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GAMBIA - Wheeler, M.

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National Health Project - The Gambia - Credit 1760 - P000812 - General
Correspondence - Mark Wheeler

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1 **1** OF **1**

PHNPR

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START
HERE

**MARK WHEELER, CENTER FOR HEALTH ECONOMICS, UNIVERSITY OF YORK,
YORK YO15DB, ENGLAND. GREATLY REGRET I COULD NOT REACH YOU BEFORE
YOU LEFT MANILA. CONTINUED DELAYS IN BANJUL. ALL CONTRACTS
REQUIRE ADDITIONAL LEVEL OF GOVERNMENT APPROVAL. HOPE OLDFIELD
INFORMED YOU. WILL TELEX IF SITUATION IMPROVES DURING MISSION.
WILL MISS YOUR HELP DURING MISSION. ALL THIS IMPLIES JANUARY
APPRAISAL. BEST REGARDS. NANCY BIRDSALL, WORLD BANK**

END
OF
TEXT

PINK AREA TO BE LEFT BLANK AT ALL TIMES

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Dear Nancy,

Please find enclosed a contact address for the next few weeks. Up to the date of my departure, I had heard nothing from anyone in Banjul. If I don't hear something before I am due to leave Manila on 14 July I will dawdle back

Best wishes

Mark.



UNIVERSITY OF YORK
CENTRE FOR HEALTH ECONOMICS
YORK, YO1 5DD, ENGLAND
TELEPHONE 0904 59861
TELEX 57933 YORKUL

MARK WHEELER

11 June to mid July

% Social Infrastructure Division

Asian Development Bank

P. O. Box 789

Manila

Philippines

Telephone 831 72 11 or 831 72 51

Telex (RCA) 23103 ADB PH, (ITT) 40571 ADB PM, (ETPI) 63587 ADB PN

23103

M. Wheeler
19/4/85

Ministry of Health, Labour and Social Welfare

Telephone numbers: 242 }
 244 } ext 4
 245 }

(Health Planning Unit: Prof Williams
Mark Wheeler (to 30/4/85)

in default of above :-

BANJUL 8624 (Permanent Secretary
direct line)

8607 (Under Secretary
direct line)

she's address ^{re}
Mark Wheeler contact at
Center for Health Economics
University of York.
YORK YO1 5DD. as from May 02/85

Presumable

The total cost of construction schemes to be financed under the IBRD/ADB Health Sector Project is \$4.828M, of which \$4.463M represents the estimated value of construction at 1985 prices, the balance being loose equipment and furniture. The main items of work

Consultant
to be engaged
\$2.572
Project
Architect
\$1.891

total project
IDA + ADB
\$3m + \$5
+1.2 million
1987 construction
1988 construction

- 1. Bousang Hospital Phase 1 Redevelopment
- 2. Community Health Nurse Training School
Relocation of existing school.
- 3. Polyclinic, Independence Drive, Banjul
replaces existing outpatient dept at Royal Victoria.
- 4. New Health Centre, Fajikunda
- 5. Upgrading 24 existing health units
13 HC's 11 disp = 23

Further details of each of the above will be found in the attached "Schedule of Construction Components."

Management of design work

It is assumed that the actual construction work will be phased, and that the design work can be phased correspondingly. It is further assumed that by the time of appraisal, it will NOT be necessary to produce full tender documentation, but only sketch outlines and preliminary cost estimates.

correct

The programme lends itself to the possibility of a split between items 1-4 above, valued at \$2.572M and item 5, valued at \$1.891M. It is suggested that

has established

the first four items be treated as a package to be undertaken by a consultancy firm, producing re-contract documentation in stages. Item 5 is not suitable for ~~contracting~~ ^{out} to a design consultancy because it entails prolonged in-country residence and site attendance. It would best be covered by the employment of a salaried architect, who might over a period of say, four years, combine preparation of designs and supervision of construction on items 5 with supervision of construction on items 1-4.

Phasing of design work

Items 1-4: Phase 1 (Up to Appraisal in November 1985)

Preparation of sketch outlines ~~and preliminary cost estimates~~ and preliminary cost estimates for all items.

11/85 N.B. If IBRD Appraisal Mission needs full contract ^{not essential} documentation of at least a sample of total construction, item 1 could be advanced to that stage, provided work starts promptly in May 1985, and very sketchy details of items 2-4 are acceptable. However, except for appraisal requirements, there is no advantage in accelerating this stage. With works of renovation and repair as are involved in item 1, further deterioration in existing fabric is likely to occur between completion of design work and start of construction, necessitating a post-appraisal revision of plans and cost estimates!

why? erosion?

Project Effectiveness

~~late~~ (late)

Phase 2 (up to ~~late~~ 1986)

Detailed drawings, specifications and bills of quantities for items 1 and 2.

Sketch outline drawings and preliminary cost estimates for items 3 and 4

Phase 3 (up to mid-1987)

Production of detailed drawings, specifications and bills of quantities for items 3 and 4.

Item 5 — Project Resident Architect's Programme

Phase 1 (up to Appraisal in November 1985)

Preparation of sketch outlines and preliminary cost estimates for a representative sample of sites. If required for appraisal purposes, documentation on one or two sites could be advanced to contract stage

Phase 2 (up to Project Effectiveness in late 1986)

Preparation of detailed working drawings and specification for first ~~group~~ construction group of 6-8 sites.

Preparation of sketch outlines and preliminary cost estimates of all outstanding sites.

Phase 3 (first year of Project Effectiveness — 1987)

Supervision of construction of items 1 and 2.

Supervision of construction of first group of sites under item 5.

Preparation of detailed designs for second group of ~~health~~ health centre/dispensary upgrading (8-10 sites).

Phase 4 (second year of Project Effectiveness - 1988)

Supervision of construction of items 3 and 4
Supervision of construction of second group of sites under item 5.

Preparation of detailed designs for third group of health centre/dispensary upgrading (8-10 sites).

Phase 5 (part of 1989)

Supervision of construction of third group of sites under item 5.

N.B. The preparation of contract documents for item 5 will also require the services of a quantity surveyor. It is assumed that these may be provided either by the Contracts Officer, PWD or by local consultants. These works may be tendered on the basis of drawings, specification and schedule of rates rather than bills of quantities.

Selection of Architects
Invite submissions from
selected firms? - 00 Senegal
2-3 firms capable

Cost Estimates

Advice has been received that the scale fee applicable to works of this type is 11% for architects and 4½% for quantity surveyors, of which 75% is payable in respect of ^{the} contract services in the case of architects and 50% in the case of quantity

How are
the scales
governed in
Senegal?

surveyors. Using these fees, the cost estimate for items 1-4 builds up as follows:-

	Phase 1	Phase 2	Phase 3	Total
Architect	84 067 (max)	balance	balance	212 190
Q. S.	22 928 (max)	balance	balance	57 870
	106 995	balance	balance	270 060
Probable phasing:	75 000	150 000	45 060	270 060

The costs of the resident architect, together with support services (drawing office, travel, ^{post-contract?} Quantity Surveyor) are put at \$50,000 per annum, running from mid-1985 to mid-1989, for a total of \$200,000, giving a total for all design services of \$470,000 (just over 10% of estimated construction costs, all at 1985 prices). It is possible that the architectural and quantity surveyor fees could be negotiated at a lower level.

Phasing of design costs

Assuming half annual costs for the resident architect in the period up to appraisal, and a further year before project effectiveness, ~~the~~ combined with the probable phasing of fees to consultancy firms indicated above, results in the following schedule:-

		\$
Phase 1	(up to appraisal, November 1985)	100,000
Phase 2	(up to project effectiveness, late 1986)	200,000
Phase 3	(calendar 1987)	95,000
Phase 4	(calendar 1988)	50,000
Phase 5	(to mid 1989)	25,000
		<u>470,000</u>

Schedule of Construction Components

	DM	\$ M
1. <u>Bansang Hospital Phase I Redevelopment</u> (source: Reilly Report / HRG/CRU Rev 2) Project Outline: Hospital Development Programme		
(i) Conversion/rehabilitation children's wing	2.054	
(ii) Dental, ANC, OPD	1.000	
(iii) Site fencing, drainage	0.080	
(iv) Alteration/extension theatre suite	0.225	
(v) Reorganisation/additions main block	0.216	
(vi) Rehabilitation Isolation Ward	0.181	
(vii) Other works	0.320	
	<u>4.076</u>	<u>1.019</u>

Equipment - notional sum D900,000 = \$225,000

Pre-equipment list should be prepared by appraisal

2. Community Health Nurse Training School, Bansang
(source: HRG/CRU Rev 2)

(i) School buildings: classrooms	0.100	
(ii) Dormitory	0.250	
(iv) Staff houses x 4	0.130	
	<u>0.480</u>	

Equipment - notional sum \$ 20 000

→ Dolasie ←

3. Independence Drive, Banjul, Polyclinic DM \$ M
 (Source: Reilly Report)

(i) General outpatient services	2.870	
(ii) NCH services	.700	
	<u>3.570</u>	<u>0.893</u>

Equipment and furniture included in above

4. New Health Centre, Fajikunda
 (Source: 11 Wheeler estimate derived from Gunjur, Serrekunda) 0.180

Equipment and furniture, notional sum \$20,000

5. Upgrading ²⁴ Existing Health Units
 (Source: HRG/CRU Row 2)

(i) Health Centre, minor works x 8	0.960	} relationship to HC
(ii) Health Centre, major reconstruction x 5	3.000	
(iii) Dispensary, minor works x 6	0.360	
(iv) Dispensary, major reconstruction x 5	0.600	
(v) New stall houses x 7	0.910	
(vi) Electrical supplies	1.075	
(vii) Water supplies	0.660	
	<u>7.565</u>	<u>1.891</u>

Equipment and Furniture, notional sum
D 400,000 = \$100,000

TOTAL CONSTRUCTION COST (excluding equipment)	<u>4.463</u>
TOTAL COSTS including loose equipment and furniture	<u>4.828</u>

STATEMENT OF NEED
BANSANG HOSPITAL

When the Working Group concluded its discussions on Bansang Hospital, no consolidated statement equivalent to the Statement of Need for RVH was drawn up. The present document attempts to remedy that deficiency. It draws on the Statement of Hospital Development Policy; the report of Group C on Bansang Hospital; and the minutes of the fourteenth meeting of the Working Group held on 4/8/84.

The Statement of Hospital Development Policy

The Statement refers to the priority given to primary health care and observes the corollary, that resources for hospital services will increase more slowly than for the health service as a whole. It envisages that within the public hospital sub sector, most of the additional resources will be allocated to acute general services rather than long stay institutions. Taking account of the likely rate of growth of total resources, and the relative shift of resources in favour of non-hospital services, it has been determined that the capacity will exist by the year 2000 to finance and staff around 150 - 160 beds in general hospitals. Of these, around half will be allocated to Bansang Hospital, to raise its effective bed complement from 72 at present to 150 beds. The following quotation from the Statement refers specifically to the role of Bansang Hospital:-

"Bansang Hospital will be developed to a level slightly below the RVH. There will be clinical specialist departments of general medicine, general surgery, obstetrics and paediatrics, but the minor specialties*... will not be provided at Bansang. The present bed complement of 72 is quite insufficient, and the planning target for the year 2000 is 150 beds. At full development, Bansang Hospital will be able to provide a good referral service to the eastern part of the country, and will need to transfer only a small percentage of patients to the minor specialty services in Danjui".

The Hospital site

The hospital site, adjacent to the bitumenised Soma-Basse road, is gently sloping over most of its area, and sufficiently spacious to permit long term development. Although staff housing encloses the hospital buildings on all sides except the road frontage, the interior space is more than adequate for all the developments envisaged. The western third of the site has been occupied by the State Enrolled Nurse Training School and associated staff housing; some encroachment by squatter settlement on this boundary has taken place. The site as a whole is unfenced, allowing the free passage of animals and casual visitors, which is detrimental to both amenity and security. A major constraint on staffing has been the shortage of housing, and the poor quality of the available staff houses. However, a programme of rehabilitating the oldest houses on the site has commenced, and the total stock of senior staff houses in Bansang has been augmented by construction for the SEN School and the Regional Health Team Headquarters. A contributory factor to the deterioration of housing and hospital buildings is the presence of severe soil erosion; there is a need for surface water drainage measures over the whole site. Landscaping, especially in the form of tree planting, could help to control the erosion problem and at the same time reduce the intrusion of wind blown sand during the dry season.

Fencing essential for hospital

A special feature of the hospital is the presence of the Chinese Medical Team, for whom certain allocations of space have been made in the existing buildings which would not necessarily have a place in the longer term future.

* Since the above passage was written, the revised version of the Gambia Eye Health Plan envisages that Bansang would be one of two secondary Eye Centres. The precise implications of this for resources have not been specified.

(* See page 1).

Medical and Surgical wards

The present organisation of the main ward block is division by sex, with males occupying the ground floor and females the upper floor. Each floor is divisible into wings and could therefore accommodate a division between medical and surgical patients. At present, the upper floor accommodates female medical, female surgical, obstetric and paediatric patients. Deliveries take place in a small subdivision of this ward. The existing accommodation is severely overcrowded, and the delivery facilities totally inadequate.

Since the future requirement is put at 70 beds for male and female medical and surgical services, and this is approximately the capacity of the main ward block, where these categories of patients are presently treated, the presumption naturally arises that the block will continue to be used for these purposes, and the maternity and paediatric services will be provided elsewhere (however, other configurations are possible). It is regarded as highly desirable that surgical and obstetric accommodation should be located on the same ground floor level as the operating theatre suite. This implies that the ground floor of the present block would in future accommodate male and female surgical patients, while the upper floor (to which the only access is by stairs) would accommodate male and female medical patients. This re-allocation would entail provision of additional toilets and showers on each floor.

Maternity ward

It is regarded as a priority that maternity services be re-provided at the earliest possible opportunity. The interim requirement is for 20 lying-in-beds, plus delivery suite; the eventual requirement is for 30 beds. This interim need might be met by rehabilitation and conversion of part of the existing unused paediatric ward; alternatively, totally new construction may be justified.

Paediatric ward

There is an interim need for 20 paediatric beds, and an eventual requirement for 40 beds. Although the existing paediatric ward was constructed only a few years ago, it is presently unused owing to the discovery of gross structural defects. It remains to be determined whether the building can be rehabilitated and converted at an economic cost, or whether demolition and total replacement would be more satisfactory. It is proposed that, either by conversion of the present building or by new construction, a unit combining accommodation for maternity and obstetric services should be developed to serve an interim period. At a later stage, a new paediatric ward should be built, the combined unit then serving obstetric patients only.

Isolation ward

The present position is that there is no ward permanently used and designated as an isolation ward. Existing arrangements are purely makeshift and dictated by lack of staff and accommodation. There are potentially several different categories of patient for whom some degree of segregation may be justified. These include cases of highly infectious disease, e.g. measles (mostly in very young children); sputum positive TB cases; and reactive leprosy cases (the latter two mostly in adults). To meet these various needs, ideally a facility is required whose use can be completely flexible among all ages and both sexes, and greatly differing requirements for nursing care. The capacity of this unit should be around 10 beds. This need might be met by returning the block now used by the administration to its former use as the isolation ward.

Medical service departments

The present operating theatre suite, though not ideally located at the front of the hospital site, and lacking certain ancillary accommodation, is nevertheless regarded as acceptable, and with modifications should serve out the present planning period (i.e. up to the year 2000).

The modifications needed are provision of doctor and nurse changing rooms, and the possible conversion of the present ante-room into a second operating theatre. These additions might be obtained by closing off and extending the present verandah area.

In the distant future the need will probably arise for total re-provision of the operating theatre suite, and an appropriate location for this development should be taken into account in framing the master plan for the hospital.

A similar situation obtains with regard to the X-ray and laboratory services, in that while in the distant future they will probably need to be relocated, within the planning horizon the present facilities, with some improvements, are regarded as adequate. There is a need to provide the X-ray department with patient changing accommodation and a plate store. The laboratory needs a toilet where patients can give specimens. The pharmacy is adequate for all needs envisaged.

There is at present neither CSSD nor physiotherapy department at Bansang. The best opportunity to develop a CSSD will probably come with the advent of a new theatre suite, for which space should be allotted but no detailed design is necessary in the current exercise. Similarly, it is necessary to identify a location for a future physiotherapy department, but it is unlikely to figure in the development programme until the next decade.

Outpatient services

Outpatient services are not well accommodated at present. General outpatients are divided into two; one group attends the consulting rooms of the Chinese medical team, which are located in the former private block. Patients wait under a lean-to shelter attached to this building. It is considered that this area will serve appropriately for consultant clinics in the future staffing configuration of the hospital

The second group of patients utilising the traditional outpatient service wait in the covered area in front of the medical officer's room; the nurse/dispenser does his consultations in this area, referring a proportion of patients to the doctor. Standard tablet prescriptions are dispensed on the spot, others are collected from the pharmacy in the same block. Dirty dressings are done in a partly screened shelter to the rear of the outpatient block, and injections are done in a small room near the theatre. There is an obvious need to re-arrange the accomodation to provide a better flow and greater convenience for staff and patients.

Ante natal clinics and child welfare clinics are held under an improvised but sturdy shelter added to the rear of the main block. However, there are no proper facilities for ante natal examinations and the taking of specimens, and all equipment has to be collected up and stored in a nearby room between clinic sessions. The obvious limitations of this accomodation have prompted the suggestion of a new facility, possibly on the lines of the new Gunjur outpatient block, to be built in conjunction with the new or refurbished maternity and paediatric ward(s).

Dental department

The existing accomodation in a once mobile caravan is hot and cramped and will soon cease to exist. Total re-provision of accomodation for a 2 - chair unit is urgently needed.

Administration

There are competing uses for the block now used for administration, including its reconversion to an isolation ward as discussed above. If this were to occur, the administration service would need to be accomodated elsewhere. One possibility which has been suggested is in the former kitchen and laundry block (currently used for construction materials).

Space needs to be allocated for medical records.

Maintenance unit

The only representation of the unit outside RVH at present is 1 electrician based at Bansang Hospital. However, it is intended that there should be a small team serving the buildings maintenance needs of all health facilities in the eastern half of the country. It was previously decided that the base for this service should be at the Regional HQ rather than the hospital; however, there may be more appropriate accommodation available at the hospital, including the former kitchen and laundry block (mentioned above as possible accommodation for administration), and the former garage now converted to a workshop by the Chinese Construction Team.

Kitchen, laundry and stores

These services are housed in a new building, and have adequate capacity to service a hospital of the planned size (i.e. around 150 beds by the year 2000). The only addition proposed is a covered drying area, so that the laundry service is not solely dependent on mechanical drying during the rains.

Site and services

There is a need for surface drainage over the whole site area, which is badly eroded by run off from the hill behind the hospital. There is a need to trim existing mature trees on the site, and to plant new trees both as an erosion control measure and to reduce the nuisance from dust. The whole site needs to be provided with a boundary fence, and some internal fencing for security of staff housing and controlled access to impatient areas would be desirable.

GUC supplies both water and electricity to the site. Neither service is satisfactory. The electricity supply is subject to severe voltage fluctuations and occasional interruptions.

There is a need for a voltage stabiliser and a standby generator. The water supply is grossly discoloured by dissolved chemicals, which GUC attribute to the borehole source (however, this explanation is dubious, since other consumers from the same source receive clear water. There may be a need for extensive replacement of water mains).

A new sewage treatment plant, consisting of shallow lagoons, has been constructed on the north side of the main road. This appears to have surplus capacity at present: however, the system is capable of ready extension.

Development of Inpatient Capacity

It may be helpful at this point to summarise the proposals as they relate to the increase in bed numbers. Three time periods are envisaged: the present, an interim period of uncertain duration, and the final period up to the year 2000 (the developments proposed may be realised well before that date).

Department	Present allocation	<u>Bed numbers</u>	
		Interim allocation	Final allocation
Male medical and surgical	35	35	35
Female medical and surgical	} 35	35	35
Paediatric		20	40
Obstetric		20	30
Isolation	2	10	10
TOTAL	<u>72</u>	<u>120</u>	<u>150</u>

N.B. These bed numbers should be regarded as approximate only; they may be adapted in detail to accommodate architectural considerations, provided the overall totals are not exceeded.

Probable sequence of developments

1. Rehabilitation of existing staff houses 1983 - 1986.

2. Construction of staff houses for SEN School, and extensions to SEN School 1984 - 1985.
3. Provision of interim capacity maternity and paediatric wards; replace dental department; surface water drainage and fencing site; ante natal and child welfare clinics; reallocation of outpatient accommodation
4. Extensions to theatre suite; reorganisation of male and female medical and surgical wards; isolation ward; administration transfer to new/refurbished accommodation; physiotherapy
5. Further expansion of paediatric and obstetric wards (1990s)

TERMS OF REFERENCE FOR ARCHITECT(S) ENGAGED FOR THE HEALTH SECTOR
PROJECT

1. The architect will be required to prepare plans for the construction or upgrading of the following units:-
 - (i) Bansang Hospital
 - (ii) Community Health Nurse Training School
 - (iii) ¹³14 Health Centres (including 2 new urban health centres)
 - (iv) 11 Dispensaries

2. In the case of Bansang Hospital, the architect will provide a master plan for the spatial development of the site, including all developments envisaged up to the year 2000 in the document "Statement of Need for Bansang Hospital". He will prepare detailed plans suitable for inclusion in the tender documents for the first phase redevelopment of the hospital, as detailed in the document "Project Outline: Hospital Development Programme". These documents constitute the initial briefing for this project component.

3. In the case of the Community Health Nurse Training School, the architect will produce sketch outline plans of the development envisaged, in the form of extensions to the State Enrolled Nurse Training School or as an entirely separate facility, in accordance with policy developed in the light of recommendations of the consultant on nurse training.

4. In the case of health centres and dispensaries, the architect will produce sketch outline plans for developments to be financed under this project, as described in the document "Project Outline: Basic Health Services Development Programme" (and in the case of the Independence Drive, Banjul urban health centre the document Project Outline: Hospital Development Programme). For a total of 6 sites (not including the two wholly new developments) he will produce detailed plans suitable for inclusion in the tender documents.

5. The design brief for each of the developments detailed above will be assembled by the Health Planner, who will be the point of contact between the Ministry of Health and the architect, and through whom guidance and where appropriate instructions for changes in the design brief will be channelled.
6. The architect will be provided with design office facilities in the office of the Director of Technical Services, and with the assistance of a local draughtsman engaged exclusively on project work. He will be required in the later stages of the work to collaborate with the Quantity Surveyor in the preparation of contract documents for the items detailed in paragraphs 2 and 4 above, which will constitute the first phase of construction work to be undertaken under this project. The architect will be required to seek guidance from the Director of Technical Services on the style of documentation required for tender documents and drawings in The Gambia.

consultant?

Duration:

Possible alternatives for execution:

- (i) Chinese (doubtful if they can meet conditions at 6)
- (ii) Fry Drew (hive off Bansang Hospital).

Need for quantity Surveyor

Need for local draughtsman.

consultant ? locally available ?

PROJECT OUTLINE

MINISTRY OF HEALTH, LABOUR AND SOCIAL WELFARE HOSPITAL DEVELOPMENT PROGRAMME

S U M M A R Y

This document sets out the rationale for the modest programme of developments to the two Government general hospitals in The Gambia. While the overall strategy gives priority to the extension of Primary Health Care services, because the complementary relationship between primary and referral care is recognised, it is considered essential to improve the present inadequate hospital facilities. The specific schemes now proposed represent in each case the initial phase of Master Plans for the development of each hospital, which are in turn consonant with overall policies for the role of hospitals in the context of health sector development. The principal component of the scheme at the Royal Victoria Hospital, Banjul, is the reprovision of mains engineering services and the consequential refurbishment of existing wards. At Bansang, the main item is additional accommodation to relieve the present dire shortage of space for maternity and paediatric patients. It has been ascertained that the incremental staffing needs can be met within the period.

Background to the Hospital Master Plans

The present proposals for the development of the Royal Victoria Hospital, Banjul, and Bansang Hospital, stem from the work of a planning group established in May 1983. From the outset, the group intended to produce a master plan for each site, foreshadowing developments up to the year 2000, reasoning that, since for financial and other reasons, development would inevitably take place by

instalments, it was important to have an overall structure into which each individual scheme could fit consistently with the ultimate design. What distinguishes the present proposals from earlier schemes derived from a long-term sketch outline plan is that the physical planning has been placed firmly in the context of the overall sectoral development plan.

The planning group approached its work in stages, the first culminating in the publication of a "Statement of Hospital Development Policies". The second stage involved the refinement of the medical service planning for each hospital, within the framework of the statement of policies. The third stage entailed determining the schedule of accommodation required to sustain the planned medical services, and comparing this with the schedule of available accommodation to identify deficiencies. The fourth stage was to have consisted of sketch designs embodying alternative layouts of the existing and incremental accommodation, together with estimates of the costs of works required. In point of fact, owing to the limited availability of architectural resources, the fourth stage has been abbreviated, and the cost estimates are derived from the schedules of accommodation (as is common practice at the preliminary planning stage).

up to
3rd stage
completed
balance
detached accom
available

In deciding the scale of ultimate development, and in its selection of early priorities, the planning group adopted as the criterion not the need of the population for services (which was assumed to be vast), but rather the much more modest determinant of what the publicly-financed health sector could afford to staff and run, in the light of overall sectoral priorities and prospective resources.

The Statement of Hospital Development Policies

The planning group did not conceive of the statement as an original formulation of policy, but simply as an elaboration of existing policy set out in the Second Plan, with an extension of the time perspective to the year 2000. The statement begins with an acknowledgement of the patterns of disease, settlement and existing health services which constitute the justification for the priority given to Primary Health Care. The statement goes on to the argument that the functions of primary and referral care are complementary: the hospitals need the peripheral services to screen out the mass of routine care, while the availability of the hospitals at the apex of the referral system provides critical reassurance to patients and staff alike that, whatever the point of entry, the system can provide care for the complex cases whose needs exceed the resources of the peripheral services. The corollary of this argument is that expansion of Primary Health Care implies expansion of hospital services, though not necessarily at the same rate. It was felt that trends in modern treatment of tuberculosis, leprosy and mental illness would shorten the average length of stay for these conditions, so reducing the demand for long-stay beds, at least in relative terms.

The statement did break new ground in the attempt to quantify the affordable scale of expansion of general hospital services. The calculation was expressed in units of hospital beds, but it was understood that these were a proxy measure for the complex of medical, nursing, technical and ancillary services that constitute the capacity of a hospital. Starting with the assumption that overall resources would grow at 3% p.a. in real terms, and that non-hospital services would be required to double in capacity and resource use by the end of the century, it was calculated that resources for hospitals would increase by 36% over the period. Applying this increase to capacity in the base year, and adjusting for slight changes in the ratios

between general and specialist units and between the two general hospitals, it was determined that there would be the capacity to operate around 150 additional general hospital beds by the year 2000.

The initial allocation of this additional capacity gave a further 70-80 beds to Bansang Hospital, on the grounds that:-

- (i) there was a manifest imbalance between the eastern and western parts of the country;
- (ii) there was gross overcrowding at Bansang Hospital (particularly in the female ward); and
- (iii) that with an existing complement of only 72 beds there was a severe imbalance between the medical service departments (and the ancillary services), and the number of beds. By expanding bed numbers to a total of 150-160, it was intended to create a better balanced hospital unit, able to provide referral services in all but the most specialised cases to the eastern half of the country.

The remaining beds were eventually allocated to the Royal Victoria Hospital, although alternative allocations to a third hospital, or to a series of "mini-hospitals" were also considered. All the figures quoted above reflect capacity by the year 2000; it was understood that because of staffing and budgetary constraints the target level could only be approached by stages.

The keynote of the policy statement is its emphasis on the need to restrain the growth of hospitals in order to permit a relatively faster rate of growth of primary care services. At the same time, it is hoped and intended that, by a combination of judicious investment and improved management, the productivity of hospitals can be raised so that the growth of service outputs will outstrip the modest increase of resource inputs,

Royal Victoria Hospital, Banjul

From this point on, it is appropriate to treat the two hospitals separately. The detailed planning of medical services at R V H culminated in a "Statement of Need" summarising the prospective growth of medical services and support departments up to the year 2000. The Statement begins by recalling the role of the R V H:- The Royal Victoria Hospital, Banjul, will continue to function as the national referral hospital. It will represent the major concentration of specialist facilities in the country, and will take referred patients not only from the western half but in appropriate cases from Bansang Hospital and the eastern part of the country. However, it is not envisaged that there will be a great addition to capacity beyond the present 283 beds at R V H; the planning target for the year 2000 is 360 beds (excluding those at satellite units).

In order to permit R V H to concentrate on its role as a specialist referral centre, it has been decided that, once alternative first-line services are available in the form of urban health centres, general outpatient services will be discontinued at R V H, and consultant clinics will be held for referred patients only.

In addition to its key role at the apex of the referral pyramid, R V H will continue to provide other critical services to the health care system as a whole. It will continue to be the main centre for the pre-registration training of medical and dental officers, the practical training of registered nurses and midwives, the basic training of all types of technicians, and refresher training for all categories of staff. Although enrolled nurse training will eventually be transferred to Bansang, it is anticipated that enrolled nurses in training will be attached on rotation to R V H departments. The senior medical staff based at R V H will be expected to take a national view of their responsibilities, and advise on the development of their specialties throughout the country. The diagnostic services of R V H will continue to support outlying units, and R V H will be the principal centre for clinical research.

Implicit in this concept of the future role of the hospital is a concern for more adequate performance of tasks already defined, rather than the adoption of new functions. In particular, the proliferation of minor specialties has been resisted.

After a careful review, department by department, of the needs for additional capacity, it was determined that female surgery, (including gynaecology), paediatrics, and ophthalmology should be allocated additional beds. A scheme to reconstruct and expand the maternity unit had already been formulated and adopted before the master planning exercise started; this scheme pre-empted almost half the total additional bed capacity, though without question for a high priority specialty. It has since been found necessary to transfer the Infectious Diseases Hospital (treating mostly tuberculosis cases) to the R V H site.

Of the medical service units, it was determined that only limited development of pathology and radiology was needed, but the theatre suite and associated facilities needed to be totally re-provided. In the light of the decision to transfer general outpatient services to an adjacent urban health centre, the opportunity will arise to reorganise the accommodation for consultant clinics, and for a casualty department which does not yet exist. The physiotherapy department needs more spacious and appropriate accommodation than it now occupies.

The kitchen, laundry and workshops are not thought to need major redevelopment, but some re-equipment and reorganisation will be required.

*recognised
basic services*

The major, and long-recognised, deficiency of the present hospital is the very poor condition of its engineering services (water, electricity, sewerage and drainage). These services have now deteriorated to the point where minimal standards of safety and hygiene have been flouted. While the urgent need to repair these gross deficiencies was long recognised, it was also understood that until the future type and location of demand for these services had been worked out, it would not be possible to plan their reprovision. Hence the Master Plan exercise was seen as pre-requisite to the essential programme of re-wiring and re-plumbing the entire hospital site. Another deterrent to action was that it was recognised that much of the accommodation attached to these services (toilets, showers, sluices) needed to be expanded and remodelled. It was logical that the two needs should be combined in one programme of work, especially as the rewiring and re-plumbing would inevitably cause great disruption to the fabric of existing buildings. Although consultancy services are now needed to plan in detail for this complex undertaking, the master planning exercise has clarified the service requirement, and cost estimates have been obtained for the two components.

While it is difficult to assign dates to future steps in implementation of the Master Plan, the probable sequence of developments can be discerned:-

- (i) Reconstruction of Maternity unit 1984-85, a major scheme financed by the UK Government;
- (ii) Transfer of the SEN School to new accommodation, 1985, and re-use of accommodation for ophthalmology, a minor scheme financed by Christian Eye Ministry and the Royal Commonwealth Society for the Blind. Construction of a residence for duty medical staff, financed by Gambia Government;
- (iii) Reprovision of engineering services (electricity, water, sewerage and drainage), and associated refurbishment of existing wards; relocation of Infectious Diseases Hospital;
- (iv) New operating theatre suite with CSSD/TSSU, nurse changing facilities, new or additional accommodation for pathology, dentistry and physiotherapy; relocation of administration.
- (v) Additional paediatric beds, closure of general outpatient services and remodelling of accommodation;
- (vi) Additional ward for female surgery/gynaecology

From item (iii) onwards, the sources of funds for developments have yet to be identified. The critical next step is the relatively large and intrinsically indivisible capital investment in new engineering services; though unglamorous, this project is essential not merely to the future expansion of the hospital, but even to the maintenance of present services. It is both feasible and necessary to complete this project within the next four years.

current
72 to 150 bed
future

Bansang Hospital

3 speciality dept.
A Statement of Need prepared for Bansang Hospital begins with a recapitulation of its role: Bansang Hospital will be developed to a level slightly below the R V H. There will be clinical specialist departments in general medicine, general surgery, obstetrics and paediatrics. The present bed complement of 72 is quite insufficient, and the planning target for the year 2000 is 150 beds. At full development, Bansang Hospital will be able to provide a good referral service to the eastern half of the country, and will need to transfer only a small percentage of patients to R V H. The Statement goes on to review the location and site of the hospital, and concludes that it is appropriate to undertake development on the present site.

It is envisaged that the total capacity of the hospital, expressed in proxy units of bed numbers, will more than double over the planning period to the year 2000. The ultimate development will provide around 35 beds in each of the four main specialties, plus a further 10 beds in a multi-purpose isolation block. The contrast with the present position lies not only in total bed numbers, but also in their distribution. The historic endowment of beds at Bansang is divided by sex: a male ward and a female ward, each of around 35 beds. The greatest pressure is experienced in the female ward, because it also accommodates obstetric and paediatric cases. The problems in the present situation can therefore be characterised as

- (i) an absolute deficiency of beds, relative to the need for hospital care arising in the eastern half of the country;

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- (ii) an internal imbalance between the capacity of medical service and domestic department, and the small number of beds;
- (iii) an imbalance in the distribution of beds between categories of patients.

All of these problems will be eased by the proposal which is the key point of the first phase redevelopment: the rehabilitation and conversion of the existing (but unused) paediatric ward into a combined obstetric and paediatric unit with a total of 40 beds. This would allow the present main ward block to be re-partitioned on the basis of specialty, putting all surgical patients on the ground floor (on the same level as X-ray and operating theatres), and all medical patients on the upper floor. A minor scheme consequential on this reallocation is the provision of additional **toilets and showers** on each floor. At a later stage in the redevelopment, it is envisaged that a new ward will be built, for either paediatrics or obstetrics, and the combined ward will be applied exclusively to the alternate specialty at that stage.

Of the medical service departments, the view was taken that with the exception of outpatient services, the other departments would be adequate through the planning period with relatively minor alterations. There is a need for improved operating theatre facilities, and the spatial planning of the site will allow for their eventual total reprovision, but within the present planning period it is felt that alterations to provide ancillary accommodation to the present suite will suffice. Minor extensions are also required to X-ray and laboratory facilities, space for which would be made available in the context of the remodelling of the outpatient services. There is a need for the provision of accommodation for ante-natal and child welfare clinics, and for the dental department.

*Probable need -
consultant
job*

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The domestic departments are well provided by a recently completed scheme, financed by a mixture of local funds and grants from the UK Government, to provide a new kitchen, laundry and stores. These departments have a capacity to serve a hospital at least as large as the development now proposed by the year 2000, and no expenditure other than for maintenance and replacement of equipment will be required within this period.

A long-standing problem at Bansang has been the insufficiency of staff housing (particularly for senior staff) and the poor quality of the available stock, as a product of accumulated neglect of routine maintenance. The position has recently improved substantially, partly by the construction of new housing (not specifically for the hospital, but constituting a pool from which the hospital can benefit) and partly by the commencement of a scheme financed by the Gambia Government to rehabilitate existing staff houses. The housing problem, which has hitherto constituted a major impediment to the proper staffing of Bansang Hospital, is therefore beginning to recede.

(11)

One other concern which it is proposed to address in the first phase redevelopment is erosion over the hospital site. Surface runoff from the hill behind it has already seriously undermined existing buildings and poses a long term threat to the entire site. It is intended to deal with the threat by a combination of tree planting, construction of surface water drains, and site fencing (to keep out animals which destroy the vegetation cover).

Bansang Hospital

D

1. (a)	Rehabilitation and conversion of existing paediatric ward to provide maternity and paediatric wards.	2,054,000
(b)	Reorganization of male and female wards, and additional sanitation	<u>216,000</u>
		<u>2,270,000</u>
2.	Replacement of Dental Department, Outpatient Department and new provision of Ante-Natal and Child Welfare clinics	1,000,000
3.	Alteration and extension of theatre suite	225,000
4.	Rehabilitation of Isolation ward	181,000
5.	Surface drainage and fencing	80,000
6.	Other works and equipment	<u>1,220,000</u>
	Total	<u>4,976,000</u>

Further Documentation

1. Statement of Hospital Development Policies
2. Statement of Need for Royal Victoria Hospital, Banjul
3. Statement of Need for Bansang Hospital
4. An Appraisal of the Building Requirements for the Upgrading and Extension of Bansang Hospital and the Royal Victoria Hospital, Banjul, The Gambia, by E.H. Riley, September 1984 (This report is the source of the cost estimates used above).

ODA

Can we obtain it?

Copies of these reports are available on application.

British architect - to run UK projects office has standard approval using British Dept of Health -

PROJECT OUTLINE

MINISTRY OF HEALTH, LABOUR AND SOCIAL WELFARE

BASIC HEALTH SERVICES DEVELOPMENT PROGRAMME

First level referral system - - - Health Centres and **D**ispensaries

S U M M A R Y

This document outlines the intentions of the Ministry of Health for the development of basic health services, the network of health centres and dispensaries that constitute the middle tier in the structure of publicly-provided services in The Gambia. Health centres and dispensaries are well distributed throughout the country, but there is a need to strengthen their capacity to render services not only directly to patients visiting the units, but also indirectly through their support of village health services. A major activity of the health centres is the provision of mobile clinic services which take immunization and ante-natal care, as well as general outpatient services, to more than a hundred locations throughout the country.

Owing to budgetary and staffing constraints which are expected to apply throughout the period of the Third Plan, the main emphasis will fall on consolidation of existing services rather than expansion to new sites. The consolidation programme will have 6 main elements: (i) rehabilitation of structures, including staff housing (ii) water and electricity supply improvements (iii) replacement of vehicles (iv) supply of equipment and furniture (v) in-service training of staff (vi) telecommunications.

Background to the Planning of Basic Health Services

The present proposals for the development of basic health services stem from the work of a planning group which was set up in April 1984. Its terms of reference did not require the production of a detailed plan to the year 2000, but rather concentrated on defining the optimum structure of basic health services, and identifying priorities in the short to medium term future. Although certain areas of policy are still to be determined, the deliberations of the group have already crystallised the main outlines of the structure, within which the present proposals for developments during the Third Plan period have been framed.

An Outline of Principal Policies

Overall policies for the health sector, as enunciated in the Second Plan document, imply a gradual shift of emphasis in health service provision from curative to preventive, from urban to rural, and from institutional to ambulatory care. The policy thrust towards maximum dissemination of services into the rural areas can be viewed as the expression in the health sector of the national priority given to rural development. The strengthening of the intermediate tier in the health care system is an indispensable means of furthering these goals. Not only are health centres and dispensaries well distributed throughout the country, but their outreach clinics multiply the number of locations at which services are made available to more than 100 throughout the country. Furthermore, health centres and dispensaries are in a position to provide essential support to village health services, which will operate in more than 250 villages by the end of the Second Plan. A very high priority is therefore given to development of this level, which it is assumed will approximately double its resource use and output of services by the year 2000.

The fundamental role assigned to the health centre is to provide, in conjunction with its outreach clinics and village health services, all the services a family needs for its health care, other than those which only a hospital can provide. The implication is that health centres will provide to their catchment populations a wide range of curative, preventive and promotive personal services, and act as the base for community services. Because the demographic and epidemiological profile reveals the high toll of sickness and premature death among mothers and young children, particular emphasis has been put on MCH services, and this thrust will continue.

In the light of this emphasis, it is envisaged that existing dispensaries, which were originally designed only for curative outpatient services (though most of them now provide additional services) will eventually be upgraded into health centres, with space, staff and equipment to handle ante-natal and child welfare clinics, uncomplicated deliveries and limited inpatient care. Certain other units, mostly those now designated as MCH Centres, will also be developed eventually to provide a wider range of health centre services.

The inherited stock of health centres is highly variable in capacity and quality. While the aim will be to ensure that each unit meets certain minimum criteria, the long term structure will not impose total uniformity. There are now, and will continue to be, some larger health centres with additional capacity which provide a referral service to an area wider than their immediate catchment areas. It is also recognised that the higher density of population in the urban and peri-urban environment of the Greater Banjul Area will permit, and may require, a different pattern of services.

It is anticipated that only selected health centres will be headed by doctors; in the majority, the senior officer will continue to be a person originally trained as a nurse. Most existing staff were trained on the traditional curriculum for the bedside nurse, and need further training for the practitioner role that they are required to perform in health centres. The basic training curriculum at the School of Nursing is being revised to prepare the nurse for both hospital and community nursing.

With a close eye to budgetary and staffing constraints, there will be avoidance of high technology in medical and domestic services, and in utilities. It is not intended to provide kitchen and laundry facilities at the smaller units (the majority), but to rely on relatives to provide meals for short term inpatients, and on hospital laundries to provide linen. In those locations where the Gambia Utilities Corporation does not provide public water and electricity services, the health centres will be provided with modest self contained supplies --- generally, hand-pumped water and emergency circuit electricity generated by diesel or solar panels.

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The emphasis on outreach clinics will be retained and enhanced, by linking up with village health services. To this end, the vehicle fleet will need to be replenished progressively, and vehicle maintenance and fuel logistics developed.

Resources for health centre services

As indicated above, it is estimated that, by the year 2000, it will be possible to roughly double the total provision of first level referral services. This calculation rests on the **assumption** that overall resources for the publicly funded health services will increase at an average rate of 3% p.a., and that the share of resources for personal health services devoted to health centres and dispensaries will be allowed to rise from 30% to 40% of the total, reflecting the priority given to this sub-sector. However, it is further calculated that in the short to medium term, the majority of incremental resources will need to be allocated in support of hospital developments which are either already in train (at RVH) or which have a very high priority (at Bansang). Furthermore, the average growth rate assumed may not be attained in the near future, without exceptional measures of support from external donors. The scenario that emerges from this analysis is that very little real growth is possible in the short to medium term, but that a substantial growth of this level of services will be sustainable in the last decade of this century. The implication is that over the next few years, the accent must be on the consolidation of existing services, largely avoiding developments which entail the use of additional staff and recurrent finance. There is much that can be done to develop the capacity of the system, even under these severe constraints, in the direction of capital investment and retraining of existing staff.

The Greater Banjul Area --- A Special Case

Although by far the greater part of the Gambian population is still rural, the urban and peri-urban population, concentrated in the Greater Banjul Area (GBA), is growing much faster than the national average rate. This has already resulted in a situation where the ratio of Government health services to population is much lower than in the country generally (especially in the peri-urban area outside Banjul city), and the disparity threatens to grow much wider in future. The inter-censal growth rate in Serrekunda is put at 10% p.a., implying a doubling of the population in 10 years. To meet the implied demand, it is proposed to concentrate the

small increment in resources available to support new services in the Greater Banjul Area. There is a current project to renovate and extend the existing Serrekunda Dispensary into a full health centre. It is similarly proposed to develop the existing Sukuta Maternity Unit into a full health centre, and to fully staff and equip the buildings at Banjulinding which are already almost appropriate for a health centre. In Banjul city, the major proposal is to construct a new urban health centre or polyclinic on Independence Drive. In principle, this development will not entail the commitment of additional resources, because it is intended to replace the general outpatient services now provided at the Royal Victoria Hospital (this project appears in the hospital development plan as reprovision of general outpatient services including ante-natal and child welfare clinics). This development would permit the closure of the present New Street clinic. It is also intended to remodel the Leman Street clinic so that it can handle larger numbers.

The Development Proposals

(i) Buildings. The present stock of health centre and dispensary buildings includes a few of relatively recent construction which are well designed and structurally sound, but the majority are inadequate either by reason of outmoded design or physical disrepair, or both. The consolidation programme envisages that all structures, including staff housing, will be brought up to an acceptable standard, and that where necessary extensions to accommodate additional services will be constructed. These additional services reflect mainly the upgrading to health centre functions of existing units in the Greater Banjul Area, and the provision of laboratories at selected health centres so that they may support the endemic disease control programmes. In selected locations, it is intended to construct new staff houses for senior staff; lack of appropriate accommodation has compounded the difficulties of inducing senior nursing staff to accept posting to rural stations, and improvement of housing conditions is extremely important as one means of rectifying the adverse reputation of rural service. The details of the construction proposals are set out in the schedule attached (which also shows the proposals for utilities).

Water and Electricity Supplies

(ii) Electricity supplies for outlying health units are a subject of great concern. Existing provision ranges from use of the public supply generated by the Gambia Utilities Corporation in the major centres, through UC-operated health station-specific services, to nothing at the majority of stations. A major problem at 8 health centres is that generating capacity has been installed far in excess of what the Ministry of Health can afford to run; thus both in locations which already have generating capacity and those which do not, there is a need to instal economical generators linked to a load of essential services only. It is considered that there is a place for solar power, generated by photo-voltaic cells, particularly to meet the critical need for refrigeration, and in selected locations for pre-heating of domestic water by direct insolation. It is hoped that an overall scheme to rationalise electricity supplies and save energy from fossil fuels can be executed in the near future, to relieve the budgetary strain caused by present inefficient arrangements.

Existing water supplies are similarly varied, and in almost all cases need some improvement. Even where a public supply is available, there is usually a need for additional storage and reticulation. Where the supply is from a well or borehole in the health unit compound, there is generally a need to provide a pump, storage and reticulation. Wherever the depth of water makes it feasible, water supplies will be handpumped (it is hoped mostly by the general public who will be given access to the supplies). In a few locations, new wells or boreholes will need to be sunk, or existing wells deepened. Details of the proposals for improvement of electricity and water supplies are given in the attached schedule.

Transport

(iii) The operation of peripheral health services is critically dependent on mobility. There are four important functions of transport: patient referral; mobility of clinic staff; supervisory travel; distribution of drugs and supplies. Vehicle maintenance has in the past been a major weakness of the system; plans are under way, and should be fully implemented within eighteen months, to improve vehicle maintenance capacity both at the national level, for which a new workshop will be constructed at Kanifing, and at the regional headquarters. Arrangements for the distribution of fuel will also be improved under schemes now approaching implementation. However, the prospects

are that there will not be adequate funding for fuel supplies from domestic sources alone. In the last year, the disappointing downturn in previously high levels of immunization coverage and attendance at ante-natal clinics was attributed almost entirely to unavailability of fuel or vehicle breakdown, resulting in failure to hold scheduled outreach clinics. The other outstanding need is for progressive replacement of the vehicle fleet. Many existing vehicles are beyond economic repair, and some which are still in service consume fuel so excessively that they are seldom used. Including vehicles used for supervision by the regional health teams, the peripheral services need a total fleet of around 60 vehicles. With an average life of 5 years, there is an implied replacement need of 12 vehicles per year on average. Selection of more appropriate vehicle types will economise on fuel consumption.

Equipment and Furniture

(iv) With the exception of a few recently completed units, the general standard of equipment is poor, and what is available is not always well matched either to service needs or to the available utilities. The number of different items required is so large, and the unit costs of each item so relatively small, that it is not feasible to present detailed lists of requirements. The approach envisaged is to obtain a number of standard kits, and to distribute their contents according to a more precise reflection of existing deficiencies.

Staff Training

(v) It was noted above that most of the senior staff of health centres and dispensaries are nurses originally prepared for a bedside nursing role. Their employment in peripheral units logically requires further training for the practitioner role which they perform; this need has been recognised, and some in-service training courses have already been held. With the advent of village health services, and the renewed effort now being made to link them with the established peripheral services, there is a greater need than ever for these nurses to refine their clinical skills and prepare for managerial roles. It is proposed to reinstitute the in-service training programme, and pass through it around 50 staff per year.

Telecommunications

(vi) A major handicap under which the whole rural system labours is isolation. Public postal and telephone services are skeletal, and many locations totally non-existent. In these circumstances, communication is effected either by the face-to-face meeting of the parties concerned, or not at all. It has long been considered that much time and expense entailed in journeys for these face-to-face meetings could be avoided if there were a system of radio communications between health stations. Both for clinical and administrative purposes, consultation by radio could often obviate the need for a journey by road. An ideal network would link each unit with its respective regional headquarters, and the regions with national headquarters and the two hospitals.

Estimates of costs

In the absence of detailed design, which has hitherto been undertaken for only two of the sites at which developments are now proposed, it is impossible to provide more than the most general estimates of the cost of works. The scope of work required varies so much between stations that the only practicable course is to use average unit costs. For building work, these estimates are derived from recent or pending contracts; for utilities, they are more speculative. The numbers of facilities involved are drawn from the schedule attached. The costs of buildings and utilities are calculated as follows:-

could be selected checked by consultant

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ITEM	NO. OF UNITS	UNIT COST	TOTAL COST
		D	D
Health centre, minor works	8	120,000	960,000
Health centre, major reconstruction	5	600,000	3,000,000
Dispensary, minor works	6	60,000	360,000
Dispensary, major reconstruction	5	120,000	600,000
(All the above include repair of existing staff houses)			
New staff houses	7	130,000	910,000
Sub-total, construction			<u>5,830,000</u>

How do they compare with new cost

- building area proposed per facility? - size of staff house - cost / m² of masonry

- bases included - foreign source component

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<u>ITEM</u>	<u>NO. OF UNITS</u>	<u>UNIT COST</u>	<u>TOTAL COST</u>
		D	D
Solar power generation:			
Health centres	14	25,000	350,000
Dispensaries	15	20,000	300,000
Solar pre heating	15	5,000	75,000
Standby generators	4	20,000	80,000
Main load generators (Inclusive of generator houses, switchgear and re-wiring)	9	30,000	270,000
Sub-total, electricity			<u>1,075,000</u>
Well digging (new wells)	3	20,000	60,000
Well deepening (existing wells)	2	10,000	20,000
Hand pumps and well protection	14	5,000	70,000
Reserve tank and reticulation:			
Health centres	9	30,000	270,000
Dispensaries	12	20,000	240,000
Sub-total, water supplies			<u>660,000</u>

It is assumed that the costs of construction would be spread evenly over five years, but that the costs of utilities would be concentrated in the first two years, reflecting the urgency of cost-saving investment.

The costs of transport are estimated on a similar unit cost basis. Assuming a fleet of 60, an average life per vehicle of 5 years, and a unit cost of D40,000 per vehicle, the annual cost of vehicle replacements would be D480,000. Assuming that each vehicle covers 20,000 kilometres per year, the cost of fuel and spares is a little over D4,000 per vehicle per year, or approximately D250,000 for the fleet. The amount currently budgetted for this part of the service is D160,000 annually, implying a shortfall of the order of D90,000 per year.

The costs of equipment and furniture are derived from a current estimate for Serrekunda Health Centre of D40,000 (~~#10,000~~) per centre. It is assumed that two sets per year would meet the requirement, divided among the total number of health centres and dispensaries. On this assumption, the cost will be D80,000 annually.

The costs of in-service training are largely met by existing budgetary provisions, but extra costs amounting to D300 per head will be incurred for transport, allowances and teaching materials. Assuming 50 trainees per year, the annual cost will be D15,000.

No meaningful estimate can be given for the cost of a national radio communication system; a notional sum of D500,000 is included.

The total costs of this programme over a period of 5 years amount to D11,390,000. This estimate does not include works for which a specific source of funding has already been identified (including Serrekunda Health Centre to be funded by UNFPA and Gunjur Health Centre to be funded by the UK Government), nor the urban health centre on Independence Drive, which is included in the costs of the hospital development programme. Some donors have made general commitments to items in this programme (UNICEF to the water supplies component, the UK Government to the construction component) but the precise form of the contributions remains to be finalised. The balance of the programme remains unfunded.

Costs Summary

COMPONENT	YEAR					T O T A L
	1986/87	1987/88	1988/89	1989/90	1990/91	
(i) Construction	1,166,000	1,166,000	1,166,000	1,166,000	1,166,000	5,830,000
(ii) Utilities:						1,075,000
- Electricity	537,000	538,000				660,000
- Water	330,000	330,000				
(iii) Transport:-						2,400,000
- Vehicles	480,000	480,000	480,000	480,000	480,000	450,000
- Fuel	90,000	90,000	90,000	90,000	90,000	
(iv) Equipment and Furniture	80,000	80,000	80,000	80,000	80,000	400,000
(v) In-service-training	15,000	15,000	15,000	15,000	15,000	75,000
(vi) Telecommunications	250,000	250,000				500,000
TOTAL	2,948,000	2,949,000	1,831,000	1,831,000	1,831,000	11,390,000

SCHEDULE OF PHYSICAL IMPROVEMENTS TO EXISTING HEALTH CENTRES AND DISPENSARIES

<u>WESTERN REGION</u>	<u>BUILDINGS</u>	<u>ELECTRICITY</u>	<u>WATER</u>
Bakau Health Centre	Minor renovation	(GJC) standby generator solar (1) (2)	(GJC) reserve tank
Serrekunda Dispensary (upgrading to Health Centre)	Major reconstruction Funded by UNFPA	(GJC) standby generator solar (1) (2)	(GJC) reserve tank
Banjulinding Dispensary (upgrading to Health Centre)	Minor renovations and extensions	(GJC) solar (1) (2)	(GJC) reserve tank, extension of reticulation
Sukuta Maternity Unit (upgrading to Health Centre)	Major reconstruction	Generator; solar (1) (2) (future GJC supply,)	well protection, pump reserve tank and reticulation
Gunjur Health Centre	Major reconstruction funded by UK#ODA	<u>Solar refrigeration</u> <u>already installed.</u> Generator	well protection, pump reserve tank and reticulation funded by UK#ODA
Brufut Dispensary and MCH clinic	1 new staff house for nurse#dispenser	Solar (3)	-
Brikama Health Centre	Minor renovation 1 new staff house for nurse#midwife	(GJC) solar (1) (2) standby generator	(GJC) reserve tank and reticulation
Bwiam Health Centre	Minor renovation, Laboratory	Generator, solar (1) (2)	-
Essau Health Centre	Major reconstruction	Standby generator, (solar (1) (2) (Future GJC connection)	(GJC) reserve tank and reticulation
Kuntair Dispensary	Major reconstruction 1 new staff house for nurse#dispenser	Solar (3)	well, hand pump reserve tank and reticulation.

<u>WESTERN REGION (CONT.)</u>	<u>BUILDINGS</u>	<u>ELECTRICITY</u>	<u>WATER</u>
Medina Bafuloto Dispensary	Minor renovation 1 new staff house for Health Inspector	Solar (3)	Deepen well, repair hand pump, reserve tank and reticulation
Jambanjelly MCH clinic	-	Solar (3)	-
Tujering MCH centre	-	Solar (3)	-
Kartong MCH centre	-	Solar (3)	-
Leman St clinic	Major reconstruction	(GJC)	(GJC) reserve tank
New St. clinic	-	(GJC)	(GJC)
Independence Drive Urban Health Centre	New construction	(GJC) solar (1) (2) Standby generator	(GJC) reserve tank
<hr/>			
<u>CENTRAL REGION</u>			
Kerewan Health Centre	Major reconstruction 1 new staff house for nurse#midwife	Generator Solar (1) (2)	
Salikene Dispensary	Major reconstruction	Solar (3)	Well protection, hand pump reserve tank and reticulation
Farafenni Health Centre	-	GJC; Standby generator (Solar (2))	(GJC) Well, hand pump, reserve tank as standby.
Nguyen Sanjal Dispensary	Major reconstruction funded by UNCDF	Solar (3)	Well protection, hand pump, reserve tank and reticulation

<u>CENTRAL REGION (CONT.)</u>	<u>BUILDINGS</u>	<u>ELECTRICITY</u>	<u>WATER</u>
Kiang Karantaba Health Centre	-	Generator, solar (1) (2)	-
Mansakonko Health Centre	Minor renovations	-	-
<u>EASTERN REGION</u>			
Dankunku Dispensary	Major reconstruction 1 new staff house for nurse#dispenser	Solar (3)	Well protection, hand pump, reserve tank and reticulation
Kudang Health Centre	-	Generator, solar (1) (2)	Reserve tank
Brikamaba Dispensary	Major reconstruction	Solar (3)	Deepen well, hand pump, reserve tank and reticulation
Kaur Health Centre	-	Generator, solar (1) (2)	-
Kuntaur Health Centre	Major reconstruction	Standby Generator, solar (1) (2) (Future supply from GPMB)	Well, hand pump, reserve tank and reticulation
Karantaba Dispensary	Minor renovation	Solar (3)	Well protection, hand pump, reserve tank and reticulation

EASTERN REGION (CONTINUED)BUILDINGSELECTRICITYWATER

Yorobawol Health Centre	Minor renovations	Generator, solar (1) (2)	-
Bajakunda Dispensary	Major reconstruction 1 new staff house for nurse#dispenser	Solar (3)	Well protection, hand pump, reserve tank and reticulation
Basse Health Centre	Major reconstruction	(GUC) standby generator Solar (1) (2)	(GUC) reserve tank and reticulation
Gambisara Dispensary	Minor renovation	Solar (3)	Well protection, hand pump, reserve tank and reticulation
Fatoto Health Centre	Minor renovation	Generator, Solar (1) (2)	-
Chamen Dispensary	Minor renovation	Solar (3)	Well protection, hand pump, reserve tank and reticulation
Diabugu Dispensary	Minor renovation	Solar (3)	Well protection, hand pump, reserve tank and reticulation
Georgetown Dispensary	Minor renovation	(GUC) Standby generator 1 new house for nurse# midwife	(GUC) reserve tank

Solar (1) = photo voltaic cell generator for health centre

Solar (2) = water pre-heating by direct insolation

Solar (3) = photo voltaic cell generator for dispensary

Mark Wheeler

file: Gambia/Wheeler

LSHTM

George Cumper }
Ann Mills } 2 economists

Patrick Vaughan
Godfrey Walker

MSH

Peter Ship did manpower report for
Gambia in '82, He came through in '84,

Did major report on drug supply

Departing 11 June.

11-
Copies to
Bruno
Jamison
Lalton 20 (spec. express)
file: Gambia/Wheeler

c/o British High Commission,
P. O. Box 507,
Banjul,
The Gambia.

14 March 1985.

Dear Nancy,

I have to thank you for various communications, some of them slightly cryptic. I received a copy of your memo of 31 January to the contributors to Working Paper No 677; David Wheeler's name was underlined, but the envelope was addressed to Mark Wheeler, leaving me in some slight doubt whether two different messages had been mis-addressed, or whether you thought I would be interested to see a very lucid summary of the research. I eventually decided on the latter, partly influenced by the thought that if I had indeed received David Wheeler's copy of the memo by mistake, your deadline for response had already passed.

The next consignment to generate a scintilla of doubt was the delivery of two parcels with copies of the CPD Discussion Papers. I was not sure whether these had come in response to my plea for teaching materials, or were designed to spread the gospel among the unenlightened in the Ministry of Finance. On that front, I have only failure to report: on one pretext or another, or just total inaction, Finance have avoided holding any meeting with us and MEPID, and have yet to communicate with either ADB or IBRD. At my instigation, our PS sent off a telex confirming the acceptability of the dates for the next mission proposed in Landell-Mills letter, with the hope rather than the expectation that this will jog Finance into action. But I despair increasingly of any rational dialogue with Finance.

I have done one other bit of preparatory work, which is to have discussions with the Medical Research Council on their ability and willingness to be involved in research studies of a socio-economic nature. As you will see from the attached copy of the file note I made on these discussions (which were confirmed as a true record by Brian Greenwood), MRC do not feel able to take on commissioned research in this area, though they can provide valuable logistic support (for a fee). They would also accomodate a financial/economic study "piggy-backed" on the Farafenni study.

Your letter dated 19 February, covering a draft paper on the cost recovery issue, raised no problems. I have skimmed through the draft, but don't feel I have any significant observations to make at this stage.

We have not yet received Stella's report---is it still intended that we should?

I hope to be seeing you, and the mission, shortly.

Best wishes,

Mark

Mark Wheeler

REC'D MID SEC BR 3/1
RECEIVED

to British High Commission,
10, Whitehall, London SW1A 2EJ,
England.
The British.

14 Feb 1985

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some of them slightly cryptic. I received a copy of your
memo of 31 January to the Commissioner for Foreign Affairs
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if I had indeed received David Wheeler's copy of the memo by
mistake, your heading for response had already passed.

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the delivery of two parcels with copies of the QED discussion
papers. I was not sure whether these had come in response
to my plea for teaching materials, or were destined to answer
to a request among the underwritten in the Ministry of Finance.
On that point, I have only failed to report on one aspect
or another, or just total inaction. Finance have avoided
holding any meeting with us and WEPF, and have yet to
communicate with either AFB or TRPD. At my invitation,
our PS sent off a telex confirming the receipt of the
letter for the next mission proposed in David Wheeler's letter,
with the hope that the association that this will
for finance into action. But I remain impatiently of any
action I might take with finance.

I have done one other bit of preparatory work, which is to
have discussion with the Medical Research Council on their
ability and willingness to be involved in research studies
of a socio-economic nature. As you will see from the attached
copy of the file note I made of these discussions (which were
confirmed as a true record by Alan Greenwood), MRC do not
feel able to take on commissioned research in this area. I
they can provide valuable background for a QED. They
would also accommodate a financial/economic study "study-paper"
on the research study.

Your letter dated 19 February, covering a QED paper on
the cost recovery issue, raised no problems. I was pleased
through the QED, but don't feel I have any significant
observations to make at this stage.

We have not yet received David Wheeler's report--is it still
incoming mail unit?

I hope to discuss it with you, and a meeting, shortly.

Best wishes,

David

David Wheeler

1985 MAR 25 PM 2:41

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File Note

I visited MRC Laboratories on 28/1/85 for a discussion with the Director, Dr. Brian Greenwood, on the potential capacity of MRC to undertake commissioned research in connection with the forthcoming World Bank health sector project (or to provide support for research undertaken under other auspices).

We began by noting that the World Bank basic needs mission in 1980 had envisaged a potentially large role for MRC, and that, although that initiative had not been pursued directly (to some extent its concerns are reflected in the proposed content of the current health sector project), the recent mission had clearly been very impressed with the past achievements and current capacity of MRC, and had proposed that part of the project concerned with the strengthening of capacity for planning, evaluation and research, should be contracted to MRC.

We agreed that the joint Gambia Government/MRC research programme provided appropriate auspices for work of a clinical/epidemiological character, such as research on schistosomiasis and respiratory diseases, and (taking account of Dr. Gowers' plea) such other conditions as might be identified.

However, it was less apparent that MRC could undertake or assist research of a sociological or economic character. It was recognised that there was interest in extending the Farafenni study by an examination of the costs of the PHC programme, and that it would be relatively simple to make such an extension, provided that a health economist or similar professional was made available (it was not an area that MRC could tackle with its present staff).

On the much larger question of a nationwide household sample survey to elicit capacity and willingness to pay for health services, Dr. Greenwood made a number of pertinent points. He emphasised the importance of sampling from different regions or ecological zones, and of taking account of seasonality (preferably by quarterly observations, and at a minimum by observations in both the rainy season and the dry season). These constraints carried the implication that valid results could not be obtained in a short period, and to the extent that detailed design of the cost recovery system depended on the collection of such data, there would inevitably be a gap between the intended starting date of the project and the time when (additional) cost recovery measures could be planned.

Dr. Greenwood made it clear that MRC did not and would not have the capacity to undertake such research on a commissioned basis. The most they would be able to do would be to provide, for a fee, statistical advice and data-processing facilities, logistic support, and some field workers. The critical input of a research director (presumably an economist or economic anthropologist) would have to come from outside.

Mark Wheeler, Health Planner, 4/2/85

1. Copies to Jamison Bruins
2. Send him 10 copies of CPD-1983, #s 7, 8, 9
3. file: Gambia/Wheeler (new)

c/o British High Commission,
P. O. Box 507,
Banjul,
The Gambia.

27 January 1985.

Dear Nancy,

Your Mali research papers, for which many thanks, arrived at the beginning of a week in which I have again been laid low by the dreaded gout (drug prophylaxis notwithstanding). So I have improved the shining hour with my feet propped up reading Birdsall et al, and drafting a summary in a form that I hope will be intelligible to at least some of my colleagues. Since I have also been reading the World Development Report, I have the sense of spending much of the last week with you.

The WDR was gratifying in that, although it contained much detail of which I was previously unaware, all the relationships suggested seemed familiar (I am referring to the Population section). But it applied a prod to my flagging resolve to try to move the family planning programme further up the policy agenda.

Since I last wrote to you, there has been no progress at all with the Ministry of Finance, and as far as I know they have communicated neither with the World Bank nor ADB. I have been pressing my PS, Jobarteh, without effect. Through indirect channels a message came back to the effect that Finance did not know what we wanted to talk about, and they wanted to see a paper with our ideas on cost recovery (something I am most reluctant to itemise at this stage of proceedings). In the end, we compromised; I wrote an agenda for the meeting, only one item of which was the cost recovery issue, and I also wrote a very neutral background paper on financing health services. Further subsequent contact with Finance brought back the answer that they were all too busy in week long meetings with the Senegalese to hold any other meeting. These delays do seem to have alarmed Abdou Njie in MEPID to the point where I understand he has now written a supporting letter to Finance, but as of yesterday no date for a meeting had been set. I will be back at work tomorrow, and trust that the pressure will by then have told. But I assume that your IBRD/ADB discussions will have taken place without specific reference to a health sector project for The Gambia.

If I say that I found the theoretical discussion in the Mali research papers more relevant than the empirical data and conclusions, I trust you will recognise that the parallel to the health services you were contemplating in Mali is our village health services, which are now operating in about 235 villages, and where the principle of cost recovery is so fully accepted that all the direct costs of the service, other than the costs of supervision, are borne by the village community. We have also, at last, instituted outpatient fees at all dispensaries, health centres and hospitals. Assuming that we are going to be discussing the potential for further cost recovery, we are obviously

my

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Main body of faint, illegible text, appearing to be a letter or document with multiple paragraphs.

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1985 FEB 12 PM 4:40
INCOMING MAIL UNIT

into a different level of fees and proportion of income.

I did note a couple of quibbles about the ability to pay calculations. Firstly, unless I missed it, the proportion of total income available as cash was not given in the tables, though the text gave reasons for believing that it was quite high in two of the three 'cercles'. Secondly, and more substantially a reservation, no data was given of the distribution of incomes at the village or household level. The use of 'cercle' level mean incomes throughout is obviously questionable if there is reason to believe the distribution is badly skewed (or even if the range around the means is wide); just such reason is supplied by the observation of a skewed distribution of expenditure on social activities.

As to the model, I find it fascinating, if only because it was couched in terms that my deficient training in economics allows me to grapple with. It does provide an elegant (at least initially elegant) theoretical basis for the intuitive feeling that the health professionals have long held, that extra resources raised by user fees and devoted to quality improvements would improve net welfare from the provision of health services.

In my interpretation, the key feature of the model is the behaviour of the supply curve. The model treats it as axiomatic that the proceeds of user fees are available to increase the quantum of service provided (with a nod at one point to acknowledge the fact that administrative costs were assumed to be zero). Actually, there are points to be made both in theory and practice about this assumption. Theoretically, even if the proceeds of the user fee collection are not applied to expanding the service in question, there can be an equal or even greater increase in welfare if they are applied to the provision of some other service. In practice, in The Gambia, general fee proceeds are not available to the collecting agency. Even if they were, it does not follow that the collecting agency would be better off; there could be a compensating reduction in the subsidy from general tax revenue. In practical political terms, given the nature of the bargaining relationship between Finance and the spending ministries, health could actually suffer for its pressure to raise fees---Finance could take the view that if health were to keep the proceeds of user charges, it would have to finance all its incremental expenditure in this way. This is a very real fear that I expressed to you, or some of the team, during your visit. The model assumes a rational/benevolent decision that the subsidy is fixed* in total; our Ministry of Finance is neither rational nor benevolent.

The second point about the supply curve is that one is forced to question what is meant by movement along the supply curve from the initially constrained position. Referring to the "Strategies" paper, in Figure 2 the notion is introduced that by imposing or raising fees extra resources are raised that may be applied not just to increasing the quantum of output but to changing its quality and accessibility characteristics. These changes are represented by drawing a new supply curve, above and to the left of the original. Just a minor quibble about

* at any point of introduction of fees. Obviously, we want tax revenue for health to continue to rise in line with total revenues.

that; the two curves are drawn parallel, but they should surely converge at Q_1 --- no, forget that, further thought makes it acceptable.¹ The real point I was working up to is that if the extra resources can be redeployed to generate a new supply curve in Figure 2, they can equally in Figure 1, and would similarly induce a shift in the position of the private demand curve, giving rise to a different equilibrating point, presumptively closer to the real optimum. However, as you acknowledge in the text but don't include in any of the figures, the shift in private demand is almost certainly (under what conditions not?) accompanied by a corresponding outward shift of the social demand curve. Now I take the point that the model is a gross simplification of reality, and you don't need to assume a shift in private demand in Figure 1 in the same way that you do in Figure 2, but the policy-relevant issue is that even in conditions of excess demand there is a welfare gain to be made by a combination of user fees plus quality improvements which is greater than the gain from raising fees only. Going back towards my original point, in Figure 2 the intersection of the original supply curve and the zero price line could never have been an efficient point at which to produce, given that (as the curves are drawn) the same resources could have been used¹ to produce at the intersection of the new supply curve SS_1 and the zero price line. At this point, a smaller number of units of service would have been produced, but each would have a higher private (and social) value as indicated by the shift in the demand curve(s) and the area under the demand curve in each case.

I couldn't understand the parabolic shape of the supply curve until I realised it was the product of the assumptions of a constant subsidy and a constant marginal cost---but as I am sure others have pointed out, the parabolic shape itself implies increasing returns to scale. Again, I take the point that the assumption of constant marginal costs is not integral to the model, but only a matter of graphical convenience.

Well, I am not sure what all that has accomplished, except to reveal to you how long it is since I applied myself to any formal economic analysis, but if there is any follow up to the material you have sent (particularly in published form) I would like to know. I guess I am rehearsing a class or two for my forthcoming course. Incidentally, I notice the status of all the documentation you have sent, but would there be any objection to supplying me with extra copies of the*CPD Discussion Papers for teaching purposes?

My regards to the rest of the team, and to you.

With best wishes,

Yours sincerely,



Mark Wheeler.

Copy to Barbara Burns
Barbara -- Comments?

c/o British High Commission, Nancy
P. O. Box 507,
Banjul,
The Gambia.

file: Gambia

8 January 1985

Dear Nancy,

Seasonal greetings from all here to you and your team: I hope you all enjoyed a merry Christmas, and are now prepared for a preposterous New Year (I only heard that one the other day---thought it was worth passing on).

To business: things have not gone altogether smoothly since you left these shores. Because official correspondence with ADB (and apparently with you in money matters) has to be channelled through Finance, and since they were pretty well detached from the Donors' Conference and totally uninvolved in the Health Resources Group meeting, we have a communications problem. Since Bala-Gaye has hardly been in the country since then, things have not moved fast. We are now pressing them for a meeting to try to brief them so that they write to you, but I fear that they may well not act before your joint ADB/IBRD consultation takes place. Pages 7-4 and 7-5 of the Donors' Conference report makes wry reading in the light of this experience.

Although I have had no direct reaction from anyone in Finance, I am told that the cost recovery issue (or more precisely, the notion of channelling revenue back into increased health service expenditure) is looming as something of a bogey. I am proposing to write a brief paper dealing with general principles, but I think Finance (and MEPID) would actually like us to come forward with illustrative proposals. I am most reluctant to approach the specifics before we have some real data behind us, because I don't want us to be prematurely committed to, or condemned by, a half-baked scheme.

Since this is a quite unofficial letter, can I ask whether you (in your official capacity) are committed to charges on 'ideological' grounds, or is the concern really resource mobilisation? If the latter, I think there is much more potential in getting the nugatory expenditure on the cleansing contract off our backs than there is in squeezing bututs out of the peasants. I am a bit worried; did your team catch on to the cleansing contract, or did you just decide that it was too politically protected to be profitably tackled (and if you don't have leverage, nobody inside the system does!) I ask this question with real concern: when I spoke once to Stella, she seemed to think it was cleaning up health facilities, and on the last occasion when I had dinner with you, Stella and Dean, you all seemed fairly nonchalant when I raised the issue. By the bye, the contractor has just been awarded a 10% increase in the payments due---Finance asked us to finance the increase out of savings on other charges.

My successor, Pap Williams, has now taken up his duties. It is early days yet, and you will have the opportunity to form your own judgements on your next visit, but I sense that you are going to encounter a very different style of health planner. Pap has been heard several times saying that he does not intend to do anything boring. I suspect that as activity intensifies, you will find yourselves relying increasingly on Peter as a point of contact with some prospects of dependable results. I am very conscious of how much remains to be done to flesh out the substance of the project.

Finally, I would like to say how happy we were with the composition of your party---we really did feel a surge of empathy running both ways. We look forward to seeing you in March/April. Incidentally, you might like to know that we have selected March 20/21 as the dates for the national workshop on the review of the Primary Health Care programme in the Gambia. We assume you will be coming later than that, but it might be nice if you could take in this meeting at the start of your visit---always assuming that you are asked by Finance in due time!

Best wishes,

Mark

Mark Wheeler.

Copy to Barbara Burns
Barbara -- Comments?

c/o British High Commission, Nancy
P. O. Box 507,
Banjul,
The Gambia.

file: Gambia

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Mark Wheeler.