory approaches to disseminate health, nutrition, water and sanitation messages.

The Government of The Gambia through the Ministry of Health and Social Welfare has successfully used this approach to revitalize and strengthen its primary health care (PHC) strategy by building community capacity for health, setting up PHC Working Party meetings and continuing to provide human resources for health. The adoption of the Baby Friendly Community Initiative (BFCl) in promoting child survival and development illustrates the Government’s effort to promote the nutritional status of infants and young children. The BFCl was piloted in 12 communities in the Lower River Division (LRD) of The Gambia in 1995, realizing remarkable progress in feeding practices, and leading to the expansion of the initiative to 326 communities. As a relatively low-cost community-based initiative it represents a sustainable approach.

**Developing more robust health systems**

The Gambia’s Primary Health Care Action Plan (1981–1985) was based on the Alma Ata Declaration on Primary Health Care. Village health workers (usually male) and traditional birth attendants (female) were trained in 230 large villages; 40 key villages were selected and now have a resident community health nurse. Primary health care is provided at village level by the Village Health Service (VHS) and at the secondary level at Minor and Major Health Centres. VHS is provided in villages with a population over 400 situated away from locations with health facilities. To provide for underserved, remotely located villages with fewer than 400 inhabitants, villages close together became PHC clusters. All PHC villages or clusters have a Village Health Worker and/or a trained Traditional Birth Attendant. Community health workers are volunteers selected by their communities after a process of sensitization and are trained by the Ministry of Health and Social Welfare. PHC villages are organized into ‘circuits’, comprising between five and nine PHC villages. Trained Community Health Nurses supervise each circuit. To promote community participation, Village Development Committees were established in all PHC villages.

In 1981 the Health Education Unit (HEU) of the Ministry of Health and Social Welfare was established to coordinate all Information Education and Communication (IEC) activities of the Ministry of Health and Social Welfare and other partners in disseminating health information in the country. The HEU is the only structured unit within the Ministry mandated to create awareness on health-related issues among the population.

Currently, the Health Policy and Master Plan (2007–2020), ‘Health is Wealth’, seeks to promote
health, and strengthen linkages between health and economic productivity (19). Its guiding principles are: equity (including gender), ethics and quality, skilled staff retention and circulation, health systems reform, and partnerships. The policy identifies areas of intervention including: public health programmes and clinical delivery through a basic health care package, environmental health and safety, health education, expanded programme on immunization, disease control, reproductive and child health, nutrition, basic clinical care, health systems strengthening and capacity building; community participation and traditional medicine. How effective this has been is not yet clear.

The Gambia’s health care sector three-tier system comprising primary, secondary and tertiary levels is under great pressure due to population growth rates, inadequate financial and logistic support, shortage of adequately and appropriately trained health staff and high attrition rates. Poverty and lack of education have led to inappropriate health-seeking behaviours. The primary level consists of 492 PHC Village Health Services and Community clinics; the secondary level comprises the Minor and Major Health Centres; and the tertiary levels comprise General Hospitals and Teaching Hospitals. In contrast to public sector primary health care, the secondary level, made up of 52 public health facilities and 221 ‘trekking’ (remote) sites, is complemented by private and NGO-run health facilities.

Building capacity in health promotion

Onya (20) describes the ‘serious’ lack of training capacity in African health promotion. Apart from South Africa, academic infrastructure for health promotion is underdeveloped. Where health promotion is offered, it tends to be as part of a medically dominated university public health department.

Capacity development in health promotion in The Gambia is inadequate, according to local health workers. Since 2008, the University of The Gambia, the Ministry of Health and Leeds Metropolitan University have worked in partnership to address capacity in Public Health and Health Promotion. Leeds Metropolitan University, one of the first in England to run a specialist health promotion Masters course, attracts students internationally but more recently has run courses in-country (in Zambia from 2003 (21), and later in The Gambia). Rather than having one Gambian annually on its UK Masters in Health Promotion, it has, in three cohorts, 23, 37 and 30 students respectively on courses run in The Gambia (most are Gambians with some from Sierra Leone). This provision increases the likelihood of creating a ‘community of practice’ and a critical mass of professionals immersed in the discourse and methods of health promotion. Scholarships from the Commonwealth Scholarships Commission have made the work possible, and the National AIDS Secretariat funds half of the second and third cohorts. Crucially, the initiative has the support of the Ministry of Health.

Working within traditional and new settings

Two terms which have entered the health promotion discourse in The Gambia are Fankanta and Bantaba. Both concepts are based on traditional values and practices and have been harnessed in new ways.

The Fankanta Initiative originated to highlight reproductive health in a country with high rates of fertility and maternal mortality. Although family planning is a big issue in The Gambia, it cannot be discussed openly. To clear misconceptions surrounding family planning, a nationwide survey in 1996 assessed people’s perceptions and suggestions for improvement. The results led to the Fankanta initiative, a Mandinka word meaning planning for the future, and an acceptable euphemism for family planning. Since 1997, Fankanta has had two components, ‘Support for family planning’ and ‘HIV/AIDS and STI control’. Traditional leaders, community health workers, women’s support groups and youth associations are strongly involved with its participatory approach involving negotiating intervention principles with partners to obtain consensus. Fankanta includes culturally sensitive strategies and gains the active participation of religious leaders. The Fankanta concept has been adopted in Agriculture and Community Forest Management and most recently in telecommunications. As an expression which stresses the importance of thinking about the future, it has resonance with the idea of sustainability, deferred gratification and thinking about the implications of actions.
The Bantaba approach, derived from the Mandinka word meaning a meeting ground or a ‘conversation’ at community level, where community members meet to discuss community issues and concerns, was initiated by new models of health communication otherwise called ‘Operation 2010’, undertaken in communities by multidisciplinary health field workers. Bantaba creates a forum for community members to discuss pertinent health issues, share positive experiences and lessons, and encourage positive changes. This community forum helps to mobilize influential community leaders to take charge of health promotion. It is a community-driven behaviour change strategy based on the principles of participatory appraisal and finding solutions to health problems important to communities, with health workers facilitating. It is a tool for empowerment by enhancing communication, analytical, problem-solving and health skills.

Cultivating political will

President Jammeh takes a personal, sometimes controversial (22) interest in improving health. Underscoring the importance assigned to HIV/AIDS, a national AIDS control programme under the Ministry of Health and Social Welfare and the National AIDS Secretariat were set up directly under the Office of the President to oversee the activities programmed for HARRP (HIV/AIDS Rapid Response Project), a USAID project implemented for an initial period of three years. Due to widespread publicity and the level of importance given to HIV/AIDS by the Gambian leadership, today, throughout The Gambia, private individuals and organizations are involved in running campaigns and maintaining pressure groups, educational and social groups, working alongside the Gambian Government. The prevalence of HIV, at 1.6% (HIV1) and 0.4% (HIV2) among antenatal women, remains very low by African standards (23).

In The Gambia, policies are developed in partnership with health, social welfare, environment, agriculture, food and nutrition, finance, economic planning, education and social development professionals, and academicians, helped by well-developed networks. Examples of partnership working are the Multisectoral Working Group on Early Childhood Care and Development, the Multidisciplinary Facilitation Team at community and district levels, and the Technical Advisory Committee at regional levels. The effectiveness of these activities is enhanced and underpinned by collaboration and alliance building among different sectors, applied research to improve quality and effectiveness, and training to engage people effectively in health promotion work. Despite some notable areas of effective policy development and partnership working, other areas have been less successful – for example, although The Gambia has laws banning public smoking, this initiative could have been supported by mainstreaming health promotion interventions in tobacco control activities.

Generating evidence of health promotion effectiveness

Chopra (24) notes the lack of data on health inequalities in developing countries, masking inequalities. Significant causes of ill health such as exposure to pesticides (25) or work-related injuries (26) in The Gambia are relatively neglected. Surveillance data on non-communicable disease in West Africa are rare, so emergence of non-communicable disease may go unnoticed. In the near future, West Africa may have rates of diabetes comparable to industrialized countries (27). Routine monitoring data, although under-utilised, do capture improvements or declines in certain problems, and in The Gambia there are significant research organizations such as the Medical Research Council, and also the National Nutrition Agency and CIAM-Public Health and Development Centre carrying out research in nutrition and malaria respectively. Major gaps remain, however, in evaluating the effectiveness of health promotion interventions, which the capacity building initiatives mentioned above attempt to address through research and evaluation skills.

Monitoring statistics suggest improvements: the under-five mortality rate declined from 161 per 1000 live births (2001) to 131 per 1000 (2005), but 60% of these deaths can still be attributed to preventable disease such as malaria, respiratory tract infections, diarrhoea and infections – suggesting that health promotion efforts need to be strengthened. The MICS (Multiple Indicator Cluster Survey) III 2005/2006 (28) showed the unacceptably high infant mortality rate and the under-five mortality rate of 93 and 131 deaths per 1000 children born alive. Malnutrition contributes to over 60% of these
deaths, which again suggests that health promotion interventions could play a larger role.

Expansion of national safer water coverage from 23% in 1983 to 82% in 2006 means that The Gambia should meet the MDG target. This success is not matched by sanitation coverage, reaching 52% in 2006, only 31% in some rural areas and with high rates of shared sanitation facilities, widespread open defecation and less than 11% of households having water piped into their homes (17).

Preventive measures against malaria show some success: the 2006 MICS Report showed increased use of insecticide-treated bed nets (ITNs) from 14.5% in 2000 to 49% in 2006 by children under five years, and a reduction of 43% between 2000 and 2006 in episodes of fever among that age group (28). More research and process evaluation would enable greater lessons to be learnt from these successes and relative failures.

Has health promotion really developed in The Gambia?

Looking at the six areas highlighted by Amunyunzu-Nyamongo et al. (4) it’s possible to see that The Gambia has given these areas attention. However, has health promotion really developed?

Whilst the PHC approach has developed more robust health systems, there has not been a similar drive forward for health promotion. Its development was given impetus between 2000 and 2007 after three public health professionals working at the Health Education Unit and the WHO country office underwent an intensive MSc course in Public Health-Health Promotion at Leeds Metropolitan University. The knowledge gained brought about national and regional interest in health promotion, and helped to bring the Leeds Metropolitan University course to The Gambia. Since drafting this paper, the Ministry of Health and Social Welfare has established a Directorate of Health Promotion and Education (in 2012) but prior to that did not have a division or department that could co-ordinate health promotion activities or develop a health promotion strategic plan. This has meant that health promotion specialists in The Gambia have viewed health promotion as fragmented and uncoordinated, lacking an overall strategy. There are development projects, health promotion in all but name, such as the Government’s initiative, the Community Driven Development Programme (CDDP) in rural and semi-urban communities. It includes micro-credit facilities for communities, support for community gardens, skills development and community capacity building through the active participation of the community members at all stages, from planning, through implementation, monitoring and evaluation.

Despite initiatives such as the Bamako Initiative, the Baby Friendly Community Initiative, the School Health strategy, and the application of participatory rapid appraisal methods, what exists are traditional forms of health education and behaviour change interventions in schools and health facilities, somewhat top-down community outreach work, and messages on radio and television. In the past, the lack of a ministerial task force or a multi-sectoral working group on health promotion has inhibited recognition of the need for health promotion infrastructure. Those influenced by the international health promotion movement want to see a more radical and proactive strategy based on the core values that define health promotion: equity and social justice, empowerment and participative methods that are geared towards meeting the health needs and overall wellbeing of individuals, families, and communities.

Moving into more radical ‘big picture’ health promotion remains challenging—the ‘implementation gap’ continues. Leeds Metropolitan University’s involvement in public health workforce development in The Gambia aims to build up a community of practice which can then effect change. Lave and Wenger (29), developing the concept of communities of practice, felt that such communities are built through ‘apprenticeship’ – learning how to be a member, participating and gradually taking on the professional identity, language and practices of that community. One aim therefore is to create communities of practice, with learning shared in multidisciplinary groups, helping to break down the professional competitiveness highlighted above by Nyamwaya (13) and enabling a critical mass of workers to drive change from the ‘middle ground’, helping to close the implementation gap between the policymakers at ‘the top’ and local communities on the ground (30). Along with threshold concepts such as social models of health, upstream thinking, and tackling determinants, and skills such as planning, implementing and evaluating health promotion
interventions, students should emerge well equipped to implement the health promotion agenda.

The course implicitly uses an empowerment model, incorporating the three strands of building capacity (awareness, skills and knowledge), building confidence (self-esteem, social networks, internal confidence, building aspirations), and system change (collectively supporting a systematic change of culture in policy and practice) (31). Learners are expected to become independent critical thinkers – in short, ‘empowered’ workers – and thus be able to take forward their own vision of health promotion to benefit the country.

Summary and conclusions

This paper has tried to show that African countries such as The Gambia face huge development challenges, carry a large disease burden and lack basic facilities including good sanitation. Their economies are often reliant on aid funding, and often do not have well-developed local or municipal authorities able to enforce policy at the local level. There is thus an ‘implementation’ gap between the rhetoric of the major conferences, and what is achievable on the ground. Although The Gambia has addressed the six areas identified by Amunyunzu-Nyamongo et al. (4), its strategy has been based on Alma Ata, not on Ottawa, and it has not developed infrastructure for health promotion until very recently. Although there is substantial ‘health promotion’ or health education-type activity, it is not ‘big picture health promotion’, occurring at a policy level true to the Ottawa Charter for Health Promotion – addressing the social determinants of health or concerned with tackling inequalities, empowerment and with people taking control of their health. On the other hand, there is ‘small picture’ health promotion which can be seen as an adjunct to the medical enterprise, concerned with health education, encouraging people to make better use of preventive health services and so on. It is hoped that this mixed picture in one of the world’s poorest countries can provoke debate within the international health promotion community about ways forward in Africa.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of interest

The authors declare that there is no conflict of interest.

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