

NATIONAL HEALTH POLICY



REPUBLIC OF THE GAMBIA

**“HEALTH
IS
WEALTH”**

2012 - 2020

“Acceleration of Quality Health Services and Universal Coverage”

**MINISTRY OF HEALTH &
SOCIAL WELFARE
BANJUL, THE GAMBIA**



FOREWORD

Since 1996, it was deemed imperative for The Gambia to map out clearly a strategy for socio-economic development that aims at raising the standard of living of The Gambian population by transforming The Gambia into a dynamic middle –income economy. This is the fundamental objective of “The Gambia incorporated ... Vision 2020”. To the President, Vision 2020 is not a dream and the Government is committed to its attainment.

This health policy is in line with the Vision 2020 and the Millennium Development Goals (MDGs), the Gambia National Development Strategy (2012-2015) and Investment Program – The Program for Accelerated Growth and Employment (PAGE) – which will lead to achievement of all the Millennium Development Goals, especially those related to health; accomplish a three-quarters decline in maternal mortality and a two-thirds decline in mortality among children under five; to halt and reverse the spread of HIV/AIDS and to provide special assistance to AIDS orphans; and put the country on a strong footing to attaining the Vision of the President.

Development of human capital stock since then has been a leading priority in the development agenda of The Government of The Gambia, civil society, donors’ community and academia. Health, along with education and nutrition, is considered as one of the key elements of human capital stock formation. Consistent with the strategic direction for improving human capital stock, makes health central to The Gambia’s development efforts.

The theme, “health is wealth”, which is the current philosophy which our national health policy is hinged upon becomes a reality only when a healthy population can contribute to improved productivity, increased GDP and sustained economic growth and overall ensure social equilibrium. Hence the slogan:

“A Healthy population is a Wealthy population”.

The mission of the Ministry of Health is to contribute to socioeconomic development and wealth creation by promoting and protecting the health of the population through equitable provision of quality health care within the context of Primary Health Care. This mission puts the concept of health beyond the confines of curative care to other socio-economic determinants of health.

The health sector despite remarkable achievements registered since 1994 to date is still under great pressure due to a number of factors: high population growth rate, increasing morbidity and mortality, insufficient financial and logistic support, deterioration of physical infrastructure, inadequacies of supplies and equipment, shortage of adequately and appropriately trained health personnel, high attrition rate as well as inadequate referral system. Poverty and ignorance have led to inappropriate health seeking behaviours thus contributing to ill health.



Indicators of child and maternal mortality are particularly worrying. This situation is worsened by other factors related to the poverty in general resulting to the high prevalence of communicable and non-communicable diseases such as Malaria, Diarrhoea, Upper Respiration Tract Infection, Tuberculosis, Skin Disease, Accidents, Hypertension, Cancers, Eye Infection, and Pregnancy related conditions, Helminthiasis and malnutrition and HIV/AIDS and its spread. Most of these diseases can easily be prevented if appropriate environmental and lifestyle measures are taken, with more attention paid to development of health promotion and prevention actions than merely focusing on curative care alone.

The revised policy is expected to reform the health system by addressing the major traditional problems of health, the new challenges and the double burden of communicable and non-communicable diseases, curbing the HIV/AIDS pandemic and overcoming a weak health system. This reform is in line with the Local Government decentralization and planning based upon the Local Government ACT of (2002), Vision 2020 and the anti-poverty Programme for Accelerated Growth and Employment (PAGE), attainment of MDG: 4 Reduce Child Mortality; MDG: 5 Improve Maternal Health; and MDG: 6 Combat HIV/AIDS, Malaria and Other Diseases.

Implementation of policy measures will certainly impact on reducing morbidity and mortality of major diseases, promote healthy lifestyle, and reduce health risks and exposures associated with negative environmental consequences. It provides basis for an institutional and legal framework for implementation of policy measures. It also identifies relevant stakeholders that contribute to health service provision and the institutional framework for mobilizing sector-wide resources for health development. The policy update therefore provides an impetus and new direction for health sector development that will serve as the basis for driving our health sector priorities and planning as well guiding resource allocation processes in the next few years to come.

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Minister of Health & Social Welfare

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ABBREVIATIONS

ACSM	- Advocacy Communication and Social Mobilisation
AIDS	- Acquired Immune Deficiency Syndrome
ART	- Anti – Retroviral Therapy
BCC	- Behavioural Change Communication
BFCI	- Baby Friendly Community Initiative
BI	- Bamako Initiative
BTS	- Blood Transfusion Services
CBO	- Community Based Organisation
CP	- Chief Pharmacist
CSD	- Central Statistics Department
DFSQHE	- Directorate of Food Security, Quality and Hygiene Enforcement
DHS	- Director of Health Services
DNPPLS	- Directorate of National Public Health Laboratory Services
DOTS	- Directly Observed Treatment Short course
DPI	- Directorate of Planning and Information
DRF	- Drug Revolving Fund
EDC	- Epidemiology and Disease Control
EH	- Environmental Health
ENC	- Emergency newborn care
EOC	- Emergency Obstetric Care
EPI	- Expanded Program on Immunization
FP	- Family Planning
GAVI	- Global Alliance for Vaccine Initiative
HIV	- Human Immunodeficiency Virus
HMIS	- Health Management Information System
HRH	- Human Resources for Health
IEC	- Information, Education and Communication
IHR	- International Health Regulations Illnesses
IMNCI	- Integrated Management of Neonatal & Childhood
IPT	- Intermittent Preventive Treatment
ITN	- Insecticide Treated Nets
MDGs	- Millennium Development Goals
MDT	- Multi Drug Therapy
MICS	- Multiple Indicator Cluster Survey
MOU	- Memorandum of Understanding
NCD	- Non-Communicable Diseases
NGO	- Non-Governmental Organization
NPS	- National Pharmaceutical Services
OHS	- Occupational Health and Safety
PAGE	- Program for Accelerated Growth and Employment
PCU	- Policy Coordinating Unit
PHC	- Primary Health Care
PIU	- Policy Implementation Unit
PLWHA	- People Living With HIV/AIDS
PMO	- Personnel Management Office
PRSP	- Poverty Reduction Strategy Programme
RCH	- Reproductive and Child Health



RFH	- Riders for Health
RH	- Reproductive Health
RHD	- Regional Health Directorate
RHO	- Regional Health Officer
RHT	- Regional Health Teams
RTI	- Respiratory Tract Infections
STI	- Sexually Transmitted Diseases
SWAp	- Sector Wide Approach
TB	- Tuberculosis
TH	- Traditional Healer
TM	- Traditional Medicine
TOR	- Terms of Reference
VC	- Vector Control
VCT	- Voluntary Counselling and Testing
VDC	- Village Development Committee
VDRL	- Venereal diseases reference laboratory
VHC	- Village Health Committee



1.0 INTRODUCTION

1.1 Location, Size and Climate

The Gambia is located on the West African coast and extends about 400 km inland, with a population density of 128 persons per square kilometre. The width of the country varies from 24 to 28 kilometres and has a land area of 10,689 square kilometres. It is bordered on the North, South and East by the Republic of Senegal and on the West by the Atlantic Ocean. The country has a tropical climate characterised by two seasons: rainy season (June – October) and dry season (November-May).

According to the Population and Housing Census (2003), the population is estimated at 1.79 million, with annual growth rate of 2.74 %. About 60% of the population live in the rural area; and women constitute 51% of the total population. The crude birth rate is 46 per 1000 population while the total fertility rate is 5.4 births per woman. The high fertility level has resulted in a very youthful population structure. Nearly 44% of the population is below 15 years and 19% between the ages 15 to 24. Average life expectancy at birth is 64 years overall with females constituting 59 and males 55. Please see **Appendices: A & B**.

1.2: Health Status of the Population

The Gambia has an Infant Mortality Rate of 75/1000 live births, 60% of which is attributable to malaria, diarrhoeal diseases and acute respiratory tract infections. The main causes of mortality in infants (0-12 months) are neonatal sepsis, premature deliveries, malaria, respiratory infections, diarrhoeal diseases and malnutrition. For child mortality, main causes are: malaria, pneumonia, malnutrition, and diarrhoeal diseases. The Maternal Mortality Ratio is estimated at 730/100,000 live births, the majority of which are due to sepsis, haemorrhage and eclampsia (Maternal and Neonatal Survey 2001).

The period 1999 to 2009 has witnessed a decline of total outpatient consultations from 40% to 32.5% respectively, while diarrhoeal diseases for under fives accounts for 19.5% and pneumonia 16.4% of IMNCI cases reported for 2009. Severe diarrhoea is 10.8% compared with severe pneumonia, which is 48.8% for IMNCI admissions respectively. The HIV prevalence rate is 1.6% for HIV1 and 0.4% for HIV2 (sentinel surveillance, 2008).

Tuberculosis remains a disease of public health importance in The Gambia. Generally, the case notification for all forms of TB has also markedly increased in recent years. A total number of 2053 TB patients (all forms) was detected in 2008 in the Gambia. The rate of new smear positive cases have been increasing steadily from 61 per 100,000 in 1994 to 87 per 100,000 in 2006, 2007 and 2008 respectively. Similarly, the rate for All Forms of TB (New sputum Smear positive, New negative, Extra-pulmonary TB, Relapse, Failure and Return after default, others) have also increased. This increase is attributed to both improved surveillance and increased incidence as a secondary infection associated with HIV-1.



There has been an increase in national coverage for fully immunized children to a present level of 79.6 % for under 1 year and 84.9% for the under 2 year (2004 EPI cluster survey). The routine national immunization coverage is above 90% in 2010 for all the antigens (EPI, 2010). Please see **Appendix C**.

Malnutrition continues to be a major public health problem in The Gambia. The MICS 2006 indicated 19% stunting, 6.8% wasting and 17% underweight. Diabetes Mellitus is estimated to affect about 1% of the population while a study found that about 16% of urban women are obese compare to only 1% of rural women. A WHO survey in 2008 reveals the prevalence of other NCD risk factors as follows:

- 24.5% prevalence rate of smoking amongst 13-15 year olds.
- 31.3% prevalence rate of smoking among youths aged 25 to 34 years.
- About 2% of the adult population, aged 25 – 64 years, drink alcohol
- Low consumption of fruits and vegetables, with the average mean number of days for fruits and vegetable consumption among adult males and females estimated at 3.3 and 5.0 respectively
- About 22% of the adult population (males and females) have a low level of physical activity, whilst nearly 59% of adults do not engage in rigorous physical activity. In the same vein, on average, Gambian adults spend 231 minutes per day on sedentary activities
- On average, 41.4% of adults Gambians never had their blood pressure tested. Similarly, about 24.4% of the adult population have raised blood pressure (25.5% for men and 23.4% for women)
- About 90.5% of adults (92.1% of men and 89% of women) never had their blood sugar tested
- About 39.5% of the adult population (33.7% for men and 45.3%) are considered overweight with mean BMI >25kgM2

Safe water is an essential pillar of sustainable health for the population. Access to safe water is 85.1% of the overall households; with 79.9% urban and 64.9% rural and access to proper sanitary facilities are not encouraging thus limiting to only 26% (PRSPII) for the entire country.

The 2008 poverty assessment indicated that overall poverty to be at 55.5% with a poverty gap of 25.9% and poverty severity at 14.3%. However there are regional variation with rural poverty incident of 63% and an urban incident of 57%. See **Appendix: D**.

Considerable progress has been made in the areas of: EPI Coverage, expansion of health facilities and in recruitment of trained health personnel. Success has been registered in the implementation of the Baby Friendly Community Initiative and the Bamako Initiative.

Also, relevant policy documents were developed including that of Nutrition, Drug , Malaria Reproductive and Child Health , Human Resource for Health , Maintenance , Mental Health , HIV/AIDS , Health Management Information System , National Blood Transfusion , Information Technology , and others such as Traditional Medicine, National Public Health Laboratory and the Health Research Policies at various stages of development.



1.3: Problem Statement

- General health system challenges including the effects of previous high population growth rate; inadequate financial and logistic support; weak health information system; uncoordinated donor support; shortage of adequately and appropriately trained health staff; high attrition rate and lack of efficient and effective referral system. In addition, poverty, low awareness of health issues and poor attitude of service providers have led to inappropriate health seeking behaviours and contributed to ill health. These factors have seriously constrained efforts to reduce morbidity and mortality rates as desired and as a result health care delivery throughout the country has not lived up to expectation.
- The frequent changes in top management positions at The Ministry of Health have been hampering continuity, institutional memory and policy flow. The need to have a clear direction to improve quality of health care and reduce the high morbidity and mortality rates requires a stable, supportive, organisational and management framework with a strong flexible and knowledgeable leadership, able and willing to take informed decisions.

1.4: Policy Orientation

From the available statistics, it is important to enhance the delivery of quality health services in order to reduce the high prevailing morbidity and mortality rates.

The need to review the current health policy framework has been influenced by the following factors:

- The high disease burden (communicable and non-communicable diseases) needs intensification of efforts in our service delivery packages;
- The disparity in the demand by the population and quality of services at different levels of health care;
- Lessons learnt from the implementation of certain health projects/programmes like Primary Health Care, Bamako Initiative and Drug Revolving Fund to improve financing of health services;
- The need for stronger partnership and coordination in the health sector with the donors, NGOs, private sector and the community in delivering health services to the population;
- Formulation and implementation of other sector policies impacting on the health outcomes;
- To keep pace with the Decentralisation and Local Government Reforms which emphasises an integrated management of government services, including health to the regions. The devolution of authority, responsibility and resources to the regions shall be directed by the policy framework;
- The absence of a co-ordinated monitoring and evaluation system to measure performance and plan for improvements and ensure accountability; and



- The limited collaboration between the traditional healers and the formal health sector.

1.5: Health System

The Ministry Of Health and Social Welfare (MOH&SW) is responsible for overall policy formulation, planning, organisation and coordination of the health sector at national, regional, district and community levels. In order to facilitate efficient and effective coordination of the sector, the following coordination structures have been established.

1.5.1 Central Level

The MOH&SW Head Office in Banjul is responsible for overall formulation and direction of the national health agenda, including policy and regulatory frameworks, national health planning and priority setting, coordination, and monitoring and evaluation of health sector performance. It is also responsible for resource mobilization and allocation, and provision of technical support and supervision to the regions and specific health programmes. In order to facilitate efficient and effective performance of these functions, MOH&SW has established coordination structures at national level, which include specific directorates and programme management units, responsible for coordinating specific areas of focus. The current organizational structure at the Ministry includes the following main departments, directorates, and programme units;

(a) Department of Medical and Health

The department of Medical and Health comprised of the following directorates:

- Directorate of Health Services (DHS)
- Directorate of Planning and Information (DPI)
- Directorate of Food Standards, Quality and Hygiene Enforcement (FSQHE)
- Directorate of National Public Health Laboratory Services (NPHLS)
- Directorate of Health Promotion and Education (HPE)

i. Directorate of Health Services (DHS)

The DHS is responsible for the coordination, management, monitoring and supervision of health care services within the country. The DHS provides technical advice to the Permanent Secretary and the Minister of Health and Social Welfare.

It also coordinates the functions of the following programme areas: Reproductive and Child Health, Integrated Management of Neonatal and Childhood Illnesses (IMNCI), Expanded Programme on Immunization (EPI), Public Health, National Leprosy and Tuberculosis Control Programme (NLTP), National Aids Control Programme (NACP), National Malaria Control Programme (NMCP), Bamako Initiative (BI), Nursing, Traditional Medicine and Regional Health Services provision and pharmaceutical services.

ii. Directorate of Planning and Information (DPI)

The Directorate of Planning and Information is responsible for the overall planning, budgeting, monitoring and policy and strategy formulation. It includes the following



programme areas: Budget, Planning and Policy Analysis; Human Resource Management; Health Planning, Monitoring and evaluation, Policy Implementation, Health System Research, Registration of Births and Deaths, Disease Control, Maintenance Policy Monitoring, Information Technology and Health Management Information System.

iii. Directorate of Food Standards, Quality and Hygiene Enforcement (FSQHE)

This Directorate has a clearly defined Term of References and is charged with the responsibility to execute laws under the Food Act 2005 as follows:

- Control of foods in restaurants, hotels, schools, and other boarding facilities (*Section 14(a)*)
- Responsible for assuring food hygiene, safety and sanitation in hospitals and health facilities, food establishments and premises including markets and streets (*section 14(b)*)
- Responsible for the control of meat, poultry, milk and other processed and unprocessed foods of plants or animal origin after post-mortem inspections including those in markets and groceries.
- Responsible for the control of exports and imports of poultry, animals and products of animal origin, including milk and shall be effected in conjunction with authorized officers at the points of entry.
- Responsible for the certification of food businesses and all other certification pertaining to food including food handler's

iv. Directorate of National Public Health Laboratory Services (NPHLS)

National Public Health Laboratory Services (NPHLS) is the institution coordinating the services of a network of laboratories. Its roles and functions include:

- Set standards, protocols and guidelines relating to national health laboratory services for public and private.
- To ensure equitable distribution of laboratory infrastructure, equipment and supplies throughout the country.
- Provision of support (technical and laboratory services) to other institutions for public and private
- To establish and enforce quality assurance mechanism for both public and private institution
- Monitoring and supervision of national health laboratory services in both public and private

v. Directorate of Health Promotion and Education (DHPE)

Health Promotion and Education involves behavioural change communication, advocacy and social mobilization. The components of the Directorate of Health Promotion and Education includes the following areas such as: Print, Electronic and Traditional Media; Non-Communicable Diseases, School Health, Community-based Information Education and Communication (IEC)/Behaviour Change Communication (BCC); Behavioural Research, Monitoring and Evaluation, Nutrition Education and



Promotion, Injury and Road Traffic Accidents, Hygiene and Sanitation Education, Environmental Communication and Population Health.

The mandate and responsibilities of Health Promotion and Education Directorate shall include the following:

- Planning, designing, implementing, evaluating and coordinating overall health promotion and education interventions for the Ministry of Health and Social Welfare;
- Foster collaboration between the health and other sectors of government as well as institutions, organizations and the private sector to address the broad determinants of health;
- Support and coordinate formulation of and or strengthening the implementation of national health promotion policy and national health policy, legislations or strategies for tobacco control in line with the WHO Framework Convention on Tobacco Control;
- Provision of technical advice to the Ministry of Health and Social Welfare on International protocols, instruments and conventions that have a public health and health promotion underpinning;
- Act as the technical adviser to the Ministry of Health and Social Welfare and oversee patient education/counselling in the country's medical institutions as part of the health promoting hospital initiatives with a view to ensuring quality care for the poor and the socially deprived;
- Act as the technical body to regulate health information dissemination in the country.

(b) Department of Social Welfare

Directorate of Social Welfare (DSW)

The Department comprised of the Directorate of Social Welfare (DSW).It is responsible for the promotion and protection of the rights and welfare of vulnerable persons such as children, the elderly, persons with disability and adults in difficult circumstances. To enable them maximize their potential and minimize problems arising out of the imbalance between themselves and their environment as a result of social change. Their services focus on the social protection of individual families and groups.This includes the welfare services to the vulnerable families and individuals, child rights and protection services, elderly care, disability care services and regional social welfare services provision and management.

1.5.2: Regional Level

The Regional Health Directorates are headed by Regional Directors of Health Services, who are directly responsible to the Permanent Secretary through the Director of Health Services. Regional Directors of Health Services are responsible for coordinating policy interpretation, planning and implementation of health services, and monitoring and evaluation of health service delivery, within their respective



regions. They are also responsible for providing technical support oversight to the basic health facilities.

1.5.3: Community Level

The Village health services were established in the early 80's to provide primary care at community level. Village health post (VHP) were set up in all settlements with a population of more than 400 inhabitants, served by a trained village health worker (VHW) and a trained traditional birth attendant (TBA) who are supervised by the Community Health Nurses (CHNs). They are also selected and supported by the Village Development committees (VDCs) at community level.

1.6: Health Service Delivery

(a) Public Health Sector

Health Service delivery is organized into three tier system:

- (1) Primary (Village Health Services)
- (2) Secondary (Minor and major Health Centres)
- (3) Tertiary (Hospitals)

1) Primary Level (Village Health Services (VHS))

The VHS consist of community health workers (traditional birth attendants (TBA) and village health workers (VHW) who are often the first point of contact between individuals, families and communities within the health system. These community health workers are supervised by trained community health nurses (CHN). TBAs provide care for pregnant women, conduct normal deliveries, identify and refer obstetrics emergencies. The VHWs on the other hand are involved in health promotion and prevention measures, the treatment of minor ailments, and refer cases beyond their scope of management.

The village health services are complemented by the Reproductive and Child Health (RCH) trekking visits from the health centres. The RCH package includes: antenatal care, child immunization, growth monitoring, registration of births and deaths and limited treatment for sick children.

2) Secondary Level

The secondary level care delivery system consists of minor and major health centres:

- **Minor Health Centre**

The minor health centre is the unit for the delivery of basic health services including basic emergency obstetric care. The national standard for a minor health centre is 20-40 beds per 15,000 population. The minor health centre is to provide up to 70 percent of the Basic Health Care Package need of the population.



- **Major Health Centres**

The major health centre serves as the referral point for minor health centres for services such as: comprehensive emergency obstetric care (surgical, blood transfusion services and further medical care). Additionally, they also offer services such as infant welfare and ante natal services, surveillance and dental services. The standard bed capacity for major health centres range from 110 -150 beds per 150,000 - 200,000 population.

3) Tertiary Level

The general hospitals serve as referral points for the Major health centres as they provide specialised services. The Royal Victoria Teaching Hospital (RVTH) also serves as the referral hospital for the general hospitals.

(b) Private Health Sector

This includes the private for profit and private for non-profit. These are few (numbering less than 20) and smaller in sizes each with bed capacity less than 50 and less than 10 per cent of these are located in the rural community. The large majority are located in the Greater Banjul Area, making choice in health services delivery point in the rural community very limited.

(c) Traditional Medicine

The traditional healing system has been with us from time immemorial. The system includes bone setters, herbalists, spiritualists, birth attendants and those who combine the methods. The System continues to contribute significantly to the health of the population hence the need for their promotion and strengthening collaboration with the orthodox medicine. However, major concerns have been raised about the activities of quacks in the traditional system and the demand for the urgent regulation of the system is equally paramount.

2. 0. VISION AND MISSION

2. 1 Vision

Provision of quality and affordable Health Services for All By 2020

2. 2 Mission

Promote and protect the health of the population through the equitable provision of quality health care.

3.0 GOAL AND TARGETS

Noting the challenges confronting the health sector, and having conceived the vision, mission and guiding principles, a number of key result areas were identified that would collectively have potential for maximum impact on the health status of the citizenry.



3.1. Goal:

Reduce morbidity and mortality to contribute significantly to quality of life in the population.

Morbidity and mortality rates due to communicable diseases have decreased over the years but more pronounced in non-communicable diseases especially among youths and women. In addition to the earlier mentioned health challenges, the main factors contributing to this high morbidity in the population include social determinants and related factors such as poverty, unhealthy environment, unsafe working conditions, poor sanitation, poor nutrition, road traffic accidents, poor access to safe water and poor housing for many. The main causes of mortality within the population are: Malaria, Pneumonia, Anaemia, Diarrhoeal Diseases, road traffic accidents, pregnancy complications and Cardiovascular Diseases. Of increasing concern are the incidences of Tuberculosis and HIV/AIDS in the population.

3.2 Targets

- Infant mortality rate reduced from 75/1000 in 1999 to 28/1000 by 2015,
- Under five Mortality rate reduced from 75/1000 in 1999 to 43/1000 by 2015,
- Maternal Mortality ratio reduced from 730/100000 to 150/100000 by 2015,
- Life expectancy national increased from 63.4 years to 69 years ,
- Life Expectancy for women increased from 65 years to 70 years by 2015,
- Life expectancy for men increased from 52.4 years to 58 years,
- Malaria incidence reduced by 50% by 2015,
- HIV/AIDS Prevalence reduced - HIV1 from 1.6% to 0.5% and HIV2 from 0.4% to 0.1% by 2015),
- Total Fertility Rate reduced from 5.1 in 1999 to 4.6 by 2015,
- Diagnose at least 70% of the total estimated incidence of new smear positive cases annually and cure at least 85% of new sputum smear positive patients by 2015,
- Reduce morbidity due to non communicable diseases by 10% by 2015
- Reduce morbidity due to other communicable diseases by 50% (2007 base).
- Set up a monitoring and evaluation system to ensure timely feedback for corrective measures by 2013
- Advocate for and influence the enactment of an all-purpose Social Welfare Act by 2013
- Set minimum care standards of practice for institutions caring for children by 2013
- Decentralise social welfare service to all regions by end of 2014
- Set up and maintain a Data Base System for information sharing for all the Units of the Ministry of health by 2015
- Establish a National Social Welfare Trust Fund for the needy and vulnerable groups including children and persons with disabilities by 2015.
- Develop a National Child Protection Strategy and operational Plan by 2013.
- Advocate for the signing and eventual ratification of the UN Convention for persons with disabilities by end of 2012.
- Set up a National Plan of Action for the prevention of disability and rehabilitation of persons with disabilities in accordance with the United



Nations Standards Rules on Equalization of Opportunities for Persons with Disabilities by 2013.

- Develop and implement various programmes for the protection and promotion of the rights and welfare of the differently vulnerable and needy groups in The Gambia by 2014
- To reduce the prevalence of blinding trachoma to below 5% in any given community by 2020.
- To ensure that at least 80% of all straightforward cataract surgery patients have visual acuity of no less than 6/18 with best correction by 2015
- To increase immunization coverage to at least 90% for all regions and to sustain 96% coverage for Penta 3 nationally by 2015.
- To contribute to the reduction of mortality due to road traffic accidents by 50% by the year 2020.

4.0 GUIDING PRINCIPLES

4.1 Equity

Provision of health care shall be based on comparative need. Accessibility and affordability of quality services at point of demand especially for women and children, for the marginalised and underserved, irrespective of political national, ethnic or religious affiliations

4.2 Gender Equity

The planning and implementation of all health programmes should address gender sensitive and responsive issues including equal involvement of men and women in decision-making; eliminating obstacles (barriers) to services utilisation; prevention of gender based violence.

4.3 Ethics and Standards

Respect for human dignity, rights and confidentiality; good management practices and quality assurance of service delivery.

4.4 Client Satisfaction

Accessibility to twenty-four hour quality essential services especially emergency obstetric care and blood transfusion services; reduced waiting time; empathy in staff attitudes; affordability and adequate staffing in health facilities.

4.5 Cultural Identity

The recognition of the importance of local values and traditions, and use of traditional structures such as Kabilos, kaffos, traditional healers and religious leaders.

4.6 Health System Reforms

Devolution of political and managerial responsibilities, resources and authority in line with the Government decentralisation programme; capacity building for the decentralised structures (institutions)

4.7 Skilled staff retention and circulation

Attractive service conditions (package); job satisfaction to encourage a net inflow of skills



4.8 Partnerships

Community empowerment; active involvement of the private sector, NGOs, local government authorities and civil society; effective donor co-ordination

4.9 Evidence based health care

Health planning, programming and service delivery shall be informed by evidence-based research.

4.10: Patient bill of rights

The Patient's Bill of Rights helps patients feel more confident in the health care system. It assures that the health care system is fair and it works to meet patients' needs; gives patients a way to address any problems they may have; and encourages patients to take an active role in staying or getting healthy.

4.10.1 Information disclosure

Patients have the right to accurate and easily-understood information about his/her healthcare plan, health care professionals, and health care facilities. This must be done using a language understood by the patient so that he/she can make informed health care decisions.

4.10.2 Choice of providers and plans

Where possible every patient shall have the right to choose health care providers who can give him/her high-quality health care when needed.

4.10.3 Access to emergency services

In emergency health situations including severe pain, an injury, or sudden illness that makes a person believe that his/her health is in serious danger, he/she shall have the right to be screened and stabilized using emergency services. He/she should be able to use these services whenever and wherever needed without needing to wait for authorization and any financial payment.

4.10.4 Participation in treatment decisions

Every patient shall have the right to know his/her treatment options and take part in decisions about his/her care. Parents, guardians, family members, or others that they identify can represent them if he/she cannot make his/her own decisions.

4.10.5 Respect and non-discrimination

Every patient must have a right to considerate, respectful and non-discriminatory care from his/her health care provider (s),

4.10.6 Confidentiality of health information

All patients must have the right to talk privately with health care providers and to have his/her health care information protected. He/she shall have the right to read and copy his/her own medical record. He/she shall have the right to ask that his/her health care provider change his/her record if it is not correct, relevant, or complete.

4.10.7 Complaints and appeals

Every patient shall have the right to a fair, fast, and objective review of any complaint he/she may have against any health plan, health care provider/personnel or health



institution. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities.

5.0: IMPLEMENTATION FRAMEWORK FOR HEALTH CARE PROGRAMS AND STRATEGIES

Preamble

The existing minimum health care package shall be strengthened to make available and accessible quality basic health services at all levels of the health care delivery system. This is essential towards addressing the common causes of morbidity and mortality in The Gambia with particular attention to vulnerable groups and individuals. This has implication for planning, (resource mobilisation and allocation) as well as implementation of other policies.

The Basic Package will be delivered through the following programme areas:

5.1. Environment, Health and Safety

Preamble

Environmental health and safety is an important determinant of health outcomes and still remains a major challenge for the Ministry of Health and partners.

There is a variety of determinants which contribute to health improvement. Even though most of these health determinants are the responsibility of the Ministry of Health, certain are the responsibility of other Departments or services. Implementation of these actions necessarily requires close inter-sectoral collaboration between these Departments and the Ministry of Health. The aim is to influence policies and strategies of all stakeholders in the management of the environment. These activities include, among others: water distribution and sanitation systems to meet essential health needs, training of medical and paramedical personnel, including specialized training, and health research, including biomedical and epidemiological research, as well as research on health system operations, public hygiene activities (refuse collection, removal of household waste, and health inspections), management of hazardous chemicals and pesticides traffic safety, prevention of road accidents, workplace safety; prevention of work-related injury and illness, activities providing food supplements to people who need it and medico-social activities for vulnerable groups.

The Government is cognisant of the effects of the environment on the socioeconomic growth and development including health, and henceforth developed and implemented the National Environment Management Act (1994), the Food Act (2005), and the Public Health Act (1990). Additionally, the President initiative 'Operation Clean The nation' is geared toward addressing environmental issues. In recent years, there has been noted increase in the incidence of road and domestic accidents and those from industry thus warranting interventions to address occupational hazards.



Objective

- To reduce the frequency of environmental health and safety related diseases/conditions by 30% by 2020.

Policy Measures

- Enforcement of environmental health related Acts
- Institute proper management of solid, gaseous and liquid wastes
- Strengthen the environmental units of key municipalities

5.2. Health Promotion and Education

Preamble

Health education and promotion, mainstreamed in all health care programmes is important to the National health care services delivery. At present there is no Health education and promotion policy to guide the effective dissemination of health messages in the general population.

This has led to the current situation of uncoordinated approach to the development and dissemination of comprehensive health messages. As a result the desired impact of the programme continued to pose challenges in the health services delivery.

Objective

- To raise awareness among the population through the provision of relevant health information that would promote, protect and improve health outcomes.

Policy Measures

- Develop and implement a comprehensive health education and promotion policy.
- Establish an effective coordinating mechanism among all stakeholders for correct and consistent health messages.
- Strengthen the capacity of service providers on information, communication and education and behavioural change communication strategies.

5.3. Expanded Programme on Immunisation (EPI)

Preamble

Though immunisation coverage continues to be impressive in The Gambia vaccine preventable diseases such as measles, TB, DPT poses as important challenges for the health sector. However, due to frequent staff movement and high attrition rates, inadequate government and donor funding, cancellation of outreach clinics and high defaulter rates, the routine coverage has dropped from 93.08 % in 2004 to 89.2 % in 2005. Other challenges include limited storage capacity especially at health facility and regional Health Office levels and over-aged cold chain equipment. . Surveillance



is very important in the management of vaccine preventable diseases and is done in collaboration with the disease control unit for overall coordination.

The vaccine independent initiative introduced in the mid 1990s into the EPI programme led to the creation of a budget line for vaccine and logistics. This budget line has been increasing over the years for the procurement of all traditional vaccines, and the logistics, while new vaccines are funded by GAVI.

Objectives

- To increase immunization coverage to at least 90% for all antigens at national and regional levels.
- To ensure vaccine security for all vaccine preventable diseases

Policy Measures

- Mobilize additional financial resources for the EPI programme
- Strengthen the effectiveness and efficiency of the EPI delivery system
- Improve surveillance mechanism for early detection and response to vaccine preventable disease outbreaks

5.4. Disease Control

Preamble

Strategies/programmes based on Integrated Disease Surveillance and Response (IDSR) have been put in place to control diseases such as, HIV/AIDS, malaria, Tuberculosis, measles and eye diseases. However, the threat of epidemic prone diseases including meningococcal meningitis, cholera and yellow fever constitute a major public health concern. Other diseases such as poliomyelitis, lymphatic filariasis and leprosy are at the point of elimination. Non-communicable diseases such as diabetes, hypertension, mental health illnesses, asthma, cardiovascular diseases, including other neglected chronic diseases and cancers continue to pose major public health challenges. To maintain a ready state of preparedness and a swift response to diseases with epidemic potential, the Government of The Gambia will strengthen the epidemiological surveillance system so that there is effective detection, investigation, and management of any suspected and confirmed cases of priority. Cross border surveillance will also be strengthened with the effective implementation of IHR (International Health Regulations).

The monitoring of diseases both emerging and re-emerging will be strengthened with the empowerment of regions to carry out proper monitoring and supervision of interventions. Disaster management requires a multi-sectoral approach: hence, the Ministry of Health will take the necessary measures to ensure there is an adequate level of preparedness and ability to respond to those disasters using collaborative strategies quickly and adequately.

Objectives

- To reduce the burden of communicable diseases to a level that they cease to be a public health problem



- To promote healthy life styles, increase understanding on the prevention and management of all diseases.

Policy Measures

- Strengthen disease surveillance and response capacity at all levels
- Provision of appropriate case management capacity at various levels of health care delivery system
- Community empowerment on disease prevention and control measures

5.4.1 COMMUNICABLE DISEASES

5.4.1 (i): Malaria

Policy Measures

- Community empowerment on malaria prevention and control
- Increase availability and access to LLINs for the general population.
- Strengthen integrated vector control interventions (including in indoor residual spraying)
- Strengthen the availability and accessibility of effective malaria chemoprophylaxis for all pregnant women
- Strengthen Malaria Case management in all health facilities
- Strengthen collaboration with partners in research
- Strengthen community management of malaria

5.4.1(ii): Tuberculosis

Policy Measures

- Promote the expansion of high-quality Directly Observed Treatment Short course (DOTS)
- Support the implementation of advocacy, communication and social mobilisation activities (ACSM)
- Inter-sectoral coordination to address the synergistic challenges posed by TB/HIV

5.4.1(iii): HIV/AIDS

Policy Measures

- Expand and strengthen HIV/AIDS Counselling & Testing (HCT) and Prevention of Mother to child transmission (PMTCT) services.
- Support and expand Anti-Retroviral Therapy (ART)
- Expand the care and support services for People Living With HIV/AIDS (PLWHAs)
- Support sentinel surveillance and research in HIV/AIDS
- Intensify IEC/BCC/CSC interventions on HIV/AIDS



5.4.1(iv): Sexually Transmitted Infections (STIS) (Other Than HIV/AIDS)

Policy Measures

- Effective information, education and counselling of the populace
- Provision of STIs drugs and supplies in all facilities with a view to increase access
- Train health care workers on the syndromic treatment and management of STIs with a view to provide proper treatment
- Set up well equipped laboratories in all major health centres and hospitals
- Establish STI clinics targeted specifically for most at risk populations (MARPs)
- Provision and distribution of condoms to MARPs
- Monitoring and supervision of STI services

5.4.1(v): Diarrhoeal Diseases

Policy Measures

- Increase access to safe water and improved sanitary facilities
- Strengthen case management , prevention and control

5.4.1(vi): Trachoma (Eye Disease)

Policy Measures

- Elimination of blinding trachoma
- Reduce the prevalence of active trachoma to below 5% in all communities
- Intensify IEC/BCC/CSC intervention
- Conduct a survey to determine the prevalence of cataract per region and set up regional cataract surgery targets after Training more nyateros to identify and refer all cataract cases in their communities
- Adequate supply of equipment, drugs and consumables for eye surgery (cataract, glaucoma, retina)
- Training of eye care providers in the prevention and management of corneal ulcers
- Provision of optometrist assistant in each secondary eye care unit to deliver services in each division
- Development of a national Eye care program policy

5.4.2: NON- COMMUNICABLE DISEASES (NCDs)

Preamble

The World Health Organization (WHO) 2005 Report on chronic diseases indicated that the majority of deaths worldwide for all ages are due to chronic diseases such as cardiovascular diseases (mainly heart disease and stroke), cancer, chronic respiratory diseases, and diabetes. Non Communicable Diseases (NCDs) are a consequence of unhealthy diet and lifestyle such as tobacco use, physical inactivity and harmful use of alcohol, constitute a major public health problem and are known, for both their high financial and social cost for families, communities and countries.



As stated earlier, chronic non-communicable diseases such as hypertension, diabetes and cancers are on the increase in the Gambia. A population-based situation analysis conducted in 2001 revealed that 8.6% of the adult urban population and 1.4% of the rural adult population had diabetes mellitus. The same study revealed that between 10 to 20% of the population was chronically infected with hepatitis B. These findings are not at great variance from studies conducted by Van Der Sande et al (1996 & 2001) which showed 9.5% of adults over 15 years were hypertensive according to WHO criteria (a diastolic blood pressure of 95 mmHg or above and/or systolic blood pressure of 160 mmHg or above).

There is a risk of the health system being confronted by an increase in the number of cases of **non-communicable diseases** and as such adequate measures are being taken to alert those responsible for the prevention, diagnosis, treatment including the management of such diseases. These diseases are commonly cancer, diabetes, cataract, arterial hypertension and those associated with tobacco consumption, alcohol abuse, an inactive life style and environmental pollution. Oral health, the prevention of blindness and physical rehabilitation services for handicapped people are to be improved.

Objective

- To reduce the burden of NCDs Risk factors in the Gambian population through the promotion of healthy behaviours, lifestyles and appropriate care by end 2020

Policy Measures

- To finalize and implement national NCD Policy and Strategic Plan.
- Strengthening capacity for the management, prevention and control of NCDs
- Supporting broad based participation in support of NCD prevention and control.
- Creating supportive environment for addressing the risk factors for NCD
- Building and strengthening capacity for NCD research
- Scaling up of IMNCI strategies to all levels
- Develop and provide essential (basic) Health Care Packages at different service delivery levels

5.5: Mental Health

Preamble

It is estimated that approximately 27,000 people in the Gambia are suffering from a severe mental and/or substance abuse disorder and that a further 91,000 Gambians have a mild disorder still requiring treatment (World health Survey, 2004) .A local prevalence study in the Gambia, puts prevalence rates higher (at 20%) and leads to estimates of approximately 180,000 people suffering from a mental or substance abuse disorder. Providing effective treatment and support to all these people is challenging, given the scarce health resources in the Gambia and an overall situation of poverty in the country, where 34% of the population live below the poverty line and 18% of the population are extremely poor. However, consultation



with many different experts, health professions and key individuals from different government sectors has highlighted the great need, willingness and strategies required to strengthen the overall mental health system in order to provide effective treatment and care to those in need as well as to promote the mental health of all Gambians.

Objective

- Improve access to quality mental health care for all Gambians

Policy Measures

- Implement the Mental Health Policy and Strategy
- Strengthening capacity for the diagnosis, management, prevention and control of mental and neurological disorders
- Providing quality, equitable and affordable mental health services to the general population
- Promote IEC on substance abuse
- Promoting advocacy for the reduction of stigma and discrimination against people with mental and neurological disorders
- Strengthening community involvement and participation in mental health care service delivery
- Operationalise the revised current Lunatics' Detention Act of 1917 taking into account a new mental health legislation Establishing and strengthening capacity for mental health research
- Strengthen the prevention, case management and control of mental health illnesses country wide
- Develop a Mental Health Act.

5.6: Reproductive and Child Health

Preamble

RCH services are provided at all levels of the health system by both public and private facilities at base and outreach through a network of health facilities across the country. With an impressive nationwide coverage RCH indicators have over the years been reduced significantly. For example, MMR high has reduced from 1050 to 730 per 100,000 live births between 1990 and 2001(DOSH 2001). Child health indicators have equally been reduced. Infant mortality rate has improved from 167 (1983) to 75 per 1000 live births (2003); and under-five mortality rate has also reduced from 154 to 99 per 1000 live births between 1990 and 2003.

Despite these achievements, RCH indicators are still unacceptably high and pose as tough a challenge for the country. Stark regional variations also exist with the above indicators. For example, MMR is two-fold higher in rural than in urban areas and under-five mortality is three-fold higher in Lower River Region than that of Banjul (137 vs. 41).



A combination of factors (health and non-health service related) is responsible for the above high RCH indicators. Unmet need for RCH services particularly emergency obstetric care services resulting mainly from lack of basic RH equipments and supplies, acute shortage of skilled health professionals, weak referral system and inadequate financial resources for RCH services are some of the health services. In addition to these, non-health service related factors including high fertility rate (national 5.4), poor and inadequate nutrition, poor socio-economic status manifested by poor housing, limited availability and access to safe water and basic sanitation are important determinants.

Objective

- To reduce mortality and morbidity related to but not limited to childhood, reproduction and the reproductive system across the country

Policy Measures

- Strengthen and promote 24/7 Emergency Obstetric Care concept;
- Strengthen and promote Emergency neonatal care;
- Advocate and ensure Implementation of the national reproductive health commodity security plan;
- Introduce and institutionalise peri-natal reviews and audits;
- Maintain, promote and protect the free of cost policy for MCH services;
- Establish a minimum RCH care package;
- Monitoring, evaluation and research
- Increase awareness on sexual, reproductive and child health issues;
- Promote partnership and coordination among all stake holders in the field of RCH;
- Create opportunities for the improvement of the nutritional status of the vulnerable groups.
- Operationalize operating theatres in all major health facilities.

5.7: Integrated Management of Neonatal and Childhood Illnesses

Preamble

The Government of The Gambia adopted the Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy in 1999 to address the high morbidity and mortality among children under five years. The IMNCI strategy combines improved case management of childhood illness in first-level health facilities with aspects of nutrition, immunization, disease prevention, and promotion of growth and development. There are three components of IMNCI which are: improving the skills of health workers; improving the health system, and improving household and community practices.

The IMNCI strategy is a technically sound, comprehensive and evidence-based strategy focusing on the main threats to children's health and focus mainly on the prevention and adequate treatment of malaria, diarrhoea, pneumonia, measles and malnutrition because they are responsible for about 70% of deaths among children



under five years. It targets children under five years and focus on the five main causes of mortality in children under the age of five.

Objective

- To reduce mortality and morbidity associated with major causes of disease in children less than five years of age.

Policy Measures

- To monitor growth and development of children under the ages of five
- To build the capacities of health workers on IMNCI Case Management Skills
- To strengthen collaboration with traditional healers and other community partners for effective implementation of community component of the IMNCI strategy.
- To strengthen the implementation of the IMNCI strategy in all seven health regions in the country.

6.0: BASIC HEALTH CARE AND LEVELS OF DELIVERY

6.1 PRIMARY HEALTH CARE (PHC) SERVICE

Preamble

The Gambia adopted Primary Health Care (PHC) in 1979 following the Alma-Ata declaration in 1978. Subsequently a PHC Plan of Action for the period 1980 to 1985 was formulated which formed the basis for a National Health Policy. In the Plan of Action, PHC has been defined as:

An approach aimed at mobilising all potential resources including the communities' own resources, towards the development of the National Health Care System, the aim being to extend health services coverage to the entire Gambian population and to attract the main disease problems of the communities. PHC is also a mechanism for ensuring an equitable re-distribution of the limited health resources available in the country in favour of the under-served majority, who live and work in the rural area.

At present quite a number of PHC villages are not functioning optimally. Reasons for non performance are attributed to several factors namely an ineffective VDC, lack of support for community health workers, shortage of drugs and lack of supervision. A selective PHC programme has been designed to intervene at village level to control priority diseases such as Acute Respiratory Infection, Diarrhoeal Diseases, Tuberculosis, Malaria, Preventive Eye Care and HIV/AIDS.

Support to and capacity building at primary level are essential for sustaining of basic PHC technologies needed to address common health problems affecting women and children, and management of development projects which have an impact on health e.g. community water supplies, sanitation, home based care for malaria, etc.



In order to restore the functionality of all existing PHC villages, the Ministry of Health in collaboration with stakeholders and the community will review the present VDC system.

The development of the VHS has been in isolation to the BHS. The latter possesses a wide range of resources to support the VHS. The policy calls for define linkages between the BHS and the VHS. A basic health facility will be linked to a number of trekking stations and PHC villages. This group of facilities and the population it serves (including non primary health care villages) will constitute a CATCHMENT AREA.

The basic health facility will perform the first line supervision and provide support in the areas of training and supply of drugs to the VHS. Each catchment area will have a catchment area committee. The latter will be closely involved in the management, planning, monitoring and evaluation of services provided in the area under its jurisdiction.

6.1.1 Service Expansion

At present, health services are provided by 546 health posts at the primary level. When PHC was introduced in 1979 some villages which did not qualify for reasons of numbers now qualify. The present policy of establishing PHC in villages with a population of 400 or more or where access is difficult will continue so as to accommodate new villages. In view of the numbers of villages to be involved, villages in vulnerable areas will be given first consideration, especially those in the north bank of CRR and URR as per the recent UNICEF MICS findings.

To provide the required supervision and support, new key villages and circuits will be established simultaneously. NGO and Government partnership is essential and will be encouraged especially in the planning and inauguration of new PHC villages, so that NGO intervention and resources can be better maximised.

Currently 21 NGO health facilities and 19 private clinics and 18 Community-owned/managed Clinics complement government health services. In spite of the fact that this health policy calls for participation of the private sector and communities in the provision and management of health services delivery, the absence of clear guidelines and enabling policies and Acts has limited the capacity of the Ministry to control the unprecedented wave of expansion of services at these levels. New health mapping studies will be undertaken to determine health services expansion, especially in key growth centres and within the urban areas where population continue to grow at an alarming rate.

Objective

- To ensure access to basic health care for all Gambians
- To improve access to tertiary health care services for the Gambian population
- To ensure the functionality of all existing PHC villages

Policy Measures

- Strengthen/ build capacity at primary level
- Regulate service delivery/expansion at primary levels
- Mobilise and provide the pre-requisite resources



6.1.2 Community Participation

Preamble

Communities (individual and families) are recipients of health services. Thus, their involvement and participation in planning and implementation of health serviced delivery is crucial for health care services uptake and sustainability.

Objective

- To build the capacity of communities to enhance their participation and involvement in health service delivery.

Policy Measures

- Promote community involvement and participation on health and health related issues.
- Build community capacity to make Informed decision on matters relating to their health

6.1.3 Bamako Initiative (BI)

Preamble

The concept of Bamako Initiative as a strategy was adopted in 1993. It aims at strengthening Primary Health Care (PHC) by providing a framework for co-financing and co-management of health services by government, donors and beneficiaries communities. It serves as a basis for provision of essential health care services especially at village level.

Objective

- To improve Bamako Initiative for effective implementation of Primary Health Care (PHC) by 2020.

Policy Measures

- Strengthen service organization and management at community and district level health centres to maximize effective coverage with Minimum Care Packages
- Minimize recurrent costs and balance cost-sharing with the community in order to ensure efficiency, sustainability and equity.
- Strengthen community empowerment for sustainability

6.2 SECONDARY HEALTH CARE SERVICE

6.2.1 Major Health Centres

The Major Health centre at the intermediate level has been designed to provide referral services for obstetric emergencies, essential surgical and medical care. A fully functional MHC is one of the strategies for the reduction of the high MMR and



IMR. Providing quality services at this level develops confidence in the PHC system whilst ensuring that such services are brought closer to the community. In spite of the critical role that Major Health Centres have to play, their full impact is yet to be felt, because of several constraints All Major Health Centres are still to be provided with the full complement of equipment and supporting facilities such as blood transfusion services, etc. Human resources to carry out all the envisioned functions are in short supply whilst shortage of accommodation has prevented the few available staff from taking up residence. A fully functional Major Health Centre is vital in providing not only referral services but also the necessary environment for training all health workers in the Regions and fostering an atmosphere for operational research.

Objectives

- To ensure access to basic health care for all Gambians
- To improve access to tertiary health care services for the Gambian population
- To ensure the full operationality of all six (6) Major and thirty eight (38) Minor Health Centres by 2020.

Policy Measures

- Strengthen all Major and Minor Health Centres
- Increasing staffing capacity and equipment of the existing public health centres to meet the national standards.
- Support to health care reforms and infrastructural development and expansion of health care facilities
- Advocate and encourage establishment of Maternal and Child Health clinics operated by Registered Nurse-Midwives Ensure that all major and minor health centres are provided with all required standard equipment, logistics and support facilities to make them fully functional
- Development of an up-to-date standard list of equipment for Major and Minor Health Centres
- Encourage NGO provision of basic health care for the rural communities.
- Assessment and certification of all private and NGO health centres and clinics
- Provision of minimum staffing levels as well as adequately furnished accommodation for such staff
- Provision of vehicles to ensure that trekking and evacuation functions are executed simultaneously

6.2.2 Minor Health centres

The physical infrastructure of the majority of Minor Health Centres is in a state of disrepair and dilapidation due inadequate maintenance. The majority lack the required equipment because of wear and tear and non replacement, a situation that is not conducive to good work and, staff morale or efficiency. The absence of an inventory system has made it difficult to establish accountability. Attention will be given to the provision of logistics such as stand by generating sets, water tanks, telecommunication sets including ICTs facilities.



Objective

- To ensure access to basic health care for all Gambians
- To improve access to tertiary health care services for the Gambian population
- To refurbish and equip the existing thirty-eight (38) Minor Health Centres

Policy Measures

- Increasing staffing capacity and equipment of the existing public health centres to meet the national standards.
- Support to health care reforms and infrastructural development and expansion of health care facilities
- Advocate and encourage establishment of Maternal and Child Health clinics operated by Registered Nurse-Midwives Carry out a physical assessment of all Minor Health Centres in order to establish the state of disrepair
- Establish an electronic database for physical infrastructure
- Put in place an Inventory System for all the equipment and rules to determine their retention and disposal
- Encourage NGO provision of basic health care for the rural communities.
- Assessment and certification of all private and NGO health centres and clinics.

6.3 TERTIARY HEALTH CARE SERVICE

The seven (7) Public Hospitals (1 Teaching, 5 General and 1 Regional Eye Care) will serve as the referral points for all cases referred from primary and secondary levels. Emergency cases referred and transported from secondary level will enjoy free treatment. Those otherwise referred will be exempted from consultations.

Services provided will depend on available resources, priority health problems and prevailing health conditions as dictated by existing Health Policy. Hospitals will also serve as the National Centre for training, biomedical and clinical research. Apart from established research centres and medical training institutions, they will be preserved to lead the Ministry's science, technology and innovation policy initiatives. The role and relationships of the RVTH as a teaching hospital vis-a-vis academic institutions such as the University of the Gambia (UTG) under the Ministry of Higher Education, Research, Science and Technology (MOHERST) will be clarified.

Objective

- To ensure strengthening tertiary health care services

Policy Measures

- Strengthen the service delivery capacity of Hospitals to provide the needed specialist care
- Classification and accreditation of all existing hospitals (Public & Private)
- Develop Tertiary Care packages for all the categories of hospitals
- Develop equipment, infrastructure standards and staffing norms for hospitals
- Refurbish, equip and ensure full functionality of the hospitals



- Develop a strategic plan to map out future developments to ensure sustainability.
- Revive the Inventory System and ensure the upkeep of all assets (equipment and infrastructure) for improved service delivery.

The hospitals will continue to enjoy semi autonomous status within the MOH with control over administrative and financial management according to set government financial and administrative rules and regulations. Key professional staff will be provided on a secondment basis according to set terms and conditions from a MOH pool.

The percentage coverage presented in **Appendix E** estimates the number and distribution of all type health facilities in the country while **Appendix F** shows the distribution of hospitals in the Regions.

Basic/minimum care package for each level of care delivery is important to enhancing standards and also serve as an effective mechanism for control in health service delivery as set out in **Appendix G**. To that end basic health care package for each care level and programme shall be established and promoted at all times.

6.4: Organisation and Management

Preamble

The existing health management structures need to be strengthened to be more responsive to the health service delivery. There is a need for improvement towards reliable and quality health care delivery which may require health sector reform. Linkages and functions of all structures will be strengthened for better health services delivery and management.

Objective

- To improve the effectiveness and efficiency of Health Services Management System by 2020.

Policy Measures

- Decentralise the provision of health services through the regional directorates
- Strengthen organisation and management of the health care delivery system.

6.5: Human Resource Management

Preamble

In recognition of the growing demand for health care services which led to an increase in the number of health facilities, the need for more skilled staff becomes apparent. This is exacerbated by inadequate output from the health training institutions and the high attrition rate. Inequitable distribution of available health care professionals is a major concern. The pay and incentive packages for health care professionals needs to be revised to attract and retain health staff.



Objective

- To establish a vibrant and critical mass of human resources for health by 2020

Policy Measures

- Strengthen staffing, code of conduct and standards
- Accelerate and support HRH training
- Strengthen and support equitable HRH distribution, motivation and retention
- Draw and attract funding for HR development.
- Strengthen the human resource unit
- Advocate for Incentive schemes for trained professionals

6.6: Infrastructure and Logistics

Preamble

Availability of appropriate infrastructure and medical equipment is a major cross-cutting intervention in strengthening the implementation of health programmes. Inadequate and inequitable distribution of health infrastructure and equipment across the country has continued to present major challenges to the health sector.

Over the past 5 years, significant efforts and resources have been invested in strengthening health infrastructure, equipment and transport. Currently, the infrastructure and logistical arrangements and maintenance policy need to be reviewed for equity and prompt access to health care services. The main objective is to significantly improve the availability, distribution and state of essential infrastructure and medical equipment, so as to improve equity of access and quality of health services. A Capital Investment Plan (CIP) covering the period 2012-2015 will be developed, in conjunction with the Districts and Regional Health Teams. The CIP has been prioritized and will be the main tool for planning on capital investment. Significant efforts will also be directed towards renovation of the existing health infrastructure and, the renovation and expansion of health training institutions. These efforts are also being supplemented with the private sector initiatives, which have led to the renovation and construction of several public health infrastructures. :

Objective

- To improve the infrastructure and logistic requirements of the public health system for quality health care by 2020.

Policy Measures

- Strengthen the maintenance team at all levels
- Strengthen the available infrastructure and logistics for public health facilities.
- Develop and maintain infrastructural standards for all categories of health facilities

6.7: Health Management Information System (HMIS) and Research

Preamble



Reliable and readily available health information is crucial for evidence based planning, monitoring and decision making for health service management.

Currently HMIS needs to be reviewed to address the limited capacity and resource requirement for research and effective management of national health information. The growth of any national health service must be responsive to research innovations of all types. Whilst there is an abundance of research on the biomedical services there is a paucity of research on health systems, and local capacity for such research is limited. The establishment of a national body (functional autonomous National Health Research Council) to coordinate and set priorities of all research within the health sector is crucial.

Health managers and policy makers need evidence-based information to promote rational decision-making in programmatic and policy matters. Such information has to come from sources that include health research findings. Research has led to tangible improvements. It has a key role to play in the ongoing health development process. The first priority is to set up a database of all research conducted in the country and a review of their findings. One of the reasons for this is the fact that the Directorate of Planning and Information (DPI) presently lacks material resources that will enable an effective and efficient running of the Health Systems Research and Documentation Unit.

Objective

- To improve timely collection of health data and availability of reliable health information by 2020.

Policy Measures

- Advocate, support and promote interest in research.
- Establish monitoring and evaluation plan
- Strengthen the existing health information system for effective utilization
- Strengthen capacity towards health system research and documentation.
- Promote and strengthen birth and death registration.

7.0: HEALTH FINANCING

Preamble

In 1988 a Cost Recovery Program was started as part of the national health development program. This established the Drug Revolving Fund and the introduction of user fees as a form of health financing. The Bamako Initiative (BI) was introduced in 1993 as a further development on the Cost Recovery Program. Although some successes were registered with both types of financing strategy, universal access and coverage still remains a major challenge.

Healthcare service financing is a challenge the world over but more pronounced in developing countries where government budgetary allocation to the health sector is less than optimal and health insurance schemes have limited coverage or non-existent. There is need for health financing policy for the country. Government allocations to the health sector as a percentage of the total national budget continue



to improve, ranging from 7% to 10% in the past five years¹. This is still below the Abuja Declaration of 15% budgetary allocation to the health sector. Health care is provided almost free, especially for maternal and child health services since the introduction of the policy in 2007 by of President of the Republic.

In 2007, the first National Health Accounts (NHA) for The Gambia was constructed covering the fiscal years 2002 – 2004. The results revealed marginal increase in total health expenditure (THE). As a percentage of GDP, the THE was 16.1% in 2002, 13.9% in 2003 and 14.9% in 2004. Per capita health expenditure was D895 in 2002, D1026 in 2003 and D1203 in 2004. This ranges between US\$33 and US\$40, almost matching the WHO Commission for Macroeconomics and Health (CMH) recommendation of US\$ 34 per capita expenditure for a package of essential health services. It is instructive that the bulk of these funding came from donors as over 66% of the total health funding came from international health development partners.

While Government's contribution to THE grew from 18% in 2002 to 24% in 2004, evidence indicates a decline in household's direct out-of-pocket payments (OOP) contribution to total health expenditure, contributing 12% in 2002, 11% in 2003 and 9% in 2004. Total Out-of-pocket expenditure on health as percentage (%) of private expenditure on health is estimated to be consistently high at 70%² for 2004, 2005 and 2006 signalling the heavy burden of funding health on households.

Health financing system in The Gambia is organized through government tax revenue, allocated by the Ministry of Finance and Economic Affairs to various financing agents, e.g. Ministry of Health, Education, Defence, Interior and Foreign Affairs. The contribution from direct out-of-pocket payments (OOPs) for health goods and services do not go through any resource pooling and risk-sharing mechanism. Some private sector operators (Banks and NGOs) do provide medical cover for their employees, either through self-operated health clinics (e.g. Gambia Ports Authority (GPA) Clinic) or by paying premiums into private health insurance schemes. However there is no social health insurance in the Gambia. Other innovations include the Private Sector adopting hospital wards in health facilities for funding.

Currently the funding from international donors (e.g. bilateral and multi-lateral agencies, Global Fund for AIDS, Tuberculosis and Malaria, GAVI) is channelled directly to the intervention programmes through the Ministry of Health. To a lesser extent the Local Government Authorities also contribute to health financing in the area of environmental sanitation and the employment of auxiliary health workers. Therefore, there is a need to establish a strong coordination mechanism in order to ensure accountability and transparency for the use of funds obtained from both Government and donor sources.

This policy is in favour of the transition to universal coverage so as to contribute to meeting the needs of the population for health care and improving its quality, reducing poverty, attaining the Millennium Development Goals (MDGs) and Paris Declaration on Aid Effectiveness.

¹ Budget estimates for the period 2002 - 2007

² World Health Report 2007



Objectives

- To establish an effective public health sector financing mechanism by 2020;
- To ensure provision of universal health coverage in order to meet the health needs of the entire population.

Policy Measures

- Advocate and mobilise financial resources for health
- Strengthen the management of available financial resources in the health sector
- Explore other financing mechanisms to support the introduction of a national health insurance scheme
- Introduction of SWAp in the Ministry of Health

8.0: LEGAL FRAMEWORK

Preamble

There are many health or health-related Laws and Acts that seek to regulate and/or influence outcomes. Some of these Acts or laws are outdated and do not reflect current realities in health care delivery. Therefore, it is necessary to review and update these laws/Acts for positive health outcomes. There is also a need to enact new laws given the emergence of new developments and challenges requiring control affecting health systems management including service delivery.

Objective

- To ensure all health and health related Acts reflect the current realities in the health domain.

Policy Measure

- To develop, review and update health and health related laws and acts to make them more responsive to current healthcare needs.

9.0: PARTNERSHIPS

Preamble

Sector-wide approaches (SWAp) will be used to build on the national development strategy; i.e. the PAGE. Therefore, actions in the health sector will have more of a sustainable impact if they are integrated into the national development programmes. Inter-sectoral consultation and collaboration is essential in the implementation of major health strategies. The creation of an institutional framework is necessary in order to allow inter-sectoral collaboration at the various levels of the health system.

National, regional and international cooperation are in line with the activities outlined in the health sector strategic plan by the Ministry of Health for the implementation of



the Health Sector Policy. Multilateral, bilateral and non-governmental cooperation is founded on the basis of mutual agreement between the Government and the donor country or organisation.

Mechanisms for the joint management and evaluation of resources to support the functioning of health services are to be strengthened. The mechanisms for national and international coordination, as initiated by the Ministry of Health and certain partners, are to be put in place under the umbrella of a sector-wide approach.

Effective partnership and participation can contribute significantly to financing health. However, priorities of actors may differ from that of the national health agenda. This promotes vertical health programmes, inefficient utilisation of health services which also has negative impact on the sustainability and overall performance of the health system. For these reasons better coordination mechanism of all actors and partners in health and healthcare delivery is required for sustainability and better outcomes.

Objective

- To introduce a clear and effective coordination mechanism for all stakeholders in health and healthcare delivery

Policy Measures

- Encourage stakeholders' participation in health.
- Strengthen Inter-sectoral collaboration.
- Introduce and promote sector-wide approach in health.
- Strengthen the implementation of the MOU between Ministry of Health and the partners involved in health care delivery.

10.0. TECHNICAL SUPPORT SERVICES

10.1: Pharmaceutical Services.

Preamble

Reliable availability of essential medicines (drugs, basic equipment, vaccines, contraceptives and other medical supplies) are critical to provide quality health care service and towards the attainment of positive health outcomes. However, uninterrupted availability of supplies requires that the needed financial resources are allocated. The Gambia still provide free health care services.

Government budgetary allocation for health products has not increased significantly lately. There has been a major increase in demand due to population increase and coupled with the rapid expansion of health facilities. These factors contribute to the periodic shortages of medicines and other medical supplies. The bureaucratic process involves in the procurement of pharmaceuticals and other medical supply requires improvement. However the Global Fund is providing some amounts of funds for pharmaceutical and health products to complement government's effort in the fight against HIV/AIDS, Malaria and tuberculosis.



Government funding is supported by Global Alliance for Vaccine and Immunisation (GAVI) for the introduction of new vaccines, and UNICEF continues to support the vaccine procurement process. However, there is an urgent need for government to increase investment in the new vaccines on a sustainable basis.

Availability of contraceptives is essential for promoting reproductive and child health outcomes and has always been a challenge as support provided by donors is limited thus, creating intermittent shortages.

Lately the Logistic Management information System (LMIS) is being set up for strengthening the supply management chain. The system will be used for capturing, collecting and provision of data on medicines and other medical supplies consumption from health facilities which will be analysed and results used for informed decision making.

Objective

- To ensure available and affordable essential medicines that are safe, efficacious and of the required quality
- To ensure availability of consumption data on medicines and other medical supplies

Policy Measures

- Transform the supply management system for essential medicines for the public sector into a semi autonomous institution
- Advocate for increased government funding for pharmaceuticals
- Improve the drug supply system and promote the rational use of medicines and supplies.
- Strengthen the National Medicines Regulatory Authority and enact the necessary laws toward attaining quality products
- Encourage greater private sector involvement in the provision of essential medicines especially for the rural community
- Establish quality control testing of pharmaceuticals.
- Strengthen and maintain the Logistics Management Information System (LMIS).

10.2: National Blood Transfusion Services

Preamble

Availability of safe blood for transfusion is an essential element in the delivery of health services particularly those related to maternal and child health services. Unreliable supply of blood interrupts general clinical care for example surgical operations and road traffic accidents. There is need for an uninterrupted supply of safe blood.

Blood transfusion services in The Gambia were limited to RVTH and Bansang hospital for several years. Over the years transfusion services have been expanded to other tertiary hospitals (the Sulayman Junkung General Hospital in Bwiam, The Armed Forces Provisional Ruling Council Hospital in Farafenni) and some major



health centres. Although efforts have been made in the past through public campaign but expansion of services coupled with limited number of voluntary blood donor has created a gap between the need and availability of safe blood in health facilities in the country. This has implications on receiving prompt and timely care.

A blood bank has also been established at the RVTH, which supplies blood to the other hospitals. However, the demand is always greater than the supply. Furthermore, during emergencies, transportation of blood to the other peripheral centres experience delays in delivering the right quantity at the right time. In order to make safe blood available to the population in times of need, blood banks should be established in all major health centres and hospitals in the country and more bleeding centres in the communities

Objective

- The provision of adequate and safe blood for appropriate treatment of patients at all times.

Policy Measures

- Strengthen the national blood transfusion programme for improved service delivery.
- Strengthen and advocate for voluntary and non-remunerated blood donation.
- Promote research in blood transfusion services.

10.3: Laboratory Services

Preamble

For accurate diagnosis and appropriate patient management, effective and functional laboratory services are required. However, The Gambia is still dependant on laboratories outside the country for some specialized investigations. Therefore, laboratory service in The Gambia should be strengthened and expanded. The Private sector and NGO though few compliments the public sector. However, their services are not affordable to a vast majority of Gambians.

Objectives

- To institute timely, accessible, availability, affordability and reliable results for accurate diagnosis

Policy Measures

- Strengthen capacity of the laboratory programme for improved service delivery.
- Expansion of laboratory services to meet service demands of the population
- Expansion of the laboratory surveillance programme
- Strengthen quality control and quality assurance for laboratory services.
- Promote research in laboratory service



10.4: Radiology Services

Preamble

Radiology like laboratory services is key to accurate diagnosis and proper patient management. However, radiology services though has expanded over the years is still limited to few public health facilities (RVTH, Bansang, AFPRC and Sulayman Junkung hospitals) and certain private and NGO health facilities. In addition to the limited services, access and affordability, provision of X-ray equipment and maintenance are still challenges to a majority of Gambians. Therefore, the need for improvement and expansion is critical.

Objectives

- To ensure uninterrupted supply of x-ray consumables and equipment
- To ensure affordable and accessible service delivery for prompt and accurate diagnosis

Policy Measures

- Strengthen capacity of the radiology programme for improved service delivery.
- Expansion of radiology services to meet service demands of the population.
- Strengthen quality control and quality assurance for radiology services.
- Promote research in radiology services.

10.5: Referral System

Preamble

Effective and efficient referral services from one level of health care to another (community, secondary to tertiary and community) are important in patient management and disease outcome. However, the current referral system still has major challenges. Some of the challenges include inadequate number of ambulances, intermittent shortage of fuel, inadequate capacity to manage cases effectively, inadequate feedback mechanism, inadequate referral protocol and guidelines and late referrals especially at community level. This situation is further compounded by limited (only receiving) telecommunication services within health facilities. A referral system that enhances speedy and safe evacuation of patients is necessary.

Objective

- To ensure an reliable, effective, efficient and sustainable referral system is in place.

Policy Measures

- Develop and/or update the referral protocols, guidelines and standards
- Strengthen capacity of referral service provision at all levels for effective and efficient service delivery
- Conduct effective operational research on the current referral system



11.0: TRADITIONAL MEDICINE

Preamble

Traditional health care constitute an important component of the national health delivery system as it serves as the first point of contact for a significant proportion of Gambian population. . The traditional health care system is a community based self-sustaining health care service and therefore can complement the public health service. Traditional medicine practitioners are scattered throughout the country. Apart from indigenous practitioners, today the system has been invaded by all types of practitioners from the sub-region. Not much information is available on the background of some of the practitioners especially those of foreign origin. Traditional medicines require more research for improved health benefits.

The market is flooded with all sorts of herbal and even enhanced herbal products and their safety cannot be ascertained or supported. Traditional Healers Groups and Association exist in many regions in the country, but a body to regulate the practice of traditional medicine as well as a complete enactment for the protection of the population do not exist. In addition, a system does not exist for registration and licensing of traditional medicine practitioners in The Gambia.

Objective

- To strengthen Tradition health care/medicine as a complement to the public health system.
- To promote partnership with traditional practitioners with a view to improve health service delivery.

Policy Measures

- Implementing the Traditional Health Policy and its Strategies
- Establish and maintain a regulatory mechanism for the control of traditional medicine
- Facilitate collaboration with traditional medicine agencies of other countries for exchange of useful information and experiences.
- Promote and support operational research on Traditional Medicine.
- Strengthen the traditional medicine unit.

12.0: HEALTH CARE TOURISM

Health Care Tourism (HCT) can be very expensive for individuals and families and even to nations. Though Gambia's health care system has and continue to expand, still some conditions cannot be managed in country. Like many parts of the world the country continues to attract tourists, especially from the western hemisphere who often seek health care from the national health system.

Health care tourism or Medical Tourism refers to the rapidly-growing practice of travelling across international borders to obtain health care. It also refers to the practice of healthcare providers travelling internationally to deliver healthcare.

In order to attract Health/Medical Tourists, it is important to strengthen health services delivery at all levels. The long term vision is to ensure that health facilities



in the country can offer quality and affordable health care on a sustainable basis to individuals within the sub region and beyond.

Objective

- To establish an effective, efficient and transparent health care tourism mechanism and support system that is equitably applied.

Policy Measures

- Develop national guidelines, standards and protocols for Health Care Tourism (HCT)
- Develop and introduce public support criteria for HCT

13.0: IMPLEMENTATION, MONITORING AND EVALUATION

Preamble:

An implementation and monitoring strategy is required for tracking performance of this health policy framework. It is through this approach that improvement in the overall health system performance can be measured. It is important that the Ministry further strengthen supervision, monitoring and evaluation activities at all levels on regular basis. The Directorate of Planning and Information will be responsible, for the formulation and evaluation of the implementation/monitoring strategies. For effective implementation of the M&E strategy, an M&E Unit will be created under the Directorate of Planning and Information. The definition of functions of various levels of the health system including hospitals in the implementation and monitoring of the policy has been in **Appendix H**.

Objective

- To establish an effective and efficient supervision and monitoring mechanism within the sector.

Policy Measures

- Develop and implement a national M & E framework
- Develop a comprehensive supervision, monitoring and evaluation plan for all levels within the health system including the Private Sector.
- Establish and support national supervision and monitoring teams such as the RHDs and Inspectorate teams
- Perform continuous monitoring on the implementation of all programs and projects including those supported by donors.
- Utilise the existing DHIS2 and other software products available to monitor and evaluate the effectiveness and efficiency of health services delivery.

14.0: QUALITY ASSURANCE FRAMEWORK

Preamble:

The existence of professional health associations helps the Ministry of Health to better organise the medical, dental, pharmaceutical, nursing and paramedical



professions. The strengthening of their structures will allow them to better understand their role, most notably in: the recognition of qualifications, the registration of health practitioners, the management of problems relating to professional ethics, and the elaboration and revision of professional classifications according to qualification and specialisation as set out in **Appendix I**. Equally, they must support the Ministry of Health in the accreditation of services and the certification of professionals.

In order to fulfil the above functions, an effective quality assurance system which has the potential to improve quality health care services according to set standards, reduce risks and produce positive impact on morbidity, mortality, differentially-abled and malnourished children will be put in place. A comprehensive quality assurance mechanism within the health sector will be developed and introduced using these existing structures.

14.1: Public Health Council

In view of the function of public health cadre which include environmental health activities, food safety and quality, occupational health, immunization and health promotion, just to mention a few; the need to regulate public health practice in the Gambia is very crucial. Therefore the establishment of a Public Health Council to regulate public health functions is paramount. The organisational relationship of this body with the wider set of other institutions is illustrated in the organogram of the Ministry of Health and Social Welfare represented by **Appendix J**.

The Public Health Council shall be established by an Act of Parliament and its function shall include, among other things:

- Registration of public health officers.
- Provide guideline for the training of PHOs.
- Set standards for public health practice.

14.2: Clinical Audit Unit

Establish Clinical Audit Units in all health facilities so as to strengthen routine assessment of adherence to set standards and norms. This is the mandate of the Medical and Dental Council in collaboration with the Ministry of Health and Social Welfare.

14.3: Board of Health

A Board of Health to be established to comprise of representatives of the various Councils, policy makers within and out of the Health Sector, health professionals within and outside the Public Health System.

The functions of the Board shall include, among other things:

- Review and approve national health service standards
- Monitor quality of health services nationally
- Accredite all public, private and NGOs health facilities for service delivery



15: CONCLUSION

This Policy was developed through consultations with and inputs from all stakeholders including Sector Ministries, Local Government Authorities, Faith-based Organisations, NGOs, Opinion leaders, Catchment Area Committees, Multi-Disciplinary Facilitation Teams (MDFT's), and other partners in the provision of health care across the country. The Ministry and partners, notably from WHO and UNICEF, have demonstrated sustained interest and commitment to the policy process.

The need to address the general health system challenges including the effects of high population growth rate; inadequate financial and logistic support; weak health information system; uncoordinated donor support; shortage of adequately and appropriately trained health staff; high attrition rate and lack of efficient and effective referral system has been highlighted. Therefore, renewed commitment is required from staff of Ministry, as well as Government and NGO and all citizens to achieve our desired goal of a "healthy and wealthy nation".

There is clear evidence that from 1994 to date there has been massive expansion in terms of health infrastructural development and health care needs. The commitment of the Government to implement this policy is demonstrated by the current structures established at both central and regional levels, the strengthening of health training institutions and capacity building through the training of staff both at local and international levels. The country's vision statement also gave a very clear direction as to where the Gambia would want to be by 2020.

**APPENDIX A****THE POPULATION OF THE GAMBIA BY REGIONAL BREAKDOWN**

Regions	GR	2003	2007	2011	2015	2020
Banjul	- 1.87	35,061	32,604	30,319	20,194	25,747
Kanifing	3.5	322,735	364,568	410, 669	458, 857	519, 139
Brikama	5.2	389, 594	477,172	584,438	715,816	922,316
Mansakonko	1.0	72,167	75,097	78,147	81,320	85,468
Kerewan	1.0	172,835	179,853	187,156	194,755	204,689
Kuntaur	1.5	78,491	83,307	88,420	93,845	101,098
Georgetown	2.0	107,212	116,050	125,616	135,971	150,123
Basse	1.6	182, 586	194,555	207,309	220,898	239,145
Gambia	2.74	1,360,860	1,516,053	1,689,167	1,882,048	2,154,411

Source: 2003 Population Census

APPENDIX B**TOTAL FERTILITY RATE BY REGION**

Regions	1993	2003
Banjul	4.7	3.9
Kanifing	4.7	4.0
Brikama	5.9	5.0
Mansakonko	7.0	6.1
Kerewan	7.3	5.8
Kuntaur	NA	6.2
Georgetown	6.5	6.0
Basse	6.6	6.2
Gambia	6.0	5.4

Source: 1993 & 2003 Population Census

**APPENDIX C****ROUTINE IMMUNISATION DATA BY YEAR/PERCENTAGE FROM 2001-2010**

Antigens	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
BCG	50.6	88.0	81.85	83.4	83.4	90	95	94.49	94	92
Hep 3	55.3	83.0	73.71	89.5	89.5	93	92	98.55		
OPV3	44.8	70.0	85.71	91.4	91.4	92	94	96.77	97	97
DPT/Hib3	56.6	80.0	78.86	89.2	89.2	91	94	96.14	98	97
TT2	82.0	70.0	46.54	70.0	71.48		84	79.76	79	75
Measles	51.8	83.0	67.47	82.0	81.47	90	85	90.74	96	92
Yellow Fever	32.3	85.0	67.97	82.0	87	89	85	94.01	96	92

Source: EPI, MOH

APPENDIX D**Percentage of population below poverty lines 1989, 1992, 1998 and 2003**

	Food poverty			Overall poverty		
	Banjul	Urban	Rural	Banjul	urban	rural
1989		33	44		64	76
1992	5	9	23	17	40	41
1998*	7	22	45	21	48	61
2003	N/A	N/A	N/A	10.6	57	63

Source: Reports on the 1989 and 1993-94, 1998 & 2003/04 Household Surveys.

*Estimated for comparative purposes using a CPI based inflation of the 1992 poverty lines

APPENDIX E**Table 1: showing distribution of minor health facilities**

	Public	NGO	Community	Private	% coverage
URR	6	1	6	-	67
LRR	3	-	2	1	60
CRR	7	2	-	2	75
NBR	8	2	1	-	100
WR	5	5	9	3	30
KMC	2	4	2	10	18
Banjul	2	-	-	-	100

**APPENDIX F****Table 2: showing distribution of hospitals by health region**

Region	General Hospitals	NGO/Private Hospital	Teaching Hospital
URR	0	0	0
LRR	0	0	0
CRR	1	0	0
NBR	1	0	0
WR	1	0	0
KMC	2	3	0
BCC		0	1

APPENDIX G**Table 3: MINIMUM HEALTH CARE PACKAGE**

VHS	Minor H/C	Major H/C	Regional Hospital	Teaching Hospital
<ul style="list-style-type: none"> Primary care service (including treatment of minor illnesses and referrals, environmental health & sanitation, antenatal, delivery and postpartum care, home visits, community health promotion activities) 	<ul style="list-style-type: none"> Maternity care (antenatal, delivery and postpartum) Family Planning STIs/RTIs/HIV/AIDS prevention and control IMNCI Immunisation Neonatal and child health Maternal and child nutrition Basic EMOC Basic emergency newborn care (ENC) Disease prevention and control (malaria, TB, etc) Health protection and control Basic Lab services (HB, BF, VDRL, Urine analysis TB and HIV screening) in-patient service Referral services Dispensary Eye care services Out-patient services Registration of births and Deaths 	<ul style="list-style-type: none"> All services provided at minor H/C level Comprehensive emergency obstetric care (including theatre and blood transfusion services) Functional theatre Comprehensive emergency newborn care In-patient services Pharmacy Services Basic Lab. services including HIV and TB Screening. 	<ul style="list-style-type: none"> All services provided at major H/C level Specialist care and service Higher level referral services Specialised dental and eye care services Comprehensive laboratory services Radiology services 	<ul style="list-style-type: none"> All services provided at regional hospital level Specialist hospital services (in- and out-patient services) Post-mortem and embalment services Overseas referral

**APPENDIX H****Table 4: Functions of various levels of the health system including hospitals in the implementation and monitoring of the policy**

Central Level	Regional Level	(Hospitals)
<ul style="list-style-type: none"> • Policy formulation, setting standards, and quality assurance. • Resource mobilisation and allocation • Capacity development and technical support. • Provision of nationally co-ordinated services, e.g. Epidemic control • Co-ordination of health research. • Legislation • Monitoring and Evaluation of the overall health sector performance (M&E Template) • Advocacy/Partnership with stakeholders 	<ul style="list-style-type: none"> • Implementation of the Health Master Plan • Planning and management of regional health services • Provision of disease prevention, health promotion, curative and rehabilitative services, with emphasis on the Basic Care Package. • Control of Communicable Diseases of public health importance in the regions • Vector Control. • Encourage provision of safe water and environmental sanitation • Health data collection, management, interpretation, dissemination and utilisation • Health System Research • Community partnership and advocacy • Resource mobilisation and allocation • Supervision of health care services 	<ul style="list-style-type: none"> • Planning and Management of Hospital Health Services • Provision of Hospital Health Packages • Training of professional staff • Referral for specialist care • Hospital data collection, management, interpretation, dissemination and utilisation. • Clinical research • Supervision of tertiary health care

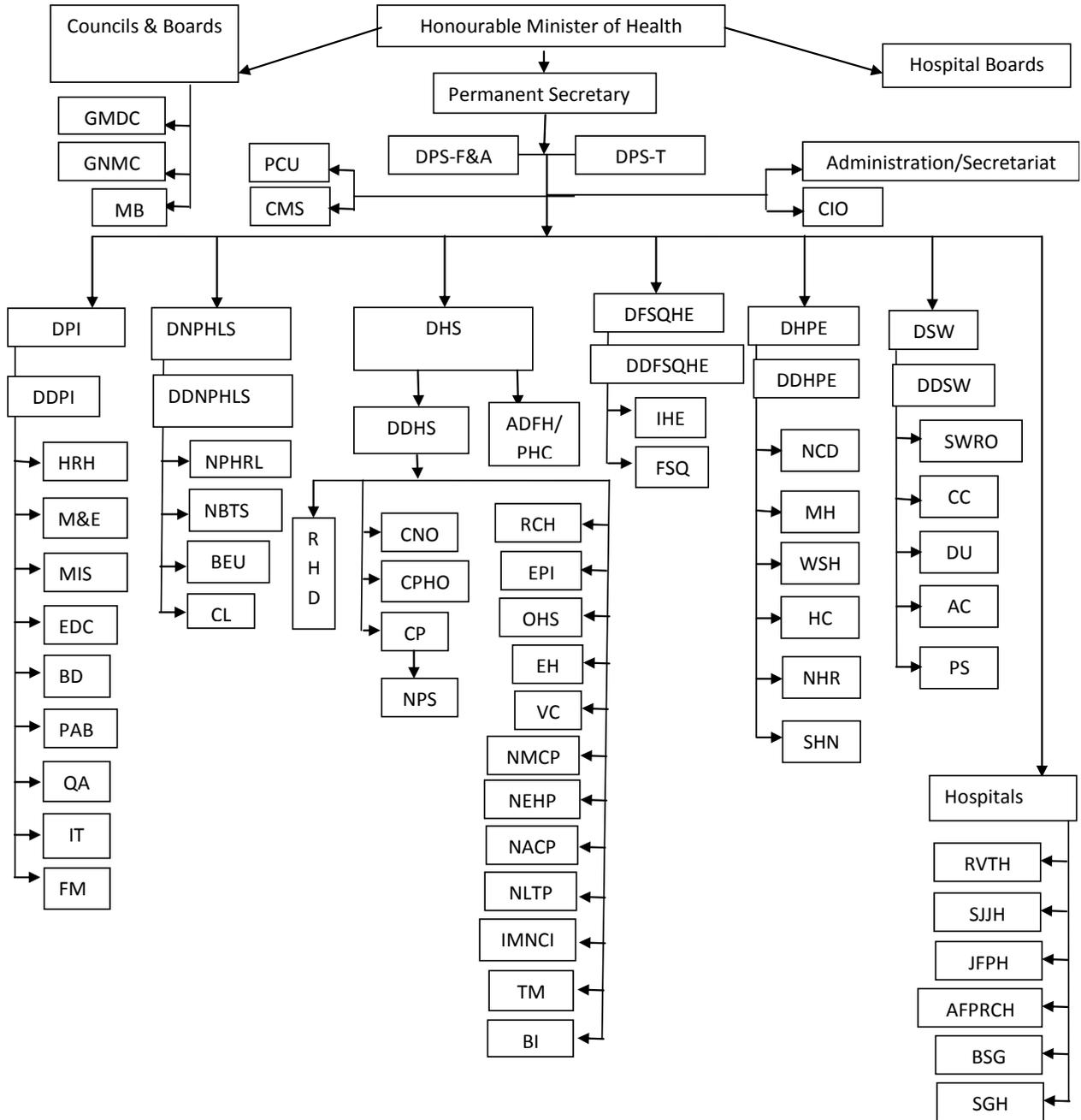
APPENDIX I**Table 5: showing the role of councils in quality assurance of health care services**

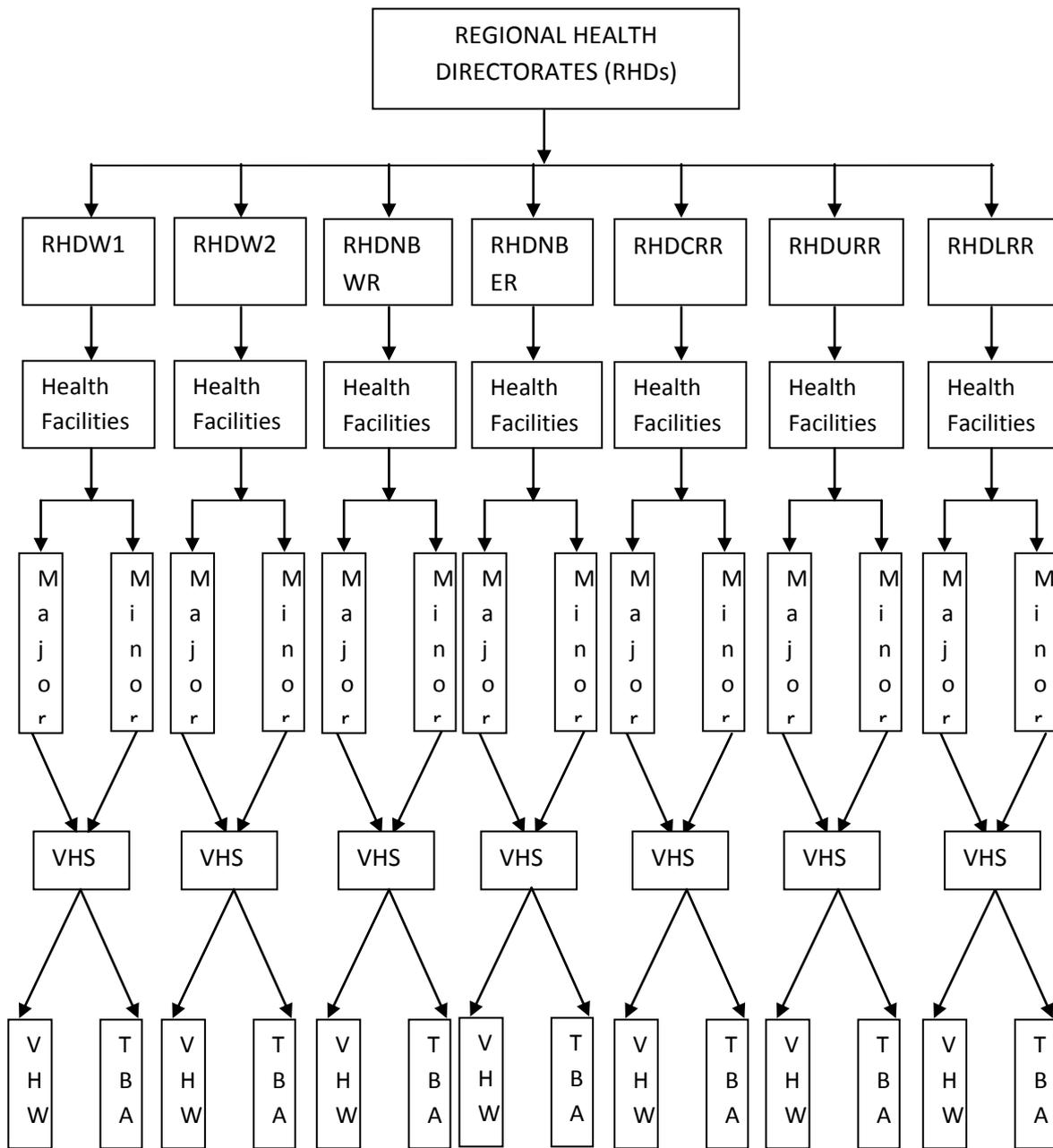
Medical and Dental Council	Nurses and Midwives Council	Pharmacy Council	Public Health Council
<ul style="list-style-type: none"> • Registration of medical and dental officers • Regulation of Medical and dental practices and ethics • Provide guidelines for training of Medical Officers • Establish clinical audit unit • Conduct periodic clinical audit exercise in all regions. 	<ul style="list-style-type: none"> • Registration of nurses and midwives • Regulation of Nursing and midwifery practices and ethics • Provide guidelines for training of nurses and midwives 	<ul style="list-style-type: none"> • Registration of pharmacists and other pharmaceutical cadres • Regulation of Pharmacy practices and ethics • Provide guidelines for training of pharmacists, technicians and assistants 	<p>The public health council shall be established by the act of parliament and its function shall be:</p> <ul style="list-style-type: none"> • Registration of public health officers • Regulation of Public health practices and ethics • Provide guideline for the training of PHOs. • Set standards for public health practices



APPENDIX J

Figure 1: ORGANOGRAM OF THE MoH&SW





**Organogram Abbreviation:**

DPS-F&A – Deputy Permanent Secretary – Finance & Administration
DPS-T – Deputy Permanent Secretary - Technical
DPI – Directorate of Planning and Information
DDPI – Deputy Director of Planning and Information
HRH – Human Resources for Health
M&E – Monitoring and Evaluation
MIS – Management Information System
EDC – Epidemiology and Disease Control
B&D – Births and Deaths
PAB – Policy Analysis and Budgeting
QA – Quality Assurance
FM - Facilities Maintenance
IT – Information Technology
DNP HLS – Directorate of national Public Health Laboratory Services
NPHRL – National Public Health Reference Laboratories
NBTS – National Blood Transfusion Services
BEU – Biomedical Engineering Unit
CL- Clinical Laboratories
DHS - Directorate of Health Services
DDHS – Deputy Directorate of Health Services
PHC – Assistant Director Family Health / Primary Health Care
RCH – Reproductive and Child Health
EPI – Expanded Programme of Immunisation
OHS – Occupational Health Services
EH – Environmental Health
VC – Vector Control
IMNCI – Integrated Management of Childhood Neonatal Illnesses
CNO – Chief Nursing Officer
CPHO – Chief Public Health Officer
CP – Chief Pharmacist
NPS – national Pharmaceutical Services
CMS – Central Medical Stores
NMCP – National Malaria Control Programme
NLTP – National Leprosy and Tuberculosis Control Programme
NACP – National Aids Control Programme
NEHP – National Eyecare Health Programme
TM - Traditional Medicine
BI – Bamako Initiative
DFSHQE – Directorate of Food Standards Quality Hygiene Enforcement
IHE - Inspection & Hygiene Enforcement
FSQ - Foods Standard & Quality
DHPE – Directorate of Health Promotion and Education
DDHPE – Directorate of Health Promotion and Education
NCD – Non-Communicable Diseases
MH – Mental Health
WS – Water and Sanitation Hygiene
HC – Health Communication
NHR – National Health Research
HPP – School Health and Nutrition
SWRO – Social Welfare Regional Offices
CC - Child Care
DU - Disability Unit
AC - Adult Care
PS – Professional Services
RVTH – Royal Victoria Teaching Hospital
SJJH – Sulayman Junkung Jammeh Hospital



JFPH – Jammeh Foundation for Peace Hospital
SGH – Serekunda General Hospital
AFPRC – Armed Forces Patriotic Ruling Council Hospital
BSG – Bansang Hospital
GMDC – Gambia Medical and Dental Council
GNMC – Gambia Nurses and Midwives Council
MB – Medicine’s Board
CIO – Central Inspectorate Office
RHDW1 – Regional Health Directorate Western 1
RHDW2 – Regional Health Directorate Western 2
RHDNBW – Regional Health Directorate North Bank West
RHDNBE – Regional Health Directorate North Bank East
RHDCRR – Regional Health Directorate Central River Region
RHDURR – Regional Health Directorate Upper River Region
RHDLRR – Regional Health Directorate Lower River Region
VHS – Village Health Services
VHW – Village Health Worker
TBA – Traditional Birth Attendant

