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Original Article

Non-Governmental Organisations and Health Service Delivery in The Gambia: A Case Study of The Hands-On-Care Clinic

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ABSTRACT

This study mainly assessed the performance of the Hands-on-Care (HoC) Clinic, a Non-Governmental Organisation, in sexual and reproductive health service delivery in The Gambia and identified the challenges being faced by the organisation. Both primary and secondary data were used for this study. Primary data were collected using a questionnaire, in-depth interviews, and Participant Observation. The staff and patients of HoC Clinic and the two support societies were targeted for the study. The results of the study revealed that NGOs play vital roles in the delivery of health services. HoC Clinic has made and continues to make significant contributions to the sexual and reproductive health of The Gambia. The results also showed that it contributes individually and collectively in a participatory manner to improving the quality of life of all Gambians and non-Gambians alike. Based on the cumulative responses of staff, patients, and support societies and in consultation with relevant institutional documents, it could be observed that the institution continues to perform extremely well in the provision of sexual and reproductive health services to the people despite challenges in terms of human and material resources as alluded to by many respondents during the study. The performance of the institution was said to have been hindered by a poor commitment from the government, high reliance on donors, limited funding from other partners, and an unstable political environment, among others. The study concluded that NGOs play important roles in health service delivery, especially in developing countries where the government lacks the power to do all for its citizens. This makes them indispensable to the development of a country as they fill the gap the government is unable to fill.

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INTRODUCTION

The Gambia is an attractive tourist destination located along the River Gambia on the west coast of Africa which Capital city is Banjul. It is the smallest country on the African mainland with a population of 1.9 million inhabitants growing at the rate of 3.2 percent per year (GBoS, 2015). It is surrounded by Senegal on the North, East, and South and on the West by a short part of the Atlantic Ocean. The Gambia gained its independence from the United Kingdom on February 18, 1965, and declared a republic on April 24, 1970. The Gambia is a member of the Commonwealth, African Union (AU) as well as the Economic Community of West African States (ECOWAS). The origin of NGOs in The Gambia dates to 1964 when Catholic Relief Services (CRS) was invited by the then Catholic Bishop of Banjul and assumed an NGO status Christian charity mission whose presence was felt in providing emergency relief to vulnerable communities during emergencies, strengthening food security to tackle malnutrition, enhancing healthcare services, and providing education opportunities for the children and the family members (Catholic Relief Services, 2016). By the late 1960s, a number of national NGOs and international NGOs became operational in The Gambia. These include Freedom from Hunger Campaign (FFHC) and The Gambia Family Planning Association (GFPA) established in 1968. During the 1960s to mid-1970s, there was little growth in the NGO community in The Gambia. This period coincided with the dawn of political independence when the national government was expected to provide for the basic needs of citizens.

The second phase was from the mid-1970s to 1980. This period witnessed the establishment of international NGOs such as Action Aid the Gambia (AATG) established in 1979, Canadian University Services Overseas (CUSO), and CARITAS The Gambia. This period coincided with the Sahelian drought when The Gambia experienced a serious shortfall in overall agricultural output. Since their establishment, they have become important channels of delivery of social services and implementation of other development programmes, especially in the areas where government capacity is weak or non-existing (GBoS, 2005). This covers all problem-areas such as health (HIV/AIDS), food security, education, women empowerment, agriculture, environmental protection human right-based approaches to development, and advocacy, among others. The period 1980-1994 witnessed an increase in their number and activities in The Gambia to cater for the needs of children, the visually handicapped and the aged. Among them was the Christian Children Fund and now Child Fund the Gambia committed to solving the plight of deprived, excluded, and vulnerable children in The Gambia.

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The 1980s coincided with a decline in the economic fortunes of The Gambia with the standard of living of people eroded as a result of the debt burden that impeded meaningful economic development during that period. This led to the implementation of the Economic Recovery Programmes (ERP) under the supervision of the World Bank and International Monetary Fund whose emphasis was on reviving the economy and reducing its financial commitment to the social service sector through structural adjustment policies and programmes recommended by the Briton Wood institutions. A number of public institutions were privatised and cost recovery schemes were introduced in the health and education sectors. The partial disengagement of government in these sectors resulted in larger roles for NGOs to fill the gap left by the government in order to make The Gambia a conducive place to live in.

Despite the enormous contributions of NGOs to the well-being of the people, especially in the area of health, their roles and contributions are overlooked by most governments. In view of the above, this study seeks to examine the role of non-governmental organisations in health service delivery in The Gambia with particular reference to the "Hands-on-Care" (HoC) Clinic. HoC Clinic is one of the leading NGOs in the country and it focuses on the provision of health services such as sexual and reproductive health services, psychosocial support, advocacy, care and nursing, information services, and health system strengthening through capacitating and upgrading healthcare workers as well as home-based/palliative care services. Studies have revealed that, in terms of the delivery of chronic care services, the government is committed to the provision of such services at no cost to patients. However, home-based palliative care, which is known to be a vital component of chronic care under the Global Fund for AIDS, Tuberculosis, and malaria has been delivered mainly by NGOs, including the HoC, which is our major interest.

Other NGOs that focus on health services delivery in the Gambia include the Gambia Family Planning Association (GFPA), Action Aid International the Gambia, Catholic Relief Services (CRS), Catholic Development Organization (CDO), BAFROW, The Gambia Red Cross Society, Gambia Committee on Traditional Practices (GAMCOTRAP), Nova Scotia Gambia Association and Public Health Research & Development Centre, among others. These institutions have been able to reduce the health services delivery burden on the government of The Gambia through their partnership with major donor agencies and like-minded international development partners and charities.

In order to assess the roles of NGOs in the provision of health services, the study was guided by the following questions with particular reference to the HoC Clinic:

- What are the mission, vision, and goals of the HoC Clinic in health service delivery in The Gambia?
- How effective has HoC Clinic been in the provision of sexual and reproductive health services in The Gambia?
- What are the challenges being faced by HoC Clinic in the area of sexual and reproductive health in The Gambia?

CONCEPTUAL REVIEW.

Non-Governmental Organisations (NGOs)

Non-governmental Organisations (NGOs) are basically those categories of entities that do not belong to the government sector and whose operation is not for the purpose of having financial gain or profit. According to Epstein & Buhovac (2009), NGOs include a wide variety of organisations from charitable organisations, social service agencies, religious and fraternal organisations, health care societies and health organisations, educational organisations, environmental organisations, sports, and recreational organisations, to funding foundations, business and professional organisations and political parties. Arguably, their purpose of existence is to generate improvements in the lives of individuals, members, organisations, communities, and society, it was added. In the words of the United Nations (2003), cited in Das & Kumar (2016), NGOs typically possess a very distinctive feature as private institutions serving public purposes. They are called by various names such as Not-for-profit institutions, Third sector organisations, Voluntary

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organisations, Community-based Organisations (CBOs), charitable organisations, Non-Governmental Development Organizations (NGDOs), Private Development Organizations (PDOs), Public Service Organizations (PSOs), and so on.

In another dimension, the World Federation of Public Health Associations (WFPHA) (1978) defined NGOs strictly as professional, specialised, and technical organisations; broadly-based associations of persons or groups organised for a particular purpose such as information and service activities, educational institutions and associations, social welfare organisations, religious groups, women's organisations, youth groups, trade unions, and family planning associations, to name a few. These organisations are often task-driven and formed by people of common interest targeting a given mission or missions. Such missions include services and humanitarian functions, advocating for the need of the poor and socially excluded people, promoting political participation in government, monitoring government policies and operations, and some others usually to further the political or social goals of its members around specific issues like encouraging the observance of human rights, health services delivery, improving the natural environment, accountability in government, improving the welfare of the disadvantaged, and representing a corporate agenda. Others include acting primarily as lobbyists as well as conducting programmes and activities such as poverty alleviation, provision of food for the needy, village development, adult education to eradicate illiteracy, and so on (Adesopo, 2020).

Citing World Bank, Malena (1995) defined NGOs as private organisations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development. NGOs also play an important role in supporting the voiceless, minorities, and the deprived, excluded, and vulnerable people in society through direct support, advocacy, and lobbying. Thus, in the context of service delivery, NGOs seek to improve the access of the people to the service provided by the state.

The term NGO came into the currency at the end of the Second World War, as the United Nations sought to differentiate between inter-governmental specialised agencies and private organisations (Hall-Jones, 2006). According to him, the first international NGO was probably the Anti-Slavery Society formed in 1839. The anti-slavery movement, which reached its height at the end of the 18th century, was the catalyst for many organisations that followed. Notably, early NGOs grew out of wars, including the Red Cross in the 1850s after the Franco–Italian war; Save the Children after World War I; and Oxfam and CARE after World War II. Consequently, NGOs have been playing major roles in the development of the masses, especially those in developing countries.

From the late 1980s, NGOs assumed a far greater developmental role than before. NGOs were first discovered and then celebrated by the international donor community as bringing fresh solutions to long-standing development problems characterised by inefficient government-to-government aid and ineffective development projects (Lewis, 2009). That is, they are seen to be more effective in social service delivery, especially in developing countries where governments fail to deliver the desired social services as expected. Some others also exist to further the political and social goals of the people like improving the natural environment, encouraging the observance of human rights, improving the welfare of the disadvantaged, and representing a corporate agenda. Others include acting primarily as lobbyists as well as conducting programmes and activities such as poverty alleviation, provision of food for the needy, village development, adult education to eradicate illiteracy, and so on. As of 2015, there were an estimated 10 million registered NGOs worldwide (IBSO, 2015) and the number must have increased mainly since then. Most of these NGOs working in developing countries have their bases in rural areas and urban slums where government impact is not all that felt (Mushtaque, Chowdhurry, & Perry, 2020).

Health Service Delivery

Service delivery generally is a continuous and (cyclic) process for designing, developing, and making accessible user-focused municipal services to the target population or client community. The

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process establishes a kind of relationship among the policy makers, service providers, and the populace. There is a large number of such services ranging from the water supply, sewage collection and disposal, street lighting, parks, and recreation, to health services, among others, which their provision is a major task before governments at all levels. Beyond provision, governments must guarantee continuity by making them accessible and affordable to all.

Health service delivery specifically is one of the key components of the fundamental human rights of the people and as the such government has a critical role to play in the effective and efficient delivery of such services. Basically, health service delivery is all about making health-related services available to patients as they are needed. That is patients, having access to treatment and supplies whenever they desire such. According to World Health Organization (2007), good health services are those that deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources. WHO made this the first of the six building blocks of a health system. Others are from the point of view of the health workforce, health information, health financing, leadership and governance, and medical products, vaccines, and technologies. The service delivery building block is concerned with how inputs and services are organised and managed to ensure access, quality, safety, and continuity of care across health conditions and across different locations and over time. These are described by WHO, OECD & WB (2018) as foundational elements critical to delivering quality healthcare services and that to ensure quality is built into the foundations of the systems, governments, policy makers, health system leaders, patients, and Clinicians should work together to ensure a high-quality health workforce; excellence across all healthcare facilities; safe and effective use of medicines, devices, and other technologies; effective use of health information systems; and developing financing mechanisms that support continuous quality improvement. The emphasis above is on the key indicators necessary for quality, effective and efficient health service delivery in the absence of which people are at the mercy of the Civil Society Organizations (CSOs) that may want to occupy the gap created by government failure.

The challenge before any government today is how to reach the whole population in terms of health service delivery. At a point in time, governments chose to believe so much in the size of the hospital in the delivery of health services and have been disappointed in most cases as these large hospitals could only serve a small part of the target client. This is because of their fewer number and secondly, they are designed more for serious diseases and not for the delivery of comprehensive healthcare services that would have covered a larger population. Scholars have identified the cost of running these large hospitals and their failure or inability to meet the delivery expectations of the people as the main reason that led many countries to seek “alternative” models of delivery to institute a system that would be less expensive and at the same time meeting the expectations of the (rural) population. It is a convenient point to emphasise that the design of the health service delivery system differs from country to country as it is designed and developed in relation to their needs and resources. Common to all of them are primary healthcare and public health measures. In some countries, the delivery system is planned and handed over to private organisations to drive it. In others, the system is made participatory, whereby concerted efforts are made by governments, trade unions, religious and charity organisations, and other coordinated bodies to deliver healthcare services to the target population or client community.

NGOs and Health Services in the Africa Continental Scene

The role of NGOs in healthcare service delivery remains the same across the world. However, their roles are more prominent in developing countries where access to social services is limited and challenging due to the persistent failure of governments may be a result of many years of conflict and/or bad leadership that has led to the collapse of the public healthcare system. The World Health Organisation has acknowledged increasing recognition of its roles in complementing government programs and creating an effective people’s voice in respect of health service requirements and expectations, according to Nimadi

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and Kumar (2016). Accordingly, many countries across the globe have opened up the opportunity for the participation of NGOs in providing health services. In Malawi, for instance, NGOs are major stakeholders in health service delivery have been part of initiatives to prioritise health research and are critically positioned within national research policies. Flint, a large Malawian NGO that works on issues affecting women and young people, including sexual health, and Clay, a medium-sized one that undertakes community mobilisation in several sectors, including HIV and gender are good examples in Malawi. NGOs such as the Family Life Association of Swaziland (FLAS); School HIV/AIDS, Population and Education (SHAPE) Unit, and The AIDS Information and Support Centre (TAISC) are examples in Swaziland whose role is mainly enlightenment about family health, family planning, prevention of sexually transmissible infections, including HIV, and the provision of support services to people living with HIV and their roles have been complementary to government efforts in HSD.

According to Hecht and Tanzi (2015), NGOs, particularly those related to religious institutions, contribute importantly to the provision of health services in many low-income countries. In Tanzania and Haiti, for instance, NGOs operate nearly half of the hospitals and in Cameroon and Uganda, they manage 40 percent of health facilities in the country. In Ghana and Nigeria, about a third of all hospital beds are located in missions, it was added. Edmond (2014) observed that in post-war South Sudan, NGOs continue to provide the bulk of health services and are estimated to tune with 80 per cent of the health services. These include international non-governmental organisations, faith-based organisations, and local non-governmental organisations or community-based organisations.

In Uganda, there has been tremendous growth in the number of NGOs and they have been prominent in complementing government efforts because their roles are immense in both service delivery and the development of democracy in the country, especially in addressing the problem of poverty and underdevelopment as manifested in poor health indicators (Kankya, Akandinda & Rwabukwali, 2013). It was added that faith-based or religious non-governmental organisations have a long history of health service provision in Uganda, although some others featuring lately to make their impact felt in healthcare schemes.

Theoretical Framework: The Systems Theory

This work is anchored on Systems Theory (ST) as it is known to be a very good framework that can assist in solving many complicated problems in relation to healthcare delivery. It is assumed mainly that a system is an entity made up of multiple interrelated and interdependent smaller parts (subsystems). Such an entity is defined by its boundaries and the interaction among the subsystems creates what is known as a complex system as any slight change in one part of the system affects other parts and the whole system alike. ST seeks to explain and develop hypotheses around characteristics that arise within complex systems that seemingly could not arise in any single system within the whole.

ST is defined by Wilkinson (2011) as a conceptual framework based on the principle that the component parts of a system can best be understood in the context of the relationships with each other and with other systems rather than in isolation. ST was first introduced in the 1940s by the Austrian Biologist Karl Ludwig von Bertalanffy when he sought to find a new approach to the study of life or the living system. It was further developed and propagated by W. Ross Ashby and George Bateson. The theory has been applied to several disciplines since then. The common language across the diverse disciplines is the concept of "system", which is simply a group of interacting, interdependent elements that form a complex whole. David Easton (1953) for instance, applied it to the social and management sciences field with the same line of argument that a system is made up of different parts that make up a whole and that the desirable condition is for the parts to work harmoniously together to sustain the complex whole.

When applied to healthcare delivery, it is common knowledge that the healthcare system is a complex whole involving various stakeholders such as the policy makers, institutions/agencies, and groups of people in terms of health professionals such as Medical Doctors, Nurses, Social Workers, Pharmacists, Physiotherapists, and such others

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interacting and interdependent on a daily basis to deliver healthcare services at different levels of care. Such levels range from the provision of services for the prevention of diseases to the provision of palliative or end-of-life care. Further to this, any breakdown in the chain of interaction affects the service delivery structure and by extension, the entire health service system. What this means is that it is imperative to see the smaller parts and components in the larger system as being critical to the performance and sustenance of the whole health service delivery system.

METHODOLOGY

Area of Study

HoC Clinic is a charitable organisation founded in The Gambia in 1999 in response to the sexual and reproductive health needs of the community. Today, it provides a high standard of treatment, care, and support for chronically ill patients including People Living with HIV. HoC provides sexual and reproductive health services in the context of home-based care. It also provides treatment, care, and support for chronically ill patients to enable them to live a productive and dignified life. These goals are addressed by 37 dedicated and qualified teams of doctors, nurses, social workers, and health administrators.

The service delivery effort of HoC Clinic has been a joint effort of the institution and other partners such as the National AIDS Secretariat, ActionAid International, National AIDS Control Program, National Public Health Laboratory, Central Medical Store of the Ministry of Health, UNAIDS, Africa Palliative Care Association Gambia Armed Forces HIV/AIDS Prevention Program and other Support Societies.

The Population of the Study

The population for this study comprised categories of staff, i.e. Medical, Paramedical, Administrative of the HoC, who are 37 in number, and 1932 patients/beneficiaries of the organisation at the time of data collection. The patients included were HIV/AIDS patients, those with sexually transmissible infection, and other chronic health conditions, including non-communicable diseases. The principal executive members of the two existing Support Societies affiliated with the institution, namely Nganiya Kiling and Allahtentu Support Societies, are also part of the population. The Presidents, Vice Presidents, Secretaries, and Program Officers of the two Support Societies, totalling 8, were also targeted.

Sampling Techniques and Sample Size

The sample size consisted of two categories of respondents which were staff of HoC and patients/beneficiaries. All members of the staff of HoC, totalling 37; and 10% of the 1932 patients/beneficiaries, totalling 193, were sampled for the study. This brings the sample size to 230 respondents. For interview administration, the whole of the senior management of the support societies was sampled for the study, totalling 8. The study targeted this category of people because of the key roles they perform in their capacities as stakeholders and beneficiaries.

In trying to determine the results, simple, convenient, and purposive sampling methods were used to sample the 193 beneficiaries and 37 HoC staff, respectively. The convenience/Accidental sampling method was used to sample the beneficiaries because all of them were not readily available in the same place, which made the researcher target members who were conveniently available to provide the information needed for the study. Despite this, the method ensured that each and every member of the population stood a chance of being included in the sample.

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Table 1: Sample Size Determination Table

S/N	Category	population	Sample size	Sampling technique
1	Patients (HoC)	1932	193	Convenience
2	Health Care Workers (HoC)	37	37	Purposive
3	Total	1969	230	

Source: Fieldwork (2019)

Types and Sources of Data Collection

Both primary and secondary data were used for the study. Primary data were collected through questionnaires, in-depth interviews, and participant observation, while secondary data were sourced from scholarly works in the form of textbooks and journal articles as well as the institution's publications and reports.

The interview conducted gave an opportunity to obtain first-hand information from the respondents of the support societies on their perception of the contribution of HoC in the delivery of basic health services. The two societies were Nganiya Kiling and Allahtentu whose role is mainly advocacy for the People Living with HIV in the society. Participant Observation was the third instrument used to collect data and this gave the opportunity to observe people in their natural work environment by taking an active part in the activities of the group being observed and asking questions and taking note of relevant information.

RESEARCH RESULTS

Socio-Demographic Attributes of the Staff of HoC

The first set of information gathered on the clinical and administrative staff of HoC was their personal data to enable the researchers to fit the workers' personal characteristics with their responses to the issues explored in the study. Besides, such background information on the respondents gave an idea of their composition.

The information gathered on the distribution of staff by category showed that 64.9% of respondents were Clinical Staff, whiles 35.1% were Administrative Staff. This shows that the majority of the staff are clinical. This is in view of the fact that HoC Clinic is a health-related NGO whose primary role is to deliver health services. This is the reason why most of the staff are either medical doctors, nurses, social workers, or counsellors (see *Table 2*). The few other staff play administrative and managerial roles in the day-to-day affairs of the organisation for effective and efficient service delivery. The details are presented in the table below. Out of the 37 respondents, 67.6% were male, while 32.4% were female. The higher percentage of men over women showed that more men were working as staff in the organisation (see *Table 2*).

Table 2: Socio-Demographic Attributes of The Staff of HoC

Characteristics		Frequency	Percentage
Category	Administrative	13	35.1
	Clinical	24	64.9
	Total	37	100.00
Gender	Male	25	67.6
	Female	12	32.4
	Total	37	100.00
Age	20-30	11	29.7
	31-40	11	29.7
	41-50	10	27.0
	51-60	3	8.1
	>60	2	5.4

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Characteristics		Frequency	Percentage
	Total	37	100.00
Marital Status	Married	27	73.0
	Single	8	21.6
	Divorced	2	5.4
	Total	37	100.00
Educational Qualifications	Non-formal education	1	2.7
	Diploma/HND	12	32.4
	BSc/BA	2	5.4
	MSc/MA	4	10.8
	PhD	1	2.7
	CHN	3	8.1
	SEN	2	5.4
	CAN	3	8.1
	SSS	7	18.9
	UBS	2	5.4
	Total	37	100.00
Length of Service	1-5	13	35.1
	6-10	12	32.4
	11-15	2	5.4
	16-20	3	8.1
	21-25	2	5.4
	26-30	2	5.4
	31-35	2	5.4
	>35	1	2.7

Source: Fieldwork (2019)

The analysis of the age distribution of the respondents is presented in *Table 2*. It shows that 29.7% of the respondents were between 20-30 years of age and an equal percentage of those fell between 31-40 years. The remaining distribution goes thus; 27 % were between the ages of 41-50 years, 8.1% were in the category of 51-60, and 5.4% were above 60 years. This suggests that the majority of the respondents were in the range of 20-40 years. Thus, it can be said that the majority of HoC staff are made up of young and active workers. The data gathered on the marital status of the respondents revealed that 73% of them were married while 21.6% were single, and 5.4% were divorced. Thus the majority of the respondents were found to be married (see *Table 2*).

The information gathered on the educational level of respondents as shown in *Table 2*. It showed that 32.4% had attained an HND level of education, 18.9% had secondary education; 10.8% had master's degree, 8.1% were CHN and CNA, respectively, 5.4% had BSc/BA, SEN, and UBS education each, and 2.7% had PhD and non-formal education respectively. The information gathered on respondents' length of service is presented in *Table 2*, and it shows that a reasonably large number of the respondents (35.1%) fell under 1-5 years, followed by 6-10 years (32.4%), 11-15 (5.4%), 16-20 (8.1%), and the rest fell under range 21-35 years of service. The meaning of this is that the institution serves as a stepping stone or a training ground for most young healthcare workers who may want to gain the necessary experience and practical knowledge. Thus, HoC is found to be a Centre of Excellence in terms of training young healthcare workers in health service delivery.

Patients' Socio-demographic Characteristics

From table 8 below, the majority of the patients (81.9%) were Care Patients (CP), 9.8% fell under other Sexually Transmissible Infections (STIs), while the rest (8.3%) were under other conditions. This pattern can be traced to the fact that the centre is the largest ART site that equally oversees twelve hospitals and health centres on home-based care services. The majority of the patients (68.9%) were female, while 31.1% were male. That means the majority of those who sought medical attention were females. It can be observed here therefore that women have greater health-seeking behaviour than

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men. About 33% fell between the ages of 41-50 years, 28% in the age range 31-40, 21 % in 20-30, 11.4% in 51-60, and the rest (6.2%) fell above 60 years. The majority of the patients (59.1%) were married, 18.6 % were widows/widowers, 16.1% were singles, and the rest (6.2%) were divorced. With regard to their education status, the majority of the patients (51.8%) were illiterate, while 48.2% were found to be literate.

Table 3: Patients' Socio-demographic Characteristics

Characteristics		Frequency	Percentages (%)
Category of Patients	Care, patient	158	81.9
	Other STIs	19	9.8
	Others	16	8.3
Gender of Patients	Male	60	31.1
	Female	133	68.9
Age of Patients	20-30	41	21.2
	31-40	54	28.0
	41-50	64	33.2
	51-60	22	11.4
	>60 years	12	6.2
Marital status of patients	Married	114	59.1
	Single	31	16.1
	Widow/widower	36	18.6
	Divorced	12	6.2
Education Level of Patients	Illiterate	100	51.8
	Literate	93	48.2

Source: Fieldwork (2019)

Analysis of Primary Data on Research Issues

Staff Responses on the Examination of the Mission, Vision, and Goals of HoC

In an attempt to elicit information on the institution, questions were asked about workers' opinions on the mission, vision, and goals of the institution in health service delivery. First, workers were asked a question about the institution's capability in the provision of sexual and reproductive health services. The information gathered showed that 91.9% agreed and strongly agreed that HoC provides adequate service in the area of sexual and reproductive health as enshrined in the mission statement, while 2.7% disagreed with the statement, and 5.4% could not decide. Workers were again asked about the provision of treatment for HIV/AIDS and other chronic conditions; a total of 89.2% agreed and strongly agreed that HoC provides treatment for HIV/AIDs and other chronic conditions, while 8.1 % strongly disagreed with the statement.

Again, workers were asked whether HoC contributes individually and collectively to improving the lives of patients. A total of 83.7% agreed and strongly agreed that HoC contributes individually and collectively in a participatory manner to improving the quality of life of all Gambians and non-Gambians alike, while 10.8% disagreed and strongly disagreed with the statement, and 5.4% were undecided. Respondents were also asked whether the institution provides training in the area of sexual and reproductive health and 91.9% agreed and strongly agreed that HoC provides training on sexual and reproductive health, while 8.1% disagreed and strongly disagreed with the statement.

On the mission, vision, and goal of HoC spearheading the provision of effective and efficient home-based/palliative care services, 91.8% agreed and strongly with the statement, 5.4% disagreed and strongly disagreed and 2.7% were undecided. Furthermore, respondents were asked whether HoC sensitises communities on sexual and reproductive health as enshrined in their mission statement and 81% agreed and strongly agreed with the statement;

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8.1% disagreed and strongly disagreed with the statement, and 10.8% were undecided.

Finally, respondents were again asked whether HoC partners with stakeholders in the formulation of health policies and guidelines and 86.4% agreed and strongly agreed with the statement, while 5.4 % strongly disagreed with the statement and 8.1% could not decide. Based on cumulative average responses, the majority of the respondents (88%) agreed and strongly agreed that the aforementioned items reflected the mission, vision, and goals of the institution. The table below shows a summary of the mean cumulative responses.

Table 4: Staff responses on the examination of the mission, vision, and goals of HoC

Variable	SA	A	U	D	SD
Provides adequate service in Sexual and Reproductive health	22 (59.5)	12 (32.4)	2 (5.4)	0 (0.0)	1 (2.7)
Provides HIV/AIDS Treatment and other chronic conditions	25 (67.6)	8 (21.6)	0 (0.0)	1 (2.7)	3 (8.1)
Contributes individually and collectively in a participatory manner to improving the quality of life of all Gambians and non-Gambians alike.	18 (48.6)	13 (35.1)	2 (5.4)	2 (5.4)	2 (5.4)
Provides training on sexual and reproductive health	19 (51.4)	15 (40.5)	0 (0.0)	1 (2.7)	2 (5.4)
Spearheads the provision of effective and efficient home-based care services	18 (48.6)	16 (43.2)	1 (2.7)	0 (0.0)	2 (5.4)
Sensitises communities on sexual and reproductive health including prevention, control, and management of chronic medical conditions	13 (35.1)	17 (45.9)	4 (10.8)	0 (0.0)	3 (8.1)
Partners with stakeholders in the formulation of health policies and guidelines	14 (37.8)	18 (48.6)	3 (8.1)	0 (0.0)	2 (5.4)
Mean Percentage Score	49.8%	38.20%	4.6%	1.5%	5.8%

Key: SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree

Source: Fieldwork (2019)

Staff Responses on the Performance of HoC Clinic in Sexual and Reproductive Health

Table 4 below shows the responses of the staff on the performance of HoC in sexual and reproductive health. Questions were asked about their opinions and the following responses were given. Respondents were asked whether the institution has a well-structured health system, 83.7% agreed and strongly agreed that HoC has a well-structured sexual reproductive health service for patients, while only 2.7% disagreed with the statement and 13.5% were undecided.

Again, staff was asked whether adequate human resources exist for the provision of reproductive health services, and 48.6% agreed and strongly agreed to this, 43.2% disagreed and strongly disagreed, and 8.1% could not decide as to the adequacy of human resources to provide such services. Respondents were also asked whether patients are treated with dignity and respect. A total of 97.3% agreed and strongly agreed that patients are treated with dignity and respect, and only 2.7% strongly disagreed with this.

On the availability of a system being in place for measuring health outcomes in the organisation, 78.4% agreed and strongly agreed that it did exist, 8.1% disagreed and strongly disagreed, and 13.5% were undecided. As per the sufficiency of the level of follow-up care to accurately evaluate the impact of treatment on its patients, 75.7% agreed and strongly agreed that it was sufficient, 10.8% disagreed and strongly disagreed, and 13.5% were neutral.

Furthermore, information was gathered on whether the morbidity and mortality data of patients improved from year to year, and a total of 62.1% agreed and strongly agreed that the morbidity and mortality data had improved from year to year, while 16.2% disagreed and strongly disagreed with the statement and 21.6% undecided. On whether the

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average turnover time of service delivery to patients is impressive, the majority (81%) agreed and strongly agreed that the turnover time is impressive, while 13.5% disagreed and strongly disagreed, and 5.4% could not take any position.

Efforts were also made to gather information on whether there is an effective communication system in the organisation. The majority (89.2%) agreed and strongly agreed that there is efficient communication among staff, while 8.1% disagreed and strongly disagreed, and 2.7% were neutral. Respondents were also asked whether health education provided by the HoC positively impacts the health awareness of the patient population and the majority of the respondents (89.2%) agreed and strongly agreed with the statement, while only a small proportion (5.4%) disagreed strongly disagreed and 5.4% could not decide.

An attempt was also made to find out whether there is a system in place for training local health care providers and the majority (67.5%) agreed and strongly agreed to this, 16.2% disagreed and strongly disagreed, and 16.2% of them undecided. As per HoC keeping records on every patient treated, the overwhelming majority (97.3%) agreed and strongly agreed that the institution keeps records of every patient treated, while only 2.7% disagreed with the statement.

Furthermore, efforts were made to know whether the outcome of each treatment is tracked and recorded in the patient's folder for future reference; the majority (94.6%) agreed and strongly agreed with the statement, while only 5.4% disagreed with the statement. Another issue that determines the performance of HoC is its compliance with WHO standards, where the majority (83.7%) affirmed that HoC meets WHO treatment guidelines and standards while only a small proportion (13.5%) disagreed and strongly disagreed with the statement and 2.7%, could not decide.

Table 5: Staff responses on the assessment of the performance of Hands-on-Care in the area of Sexual and Reproductive Health

Variable	SA	A	U	D	SD
Well-structured reproductive health	14 (37.8)	17 (45.9)	5 (13.5)	1 (2.7)	0 (0.0)
Adequate human resources exist	2 (5.4)	16 (43.2)	3 (8.1)	15 (40.5)	1 (2.7)
Treat patients with dignity and respect	26 (70.3)	10 (27.0)	0 (0.0)	0 (0.0)	1 (2.7)
There is a system in place for measuring health outcomes	8 (21.6)	21 (56.8)	5 (13.5)	2 (5.4)	1 (2.7)
The level of follow-up is sufficient	9 (24.3)	19 (51.4)	5 (13.5)	3 (8.1)	1 (2.7)
The morbidity and mortality data improved	6 (16.2)	17 (45.9)	8 (21.6)	4 (10.8)	2 (5.4)
The average turnover time of service delivery to patients is impressive	12 (32.4)	18 (48.6)	2 (5.4)	4 (10.8)	1 (2.7)
There is an effective communication system	14 (37.8)	19 (51.4)	1 (2.7)	2 (5.4)	1 (2.7)
Health education provided by HoC impacts the health awareness of the patients	23 (62.2)	10 (27.0)	2 (5.4)	1 (2.7)	1 (2.7)
There is a system in place for training local health care providers	7 (18.9)	18 (48.6)	6 (16.2)	5 (13.5)	1 (2.7)
HoC keeps records on every patient treated	23 (62.2)	13 (35.1)	0 (0.0)	0 (0.0)	1 (2.7)
The outcome of each treatment is tracked and recorded in the patient's folder	27 (73.0)	8 (21.6)	0 (0.0)	1 (2.7)	1 (2.7)
HoC meets the WHO treatment guidelines and standard	14 (37.8)	17 (45.9)	1 (2.7)	4 (10.8)	1 (2.7)

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Variable	SA	A	U	D	SD
HoC meets annual service delivery targets	15 (40.5)	12 (32.4)	9 (24.3)	0 (0.0)	1 (2.7)
HoC has professional human resources for effective and efficient service delivery	4 (10.8)	26 (70.3)	5 (13.5)	1 (2.7)	1 (2.7)
Mean Percentage Score	37%	43%	9%	8%	3%

Key: SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree

Source: Fieldwork (2019)

Again, the workers were asked whether HoC meets annual service delivery targets and 72.9% of the respondents agreed and strongly agreed with the statement, while only 2.7% disagreed with the statement and 24.3% could not take any position. The last question on the assessment of the performance of HoC on-health service delivery was to find out whether HoC has professional human resources for effective and efficient service delivery and the majority of the respondents (81.1%) agreed and strongly agreed with the fact that HoC had them while 5.4% disagreed and strongly disagreed and 13.5% were neutral.

Based on individual responses, there were variations regarding acceptance and denial of assessed items towards the performance of the institutions, as shown in the table below. However, based on the cumulative average response, the majority of the respondents (80%) agreed and strongly agreed that the aforementioned items reflected the performance of the institution, while only 11% disagreed and strongly disagreed and 9% could not decide. The table below shows the summary of the mean cumulative response.

Staff Responses on the challenges facing Hands-on-Care in the delivery of health services

This section covers the challenges facing HoC in the delivery of reproductive health services. The first question was whether HoC maintains highly trained human resources for the provision of health services. To this question, 48.6% of the workers expressed that the institution still maintains highly trained staff, while 40.5% were of the view that HoC does not maintain highly trained staff for the provision of health services, and 10.8% were undecided.

The next question is on whether care is negatively affected by resource limitations 83.8% of the workers affirmed that it is negatively affected by resource limitations such as medical supplies, equipment, and lab consumables, while 10.8% of workers disagreed and strongly disagreed, and 5.4% could not decide. On whether the problem of the high staff attrition rate is due to poor remuneration, the majority (81%) expressed that staff attrition at HoC was due to poor remuneration, while only 8.1% disagreed and strongly disagreed with the assertion and 10.8% were neutral (See *Table 6*).

Efforts were also made to ascertain whether resource limitation affects health services delivery in terms of home-based care and outreach health services at HoC. To this, 81% agreed and strongly agreed, while only 13.5% disagreed and strongly disagreed and 5.4% could not take any position. Furthermore, workers were asked about the extent to which reliance on a single donor affects service delivery and the majority (83.8%) indicated that high dependence on a single donor affects health service delivery, 10.8% disagreed and strongly disagreed, and 5.4% were neutral.

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Table 6: Staff responses on Challenges being faced by Hands-on-Care

Variable	SA	A	U	D	SD
HoC maintains highly trained human resources for the provision of health services	3 (8.1)	15 (40.5)	4 (10.8)	14 (37.8)	1 (2.7)
Care is negatively affected by resources limitation (e.g. lack of medical supplies, clinical spaces, utility vehicles, etc.)	10 (27.0)	21 (56.8)	2 (5.4)	3 (8.1)	1 (2.7)
Staff attrition at HoC due to poor remuneration	16 (43.2)	14 (37.8)	4 (10.8)	1 (2.7)	2 (5.4)
Resource limitation (affecting home-based care and outreach health services)	15 (40.5)	15 (40.5)	2 (5.4)	4 (10.8)	1 (2.7)
High dependence on a single source of income affects service delivery	21 (56.8)	10 (27.0)	2 (5.4)	2 (5.4)	2 (5.4)
Stigmatisation and discrimination affect health service delivery	12 (32.4)	16 (43.2)	2 (5.4)	5 (13.5)	2 (5.4)
The unavailability of transport return fares affects the adherence of patients to treatment	13 (35.1)	18 (48.6)	5 (13.5)	0 (0)	1 (2.7)
The abolition of nutritional support to patients affects adherence to treatment	11 (29.7)	20 (54.1)	4 (10.8)	1 (2.7)	1 (2.7)
Services delivery within government facilities limits diversification	17 (45.9)	10 (27.0)	7 (18.9)	2 (5.4)	1 (2.7)
Mean Percentage Score	35.4%	41.7%	9.6%	9.6%	3.7%

Key: SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree

Source: Fieldwork (2019)

On the issue of how stigmatisation and discrimination have affected health service delivery at HoC, the majority (75.6%) were with the view that they affect the provision of health services, while 18.9% disagreed and strongly disagreed with the statement and 5.4% could not decide (See *Table 6*). Respondents were again asked whether the unavailability of transport return fares affects the adherence of patients to treatment and 83.7% of workers affirmed that it increases the defaulting rate, while only a small proportion (2.7%) of staff disagreed and strongly disagreed with the statement and 13.5% expressed no opinion (See *Table 6*).

Furthermore, workers were also asked whether the abolition of nutritional support to patients affects treatment adherence. To this also, the majority (83.8%) agreed and strongly agreed with the statement, while only 5.4% disagreed and 10.8% could not decide. The last question regarding challenges facing the institution in the delivery of health services was whether service delivery within government facilities limits the diversification of service provision. To this, the majority (72.9%) of the staff indicated that service delivery within the government health facility limits the diversification of health services, while only 8.1% disagreed with the statement.

Based on individual responses, there were variations regarding acceptance and rejection of assessed items on challenges being faced by the institutions, as shown in *Table 6*. However, based on the cumulative average response, the majority of the respondents (77.1%) agreed and strongly agreed that the aforementioned items reflected the challenges facing the institution, while only 13.3% disagreed with the statements. The table below shows the summary of the mean cumulative response.

Patients' Responses on the Performance of HoC in Sexual and Reproductive Health

Table 7 shows the responses of the patients on the performance of HoC in-health service delivery. Questions were asked about their opinions and the following responses were given. Respondents were asked whether the institution has a well-structured health system; the majority (96.3%) agreed and strongly agreed that HoC has well-structured reproductive health services to patients and only 2.6% disagreed and strongly disagreed with the statement.

Again, respondents were asked whether adequate human resources exist to provide health services to

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patients, 89.1% agreed and strongly agreed with the statement, and 7.2% disagreed and strongly disagreed with the statement. On the question of whether patients are treated with dignity and respect, the majority of the respondents (95.4%) agreed and strongly agreed that the organisation treats patients with dignity and respect, while only 3.2% disagreed and strongly disagreed with the statement and 1.6% could not assess at all.

With respect to whether the level of follow-up care is sufficient to accurately evaluate the impact of treatment on its patients, 70.4% of the patients agreed and strongly agreed with the statement, while 19.6% disagreed with the statement and 9.8% could not decide. Furthermore, information was gathered on whether the morbidity and mortality rates of patients improved from year to year. The majority of the respondents (74.1%) agreed and strongly agreed with the statement, while 9.3% disagreed and strongly disagreed with the statement, and 16.6% could not decide.

Table 7: Patients' responses to the performance of Hands-on-Care in health service delivery

Variable	SA	A	U	D	SD
Well-structured reproductive health services to patients are in existence	107 (55.4)	79 (40.9)	2 (1.0)	2 (1.0)	3 (1.6)
Adequate human resources exist to provide health services to patients	109 (56.5)	63 (32.6)	7 (3.6)	7 (3.6)	7 (3.6)
HoC treats patients with dignity and respect	153 (79.3)	31 (16.1)	3 (1.6)	3 (1.6)	3 (1.6)
The level of follow-up care is sufficient to accurately evaluate the impact of treatment on its patients.	62 (32.1)	74 (38.3)	19 (9.8)	19 (9.8)	19 (9.8)
The morbidity and mortality rate has improved from year to year	80 (41.5)	63 (32.6)	32 (16.6)	6 (3.1)	12 (6.2)
The average turnover time of service delivery to patients is impressive	66 (34.2)	91 (47.2)	18 (9.3)	16 (8.3)	2 (1.0)
There is an effective communication system in place in the organisation.	112 (58.0)	70 (36.3)	8 (4.1)	1 (0.5)	2 (1.0)
Health education provided by the HoC positively impacts the health awareness of the patient population	147 (76.2)	40 (20.7)	5 (2.6)	1 (0.5)	0 (0.0)
HoC keeps records on every patient treated	130 (67.4)	43 (22.3)	16 (8.3)	3 (1.6)	1 (0.5)
The outcome of each treatment is tracked and recorded in the patient's folder for future reference	140 (72.5)	41 (21.2)	4 (2.1)	4 (2.1)	4 (2.1)
HoC has professional human resources for effective and efficient service delivery	82 (42.5)	93 (48.2)	6 (3.1)	6 (3.1)	6 (3.1)
Mean Percentage Score	56%	32%	6%	3%	3%

Key: SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree

Source: Fieldwork (2019)

Again, patients were asked whether the average turnover time of service delivery to patients is impressive. The majority (81.4%) agreed and strongly agreed that the turnover time is impressive, while 9.3% disagreed and strongly disagreed, and 9.3% could not decide (See *Table 7*). Efforts were also made to gather information on whether there is an effective communication system in place among team members, and the majority (94.3%) agreed that there is efficient communication among staff, while 1.5% disagreed with the statement and 4.1% were undecided (See *Table 7*).

On whether or not health education provided by the HoC positively impacts the health awareness of the patient population, the majority of the patients (96.9%) agreed and strongly agreed with the statement, while only a small proportion (0.5%) simply disagreed and 2.6% could not take any definite position. Respondents were again asked whether HoC keeps records of every patient treated,

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and the overwhelming majority (89.7%) agreed and strongly agreed that the institution keeps records of every patient treated, while only 2.1% disagreed and strongly disagreed with the statement, and 8.3% could not decide (See *Table 7*).

Furthermore, efforts were made to know whether the outcome of each treatment is tracked and recorded in the patient's folder for future reference. The majority (93.7%) agreed and strongly agreed with the statement, while only 4.2% disagreed and strongly disagreed with the statement, and 2.1% could not decide (See *Table 7*). The last question on the assessment of the performance of HoC on-health service delivery was to find out whether HoC has professional human resources for effective and efficient service delivery and a majority (90.7%) agreed and strongly agreed with the statement while only 6.2% disagreed and strongly disagreed with the statement, and 3.1% could not decide.

Based on individual responses, there were variations regarding the acceptance and rejection of assessed items on the performance of the institutions, as shown in *Table 7*. However, based on the cumulative average response, the majority of the respondents (88%) agreed and strongly agreed that HoC has performed based on the aforementioned indicators and only 6% disagreed and strongly disagreed with the statements. The table below shows the summary of the mean cumulative response.

Patients' responses to Challenges being faced by Hands-on-Care

This section covers the identification of the challenges facing HoC in the delivery of reproductive health services as observed by the patients. The first question was whether HoC maintains highly trained human resources for the provision of health services. To this question, 76.1% of the patients agreed and strongly agreed that the institution still maintains highly trained staff, while 13.4% disagreed and strongly disagreed that HoC maintains highly trained staff for the provision of health services, and 10.3% could not decide.

Again, patients were asked whether care is negatively affected by resource limitation. The majority (76.2%) of the patients indicated that care is negatively affected by resource limitations such as medical supplies, equipment, and lab consumables, while 13.5% of patients disagreed and strongly disagreed with the statement, and 10.3% could not decide. Again, patients were asked whether the high attrition rate is due to poor remuneration of staff and the majority (52.8%) expressed that staff attrition at HoC is due to poor remuneration, while only 2.6% disagreed and strongly disagreed with the statement. However, 44.5% of the patients were undecided that high attrition is due to poor enumeration, probably because they did not have access to relevant information on the remuneration package of the organisation.

Efforts were also made to ascertain whether resource limitation affects health services delivery, especially home-based care and outreach health services at HoC. To this, about 70% agreed and strongly agreed with the statement, while only 13.5% disagreed with the statement and 16.5% were undecided. Furthermore, patients were asked to what extent reliance on a single donor affects service delivery and the majority (90.1%) indicated that high dependence on a single donor affects health service delivery, while only 3.2% disagreed with the statement and 6.7% could not decide.

Patients were also asked whether stigmatisation and discrimination affect health services delivery at HoC. To this, an overwhelming majority (88.6%) were with the view that they affect the provision of health services, while 8.8% disagreed and strongly disagreed with the statement and 2.6% could not decide. Patients were again asked whether the unavailability of transport return fares affects the adherence of patients to treatment instruction; a total of 72.5% of the patients indicated that lack of transport fares for patients had increased the rate of default, while only a small proportion (23.8%) disagreed and strongly disagreed with the statement and only 3.6% could not decide.

Furthermore, workers were also asked whether the abolition of nutritional support to patients affects adherence to treatment instruction. To this also, well above half (70.4%) of the respondents agreed and strongly agreed with the statement, while 25.4% disagreed, and only 4.1% could not decide. The last question regarding challenges facing the institution in the delivery of health services was whether

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service delivery within government facilities limits the diversification of service provision. To this, the majority (84.5%) of the respondents indicated that service delivery within the government health facility limits the diversification of health services, while only 3.7% disagreed and strongly disagreed with the statement and 11.9% could not decide.

Based on individual responses, there were variations regarding acceptance and rejection of assessed items on the challenges being faced by the organisation, as shown in *Table 8*. However, based on the cumulative average response, the majority of the respondents (76%) agreed and strongly agreed that the aforementioned items reflected the challenges facing HoC, while only 12% disagreed with the statements and another 12% could not decide. The table below shows the summary of the mean cumulative response

Table 13: Patients' responses on challenges being faced by Hands-on-Care in sexual and reproductive health

Variable	SA	A	U	D	SD
HoC maintains highly trained human resources for the provision of health services	78 (40.4)	69 (35.7)	20 (10.3)	20 (10.3)	6 (3.1)
Care is negatively affected by resources limitation	97 (50.3)	50 (25.9)	20 (10.3)	23 (11.9)	3 (1.6)
Staff attrition at HoC due to poor remuneration	52 (26.9)	50 (25.9)	86 (44.5)	4 (2.1)	1 (0.5)
Resource limitation (e.g. lack of medical supplies, clinical spaces, utility vehicles, etc.)	67 (34.7)	68 (35.2)	32 (16.5)	26 (13.5)	0 (0.0)
High dependence on a single source of income affects service delivery	138 (71.5)	36 (18.6)	13 (6.7)	3 (1.6)	3 (1.6)
Stigmatisation and discrimination affect health service delivery	114 (59.1)	57 (29.5)	5 (2.6)	12 (6.2)	5 (2.6)
The unavailability of transport return fares affects the adherence of patients to treatment instructions.	78 (40.4)	62 (32.1)	7 (3.6)	41 (21.2)	5 (2.6)
The abolition of nutritional support to patients affects adherence to treatment instruction	75 (38.8)	61 (31.6)	8 (4.1)	43 (22.3)	6 (3.1)
Poor service delivery within government facilities limits the diversification of service provision.	83 (43.0)	80 (41.5)	23 (11.9)	4 (2.1)	3 (1.6)
Mean percentage Score	45%	31%	12%	10%	2%
Key: SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree					

Source: Fieldwork (2019)

DISCUSSION OF FINDINGS

Examination of the Mission, Vision, and Goal of HoC in-Health Service Delivery

The mission statement of HoC corroborated the findings of many theorists of human service delivery who stressed the importance of an internal ideology of an organisation. In order to motivate the people delivering services and to provide them with broad guidelines, it is necessary to communicate a clear vision and mission. By having a broader vision before them, people will be able to process a diversity of challenges and justify their own work. Internal ideologies tend to work best by having aspirations. This assertion has been manifested in the workforce of HoC in a number of ways discussed below.

- Provision of adequate services in the area of sexual and reproductive health as enshrined in the mission and vision statement

The majority of staff (91.9%) agreed that the institution provides adequate sexual and reproductive health services. HoC operates through a collaborative approach within the framework of the MoU signed with the Ministry of Health & Social Welfare, using a model of community home-based/palliative care for chronically ill people, including people living with HIV (PLHIV). The institution has grown to a reputable centre of

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excellence in sexual and reproductive health (SRH) as it acts as a base for all activities including voluntary counselling and testing with laboratory backup. The Sexual and Reproductive Health Clinic (SRHC) also functions as a referral centre for government and other health facilities, including community-based and private NGOs with an outpatient service targeting over 100,000 people per year (HoC, 2018 Annual Report).

- Providing treatment for HIV/ AIDS and other chronic conditions as enshrined in the mission and vision of HoC

Based on the findings from the analysis, the majority of the healthcare workers agreed that HoC's activities are in line with their mission, vision, and goals in health service delivery. The institution provides a comprehensive/continuum and confidential sexual and reproductive health services for patients living with chronic medical conditions, including HIV and AIDS living in The Gambia and beyond. HoC is one of the first centres in the country accredited to provide ART services to PLHIV. Anti-Retroviral treatment remains a prerequisite to the continuum of care since it restores immunity, prolongs and improves the quality of life of PLHIV, and as well allays the fears associated with HIV and AIDS. The provision of ART to patients is delivered systematically through a structured process. This includes Pre-ART counselling on the importance of treatment adherence, side effects, safer sex, positive living, and other relevant information**.**

- Contributing individually and collectively in a participatory manner to improving the quality of life of all Gambians and non-Gambians alike.

It was found that HoC provides comprehensive and safe Anti-Retroviral services for PLHIV to improve the quality and dignity of life in collaboration with other stakeholders. It was also gathered that the institution also treats other conditions such as diabetes; hypertension, and other conditions as a means of diversifying its operation to minimise the level of stigmatisation and discrimination against the belief of the majority of the residents that the institution is only a centre for people living with HIV/AIDS.

- Providing training in the area of sexual and reproductive health as enshrined in the mission and vision statement.

Having gained a reputation as a centre for excellence in the fight against HIV and AIDS, the institution recognises that capacity strengthening is a prerequisite for continuous quality service provision. In view of this, HoC continues to be a lead-partner in the training of healthcare professionals of various cadres with the desire to further strengthen the health system in HIV/AIDS comprehensive care.

To further consolidate HoC's lead involvement in institutional capacity strengthening, it was gathered that a team led by the Director of HoC provides clinical mentoring to all existing health facilities that deliver ART services across the country, including the Gambia Armed Forces (GAF), on a quarterly basis to strengthen their capacities for standardised quality HIV comprehensive management/Care. It also conducts training for a number of partners within the country in the same area of HIV/AIDS, incorporating Home-Based/Palliative Care management as an integral part of the program.

- Spearheading the provision of effective and efficient home-based/palliative care services as enshrined in the mission and vision

The qualitative data show that the care services cover chronically ill patients, including those infected with HIV; malnourished children; Tuberculosis (TB), Cerebro-vascular accidents (CVA), diabetic patients; pregnant mothers, mentally and physically challenged, and others. This has maximised the levels of comfort, functionality, and health of the infected persons and supported them towards dignified death. This includes physical, psychosocial, and palliative activities. Offering such a combined service, HoC ensures confidentiality and creates an enabling environment for PLHIV and other chronically ill people. The care for PLHIV also includes a socio-economic arm service with an emphasis on support in income-generating activities and a micro-financing scheme, training of family care givers and home-care volunteers continues to be an essential component of this arm.

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- Sensitising communities on sexual and reproductive health including prevention, control, and management of chronic medical conditions

The clinical, home-based care, and community arms of HoC are interrelated in the provision of effective and efficient care for registered patients. The community arm comprises an extensive IEC program in the targeted communities. The objective of the intervention is to create awareness of HIV and its related issues, including the de-stigmatisation of HIV and AIDS as well as to create an enabling environment for PLHIV. Village sensitisation meetings remain a key integral aspect of the program supported by the Home-Based Care team (staff), volunteers, and peer health educators.

- Partnering with stakeholders in the formulation of health policies and guidelines

In achieving this mission, the HoC team, led by the Director, continues to give technical support to its partners in the HIV response in a number of ways. As gathered from the official records consulted, such support are provided in the following ways:

- HoC serves as a member of the Country Coordinating Mechanism (CCM) representing Civil Society Organizations (CSO)

- Development of training manuals to be used for treatment, care, and support for PLHIV and AIDS and related illnesses.

- Support in the preparation and validation of strategic HIV and AIDS-related documents for the health sector.

- HoC is a seat holder at the national training committee for HIV and AIDS, where its role is well recognised.

- HoC also continues to serve as a centre for capacitating health care workers in various health-related fields such as laboratories, clinical nursing, Home-Based Care/palliative, social work, etc.

- There are specific community/private health facilities that sign MoUs with HoC in delivering home-based/palliative care and these are provided with on-the-job training, monitoring, supervision, as well as technical support based on institutional expertise in this discipline.

- HoC continues to be the national coordinating body for home-based/palliative care, working with eleven (11) other health (ART) facilities across the country.

- Leads the mentoring team, which serves as refresher training for healthcare workers in all ART sites.

- Partners with Africa Palliative Care Association in rolling out the palliative care services in The Gambia.

- Implementing partner for the US Department of Defense HIVAIDS Prevention Program delivering comprehensive HIV/AIDS services for the personnel of the Gambia Armed Forces, their families, and civilians served by GAF.

Assessing the Performance of HoC in Sexual and Reproductive Health in The Gambia.

In an attempt to assess the performance of HoC in sexual and reproductive health, staff, patients, and support societies were engaged in their opinions of the subject matter. According to the responses of the key members of the support societies, HoC provides care support services, financial support, training, administrative support and cost, advocacy, mentoring, and coaching on project implementation. They also revealed that the institution provides the required care and psychosocial support to patients during treatment. The findings also showed that both staff and patients were happy with the performance of the institution in the area of concern in the following ways:

- Existence of well-structured reproductive health services for patients

From the findings on the performance of HoC in sexual and reproductive health, it can be observed that both staff and patients agreed that the institution has well-structured sexual and reproductive health systems. This is with specific reference to voluntary counselling and testing with laboratory backup. This centre also functions as a referral centre for government and other health facilities, including

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community-based and private NGOs with an outpatient service targeting over 100,000 people per year.

- Adequacy of human resources to provide health services to patients

Only 48.6% of staff and a high percentage of patients agreed that HoC has adequate staff for the provision of health services. This is to the best knowledge of the patients. On the whole, staffing is not at a desirable state; although the institution is committed to providing better health services to patients, it continues to face challenges in terms of staffing.

- Treatment of patients with dignity and respect

The findings revealed that the majority of the staff and patients were of the view that HoC treats patients with dignity and respect. This is manifested in patient-staff relations as the majority of the patients prefer the institution to other facilities. Thus, staff must be guided by the dictates of the mission, vision, and goals of the institution, which is mainly to improve the well-being of people regardless of class, religion, ethnicity, or political affiliation.

- There is a system in place for measuring health outcomes in the patient population

Questions were asked about whether there is a system in place that measures the health outcome of the patient population. The majority of the respondents agreed that HoC measures the health outcome of the patients regardless of the type of sickness. These measures are backed by laboratory investigations through CD4, viral load, full blood count, and other related matters as further gathered in the course of the study.

- The level of follow-up care and the impact of treatment on its patients

With regard to this, a large percentage of staff and patients indicated that the level of follow-up care is sufficient to accurately evaluate the impact of treatment on the patients. This is due to the fact that HoC has a very vibrant home-based care team despite challenges with the vehicle and other facilities to work with.

- The morbidity and mortality data improvement from year to year

The findings also revealed that the morbidity and mortality data of patients have improved over time. This is due to the fact that health intervention by a staff of HoC is found to be so impressive. According to most patients, the routine health talks by the institution have improved their level of treatment adherence and, by extension, improved their standard of living. This, they said, has reduced the mortality rate of patients, especially those living with HIV/AIDS.

- The average turnover time of service delivery to patients

On the average turnover time of service delivery to patients, the majority (81%) of the respondents agreed it was impressive. It was observed that the majority of the patients come to the clinic to receive services as early as possible to enable them to go ahead with their individual daily businesses without spending long hours waiting for health care workers. In fact, the majority of the patients confessed that this is one of the reasons for choosing Hands-on-Care over other facilities.

- Effectiveness of communication system among team members.

Findings showed that there is effective communication among members of staff as patients are adequately informed about all service delivery points. This has helped them to access treatment without delay and thereby lessening the level of stigmatisation and discrimination.

- Health education provided by the HoC and its impact on the health awareness of the patient population

Again, findings revealed that health education provided by the HoC positively impacts the health awareness of the patient population. The majority of respondents agreed that health education has, in fact, increased their level of awareness and even adherence to treatment and by extension helped them to live a positive life.

(x) Training of local healthcare providers

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As regards the training of local care providers, the majority of the respondents were of the view that there is a system in place for training local healthcare providers. This is manifested in their routine training for healthcare workers in the institution. This is done through workshops, in-service training, and clinical mentoring.

- HoC keeps records on every patient treated

With regards to record keeping, the findings from the study revealed that there is an efficient record-keeping system in place for each patient treated. This is done through a database and comprehensive filing systems during the registration of patients.

- Tracking of the outcome of each treatment and recording in the patient's folder for future reference

Furthermore, findings revealed that the outcome of each treatment is tracked and recorded in the patient's folder for future reference. The researchers observed that there is a database in place that keeps track of all the treatment outcomes. In addition, a tickler system is also in place to trace defaulters. This is meant to assist the home-based care team in making the necessary follow-ups of the defaulting patients.

- HoC meeting the WHO treatment guidelines and standards

The findings also showed that HoC works in conformity with the WHO guidelines in the treatment of People Living with HIV. The researchers observed that even the UNAIDS highly relies on the institution for the implementation of some programmes. In fact, UNAIDS forms part of the Board of Directors of HoC.

- HoC meeting annual service delivery targets

Despite the challenges facing the institution in terms of finances, HoC still meets the service delivery targets. It should be noted that the dwindling funds from a single donor have started to make a negative impact on some service delivery targets. This was said to have led to the abolition of support for HIV sensitisation and counselling in communities and the reduction of centres supervised by the institution for the provision of prevention of mother-to-child transmission services.

- HoC has professional human resources for effective and efficient service delivery

With regard to the availability of professional human resources for efficient and effective service delivery, HoC is proud to be called a centre of excellence in terms of health service delivery, especially in areas related to sexual and reproductive health. This cannot be unconnected with the fact that there existed enough professional human resources to deliver its services. The researchers observed that HoC now attracts university students from other countries in the sub-region to gather the necessary practical skills as a module during their studies. Internally, the students of the School of Medicine and Allied Health Sciences of the University of The Gambia also visit the institution for practicals and internships. All these attest to the fact that HoC is efficient in its area of specialisation.

The Identification of Challenges Being Faced by HoC in the Delivery of Health Services

The section covers the challenges facing HoC in the delivery of health services. The findings revealed that the institution is facing numerous challenges that hamper effective and efficient service delivery in the institution.

- The problem of maintaining highly trained human resources due to poor remuneration

Findings revealed that HoC used to maintain highly trained staff for the provision of health services but a few ones remaining with the institution due to their passion for the job. Besides, the younger healthcare workers continue to leave the institution at an alarming rate due to so many factors, among which is poor remuneration, which was found in the course of the study to have led to a high attrition rate. However, most of the patients were not sure whether staff attrition was due to poor remuneration but observed that they know some staff who are no longer with the organisation have dwindled their level of confidence in the organisation.

- Resource limitation (e.g. lack of medical supplies, clinical spaces, utility vehicles, etc.)

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Although HoC is found to be effective in health services delivery, it continues to face challenges due to resource limitations. This is because the organisation offers health services at no cost to patients, which makes it difficult to adequately provide some resources for effective health service delivery. This is further revealed in the responses of respondents as the majority of them cited cases where they were required to conduct some medical examinations outside the facility in view of the fact that the required equipment was not available to carry out such investigations. Also cited was the transportation problem that affects health service delivery for home-based care and outreach services. The institution is highly reliant on Global Fund Project for mobility and by extension, service delivery. That is to say, the service delivery capability of the institutions is donor driven. The researchers observed that there is only one functional vehicle for both staff and patients. The only ambulance in the institution that takes care of routine errands such as home-based care, ambulance services, food run, and transportation of samples to reference laboratories is no more functioning optimally.

- High dependence on a single source of income by HoC

This variable deals with the dependence of the institution on a single donor. The findings showed that HoC relies only on Global Fund for the delivery of reproductive health services, and this continues to affect its performance. Thus, the lack of budget allocation from the government to the biggest HIV/AIDS treatment (ART site) shows the lack of commitment from the government to invest highly in health services. This further corroborates the finding of Edimond (2014), who argued that a good number of NGOs depend on donor funding which may not be consistent or reliable. This lack of funds affects the HoC activities because they are unable to maintain the required level in terms of service delivery.

- Stigmatisation and discrimination affecting health services delivery at HoC

This variable measures how the level of stigmatisation and discrimination has been affecting service delivery. In this study, the findings showed that stigmatisation and discrimination affect the institution's service delivery. This is because the organisation is known to be a treatment centre for people living with HIV, which has made it difficult for some people to seek medical attention from the clinic.

- Unavailability of return transport fares and adherence of patients to treatment instruction

This variable shows the relationship between adherence to treatment instruction and the level of poverty. The findings revealed that there is a correlation between poverty and adherence to treatment. Based on the opinions of the respondents, it could be observed that some patients default due to their inability to afford transport fares to access services. The researchers noticed that the abolition of the transport fare that was normally being refunded to patients affects the level of adherence to treatment instruction. This was also gathered during interaction with some defaulters who confided in the researchers that they could not afford fares to access treatment at the clinic.

- The abolition of nutritional support to patients affects adherence to treatment instruction

The findings showed that the abolition of nutritional support to patients also affects their adherence to treatment instruction. Most patients were of the opinion that nutritional support was used to help them in the treatment process as it reduces the burden on them to struggle for food in view of the fact that most of them need highly nutritious food to keep them healthy. This corroborates the finding of Gassama & Kao (2018) who argued that the respondent who reported "not eating food" as a reason for missing ART doses could benefit from social support from family members or any other significant person**.** According to him, such support can be in the form of food and other basic needs that can significantly contribute to promoting adherence to treatment instruction since some HIV-infected patients on ART may not have a stable source of income.

- Service delivery within government facilities limits diversification of service delivery.

With regards to service delivery within government facilities, the findings revealed that service delivery

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within government facilities had affected the diversification drive of the organisation. This is because the space available is not big enough to diversify health services. Thus, HoC is operating in a government facility based on the Memorandum of Understanding. All these challenges were also highlighted by both the Nganiya Killing and Allahtentu Support Societies during the interview.

CONCLUSION AND RECOMMENDATIONS

The purpose of this study was to explore the role of Non-Governmental Organizations in health service delivery with particular reference to HoC. On the whole, the HoC's work is in tandem with its vision, mission, and goals which are to improve the well-being of Gambians and non-Gambians alike through the provision of better healthcare services. On a final note, the study revealed that NGOs are indispensable in the development of a country as they fill the gap where government fails to perform.

The cumulative response of staff, patients, and support societies revealed that despite the numerous challenges confronting the institution, its performance in health service delivery had been found to be very impressive because of its well-structured reproductive health system, treatment of patients with dignity and respect, system being in place for measuring health outcomes of patients, the level of follow-up care and its impact on patients, improved morbidity and mortality data, average turn over time of service delivery to patients being impressive, effective communication system among members of staff, regular health educations to patients, training of healthcare workers, well-structured record-keeping system, meeting the WHO treatment guidelines and standards, meeting annual service delivery targets and professionals being in place for the provision of health services.

The cumulative responses of the respondents also revealed that HoC is facing numerous challenges in the provision of reproductive health services in particular and health service delivery in general, especially in the areas of staffing, inadequate supplies and health equipment, small working space, inadequate mobility, and overall resource limitation due to heavy reliance on a single source of funding for service delivery. The findings also revealed that the determinant of quality service delivery included adequate staff remuneration, better working conditions, availability of medical supplies and equipment, and strengthening of the patient-provider relationship.

To this end, it is imperative to offer a number of recommendations. First, the government should allocate a special budget for HoC for the provision of comprehensive sexual and reproductive health services. It is believed this would help in the provision of better resources to the health facility so that clinical staff (doctors, nurses, laboratory assistants, counsellors) could improve on their full potential through the availability of these resources for the improved well-being of the populace especially people living with HIV and other chronic conditions. By doing this, the government would have complimented the efforts of the donors to mitigate the problem usually associated with over-reliance on a single source of funding. This will assist the institution in areas like the provision of necessary facilities such as medical supplies and clinical spaces; nutritional support. Provision of vehicles for home-based care and outreach services and follow-up treatment, payment of salary, and improvement of same to be able to attract world-class human resources and reduce staff attrition rate, and so on.

Second, the government should conduct an in-depth evaluation of the NGOs to review key issues of efficiency in the organisations, equity of service, resource mobilisation, collaboration and referral systems between NGOs and government, community mobilisation mechanisms, and quality of service. This will provide some mechanisms for strengthening the already assisting efficiency in the NGOs.

Third, the government should step up the public enlightenment campaign, especially with respect to stigmatisation and discrimination against the patients so that they can boldly come out for treatment and enjoy the services being provided by HoC. There is also a need for the organisation to always place more emphasis on some of the other intervention areas different from HIV/AIDS in order to lessen the level of stigmatisation.

Efforts should also be made to improve the working conditions of the staff in the form of salaries and incentives, overtime, compensation, provision of a

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better working environment, risk allowances, etc., to reduce the attrition rate due to low remuneration. This is critical in maintaining and retaining highly trained staff in the institution. It should be noted that without this, HoC's status as a centre of excellence in HIV comprehensive care may be compromised in the future due to the continuous loss of highly trained staff that are replaced with none professionally trained personnel.

Finally, HoC should intensify its resource mobilisation efforts with other partners to complement Global Fund and government efforts for its sustainability. This is necessary now that the institution experiences dwindling funds from the only source supporting it presently. This will enable the institution to reintroduce and strengthen the nutritional and educational support as well as a refund of transport fares already abolished and which have been known to be critical to the adherence of most patients to treatment.

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