

CHILDBIRTH IN THE GAMBIA

Summer L. Wember

INTRODUCTION

Africa. I've always loved the way this word rolls off my tongue, the way it pulsates in my ears, and the images it conjures up in my head at its softest utterance. It's like a whisper I can always hear, a secret never to be revealed. I've always felt a deep connection to Africa for reasons that still remain a mystery. It's as if the universe has beckoned me to her shores for years and I was finally wise enough to listen. It is for these reasons that half way through my first semester back to college after a three and a half year break I heard about Professor Roberts and his summer field study program in The Gambia. My anthropology professor at the time had briefly mentioned the program to our class and I immediately followed up with her after class. She took me right down and introduced me to Professor Roberts which got the ball rolling. The next two months were spent applying for the program, and once accepted figuring out all the little details. Time flew and before I knew it the semester was coming to a close. There were papers to write, exams to take, belongings to pack, and final trip preparations to be made. This didn't leave a whole lot of time for mental preparation for the upcoming trip. It felt very dreamlike still, as if I wasn't quite sure it was actually going to happen. But as the departure date drew nearer my anticipation and excitement grew. I knew that this journey was going to be much more than a research project for school, it was going to be a time of personal growth, both spiritual and mental.

INITIAL GOALS

A major part of the Gambia Field Study Program is an independent research project which all students are required to complete. We are given the flexibility of choosing our own topic but it must be approved by Professor Roberts. We were told from the beginning to start to think about what we might want to research while in Africa so as to have some general idea how to structure our time after we finish the first half of the program. And so that Professor Roberts can try to respond to our ideas and set up some initial contacts via e-mail before our actual arrival. I found it hard to narrow my ideas down to one topic when there is so much I'm interested in. And especially since I didn't know what to expect of the country we were going to. I started with all my areas of interest and from there used the process of elimination to finally settle on the topic of midwifery. I come from a family of healers, both doctors and nurses, and thus have been raised to the tune of medicine. I have spent many hours in different labor and delivery wards of hospitals, I have listened to countless stories of laboring women, complicated cases, and I have had the privilege of witnessing several babies being born into this world. My mother and stepfather, OB nurse and OB/GYN doctor respectively, have a practice which I worked in for seven months as well. With all of this background over the years, I have given much thought to becoming a midwife and hence decided to take this opportunity to study midwifery in The Gambia. I wanted to focus on traditional midwifery, home births, traditional medicines, and folk knowledge passed down for generations

pertaining to childbirth. I wasn't sure how accessible this information would be but I was going to try.

So as we embarked on this adventure my intent was to research all aspects of midwifery in The Gambia: the number of midwives, the education they have, the care they give, the number of deliveries they do and so forth and so on. But what I learned relatively early on was that in a country of close to one and a half million people there was a grand total of only 263 midwives nationwide.¹ This meant that there were a lot of babies being delivered by people other than midwives. Therefore, I decided to broaden my research to childbirth in The Gambia and study both deliveries and pre-natal care being done by all different levels and types of health care providers. Once this decision was made, my new goal was to study the different options that women have when deciding with whom and where they were going to deliver, the type of care they are given for pre-natal, birth, and post- partum, the types of facilities that are in place, how emergencies are handled . I also found that access to Traditional Birth Attendants (TBA) was going to be much more difficult therefore making it a part of my research instead of my whole focus was going to be more realistic.

METHODOLOGY

In order to obtain the information that I needed to answer my research questions I knew that I would be doing a lot of interviewing of people as well as observing people in action. I wasn't sure how I was going to set all of this up and I didn't really feel that I had enough background information to feel comfortable walking into health clinics. I happened to get lucky because the first two weeks of the trip is spent in language and culture classes and one of our three teachers happened to be in the medical field. His name is Musa Sonko and he is a community health nurse who has been practicing nursing for 8 years. Over the course of our two weeks together we had many conversations about child birth in The Gambia and he shared with me some valuable information. Over the course of my stay in The Gambia Musa would become a good friend as well as a valuable asset to my research. Musa happens to teach at the school for community health nurses and his school also participates in the training of the TBA's so with his help I hoped to learn more about this program. By the end of our two week language and culture classes I had established plans to make a trip up to Mansakonko to visit Musa, the Soma health center, the school for community health nurses, and hopefully, with Musa's help, interview some TBA's. I had his contact information and was to call him when we returned from our up-country trip.

Although our official research wasn't to start until after our up-country trip I was able to begin early. About five or six days into the trip we stopped at the village of Bajakunda where I visited my first health center and interviewed my first midwife. It was an eye opening and intriguing experience which got me really excited for my research to come.

Once back from our up-country trip and having had my first taste of an African health center, I was ready to see more. Shortly after our return Professor Roberts took me to meet with Ismaila Njie, the Chief Nursing Officer for the country. I informed him of my interests and objectives while in The Gambia and asked for any help with contact information that he might be able to give. I couldn't just

walk into any health center and observe delivery's, I needed permission and thanks to his good graces he called two health centers, Serakunda and Ganjur, and informed them that I would be coming sometime within the next 3 weeks and to expect to hear from me soon. So that afternoon I sat down with a calendar and made a tentative schedule for the rest of our trip. I decided to visit the Serakunda health center before I made my trip to Soma/Mansakonko and to visit the Ganjur health center upon my return. I also spoke with Musa and made plans to travel back up-country on Sunday the 30th of June. After Professor Roberts approved my schedule it was set that I would be going to Serakunda health center Thursday the 27th and Friday the 28th of June. On Wednesday the 26th, Professor Roberts and I poked our heads into the health center to make brief introductions and to explain that I would be there for the next two days. With this done, everything was set.

All of my research that had been set up thus far was observing health centers and interviewing medical staff. Although this was a major part of my research I was also interested in looking at medical statistics that had already been collected. I wanted a better feel for the established medical systems and structures that were in place in The Gambia. A woman by the name of Margaret Grant agreed to provide me with some of these statistics. She was able to share with me the Public Expenditure Review 2001, the Department of State for Health and Social Welfare paper, and Census and population statistics. These reports were extremely helpful and I will be discussing some of their content later.

FINDINGS

Initial Information:

With in the first few days of being in The Gambia Musa explained to me that there are five basic levels of health care providers who conduct deliveries. The first and most common are your nurses. They are 752 in number nationwide and make up the majority of the health care providers.² There are three levels of nurses in the Gambia; community health nurses, state enrolled nurses, and state registered nurses, all of whom deliver babies. Nine months of the nursing school curriculum is devoted to obstetrical training regardless of the level of nurse. Next are the midwives who constitute the second largest division of health care providers with numbers at 263 nationwide. Third you have your doctors who, in 2001, totaled 260 and who are mostly from other countries.³ It is uncommon for doctors to do normal deliveries since they have so many other patients to attend to but in the case of a severe emergency or if surgery is needed a doctor will take over. The fourth division of health care providers who conduct deliveries are your Traditional Birth Attendants or more commonly known as TBA's. TBA's practice at the village level and they fall into two categories, the trained and the untrained. A traditional birth attendant is an elderly woman who has been appointed by the village she lives in to conduct the deliveries for that village. Traditionally a TBA has had no formal training and all of her knowledge has been passed down from generation to generation, from woman to woman, by experience. Due to lack of any formal medical training high risk cases are hard to manage and have a high percentage rate of ending with either a fetal or maternal death. There has been an ongoing movement, for many years, to bring some basic training to TBA's to help them manage these cases and also to provide better routine health care.

The TBA's will undergo a six week course, paid for by the government, 3 weeks of which will be in the class room and 3 weeks will be practical application in a health center. In order to qualify for this training the woman must come from a primary health care village which means the village must consist of at least 400 people. This leaves a lot of villages out and so the number of untrained TBA's is still very large. No one had any valid statistics for me but an estimate was given that about 30%-40% of the population still lives in non primary health care villages. This means that there are still many untrained TBA's who are conducting deliveries in small rural villages though out the country.

Bajakunda

The field study program is designed so that our official research would start after our up-country trip but I was able to actually begin while on the trip. Our last stop in The Gambia, before heading into Senegal, was in the village of Bajakunda. Baja Kunda is a serahulie village of about 4,000 people located at the very eastern end of Gambia. It was our first experience staying in an African village and unlike anything any of us had experienced, so tension and anxiety levels were high. We were to have one full day there and in order to get a richer experience of village life we were to all choose an activity to participate in for the day. I decided to visit the health center which was about a mile outside of the village. It was an easy walk, so about midmorning a group of us set out to the health center and the school which were located right across the road from one another. Upon approaching the health center the first thing I noticed was a large pavilion area which had a small congregation of people gathered inside. There was a table set up with two nurses stationed behind it and a line of women and children in front of it. We took a seat towards the back of the pavilion and waited for the line to disperse, quietly thankful for a minute to rest in the shade. As we sat I observed what was happening at the nursing station. Women, when it was their turn, would pull out a sheet of paper and hand it to the nurse behind the table. Then the women would take their child, of all different ages, and place them in a hanging scale. Their weight was then recorded on the previous mentioned paper, the children were taken down and the women went on their way. This was something that I would observe at all the health centers in the future. I later learned from Teddy, the nurse, that this was part of a nationwide program to monitor the nutritional health of children 5 years old and younger. It is between the ages of 0-5 that children are at the highest risk for death and so this program was created to help monitor and hopefully decrease the death toll. In theory women are supposed to bring their children once a month to be weighed. If the children aren't gaining weight properly then education and advice will be given. Now not all women can make it to the health centers every month to participate due to other obligations. Many women, especially in the rainy season, don't have the time because of the long hours they spend in cultivating their fields. It seems that most rural women walk to the nearest health center due to the lack of any other mode of transportation and therefore it's a time consuming event which is very disruptive to the daily schedule. But of the women and children who do come on a regular basis, this program has helped monitor malnutrition in The Gambia.

After introductions were made, Teddy agreed to show me around the Bajakunda health center. After a tour of the facility, which consisted of one relatively small

building, we made our way to the opposite side of the building where the labor ward was. It was here that I was introduced to the midwife, a man I might add, who was busy at work attending to patients. He was more than happy to speak with me, which I found to be the case most of the time, and spent the next hour or so answering my questions. He believed the average age for a women's first pregnancy is between 15 and 18 and that the average number of pregnancies per woman is 10 (numbers can vary between rural and urban settings). Not all of these pregnancies will produce living children due to miscarriages or stillborns but most women have between 8 and 12 pregnancies in the course of their lives. I also learned from him that 99% of all women in The Gambia are anemic and have to be on iron pills for the duration of their pregnancy. What shocked me the most was that the Bajakunda health center services 47 neighboring villages and has only one midwife and one sheet less delivery bed. They have only one speculum, an instrument used to view the cervix, and no consistent supply of antiseptic or sterilization methods. There was no supply of pain medication, the instruments were all dull, and any complication at all had to be referred on to Basse due to lack of proper equipment to handle emergencies. To get to Basse is a minimum an hour and a half drive and that's on a good day. As the midwife was telling me all of this I could hear the frustration in his voice. He knows that his facility needs a lot of improvements but he also knows that most of the medical facilities in The Gambia are like this and he has to do the best with what he has.

One of the things that struck me most about our meeting was simply that he was a male midwife and in our country most midwives are female. I had been wondering about this throughout our conversation and as we were wrapping things up I asked him how he was received as a male in his line of work. To my surprise he told me that most women prefer to see a male midwife because men tend to be more sympathetic to what the women are going through. This was hard for me to believe at first since it seems to be the opposite in our country but over the course of my research I would hear this same thing over and over again. What I came to realize towards the end of my stay, after having observed both male and female midwives at work, was that this did seem to be true. The females were less patient, less tolerant, and less sympathetic to their patients. There was hardness to the care that they gave. Hardened, probably, from having been through it numerous times, from having birthed several children, and from having felt that pain and come through just fine. Where as the men have no idea what it feels like to carry a child for nine months and have your body go through hundreds of changes and then have to go through the pain of labor, of contractions, of pushing the baby out. Men have no reference point for that kind of pain and therefore sympathy and concern come more readily to them.

Serekunda

I was anything but prepared for my experience at the Serakunda Health Center. I must first say that Serakunda is an urban area located in the western river division near Banjul, the capital city. It is the most densely populated area in all of Gambia with the Serekunda health center servicing a catchment area of 361,262 people as of 2001.⁴ The clinic services all types of ailments ranging from the common cold to child birth. The facility is basic and any real emergency is referred on to the hospital in Banjul. There are 16 hospital beds in the inpatient

ward but usually each bed holds 2 people so the maximum number of admitted patients at any given time would be 32. The inpatient ward is only for women and children. The clinic on average services 600-700 patients per day with around 150 of them being pre-natal, and 15 being active labor patients. The lines are massive. I've never seen anything like it. People wait for hours, on cement benches in the open air, to be seen for 5 minutes.

I spent my time just opposite the inpatient ward in the labor ward. This area consisted of an entranceway with a table and a few chairs and off the entrance were 3 curtained labor/delivery rooms. The rooms were furnished sparingly, consisting of two beds with no sheets, no pillows, no tables, and no chairs. The health centers don't have the resources to provide these things so if they are desired; people are expected to bring their own. This goes for food as well, nothing is provided for the patients. There was no curtain separating the two beds so therefore privacy was also nonexistent. My first day in the health center had been somewhat of a shock. When I left I was in a daze for the afternoon. The way deliveries are conducted here is very different from what happens at home. What struck me the most about the experience is, what I would call, a complete lack of support for the laboring women. They spent the duration of their labor totally alone. Family members aren't allowed in the rooms due to the lack of privacy for the other patients sharing the room. In theory women in labor are supposed to be checked internally every four hours for progression of cervical dilation, and fetal heart tones are to be checked every hour. Whether these procedures take place as planned depends greatly on how busy the clinic is. There is only one midwife on duty per shift and maybe two nurses no matter how many patients are in labor.

The first day I was there, there were 5 women in labor, one of whom gave birth to a son while I was present. She was 19 years old; this was her first child and she was all alone on a bed with no sheets. She was 8 cm dilated when I arrived and obviously in intense labor. Pain medication is not an option for these women since the health centers usually don't have any available. As the labor progressed and the contractions grew stronger, her wails became more frequent. The thin curtain separating her from the entrance room didn't leave much for the imagination. No one else seemed concerned that she was alone and in pain with no one to support her and make her comfortable. The staff appeared to be more concerned with other things and paid her little attention. At one point I witnessed her, completely naked, move from the bed to the floor, which was anything but clean. I had no idea what to do. Who was I to try to step in and offer my assistance, even if it was just moral support. I don't even know if it would have been wanted but I know that's all I wanted to do. After about 4 hours she was checked, now fully dilated, fully effaced, and pushing. I thought that surely someone would stay and help her push but once again she was left on her own, with, I would assume, diminishing strength.

Finally, an hour and lots of wailing later, she was declared ready. I was called into the room and within one minute the baby was born. Immediately the cord was clamped and cut, the sex revealed to mom, the baby wrapped and taken out into the entrance room where it was placed on a cart and left until later. The assisted portion of the delivery took less than five minutes. Attention turned back to the mom until the placenta was birthed and then the mother was wiped

off and covered with her clothes. Meanwhile an electric kettle was heating water to bathe the baby. The mother was to be observed for an hour after birth to make sure there were no complications and then if all was normal she was to be sent home (this is to make room for other patients). After about a half hour I bathed the baby with a sanitation pad and a bar of soap. Once clean the baby was placed on a scale and weighed, then wrapped in a clean cloth and placed on the same cart, still having not been held by mom. This mother didn't have any problems and so after the hour went by she was gotten out of bed, walked through the entrance way to the bathroom and given a bucket to take a bucket bath and clean herself up. Then she dressed and for the first time, almost 2 hours later, held her baby. A quick 2 minute talk on breast feeding was given and then mom and baby were free to leave the building. They had one more stop at the immunization table where the baby would be given two shots and then they would be able to go home. A quick 2 minute talk on breast feeding was given and then mom and baby were free to leave the building. They had one more stop at the immunization table where the baby would be given two shots and then they would be free to go home.

Meanwhile, while this has all been going on, the clinic has stayed busy. Other women in labor, people coming to get prescriptions, people coming and going from the inpatient ward and one woman having a miscarriage. It was obvious to me after five minutes and especially after two days, that the clinic was extremely understaffed for the demand it faced, the facility way too small, and the supplies were in frightening low quantities. I felt horrified at the lack of sanitation and at the lack of support that these women were given, but I was amazed at the courage and strength and resilience that these women possess.

I was beginning to gain a better understanding of the obstacles that developing countries face in terms of their health care programs. Without sufficient funding, materials, and education/trained staff it's almost impossible to provide the kinds of medical advancements that The Gambia is seeking. They are trying though, with a newly established medical school in Banjul and three public nursing schools already in existence. Funding is always an issue and The Gambia relies heavily on outside sources for support. Unfortunately their economy is in no shape to be self sufficient.

SOMA AND MANSAKONKO

Now that I'd had a few health center experiences under my belt I was really starting to wonder what births in the village were like. I was anxious to make my trip back up country to the Soma/Mansakonko area and to find out what was in store for me there. On Sunday morning the 30th of June Professor Roberts took Anne and I to the Serekunda taxi park and put us on a bush taxi to Soma. It just so happened that there were some agriculture Peace Corps volunteers working in the area and so Anne was hoping to meet with them and study rural community gardens in the Soma area. Musa was expecting us sometime that afternoon so everything was set. Neither Anne nor I had had the pleasure of a bush taxi ride yet and we learned very fast that they are quite an experience. The bush taxi we were on was the size of a mini van and was crammed full with 25 passengers and some chickens for company. We arrived in the early evening hot

and sticky and relieved to be off the bush taxi. We spent the evening relaxing and recovering from the day of traveling but arose early to get a full day of work in.

Musa helped Anne get off to a local community garden and then he took me to the Soma health center. I met with one of the staff in charge who spent the morning showing me around and answering my questions. The Soma health center is relatively new, having only been built 2 years ago, and was the nicest facility I would visit on my trip. It was a large facility consisting of many different buildings, and from what I observed, very well organized. They had a trained staff of 34 consisting of 1 community health nurse midwife, 3 state registered nurses midwives, 3 medical officers, 8 enrolled nurses, and 3 Cuban doctors. The other 16 people were technicians, pharmacists, housekeeping, and cooks.⁵ It was a quiet day in the labor ward and I arrived just minutes too late to witness the one delivery of the day.

Of the health centers that I'd visited this was the first one where I had seen mosquito nets above all the beds. Not only did they have them above all the beds but they had started a new program for all pregnant women where when you come for your first pre-natal visit you are given a pre dipped mosquito net to take home. Malaria is a severe problem for all Gambians, pregnant women included. Malaria in pregnancy can cause miscarriages and even maternal deaths. I learned that The Gambia has one of the highest rates for maternal mortality, MMR, in the sub-region. As of 1990 when the last national study on MMR was done the ratio was 10.5 deaths to 1,000 births.⁶ Though it had decreased by 35% since the 1983 survey, the percentage of MMR was still twice that of the neighboring country of Senegal.⁷ Although eclampsia, sepsis, ante-partum hemorrhage, and post partum hemorrhage are the leading causes of MMR malaria plays its part. Though national statistics are hard to compile since there is no set infrastructure to do so, it has been attempted, and a retrospective survey from the Royal Victoria Hospital, Mansakonko Health Center, Fajikunda Health Center, Kerewan and Fatoto health centers gave me a good look at some statistics. Of admitted pregnancy related conditions 40.1% were due to malaria and of those 37.2% led to the death of the patient. 23.3% of pregnancy related deaths were due to hemorrhaging and 9.4% of pregnancy related deaths was due to anemia.⁸ Kumba Sabally, a nurse midwife and Peace Corps trainer of TBA's, pointed out to me that somewhere between 30 and 50 percent of the population live in non- primary health care villages. The health problems of this segment of Gambia's population are not captured by the available official statistics.

SERA MUSA

Before I came, Musa had located a village about an hour beyond Soma where there was an untrained TBA who I could hopefully interview. We unsuccessfully tried to reach our contact person but left on the following morning anyway. So we set out on another bush taxi and after about an hour of driving through the countryside we finally came to the village of Sera Musa. The village was set back off the road so we walked the dirt path that led to the village entrance. We stopped at the first compound or Alkalo to try and find where the TBA lived and also to speak to the village head. Luck was with us, this was the village head's compound and his wife was the TBA. Musa spoke to them in Fula and explained

our purpose and asked if she would be willing to talk with us. Musa translated when he had the chance. The TBA's name was Penda and she was happy to speak with us. As more and more of the family members gathered around to see what was going on, we decided to seek shade and space and so we made our way through the women, children, and goats to a spot just outside of a mud and grass hut.

Once the commotion had fizzled away we sat down and began the interview. While this had been going on I was trying to assess how old Penda was, which in The Gambia is not such an easy task. Looks here are often deceiving but I finally guessed her age at around 50 years, and Musa would later agree with me. When we sat down Musa went ahead with our formal introductions and then the interviewing process began. I was feeling a little awkward because I didn't understand the language and I had never had a translator before. I would ask Musa a question which he would then translate into Fula and ask Penda, she would then respond in Fula to Musa who would then translate to me in English. This is how it went for the duration of our conversation. What I learned from Penda was pretty remarkable. She said that she doesn't give any prenatal care to pregnant women. If they want pre-natal care they must go to a neighboring village's health center provided they can travel the distance. She is called upon for help at both early and "ripe" stages of labor. It depends on how the pregnant woman feels as to when she calls for the TBA. Once she is called there are three indicators she uses to gauge whether the woman is truly in labor or not. If the woman's abdomen is warm to the touch, if she is vomiting, and if she is leaking 'water' then she is thought to be truly in labor, if these conditions don't exist it is considered a false alarm. Penda will go to the woman's compound where she will labor with her until she is ready to deliver. Usually there will be two other women present at the birth. One will be another respected female elder of the community and a female relative of the woman in labor. The husband is not present for the birth, unless there is a complication, but the woman is supported fully by these three women. There are three traditional folk medicines that Penda told me she gives to laboring women. The first is a blue powder, which is generally used to brighten colors in laundry, which is mixed with water and given to the woman to drink. The second is called Biki which is a salt like substance collected from the nearby lake. This will also be mixed with water for the woman to drink but it must be prepared in a calabash that has never been used before. A calabash looks like a soup ladle and is what we know as a gourd. The third medicinal drink is a mixture of soot and water. All of these are thought to help progress labor. Once it's apparent that the woman is ready to deliver she is moved to the back of her compound which is usually fenced in and private. A sack or piece of old cloth will be laid down on the dirt and the woman will lie down on top of this material for the actual birth. Since Penda is an untrained TBA she has no delivery kit or materials and must use what she has around.

Right after the baby is born the cord is cut, with a razor blade if there is one, and then the midwife will bathe the baby with warm water, heated over a fire, face down on her lap. Then the baby will be wrapped in a clean cloth and taken to another room. Attention is then turned back to the mother to birth the placenta. If the placenta doesn't come easily a large spoon will be placed in the woman's mouth and the woman will try to put as much in as she can with the thought

being that it will help to push the placenta out. Once the placenta has been delivered the mother will get up and bathe.

Before the baby goes to the breast for the first time it is given a mixture of salt, sugar, and water by the sister of the new mother or the elder woman who was present for the birth. After this the mother and baby are united and they retreat inside their home where they will stay secluded for one full week. They will be taken care of completely for the week and will reemerge one week after the birth for the child's naming ceremony. The new mother will now partially resume her light chores, laundry, cooking, cleaning, but she will not go back to the fields for quite awhile.

After my visit to Sera Musa it became obvious to me that there were both advantages and disadvantages to delivering in a health center as well as a village. The health centers provide a more modern environment with more technology such as medicines, trained personnel, and the ability to better handle an emergency situation. But the key thing that was missing was a support system for the woman in labor. This is due partly to understaffed facilities and partly to management skills. Where as if you deliver in a village setting the family and friend support is in place both during and after the delivery but the trained personnel and appropriate materials and medicines are not. This is putting the woman at a much higher risk for complications. The percentage of fetal and maternal mortality is much higher in rural village settings than it is in areas with modern health facilities. As with much of life, it's about trying to find a balance between the two. It was an incredible visit to Sera Musa, I only wish I'd had the time to learn more about traditional medicine and had time to interview a trained TBA as well. Possibly on my next trip to Africa.

CONCLUSIONS

My time in The Gambia taught me a lot, not only about childbirth in a developing country but also about myself and the world. I was given a glimpse of how medicine is practiced in developing countries. In every Health Center I visited I saw an immense struggle to be able to provide basic health care for the people. There is never enough money, enough staff, enough supplies, and especially enough medicine. The medical staff of every facility I visited did their best considering the conditions. They stretched their supplies as thin as possible, they doubled occupancy in beds, they used the floor if need be, and they dispensed their medicines until they ran out. They made the best of their seemingly bad conditions. In these facilities I carried with me a sadness which I had never felt before. There was so much suffering going on around me and I felt helpless to do anything about it. Where does one possibly begin to sort out the health care issues? The thought of what a large task it truly is, is so completely overwhelming that it's hard to comprehend, but it did invoke in me the desire to make a to try to make a difference. I realized how fortunate we Americans are. We can sneeze and with in 30 minutes be at the doctor's office where as in the Gambia it takes some people two days to reach the nearest health facility. We take to many things for granted. Death and disease saturate this country in a way in which we'll never be able to fully relate to.

Learning about the process of childbirth in The Gambia was an eye opening experience for me. I have the utmost respect for the women of this society and was amazed at the strength and resillance that they possess. In America when a woman is pregnant it is expected that she will go to the hospital once her labor begins. There she will be diligently attended by nurses and doctors and she will stay in their care for at least 24 hours. This is not the case in The Gambia. What I realized in The Gambia was that there are many factors contributing to the decision of where a woman will deliver. It depends on the financial status of the family. There is no form of insurance or social welfare program to help if you can't afford it. It also depends on the location of the nearest facility. If the woman lives far away and has no transportation then there is no way for her to get there. And if a woman does go to a facility she must make certain that another woman is helping with her children and household chores in her absence. If a woman does deliver in a facility then she has a better chance for herself and her child to survive if any complications do arise. But due to the volume of patients and the lack of staff, her personal needs will probably go unattended. If a woman delivers in her village then the risk is much greater but the care is much more in depth. A lot of the time the decisions are made for the women due to circumstance and there isn't much she can do to change it. The Gambia is making strides to improve their medical system but there is still a lot that needs to be done and maternal/fetal medicine is only one field that needs attention.

Being an American and coming from a place where there is so much material wealth, state of the art everything, and excess waste and then going to a third world country where people barely have enough money to buy a bag of rice to feed their family, gave me a new perspective on the world. I realized that we aren't taught how most of the world lives. We're brought up in a bubble and taught to believe that America is the standard for which all the rest of the world strives to become. Most of us don't know what it's like to not know when you're going to eat your next meal or what it feels like to worry if your sick child is going to die because there is no medicine. American women don't have babies with no support and no drugs and get up and walk out the door an hour later. It's sad to say but these days a lot of Americans probably don't even know what it feels like anymore to walk barefoot in the dirt. America has become so contrived and plastic that it seems as if we have lost the roots of what is really important in life. I think that there is a lot that we can learn from indigenous cultures around the world. In The Gambia you couldn't get away from these lessons, they surrounded us constantly: the importance of family and community, of hard work, and of perseverance; the value of inner strength, resilience, and humbleness; and the ability to have so little yet still willingly wear a smile on your face.

I experienced what it felt like, for the first time, to be a minority and to always stand out. I experienced a new level of frustration that accompanies the unobtainable desire to be anonymous. I gained a greater appreciation for difference and had a greater desire to accept and honor differences because they make the world a more interesting place to inhabit.

I loved my time in The Gambia. It was an eye opening experience which had a great impacted on me. I think everybody should experience a third world country and receive the gifts that it has to offer and the lessons it has to teach. It can only

help to raise awareness about the world and hopefully help people to live more consciously. I plan to travel back to Africa hopefully as soon as February!

¹ Human Resources in health, Table 3.5, page 46

² Human Resources in Health, Table 3.2 HHR ratios 2001, page 42

³ Human Resources in Health, Table 3.2 HHR ratios 2001 page 42

⁴ Preliminary Report on the Revised Health Information System and health Indicators For the year 2001, catchment area population table.

⁵ Soma Health Center Annual Report

⁶ National Maternal Mortality Survey of 1990

⁷ Public Expenditure Review, 2001, Page 62

⁸ Public Expenditure Review 2001

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