UNICEF THE GAMBIA

FINAL CONSOLIDATED AND UTILIZATION REPORT ON

NEWBORN CARE INTERVENTION

Submitted to the Dutch NatCom

Grant number: SC-149901

March 2019

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for every child

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PROGRAMME SUMMARY

Country	**The Gambia**
Programme	Child Survival and Development
Donor	Dutch Natcom
PBA Reference	SC-149901
PBA Amount	US$229,168.86
Funds spent (March 2018 – March 2019)	US$229,168.86
Balance of uncommitted funds	US$0
Duration of Contribution	May 2017 to December 2018
Type of Report	Final Consolidated and Utilization Report
Period Covered	May 2017 to March 2018
Date prepared	March 2019
UNICEF 2017-2021 Country Programme Results	**Outcome**: Children and women have access to and utilize improved and equitable quality maternal and child health services, learn and practice healthy behaviours. **Output**: Strengthened PHC system provides equitable and quality maternal and child health services specifically for under 5s, pregnant and lactating women.
Geographic Focus	National
Programme Partners	Ministry of Health and Social Welfare and Catholic Relief Services
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ACRONYMS

ASRH:	**Adolescent Sexual Reproductive Health**
CH:	**Child Health**
CHERG:	**Child Health Epidemiology Reference Group**
DHS:	**Demographic Health Survey**
EFSTH:	**Edward Francis Small Teaching Hospital**
HSS:	**Health Systems Strengthening**
HQ:	**Headquarters**
KMC:	**Kangaroo Mother Care**
LRR:	**Lower River Region**
MICS:	**Multiple Indicator Cluster Survey**
MNH:	**Maternal and Newborn Health**
MoHSW:	**Ministry of Health and Social Welfare**
RCH:	**Reproductive Child Health**
RHCS:	**Reproductive Health Commodity Security**
RMNCAH:	**Reproductive Maternal Newborn Child and Adolescent Health**
ROCS:	**Reproductive Organ Cancers**
SDGs:	**Sustainable Development Goals**
UNFPA:	**United Nations Population Fund**
UNICEF:	**United Nations Children's Fund**
WASH:	**Water, Sanitation and Hygiene**
WHO:	**World Health Organization**

[1]MAP OF THE GAMBIA

1.0 INTRODUCTION

Access to basic health services in The Gambia has improved across the country with many more children celebrating their 5th birthday now than 15 years ago. Under-five mortality has declined by 39 per cent, a significant decline from 109 deaths per 1,000 live births in 2010 to 54 deaths per 1,000 live births in 2013 (MICS 2010; DHS 2013). This decline is however not realized within the first 28 days of life. A disproportionate number of children in The Gambia are dying in the first 28 days of life, with 2,168 new-borns deaths annually, accounting for massive 40 per cent of the under-five mortality, according to the WHO (CHERG, 2014). The main causes of death are prematurity, birth asphyxia and pneumonia.

In 2017, MoH&SW developed the Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) policy and strategic plan. The policy and strategic plan provides the framework to accelerate progress to end all preventable maternal and child deaths. The last national Reproductive and Child Health (RCH) Strategic Plan was developed for the period of 2007-2014 and has already ended and New-born care was not given the prominence or necessary attention. One of the primary purpose for the recent policy and strategic plan was to achieve Sustainable Development Goals and other global priorities such as ending preventable child health deaths.

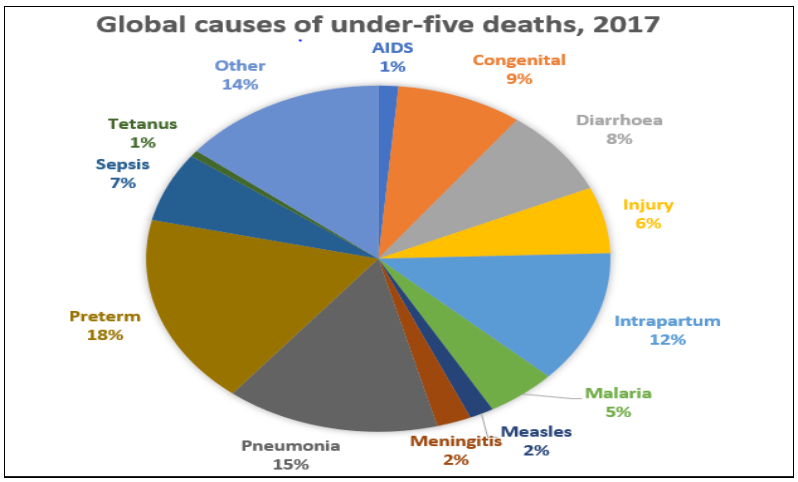
1.1: Country Situation

The Gambia, with a total surface area of 10,689 square kilometres, is situated on the west coast of Africa. The country was ranked 173 out of 189 countries in the UNDP's 2018 Human Development Index. With an annual growth rate of 2.8 per cent, the population stands at 1.8 million with life expectancy at 53 years. About 48 per cent of Gambians live below $1.25 a day with women constituting 63 per cent of the poor, whilst 76 per cent of all the poor live in rural areas. Approximately 530,000 children and youths are characterized as poor. Infant and under-five mortality rates (IMR, U5MR) have decreased during the last decade. According to the 2013 Demographic Health Survey (DHS), IMR is 34 per 1000 and U5MR 54 per 1000. Although it is difficult to measure a trend with DHS, the Multiple Indicator Cluster Survey, another national survey conducted in 2010 (which uses a different methodology from the DHS), estimated the prevalence of IMR at 81 per 1000 and U5MR at 109 per 1000 in 2010 births respectively, showing a significant drop between 2010 and 2013. Though, mortality has generally decreased, serious disparities continue to exist between

[1] Western Division (WD), North Bank Division West & East (NBSW, NBDE), Lower River Division (LRD), Central River Division (CRD) & Upper River Division (URD) are now called West Coast Region (WCR), North Bank Region West & East (NBRW, NBRE), Lower River Region (LRR), Central River Region (CRR) & Upper River Region (URR)

regions and wealth quintiles. In 2011, under-five mortality rates in the rural areas were 36 per cent higher than those in urban areas due to several contributing factors, including the limited access to affordable quality health services that are further weakened by stagnated budgetary allocations to the health sector.

Figure 2: Global causes of underfive deaths, 2017



Source : UNICEF, 2018- https://data.unicef.org/topic/child-survival/under-five-mortality/

As shown in Figure 2 above, the main causes of childhood mortality and morbidity include preventable and treatable diseases such as malaria – which is the major killer of under-fives – respiratory infections, diarrhoeal disease, and sepsis in neonates. These conditions are responsible for two-thirds of the under-five mortality. Vaccine preventable diseases such as polio and measles have rapidly declined, with zero cases reported for over five years.

1.2: Brief Overview of RMNCAH services

RMNCAH services are managed by the RMNCAH program at the Ministry of Health and Social Welfare (MoHSW). The Vision of the RMNCAH program is to improve the reproductive health status of women, neonates, children, and adolescents of the Gambia through the promotion and provision of right based comprehensive, quality, affordable and sustainable sexual and reproductive health information and services through partnership. To achieve this mission, the RMNCAH policy outlines 10 strategic priorities.

- Improving Family Planning
- Improving Maternal and Neonatal Health (MNH)
- Improving Child Health (CH)
- Improving Adolescent Sexual and Reproductive Health (ASRH)
- Improving Prevention & Treatment of Sexually Transmitted Infections, including HIV
- Improving the Prevention and Treatment of Reproductive Organ Cancers (ROCs)
- Improve access to RMNCAH services for people with special needs
- Improve Reproductive Health Commodity Security (RHCS)
- Health System Strengthening (HSS)

Specific objectives of the RMNCAH strategic interventions include the following by 2021.

- Reduce maternal mortality ratio from 433 to 315 per 100000 live births

- Reduce under-five mortality rate from 54 to 44 per 1000 live births
- Reduce infant mortality rate from 34 to 24 per 1000 live births
- Reduce neonatal mortality rate from 22 to 15 per 1000 live births
- Reduce the prevalence of malnutrition among children by 25%.
- Stunting by from 24.5% to 18%
- Wasting from 16.2% to 12%
- Underweight from 11.5% to 9%.
- Reduce the rate of mother to child transmission (MTCT) of HIV from 9.4% to <5%.

1.3: Rationale for newborn care interventions

These babies die because they are delivered at home without a skilled birth attendant and under poor hygienic conditions. The chances of a new-born surviving significantly increases when the mother delivers in a health facility with the help of a skilled and trained birth attendant. Due to lack of knowledge of services offered, combined with socio-cultural beliefs on best practices for expecting mothers, approximately 40 percent of mothers deliver at home. The main cause of death in the first 28 days of life is infection due to lack of access to appropriate care, and unsatisfactory hygiene conditions during and after delivery. These problems are further compounded by weak referral mechanisms between communities and health facilities, and lack of supplies and equipment to manage complications during birth. These deaths are preventable with the right interventions.

2.0 Results achieved from May 2017 to March 2018 through Dutch Natcom funding

2.1 Capacity Building.

A consultant was hired by UNICEF from Kalafong Hospital in South Africa to assess health facilities for the implementation of Kangaroo Mother Care as well train national trainers on KMC. The main objective was to capacitate health workers who could be trainers and facilitators at further step-down training workshops. A participant's KMC handbook was developed, especially for training health care workers in all aspects of the practice of KMC. This manual was used during the training. Similarly, a facilitator's manual was also developed and printed for the training. Health workers from five regional hospitals, three district hospitals and members of the RMNCAH program were provided with the knowledge and skills to implement KMC in their individual facilities wherever possible.

A step-down training was conducted for 48 health workers from the 7 regions of the country on Kangaroo Mother Care in Kanifing between the 17th and 22nd September 2018, this training provided the workers with the capacity to properly manage low birth weight babies by providing them with KMC. A follow-up mission by the KMC consultant to assess progress of KMC implementation could not take place due to time constraints. Additionally, 48 health workers were trained on Emergency Maternal Newborn and Child Health (EMNCH), this provided with the skills to manage complications of maternal, new born and childhood illnesses at health facility level.

Photo1: KMC step down training training


Photo 2: Demonstration of expressing milk at KMC


Photo 3: Participant at EMNCH training


Photo 4: participant at EMNCH training

2.2 Launching and Implementation of KMC at Edward Francis Small Teaching Hospital (EFSTH)

UNICEF supported the implementation of KMC at the main referral hospital in Banjul. The unit was supported by UNICEF in collaboration with the Medical Research Council and launched by her excellency the First Lady. This intervention is expected to increase the health care worker's knowledge and skills to save the lives of preterm babies.

Photo 5: The first lady visting some mothers in the KMC unit during the launch

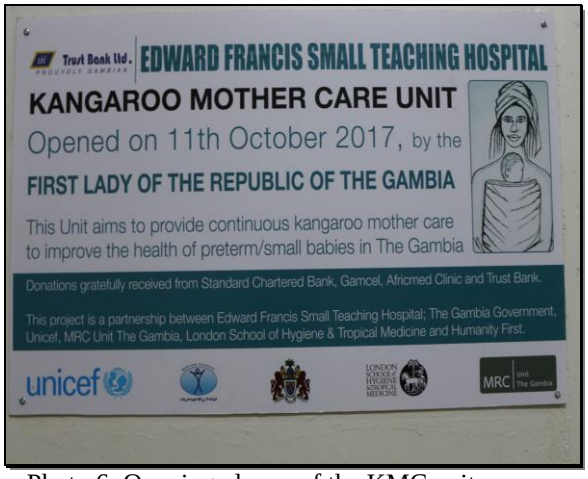


Photo 6: Opening plaque of the KMC unit

2.3 Message Development and implementation of 4+4 key household behaviours

UNICEF supported the scaling up of the promotion of key household practices for enhanced child care practices in the development of child friendly message booklets, training manual and pictorial flip chart through Directorate of Health Promotion and Education, Ministry of Health and Social Welfare. These materials will be used to facilitate sessions at community level on the key household and health related behaviours on the use of long lasting insecticidal nets, practice of exclusive breast feeding, hand washing with soap and running water at critical times, use of sugar salt solution to reduce dehydration, practice household water treatment, early health care seeking behaviour for pneumonia, **essential neonatal care and early antenatal booking**.

Message development was followed by training on key household behaviours for thirty (30) Multi-Disciplinary Facilitation Teams (MDFT) and 96 Village Support Groups in Lower River Region(LRR). The knowledge and skills acquired, enabled them to facilitate family and community dialogue for improved child care practices. In eight months, Village Support Group members and MDFTs reached 19,255 mothers and caregivers in 6 districts via household to household visits and community meetings. During the engagement process, VSGs provide information and life skills to caregivers to make well-informed decisions and to take appropriate actions to protect the health of their children especially for the newborn. These activities were followed with interactive radio program on key household behaviour for child survival. These radio programs strengthened the efforts of the VSGs and provided a wider coverage, especially in reaching underserved communities.

UNICEF continues to engage community health structures to improve health service delivery through the implementation of the key household behaviours which includes early booking for antenatal care and care for the newborn cord. In 2018, (70) Multidisciplinary Facilitation Team (MDFT)and Four (10) Technical Advisory Committee (TAC) members, 300 Village Support Groups, 50 Village Development Communities and 55 Traditional Communicators were trained on concepts, approaches, key messages and basic interpersonal communication skills for 4+4 key household behaviours.

The key household and health related behaviours been promoted are the use of Long lasting insecticidal nets, practice of exclusive breast feeding, Hand washing with soap and running water at critical times, use of sugar salt solution to reduce dehydration, practice household

water treatment, early health care seeking behaviour for pneumonia, essential neonatal care and early antenatal booking. At the end of training of MDFTs the post test conducted reveals that 96% of the participants developed knowledge and skills on basic IPC and 4+4 key household behaviours that will enable them to provide effective stepdown training of fifteen (300) Village Support Groups

2.4 Development of WASH in Health Facilities Guidelines

In collaboration with the Ministry of Health and Social Welfare WASH in health facilities guidelines was developed. The guidelines are aimed at strengthening the capacity of WASH institutions to plan, deliver and monitor WASH services. It is expected that the guidelines for WASH in Health Care Facilities will result into harmonized WASH service provision and increase access to basic WASH facilities in all Health Care Facilities in the country.

2.5 Rehabilitation of Water Points

UNICEF supported the rehabilitation of a well at the Kuntaur Health centre through this project. The dysfunctional water point had caused water shortage in the health centre and affected sanitation and hygiene conditions in the labour ward. The restoration of water supply has solved the challenge of clean water for delivery, drinking and sanitation benefitting 27,977 people in the catchment area. Additionally, in 2018 health centres namely Foday Kunda and Sare Sofi were supported. Foday Kunda had inadequate water supply affecting both the outpatient and labour ward. With the rehabilitation of the water point, 18,000 people including vulnerable women and children benefitted. Similarly, Sare Sofi had inadequate water supply for a year, the rehabilitation of the water point provided access to 24,000 people in the catchment area.

2.6 Technical Assistance

The funds from the Dutch Natcom supported the position of the Child Survival and Development officer. This post provides support to the implementation of the interventions as well as supportive supervision of the ongoing implementation. The incumbent also provided inputs for the development of a monitoring checklists for monitoring of health facilities on maternal and newborn care. The incumbent also leads the development of the WASH in health facilities guidelines as well support for the rehabilitation of water points.

2***.7 Health Sector Assessment with focus on newborn care***

UNICEF and partners have been supporting the Ministry of Health on the comprehensive assessment of the health sector. The overall objective of the health systems assessment is to assess the functionality of the six building blocks of the health system. For the improvement of maternal and newborn outcomes, UNICEF supported a consultancy on an assessment of health facilities on maternal and newborn care. The recommendations from the assessment will guide interventions towards improvement of maternal and newborn survival.

2.8 Procurement of supplies and equipment

UNICEF complemented the efforts of the Government by procuring additional essential supplies for newborn care. The supplies procured were aimed at prevention of infection and increasing child survival by procuring oxygen concentrators to aid in the treating breathing issues.

2.9 Launching of Meningitis A Campaign and Engagement of Multi-Disciplinary Facilitation Teams (MDFTs) on Social Mobilization

Meningitis A campaign was conducted in the Gambia from February 1-6, 2019, UNICEF complimented funds from GAVI Using the funds from this grant to support the implementation and launching of the campaign. The launch by the first lady and attended by the minister of Health and local authorities provided an opportunity for a high-level advocacy and awareness creation.

Additionally, MDFTs were also engaged to conduct social mobilization at district level by facilitating community engagement with community leaders and faith groups. The MDFTs were also instrumental in building the capacities of community-based organizations to ensure effective interpersonal communication by encouraging home visits and participation of target groups in campaign.

2.10 Future Plans

UNICEF will be implementing Integrated Community Case Management (iCCM). This is an evidence-based strategy to increase child survival. The objective of the iCCM for communities to have improved knowledge, adopt healthy practices on key household behaviours and have access to newborn care package, iCCM package and WASH services. UNICEF will be working in the most vulnerable communities with the worst indicators for newborn and child survival. The implementation of iCCM will ensure the results gained from implementation of this grant will be sustained and institutionalized.

3.0 MONITORING, SUPERVISION AND EVALUATION

During the reporting period, a monitoring check list based on WHO guidelines for health facilities on maternal and newborn was developed and used by UNFPA, UNICEF and WHO. This checklist was used on a joint monitoring trip with the H4+ group in January 2018 and the findings and recommendations have been shared with the ministry of health to further refine and improve the relevant services.

4.0 MAIN CHALLENGES AND LESSONS LEARNED

4.1 Main Challenges

Coordination of health interventions remains a challenge in the health sector. A working group was set up in September 2017 on maternal and newborn health with defined TORs and met regularly during 2017. However, no meeting has been held in 2018 due to internal issues in accessing funds at the MoHSW. The meetings were not regular in 2018 as well, UNICEF will continue to advocate for the regular meetings of the working group to enhance coordination of maternal and newborn care services. Within, the UN H4+ (UNFPA, UNAIDS, UNICEF, WHO, and WB), the participating agencies have been working together to ensure, complementarity of efforts, avoid duplication of programmes and resources support; reduce the transaction cost and promote a coordinated approach to programme delivery, avoid duplication and to deliver in the tenets of One UN. These UN agencies have

decided to officially form partnership on health with a view to delivering a more efficient and effective support to the Gambian health system through a coordinated approach.

4.2 Lessons Learned

The regular meetings of the maternal and newborn working group in the last quarter and the meetings provided opportunity to share information, monitoring reports and provided opportunities for the participant to share lessons learnt as well as further improve coordination of maternal and newborn care. These meetings need be held regularly.

Also, the integration and provision of WASH facilities at health centres has shown to reduce the incidence of sepsis and thus contributing to reduction of neonatal mortality.

5.0 FINANCIAL REPORTING

The Dutch Natcom funds of $41,261.94 were used to support the implementation of newborn care and child health interventions from March 2018- December 2018. Out of this, all funds have been spent. The table below shows the utilization of the programmable funds from May 2018-December 2018

UNITED NATIONS CHILDREN'S FUND (UNICEF)

OTHER RESOURCES CONTRIBUTION RECEIVED FROM: GLOBAL - HEALTH

DONOR STATEMENT BY NATURE OF EXPENSE (UNCERTIFIED) FROM 01 OCTOBER 2013 TO 21 MARCH 2019 IN US DOLLARS

Status of Contribution

External Reference:	THEMATIC HEALTH 2014-17
Description:	Thematic MTSP 2014-2017 Outcome 1: Health
Contribution Reference:	SC149901
Effective Date:	01.10.2013
Expiry Date:	31.12.2018
Recipient Office(s):	EAPR Regional Office, ECAR Regional Office, ESAR Regional Office, LACR Regional Office, MENAR Regional Office, SAR Regional Office, WCAR Regional Office, Afghanistan, Angola, Armenia, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cabo Verde, Cambodia, Central African Republic, Chad, China, Colombia, Comoros, Congo, Cote D'Ivoire, Cuba, DP Republic of Korea, Data, Research and Policy, Democratic Republic of Congo, Division of Communication, Djibouti, Dominican Republic, Egypt, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Evaluation Office, Executive Director's Office, Fiji (Pacific Islands), Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea Bissau, Haiti, India, Indonesia, Jordan, Kazakhstan, Kenya, Kosovo, Lao People's Dem Rep., Lesotho, Liberia, Madagascar, Malaysia, Maldives, Mali, Mauritania, Mongolia, Morocco, Namibia, Nepal, Nicaragua, Niger, Pakistan, Palestine, State of, Papua New Guinea, Paraguay, Peru, Philippines, Programme Division, Public Partnerships Division, Rep. of Turkmenistan, Republic of Cameroon, Republic of Kyrgyzstan, Republic of Montenegro, Republic of Mozambique, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Sri Lanka, Sudan, Switzerland, Tajikistan, Timor-Leste, Togo, United Rep. of Tanzania, Vietnam, Yemen, Zimbabwe
Agreement Currency:	Various
Funds Received:	USD 0.00
Refunds:	USD 0.00

Summary of Expenditures (USD)

Description	Cumulative Expenditure
Programmable Expenditure:	59,715,341.87
Indirect support cost 6.254330%	3,734,794.54
Total:	**63,450,136.41**
Funds Received in USD:	0.00
Unspent Balance:	**(63,450,136.41)**

Details of Expenditures (Gambia)

Description	Incurred Expense 2013-2018	Incurred Expense 2019	Cash Advances and Prepayments	Cumulative Expenditure	Commitments*
Staff and Other Personnel Costs	55,604.62	0.00	0.00	55,604.62	0.00
Supplies and Commodities	82,672.93	0.00	0.00	82,672.93	0.00
Contractual Services	26,049.34	0.00	0.00	26,049.34	0.00
Travel	7,496.12	0.00	0.00	7,496.12	0.00
Transfers and Grants to Counterparts	132,932.34	39,240.34	44,479.60	216,652.28	0.00
General Operating + Other Direct Costs	12,998.53	0.00	0.00	12,998.53	0.00
Total Programmable Cost	**317,753.88**	**39,240.34**	**44,479.60**	**401,473.82**	**0.00**
Indirect support cost 6.254330%	19,873.38	2,454.22	2,781.90	25,109.50	
Total	**337,627.26**	**41,694.56**	**47,261.50**	**426,583.32**	

6.0 EXPRESSION OF THANKS

UNICEF Gambia, the Government, and people of The Gambia express their gratitude to the Dutch Natcom for the financial support for the implementation of newborn care interventions. The results outlined above could not have been achieved without this contribution.

ANNEX 1: DONOR REPORT FEEDBACK FORM

Title of Report/Project: Final Consolidated and Utilization Report on New Born Care under the Thematic Health Non-Humanitarian fund.

UNICEF Office: The Gambia
Donor: Dutch NatCom
Date: March 2019

Donor Report Feedback Form

UNICEF The Gambia is working to improve the quality of our reports and would highly appreciate your feedback. Kindly answer the questions below for the above-mentioned report and return to Partnerships Manager who will share your input with relevant colleagues in the Country Office. Thank you!

Please return the completed form back to UNICEF The Gambia by email to:
Name: Gloria Momoh
Email: glmomoh@unicef.org

SCORING: **5 indicates "highest level of satisfaction" while 0 indicates "complete dissatisfaction"**

1. To what extent did the narrative content of the report conform to your reporting expectations? (For example, the overall analysis and identification of challenges and solutions)

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what did we miss or what could we do better next time?

_____
_____
_____

2. To what extent did the fund utilization part of the report meet your reporting expectations?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what did we miss or what could we do better next time?

_____
_____
_____

3. To what extent does the report meet your expectations in regard to the analysis provided, including identification of difficulties and shortcomings as well as remedies to these?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what could we do better next time?

_____
_____
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4. To what extent does the report meet your expectations with regard to reporting on results?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what did we miss or what could we do better next time?

_____
_____
_____

5. Please provide us with your suggestions on how this report could be improved to meet your expectations.

_____
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6. Are there any other comments that you would like to share with us?

_____
_____
_____